CCME

2016 External Quality Review

MAGNOLIA HEALTH PLAN

Submitted: March 22, 2017

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Magnolia Health Plan (Magnolia). This report contains a description of the process and the results of the 2016 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The goals of the review are to:

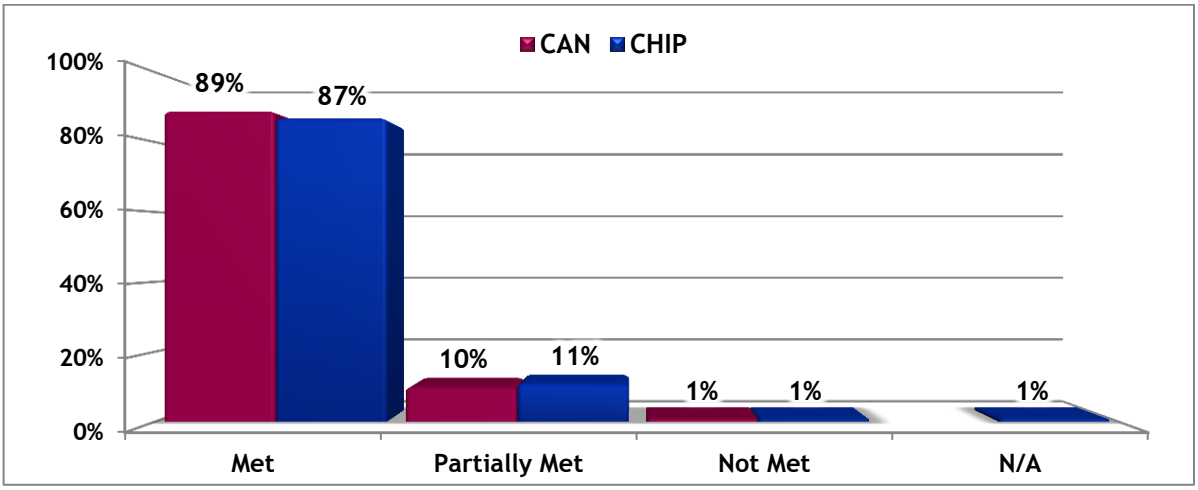
- Determine if Magnolia is in compliance with service delivery as mandated in the CCO contract with DOM.
- Provide feedback for potential areas of continued improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review includes a desk review of documents, a three-day onsite visit, compliance review, validation of performance improvement projects, performance measures, the member satisfaction survey, the provider satisfaction survey, an *Information System Capabilities Assessment (ISCA) Audit*, and a provider access study.

OVERVIEW

The 2016 annual EQR review of the CAN program shows Magnolia achieved "Met" scores for 89% of the standards reviewed. As the following chart indicates, 10% of the standards were scored as "Partially Met" and 1% of the standards scored as "Not Met." For the CHIP program, 87% of the standards received a "Met" score, 11% of the standards scored as "Partially Met," 1% of the standards scored as "Not Met," and the remaining 1% of the standards scored as "Not Applicable."

Figure 1: 2016 Annual EQR Review Results for CAN & CHIP



Overall Findings

An overview of the findings for each section follows. Details of the review, including specific strengths, weaknesses, applicable corrective action items, and recommendations can be found further in the narrative of this report.

Administration

Magnolia has adequate resources and maintains an appropriate number of qualified staff to serve the needs of members. A comprehensive set of policies was submitted for both CAN and CHIP programs. The line of business to which some policies applied was not clearly indicated. Magnolia's claims data indicates timely processing and compliance with the *CAN* and *CHIP Contracts*. Employees are required to complete annual Business and Ethics Program and compliance training. The *Compliance/Fraud, Waste and Abuse Plan* is missing some state and federal requirements. No CAN policy was found addressing the False Claims Act. Magnolia has a detailed disaster recovery plan that was tested within the past year.

Provider Services

The *Centene Corporate Credentialing Program*, adopted by Magnolia for the CAN and CHIP programs, is detailed, with specific state requirements addressed in policies via footnotes and attachments. Results of the credentialing and recredentialing file reviews showed an organized process with the majority of the files containing appropriate documentation. A "Partially Met" score was received because three credentialing files did not contain practitioner office site visits. A "Not Met" score was received for the

standard relating to site visits at initial credentialing because the *Practitioner Office Site Evaluation Tool* received during the onsite visit contained incorrect appointment availability information. This issue was identified in the previous EQR.

The Credentialing Committee is currently chaired by Dr. Becky Waterer, vice president of medical affairs. Dr. Waterer was formerly the chief medical director, but this position is currently held by Dr. Jeremy Erwin, who also serves on the committee. During the onsite visit, CCME recommended Magnolia consider having the chief medical director chair the Credentialing Committee as this is a requirement of both the *CAN* and *CHIP Contracts*. Magnolia was very receptive to implementing this change.

The *Telephonic Provider Access Study* conducted by CCME showed no improvement in the access CAN members have to their PCP. The same study was conducted for the CHIP population; however, the standard was scored as "Not Applicable" as this was the first study conducted for CHIP.

Magnolia performed a *Provider Satisfaction Survey* for CAN and CHIP, and there are concerns with the low response rate (6.4% initial sample and 36.7% later sample) which was slightly below the NCQA target response rate of 40% for surveys. The low response rate may impact the generalizability of the survey. Additionally, information on reliability and validity of the *Provider Satisfaction Su*rvey administered by SPH Analytics was not provided in the documentation.

Member Services

The Magnolia *CAN* and *CHIP Member Handbooks* are written in plain language and although they include most required elements, a few additions and corrections will be required. Preventive Health and Well-Baby and Well-Child requirements are detailed on the website, in the handbooks, and the *Provider Manuals*. Call center staff remind members during calls about adult and child screenings. CCME was provided a sample of call center recordings to review, revealing a few weaknesses that may require additional training for call center employees.

The grievance files reviewed for both CAN and CHIP reflect timely acknowledgement and resolution. Inconsistencies were noted related to grievances in documents, manuals and handbooks; for example, definitions were inaccurate, and processes for handling grievances were inconsistent and did not reflect Magnolia's CAN or CHIP policies. The *Member Satisfaction Surveys* for the adult and child membership reflected poor response rates.

Quality Improvement

Quality Improvement (QI) concerns 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. The performance measures were valid and scored within the "Fully Compliant" or "Compliant" range. There were some minor documentation errors found in the performance improvement projects. However, all projects scored within the "High Confidence" or "Confidence" range.

Utilization Management

Magnolia Health Plan's *Utilization Management Program Descriptions* for the CAN and CHIP products describe the UM Program for each product. Departmental policies and procedures provide additional detail for staff performing UM functions.

The CAN and CHIP UM Programs are evaluated at least annually; however, a copy of the *UM Program Evaluation* for CHIP was not received for this review. UM criteria and clinical policies are reviewed and approved annually. Input from local practitioners with professional knowledge or clinical expertise in the areas being reviewed is considered in the review and approval of criteria and clinical policies.

Although Magnolia policy states denials can only be issued by Mississippi-licensed physicians, Magnolia allows pharmacists to issue denial determinations without referring the review to a medical director. This is not compliant with requirements of the *CAN Contract, Section 5 (J) (1)*, or the *CHIP Contract, Section 5 (H) (1)*.

Appeals processes are defined in CAN and CHIP policies, and appeals information is included in member handbooks, provider manuals, letter templates, and the Magnolia CAN and CHIP websites. Various errors and/or omissions were noted in documentation of appeals requirements and processes for both the CAN and CHIP products. Despite these issues, CAN and CHIP appeals files were found to be handled appropriately. Several appeal resolution letters did not reference the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based, but this did not appear to be a wide-spread problem.

Magnolia's *Care Management Program Description* and policies define Care Management (CM) processes and CM files confirmed appropriate processes and functions are performed for both the CAN and CHIP populations.

Delegation

Magnolia has established policies defining the requirements for delegation including monitoring and oversight of the delegated vendor's performance. Written agreements specify the activities to be performed by the delegate and address performance standards, as well as, the penalties and sanctions for sub-standard performance.

Delegate performance is monitored via review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings, and an annual evaluation. Deficiencies are addressed with corrective action plans, as warranted. Adequate evidence of delegation oversight was provided for each delegated entity with delegation oversight activities reported to the QIC at least quarterly. The Oversight of Delegated Credentialing policy contained ambiguous information regarding oversight requirements creating confusion regarding the requirement for annual evaluation of credentialing delegates.

Table 1, Scoring Overview, provides an overview of the scores for each review section for the CAN and the CHIP programs.

Table 1: Scoring Overview

2016	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
CAN	27	1	0	0	0	28
CHIP	27	1	0	0	0	28
Provider Services						
CAN	74	7	2	0	0	83
CHIP	71	9	1	0	1	82
Member Services						
CAN	27	6	0	0	0	33
CHIP	26	6	0	0	0	32
Quality Improvement						
CAN	17	1	1	0	0	19
CHIP	18	0	1	0	0	19
Utilization						
CAN	48	5	0	0	0	53
CHIP	44	7	1	0	1	53

2016	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Delegation						
CAN	1	1	0	0	0	2
CHIP	1	1	0	0	0	2

METHODOLOGY

On November 1, 2016, CCME sent notification of the initiation of the annual EQR to Magnolia (see Attachment 1). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN and CHIP Programs.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for the purpose of offering Magnolia an opportunity to seek clarification on the review process and to ask questions regarding any of the desk materials requested by CCME.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on December 5, 2016 for review at the CCME offices (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a three-day onsite review conducted February 7-9, 2017, at Magnolia's office in Jackson, Mississippi. CCME's onsite visit focused on areas not covered by the desk review and areas needing clarification (see Attachment 2). CCME's onsite activities included:

- Entrance and exit conferences (open to all interested parties)
- Interviews with Magnolia's administration and staff

The process used for the EQR was based on the CMS protocols for EQR of MCOs. This review focused on the three federally-mandated EQR activities: compliance determination, validation of performance measures, and validation of performance improvement projects. The review also included the optional activity of member and provider satisfaction survey validations, an ISCA Audit, and a provider access study.

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are evaluated against the regulations set forth in *42 CFR § 438.358* and the contract requirements between Magnolia and DOM. Strengths, weaknesses, corrective actions, if needed, and recommendations are identified where applicable.

Areas of review were identified as meeting a standard, "Met," acceptable but needing improvement, "Partially Met," failing a standard, "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4). Separate tabular spreadsheets are included in Attachment 4 for the CAN and the CHIP Programs.

A. Administration

The reviews of the Administration sections for Magnolia MississippiCAN (CAN) and Magnolia MississippiCHIP (CHIP) lines of business focused on policies, procedures, staffing, information systems, compliance, and confidentiality. Aaron Sisk is the plan president and chief executive officer (CEO). Trip Peoples is the senior vice president of operations. Mr. Sisk is located in Mississippi and responsible for the day-to-day administration of the Magnolia CAN and CHIP health plans. The responsibilities for oversight and implementation of the Utilization Management Program and involvement in Quality Improvement are assumed by Dr. Jeremy Erwin, chief medical director. Dr. Becky Waterer, vice president of medical affairs, oversees pharmacy functions and provider education. All medical directors participate in utilization activities. The organization chart and job descriptions indicate key personnel are in place along with sufficient numbers of qualified staff to meet contract requirements.

A comprehensive set of policies that are consistent and organized are found for both the Magnolia CAN and CHIP Programs. Some corporate policies include Mississippi-specific requirements through policy attachments or addendums. During the policy review process CCME noted some policies did not indicate to which line of business the policy applied. Because Magnolia serves MSCHIP, MSCAN, and a marketplace insurance plan, policies need to clearly indicate the line of business to which they apply.

Magnolia meets or surpasses contractual requirements for claims processing for 30-day and 90-day clean claim payments. Magnolia has a detailed disaster recovery plan that was last tested in May 2016. Recovery goals were achieved.

A review of the *Fraud, Waste, and Abuse/Compliance Plan* revealed Magnolia has failed to include in the document, or the Mississippi Addendum, three federally-required elements of a compliance plan. No policy addressing the Federal False Claims Act was in place for Magnolia CAN and CHIP.

Magnolia received "Met" scores for 96% of the standards in Administration for both the CHIP and CAN lines of business. Scores of "Partially Met" are because the *Fraud, Waste, and Abuse/Compliance Plan* were missing required elements, and because Magnolia (CHIP and CAN) did not have a policy addressing the Federal False Claims Act. See *Figure 2, Administrative Findings*.

Figure 2: Administration Findings

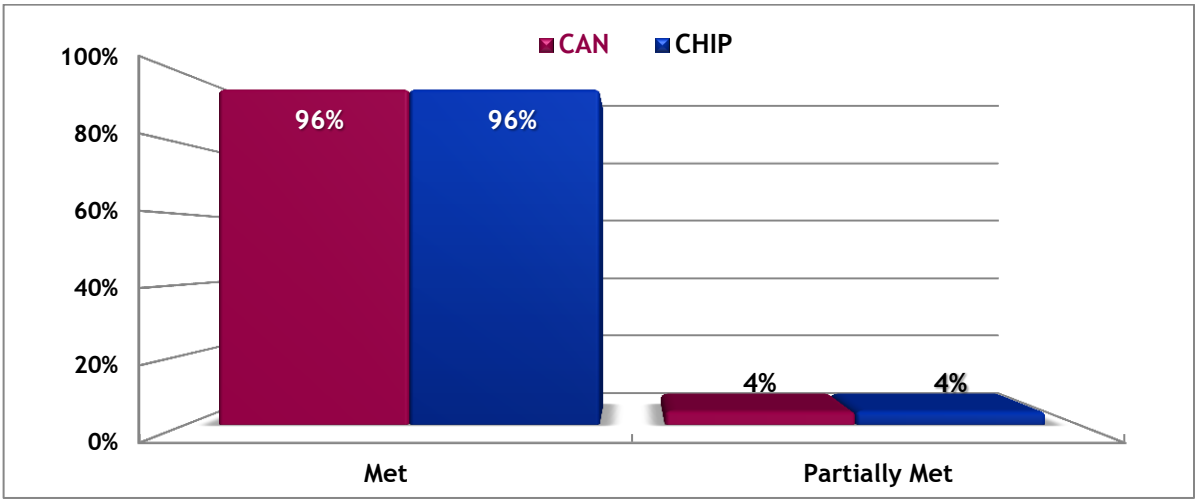


Table 2: Administration

Section	Standard	CAN 2016 Review	CHIP 2016 Review
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.	Partially Met	Partially Met

Strengths

- Magnolia's Business and Ethics Program requires all employees to complete annual compliance training.
- Two medical directors who are board-certified pediatricians are available to meet the utilization needs of the CHIP population.
- Magnolia has an extensive Disaster Recovery (DR) plan addressing resources, tasks, personnel, and recovery strategy. In May, 2016 a systems recoverability test was performed and all recovery goals were met.

Weaknesses

- Some policies did not clearly indicate the line of business to which they applied.
- The following requirements were not found in the *Fraud, Waste, and Abuse Plan*:
    - Enforcement of standards through well-publicized guidelines. Refer to *Federal Regulation § 438.608 (a) (1) (vi)* and *the CAN Contract, Section 11(B) (5)*.
    - Prompt responses to detected offenses. Refer to *Federal Regulation § 438.608 (2)* and the *CAN and CHIP Contracts, Sections 11 (B) (6)*.
    - The Contractor shall not knowingly have a relationship with an individual or entity that is debarred, suspended, or otherwise excluded from Federal participating in procurement activities under the Federal Acquisition Regulation. Refer to *Federal Regulation § 438.610 (a) (1*) and the *CAN Contract, Section 1 (B)*.
- Magnolia CAN does not have a policy defining the training and implementation of the provisions of the Federal False Claims Act.
- The compliance committee charter includes a finance officer/CFO as a member. This position is not included in the membership list attached to the charter or in the committee matrix document.

Corrective Action

- Include the missing requirements in the *Fraud, Waste, and Abuse Plan/Compliance Plan*.
- Develop a policy for the CAN line of business defining how Magnolia provides instruction on and implements the provisions of the Federal False Claims Act.

Recommendations

- Ensure all Magnolia policies for CAN and CHIP indicate the line(s) of business to which the policy applies.
- Ensure the listing of compliance committee membership is the same across all documentation.

B. Provider Services

A review of Magnolia Health Plan's policies and procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, practice guidelines, and the provider satisfaction survey was conducted for Provider Services. The *Centene Corporate Credentialing Program* has been adopted by Magnolia for the CAN and CHIP programs. Policies addressing the credentialing and recredentialing program for practitioners and organizational providers are detailed, and specific state requirements are addressed via footnotes and attachments.

The Credentialing Committee is currently chaired by Dr. Becky Waterer, vice president of medical affairs. Dr. Waterer was formally the chief medical director. This position is currently held by Dr. Jeremy Erwin, who also serves on the committee. Additional voting members of the committee include two Magnolia medical directors and six participating providers with the specialties of pediatrics, family medicine, nurse practitioner, hospital medicine, and psychiatry. The Credentialing Committee meets at least 10 times per year and a quorum is established with 50% of voting members in attendance. A review of Credentialing Committee minutes reflected good participation by the voting members. A quorum is established at the beginning of each meeting.

During the onsite visit, CCME recommended Magnolia consider having the chief medical director chair the Credentialing Committee as this is a requirement in both the *CAN* and *CHIP Contracts*. Magnolia was very receptive to implementing this change.

Credentialing and recredentialing files were reviewed for both CAN and CHIP, and results showed an organized process with the majority of the files containing appropriate documentation. One credentialing file had a signed ownership disclosure form that did not contain a date and provider office site visits were not received for three initial PCP credentialing files. Magnolia received a "Not Met" score for the standard relating to site visits at initial credentialing because the *Practitioner Office Site Evaluation Tool* received at the onsite contained incorrect appointment availability information. This was identified as an issue during the previous EQR.

Provider Access and Availability Study

As part of the annual EQR process for Magnolia, a *Telephonic Provider Access Study* focusing on primary care providers for CAN and CHIP was performed by CCME. Results of each provider access study are presented in *Table 3, Provider Access Study Results*.

Table 3: Provider Access Study Results

CAN	CHIP
As part of the annual EQR process for Magnolia CAN, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by Magnolia, from which a sample of 258 primary care providers was randomly selected for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the contracted providers.	As part of the annual EQR process for Magnolia CHIP, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by Magnolia, from which a sample of 265 primary care providers was randomly selected for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the contracted providers.
Calls were successfully answered by personnel at the correct practice for 38% (99 out of 258) of the calls, which estimates between 36% and 41% for the entire population, based on a 95% confidence interval. In comparison to last year, which had a 54% (168 out of 310 calls) success rate, this is a statistically significant decrease, Z =3.81, p < .001.	Calls were successfully answered by personnel at the correct practice for 39% of the calls (104 out of 265), which estimates between 36% and 42% for the entire population, based on a 95% confidence interval.
Of the calls that were answered successfully, 86% (85 providers out of 99) indicated they are accepting Magnolia Healthcare and 82% (70 providers out of 85) indicated they are accepting new Medicaid patients.	Of the calls that were answered successfully, 82% (85 providers out of 104) indicated they are accepting Magnolia CHIP and 77% (65 providers out of 85) indicated they are accepting new Medicaid patients.
Of the 70 providers accepting new Medicaid patients, 4 (6%) indicated an application or prescreen was necessary. When the office was asked about the next available routine appointment, 99% (69 out of 70 providers) were within contract requirements.	Of the 65 providers that are accepting new Medicaid patients, 8 (12%) indicated than an application or prescreen was necessary. When the office was asked about the next available routine appointment, 92% (60 out of 65 providers) were within contract requirements.
For the unsuccessful calls, 60% (95 out of 159) was due to being informed the physician was not at the phone number listed or was no longer in the practice.	For the unsuccessful calls, 51% (82 out of 161) was due to being informed the physician was not at the phone number listed or was no longer in the practice.

Provider Satisfaction Survey Validation

Magnolia performed a *Provider Satisfaction Survey* administered by SPH Analytics (SPHA), an experienced, NCQA-certified survey organization. As a part of this EQR, the survey was validated using the *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*.

The sections of the validation worksheet relating to the provider satisfaction survey items that were "Not Met," the reason for the finding, and recommendations for improvement are indicated in *Table 4, Provider Satisfaction Survey Validation Results*.

Table 4: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	Information on reliability of the *SPHA Provider Satisfaction Survey* was not provided.	Include information and appropriate statistical values regarding reliability of the survey.
Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	Information on validity of the *SPHA Provider Satisfaction Survey* was not provided in documentation.	Include information and appropriate statistical values regarding validity of the survey.
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	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.
Were all survey conclusions supported by the data and analysis?	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.

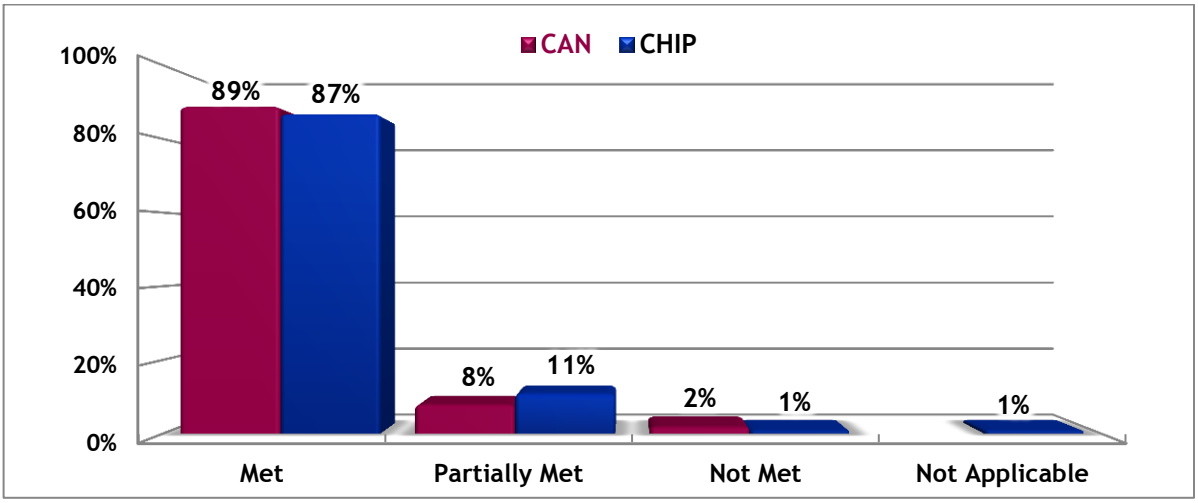
The survey results were presented and discussed in meetings with a focus on areas of improvement. In an effort to increase the response rate, the following strategies are recommended:

- Create an incentive, such as a lottery drawing for an electronic device, for those who complete the survey.
- Offer information in the newsletter regarding how previous results were evaluated and used to effect change in programs and/or services.
- Provide information in the newsletter comparing practices, specialties, or professions to motivate a higher response.

The complete worksheet is available as an attachment to this report.

As noted in *Figure 3, Provider Services Findings*, the CAN program received "Met" scores for 89% of the standards in Provider Services. For the CHIP program, the percentage of "Met" scores in Provider Services was 87%.

Figure 3: Provider Services Findings



Percentages may not total 100% due to rounding

Table 5: Provider Services

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Credentialing and Recredentialing	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Not Met	Partially Met
Adequacy of the Provider Network	Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties	Partially Met	Partially Met
	The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Partially Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	N/A

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers	Met	Partially Met
	Information regarding available translation services and how to access those services	Partially Met	Partially Met
Primary and Secondary Preventive Health Guidelines	The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO members to providers	Partially Met	Partially Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers	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	Partially Met	Partially Met
Provider Satisfaction Survey	A Provider Satisfaction Survey was performed and met all requirements of the CMS Survey Validation Protocol	Partially Met	Partially Met

N/A = Standard is Not Applicable

Strengths

- The credentialing program is well-established and all recredentialing files contained appropriate documentation.
- The provider portal on the Magnolia website contains good reference and educational information for providers regarding the CAN and CHIP programs.
- *Provider Satisfaction Survey* results are presented and addressed in QIC meetings.

Weaknesses

- At the time of the EQR, the Credentialing Committee was chaired by the vice president of medical affairs (formerly the chief medical director). The contracts for CAN and CHIP require the medical director to chair the Credentialing Committee.
- One credentialing file contained a signed ownership disclosure form without a date.
- The *Practitioner Office Site Evaluation Tool* for CAN and CHIP received at the onsite visit has incorrect appointment availability information as follows:

  - It states a 45 calendar day timeframe for a preventive health exam or routine non-symptomatic visit, when the requirement is "not to exceed 30 calendar days." This is an uncorrected issue from the previous EQR for CAN.
  - It states the timeframe for a routine, non-urgent symptomatic visit is within 10 calendar days, but the requirement is "not to exceed 7 calendar days." This is an uncorrected issue from the previous EQR for CAN.
  - It states the timeframe for urgent visits is within 48 hours, when the requirement is "not to exceed 24 hours."

- A review of the credentialing files showed PCP office site visits were not received in the initial desk materials requested. The information was requested again at the onsite and three PCP site visits were not received.
- The 2015 QI Program Evaluations for both the CAN and CHIP programs state the standard member-to-provider ratio for PCPs is 1:1,500. Policies MS QI.04 and MS.CONT.01 define the ratio as 1:2,500.
- Policies MS. PRVR.10 and MS.QI.05 define appointment timeframes for "Medically necessary initial high-risk prenatal care (For High-risk pregnancy OB/GYN providers only)." However, the appointment information listed on the website states the criteria is for "Pregnant Women Care" and the *CAN Provider Manual* states the appointment timeframes are for "OB/GYN Access". The information is not listed in the *CHIP Provider Manual*. There was confusion among Magnolia staff during the onsite visit discussion as to whether the standards applied to only high-risk prenatal care or pregnant women.
- The following information could indicate continued issues with member access to providers:
  - Results of the PCP appointment access monitoring reported in both the CAN and CHIP 2015 Program Evaluations that only 3 out of 8 measures met the performance goal of ≥90%. Failed standards included emergent visit, medically necessary initial high-risk prenatal care, EPSDT initial health check within 90 calendar days of enrollment, after-hours coverage 24/7, and patient wait time within 30 minutes of appointment.
  - The *Magnolia Health Medicaid and Ambetter Practitioner Access Analysis (July 1, 2015 – June 30, 2016)* reported access measures as not meeting goals for PCP routine and urgent appointments, PCP after-hours care, behavioral health follow-up routine care appointments, and oncology urgent appointments.
  - Results of the *Telephonic Provider Access and Availability Study* performed by CCME showed no improvement from the previous study.

- At the time of the EQR, the *CHIP Provider Manual* was not loaded to the provider portal on the website.
- The *Provider Manuals* for CAN and CHIP state that it is a member's right to receive oral interpretation services for all non-English languages free of charge. However, it does not provide any guidance to providers regarding what translation services are available and what a provider should do if a member needs translation services.
- The *CHIP Provider Manual* contains an outdated list of adopted preventive and clinical practice guidelines. It does not contain information specific to providers about using the guidelines and where to find them.
- The *CAN Provider Manual* does not contain information regarding the adopted preventive and clinical practice guidelines. There are a few references, but no information specific to providers about using the guidelines and where to find them.
- Policy MS.QI.13, Medical Record Review, states the most current version of the medical record standards is maintained on Magnolia's website; however, the information could not be found.
- Magnolia conducts medical record reviews as an ongoing process for only 15 – 16 providers annually.
- The *Provider Satisfaction Survey* reflected a low response rate which may affect the generalizability of the survey. Additionally, information on reliability and validity of the *SPHA Provider Satisfaction Survey* was not provided in the documentation.

Corrective Action

- Update the *Practitioner Office Site Evaluation Tool* to reflect correct appointment availability timeframes.
- Ensure provider office site visits are conducted in accordance with Policy MS.CONT.03, Site Assessment for New Provider Contracts.
- Ensure consistent information regarding the PCP member-to-provider ratio is conveyed in the 2016 QI Program Evaluations for CAN and CHIP, and Policies MS.QI.04 and MS.CONT.01.
- Update documents addressing appointment standards for OB/GYN (such as Policies MS.PRVR.10 and MS.QI.05, *Provider Manuals*, and the website) to reflect consistent information. Indicate whether the standards apply to high risk OB/GYN or pregnant women care.
- Implement interventions to address member access issues identified in the Provider Access and Availability Study conducted by CCME.
- Ensure the *CHIP Provider Manual* is loaded to the provider portal on the website.

- Update the *Provider Manuals* for CAN and CHIP to include information regarding what translation services are available and what a provider should do if a member needs translation services.
- Update the *Provider Manuals* for CAN and CHIP to include information regarding preventive health and clinical practice guidelines, the expectation they will be followed, and where to find them.
- Update the provider portal on the website to include the most current version of the medical record standards as defined in Policy MS.QI.13, Medical Record Review.
- Implement interventions to increase the response rate for provider satisfaction surveys and to improve survey documentation. Provide information regarding whether or not reliability and validity have been assessed in the survey, and if assessed, the values associated with the reliability and validity findings.

Recommendations

- Consider having the chief medical director chair the Credentialing Committee.
- Ensure ownership disclosure forms contain a date beside the signature.
- Continue to focus on member access to their providers. Identify the non-compliant providers and work to improve compliance to the access measures.
- Consider conducting medical record reviews on a larger sample of providers to ensure they are adhering to Magnolia's medical record standards.

C. Member Services

The review of Member Services for Magnolia included the Mississippi CAN and Mississippi CHIP lines of business. CCME reviewed policies and procedures, member rights, member informational materials, grievance files, and the *Member Satisfaction Survey*. The *CAN* and *CHIP Member Handbooks* present information in an easily understood manner and meet the sixth grade reading comprehension level. A few issues were identified in both handbooks. Handbooks are available in Spanish and alternate formats such as large font or audio.

Magnolia's call center has consistently met contractual requirements for speed of answer and abandonment rates. Staff is specialized to assist members or providers. Magnolia conducts some training for this department; however, there is no document detailing the topics to be included or the frequency of the training. Magnolia does track attendance at all trainings. Calls received on day one of the onsite visit were provided for CCME to review. Common issues were identified regarding the handling of these calls, including incomplete HIPAA identification of callers and staff appearing rushed and consequently a

bit impolite in their treatment of callers. Staff members use established scripts for conducting phone calls and are able to view system-identified care gaps and relay them to callers.

Grievance processes were inconsistent across both CAN and CHIP policies, handbooks, manuals, and the Magnolia websites. There were discrepancies in timeframes, and the definition of a grievance was incomplete in many documents. CAN and CHIP grievance file review documented Magnolia's consistency in acknowledging receipt, timely resolution, and sending resolution notices. Specific files were discussed onsite to further clarify resolution documentation. Although Magnolia does not have an excessive number of grievances, nearly 25% are noted to be related to services provided by non-urgent Medicaid transportation vendors.

Member Satisfaction Survey Validation

Member Satisfaction Surveys for both the CHIP and CAN populations underwent validation by CCME. The surveys were validated using the *EQR Protocol 5, Validation and Implementation of Surveys (Final Protocol Version 2.0, September 2012)*. Survey results were presented and discussed in committee meetings. There were low response rates for CAHPS Adult and Child surveys as well as the CHIP population. This is a common issue and in an effort to increase the response, the following strategies are recommended to enhance member response to the satisfaction survey:

- Offer incentives for completing surveys, such as stickers, pens, candy, or other small items.
- Place a stamp on the envelope instead of using a standard pre-printed stamp. Research has shown this increases response rate.
- Announce the upcoming survey on the member page of the website.
- Provide information in the newsletter clearly stating how the findings from previous satisfaction surveys have been used to affect change in the programs and services provided to members.
- Set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate). Based on this year's child survey response rate of 20.9%, a 3% increase would be statistically significant if a similar sample size of 2,665 was used. For the adult survey, the most recent response rate was 24.2%. A 4% increase in the response rate would be statistically significant, based on a similar sample size of 1,787.

Any member incentive program must be approved by DOM prior to implementation. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*.

For the CAN line of business, Magnolia received a "Met" score for 82% of the standards for Member Services and 18% of standards received a score of "Partially Met." For the CHIP line of business, the percentage of "Met" scores was 81% and "Partially Met" scores accounted for 19%.

Figure 4: Member Services Findings

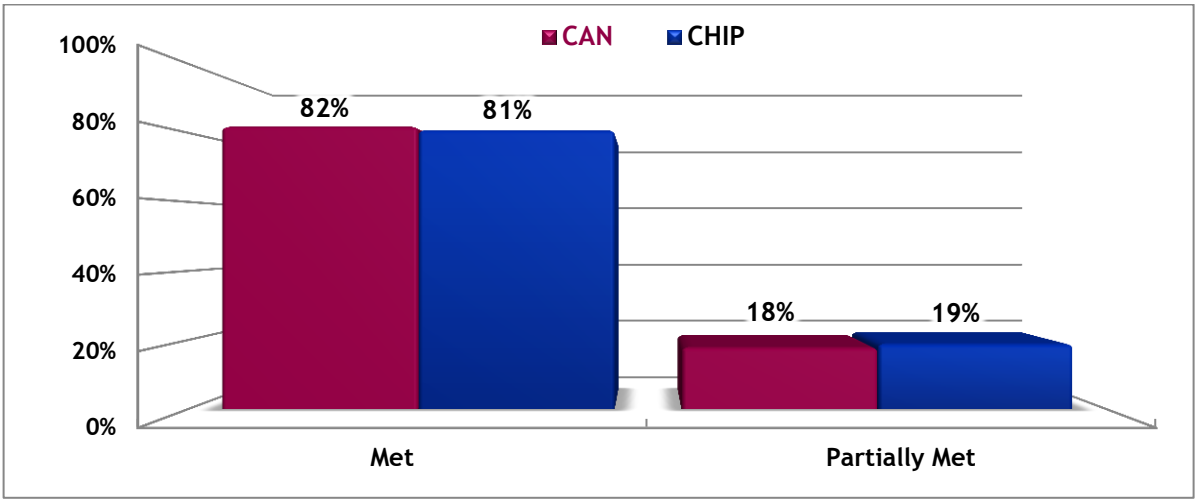


Table 6: Member Services

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Member Rights and Responsibilities	All member rights are included	Partially Met	Partially Met
Member CCO Program Education	Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled	Partially Met	Partially Met
	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Partially Met	Partially Met
Complaints/ Grievances	Definition of a complaint/grievance and who may file a complaint/grievance	Partially Met	Partially Met
	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Partially Met	Partially Met

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Complaints/ Grievances	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	Partially Met	Partially Met

Strengths

- Grievance files indicate Magnolia adheres to CAN and CHIP policies for the process of acknowledging, investigating, resolving, and notifying members of the resolution of grievances.
- Call center metrics for speed of answer and abandonment rate surpass contract requirements.

Weaknesses

- The right to be treated with respect and dignity is found in Policy MS.MBRS.25, Member Rights and Responsibilities, the *CAN Provider Manual*, and website. However, it was not found in the list of member rights in the *CAN Member Handbook*.
- The *CHIP Member Handbook* fails to include the right of members to freely exercise their rights and that exercising their rights will not affect the way they are treated by providers or the health plan. This member right is found in the *CHIP Contract, Section 6 (I) (1) (g)*.
- The *CHIP Member Handbook* and the *CHIP Provider Manual* contain discrepancies in benefit information.
- The *CHIP Member Handbook* does not include female members may have direct access to a women's health specialist in addition to a PCP. See *Federal Regulation § 438.206 (b) (2)* and *the CHIP Contract, Section 7(A)*.
- Federally required blood lead screening is not found in the list of laboratory tests on page 26 of the *CHIP Member Handbook*.
- Referrals for identified problems are not found in the list of Well-Baby and Well-Child services on page 26 of the *CHIP Member Handbook*.
- The right to privacy and confidentiality in their person and in their medical information is not found in the *CAN Member Handbook* list of member rights.
- The *CAN Provider Manual* and the provider area of the *CAN* website do not provide a list of member benefits.

- *The CAN Member Handbook* includes a list of information that can be accessed on the website. However, it does not include a description of the member portal or how to access it.
- Members are informed about Care Management and Disease Management Programs offered by Magnolia in the *CAN* and *CHIP Member Handbooks*. The Start Smart for Your Baby Program is described; however, the manuals do not mention high-risk OB Care Management.
- The *CHIP* and *CAN Member Handbooks* state if the member's primary care provider is planning to leave the provider network, a notice will be sent at least 15 days before this date occurs. However, the *CHIP* and *CAN Contracts, Sections 7 (D) (3)* state this timeframe is within 15 calendar days of notice or issuance of termination of a provider. The timeframe is also incorrect in the *CHIP* and *CAN Provider Manuals*.
- The *CAN Contract, Section 6 (D) (13) (b),* and the *CHIP Contract, Section 6 (D) (14) (b),* state the CCO must have "A multilingual notice that describes translation services that are available and provides instructions explaining how members can access those translation services." Onsite discussion determined the 1557 rule regarding this is pending approval by DOM.
- A few issues were identified while listening to call-center calls, such as incomplete HIPAA validation, rushed calls, and Centene system problems.
- The *Adult Member Satisfaction Survey* results met the minimum number of responses considered by NCQA to be necessary for a valid survey (n=432), but fell below the response rate targets set by AHRQ and NCQA. The *Child Member Satisfaction Survey* results met the minimum number of responses considered by NCQA to be necessary for a valid survey (n=557), but fell below the response rate targets set by AHRQ and NCQA (50 and 45 percent, respectively) at 20.9%.
- The *Child CCC CAHPS Survey* indicates the generalizability of the results is undetermined due to the lack of response rate information. It is difficult to determine if survey conclusions are supported by data and analysis.
- The following documents contain an incomplete definition of a grievance. Refer to the *CAN Contract, Section 6 (J), Table 5* and the *CHIP Contract, Section 2 (37):*
    - CAN Policy MS.MBRS.07, Member Grievance and Complaints Process, and CHIP Policy MS.MBRS.07.01, Member Grievance and Complaints Process, contains no definition
    - The *CAN* and *CHIP Member Handbooks*
    - The Magnolia CAN and CHIP websites
    - The *CAN Provider Manual*

- The following documents do not include the correct timeframes for grievance resolution:
    - The *CHIP Provider Manual* states the resolution timeframe is 15 days from receipt, but does not include the three-step process for grievance review and resolution.
    - The Magnolia CHIP website states the grievance resolution timeframe is within 30 calendar days of receipt, and fails to include the three-step process for review of a grievance resolution.
    - The *CHIP Member Handbook* states the timeframe for resolution is 30 calendar days from receipt and no more than 90 days in total.
    - The *CHIP Member Handbook* does not address a clinically urgent grievance process or that a member can request an extension of timeframe for resolution.
- The third-level grievance acknowledgement and resolution letters refer members to a Chancery Court. Onsite discussion confirmed this is no longer applicable and should be removed.
- The following documents fail to include that a member may request an extension of the timeframe for grievance resolution:
    - The *CAN Provider Manual*
    - The Magnolia CAN website
- *Policy MS.MBRS.07, Member Grievance and Complaints Process*, does not include the decision maker and the qualifications required to decide a grievance related to the denial of an expedited appeal.
- Discrepancies in the grievance log retention timeframe are noted among CAN Policy MS.MBRS.07, Member Grievance and Complaints Process, CHIP Policy MS.MBRS.07.01, Member Grievance and Complaints Process, onsite discussion, and the *CAN and CHIP Member Handbooks*.
- Some grievance resolution letters did not include the process taken to resolve the grievance or did not fully explain the resolution.
- Onsite discussion confirmed there is a process in place to investigate grievances related to requests to change PCPs due to dissatisfaction; however, this process is not documented.

Corrective Action

- Include the right to be treated with respect and with due consideration for his or her dignity and privacy in the *CAN Member Handbook* listing of member rights.

- Include information about the member portal, what it includes, and how to access it in the *CAN Member Handbook* or other member document.
- Revise the *CHIP Member Handbook* to include a member's right to freely exercise his/her rights, and that the free exercise of rights will not affect the way providers or the health plan treats the member.
- Update the *CHIP Member Handbook* and the *CHIP Provider Manual* with the following benefit information:
    - Information on disposable medical supplies as a benefit (*CHIP Member Handbook*).
    - Information on chiropractic care, air ambulance fixed wing, and diabetes training (*CHIP Provider Manual*).
- Include in the *CHIP Member Handbook* that women may have direct access to a women's health specialist in addition to a PCP.
- Include a description of high-risk OB care management services in the *CAN* and *CHIP Member Handbooks*.
- Correct the *CAN Member Handbook* and the *CAN Provider Manual* to reflect the correct timeframe for written notice to members if their PCP leaves the network.
- Update the definition of a grievance in the CAN and CHIP grievance policies, *CAN* and *CHIP Member Handbooks*, *CAN Provider Manual*, and the CAN and CHIP websites to match the definition found in either the *CAN and CHIP Contracts* or federal regulations.
- Update the Magnolia website and the *CAN Provider Manual* to include that members may request to extend the timeframe for grievance resolution.
- Update the *CHIP Member Handbook* regarding the urgent grievance process and member-requested extensions.
- Remove the reference to Chancery Court from the CHIP grievance final resolution letter template.
- Ensure that the timeframe for retention of grievance logs is consistent across all CAN and CHIP documentation.

Recommendations

- Include in the *CAN Provider Manual*, the CAN Provider website, or a separate document, a list of member benefits for quick reference.
- Include in the *CHIP Member Handbook* that members are asked to show courtesy and respect to providers and their staff.

- Include blood level testing in the description of Well-Baby and Well-Child services in the *CHIP Member Handbook*.
- Include referrals for identified problems in the description of Well-Baby and Well-Child services.
- Develop a multilingual notice describing translation services available and provide instructions for members to access those translation services.
- Continue to provide additional training and follow-up audits for call center staff not meeting expectations when handling phone calls.
- For the *Adult* and *Child Member Satisfaction Surveys*, focus on strategies that would help increase response rates for the Medicaid adult and child population to be more representative of the entire member population.
- For the *CAN Adult* and *Child Surveys*, set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate). Based on this year's child survey response rate of 20.9%, a 3% increase would be statistically significant if a similar sample size of 2,665 was utilized. For the adult survey, the most recent response rate was 24.2%. A 4% increase in the response rate would be statistically significant, based on a similar sample size of 1,787.
- For the *CHIP Member Satisfaction Survey*, identify methods to determine if response rate can be calculated and if denominator can be calculated using member data.
- For the *CHIP Member Satisfaction Survey*, set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate). Based on Magnolia CHIP's most recent response rate of 20%, a 3% increase would be statistically significant if a similar sample size of 2608 was utilized.
- The requirement that Magnolia conduct quarterly scheduled training for call center staff should be documented in a policy or other document and include the frequency and general content of these trainings.
- Include in Policy MS.MBRS.07 that decision makers on grievances related to the denial of an expedited appeal are decided by individuals who have the appropriate expertise, as determined by the state, in treating the enrollee's disease or condition.
- Develop a process to review member grievance resolution letters prior to mailing to ensure letter content is accurate and easy to understand.
- Document the process for investigating all requests for change of PCP for dissatisfaction as grievances in an existing or new CAN and CHIP policy.

D. Quality Improvement

Magnolia presented the *Quality Assessment and Performance Improvement Program Description 2016* for their CAN program and their CHIP program in the desk materials. Both program descriptions are reviewed, updated as needed, and presented to the Quality Improvement Committee and to the Board of Directors for approval at least annually.

Monitoring and identifying opportunities to access health care disparities as required by the *DOM Contract, Section 9* was not included in the scope of either quality improvement program descriptions. Health care disparities is a standing agenda item for the Quality Improvement Committee. During the onsite visit, the Quality staff discussed the initiatives underway for tracking and monitoring health care disparities, such as sickle cell. It is recommended this information be included in the scope of work listed in the quality improvement program descriptions for the CAN and CHIP Programs.

Magnolia's Quality Improvement Committee is the designated committee charged with providing oversight of all quality improvement activities. This committee is responsible for establishing standards and criteria for the delivery of care and services. The Quality Improvement Committee is a senior level committee and actively involves participating network practitioners. A review of the committee's participant roster indicates there are five network providers serving as voting members. Their specialties include pediatrics, family medicine, hospital medicine, and psychiatry. The committee charter indicates the membership will also include two nurse practitioners. Magnolia recruited one nurse practitioner but she does not attend regularly.

The *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)* require the health plan to establish a tracking system for reporting all screening and assessment results and diagnosis and/or treatment for members. Magnolia has systems in place for tracking initial visits for newborns, EPSDT screenings, and Well-Baby and Well-Child services. However, the health plan does not track any diagnoses identified during the assessments and treatments, nor are referrals provided as a result of the assessments.

Performance Measure Validation

As part of the EQR for Magnolia CAN and CHIP, CCME conducted a validation review of the HEDIS® and non-HEDIS® performance measures following the protocols developed by CMS. Magnolia's CAN and CHIP measures were found to be fully compliant and met all the requirements for the HEDIS® measures, per the report by Attest Health Care Advisors. These HEDIS measures were reviewed and validated in accordance with the HEDIS 2016 technical specifications for the 2015 reporting year. All relevant HEDIS performance measures for the current review year (2015) are reported in the following table. Also included in the table are the previous year (2014) rates and the change from 2014 to 2015

for Magnolia's CAN population. As shown, there were several measures having substantial rate decreases of greater than 10%, including BMI Percentile Assessments, Counseling for Nutrition, Flu Vaccinations, Controlling High Blood Pressure, and Access to Preventive/Ambulatory Health Services. Evaluation of these measures is recommended to generate action plans to improve rates.

Table 7: HEDIS Performance Measure Results

Measure/Data Element	2014 CAN Rates	2015 CAN Rates	Change from 2014 to 2015 CAN Rates	2015 CHIP Rates
Effectiveness of Care: Prevention and Screening				
Adult BMI Assessment (aba)	71.36%	69.47%	-1.89%	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)				
BMI Percentile	36.28%	24.04%	-12.24%	36.54%
Counseling for Nutrition	36.28%	25.48%	-10.80%	37.98%
Counseling for Physical Activity	30.07%	22.84%	-7.23%	35.58%
Childhood Immunization Status (cis)				
DTaP	85.93%	85.10%	-0.83%	80.00%
IPV	97.78%	95.43%	-2.35%	90.00%
MMR	94.81%	93.03%	-1.78%	90.00%
HiB	95.56%	93.03%	-2.53%	83.33%
Hepatitis B	95.56%	96.15%	0.59%	90.00%
VZV	94.81%	93.03%	-1.78%	86.67%
Pneumococcal Conjugate	84.44%	83.17%	-1.27%	86.67%
Hepatitis A	74.07%	80.05%	5.98%	73.33%
Rotavirus	46.67%	63.46%	16.79%	60.00%
Influenza	45.19%	25.00%	-20.19%	33.33%
Combination #2	84.44%	83.17%	-1.27%	73.33%
Combination #3	81.48%	78.85%	-2.63%	73.33%
Combination #4	65.19%	67.79%	2.60%	63.33%
Combination #5	40.74%	56.73%	15.99%	53.33%
Combination #6	42.22%	23.08%	-19.14%	30.00%
Combination #7	35.56%	46.88%	11.32%	46.67%
Combination #8	37.78%	22.12%	-15.66%	26.67%
Combination #9	22.22%	15.87%	-6.35%	20.00%
Combination #10	20.00%	14.90%	-5.10%	16.67%
Immunizations for Adolescents (ima)				
Meningococcal	31.88%	48.56%	16.68%	50.00%
Tdap/Td	47.15%	73.32%	26.17%	82.26%
Combination #1	29.03%	47.36%	18.33%	50.00%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	8.68%	12.06%	3.38%	16.67%
Lead Screening in Children (lsc)	59.12%	68.87%	9.75%	66.67%

Measure/Data Element	2014 CAN Rates	2015 CAN Rates	Change from 2014 to 2015 CAN Rates	2015 CHIP Rates
Breast Cancer Screening (bcs)	49.70%	55.18%	5.48%	
Cervical Cancer Screening (ccs)	57.82%	59.14%	1.32%	
Chlamydia Screening in Women (chl)				
16-20 Years	53.03%	49.14%	-3.89%	35.20%
21-24 Years	63.02%	62.39%	-0.63%	
Total	60.64%	58.25%	-2.39%	35.20%
Effectiveness of Care: Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis (cwp)	53.63%	51.62%	-2.01%	60.28%
Appropriate Treatment for Children With URI (uri)	63.08%	NR	NA	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	27.02%	NR	Na	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	23.44%	27.34%	3.90%	
Pharmacotherapy Management of COPD Exacerbation (pce)				
Systemic Corticosteroid	39.51%	39.30%	-0.21%	
Bronchodilator	76.18%	74.51%	-1.67%	
Medication Management for People With Asthma (mma)				
5-11 Years - Medication Compliance 50%	45.11%	44.52%	-0.59%	
5-11 Years - Medication Compliance 75%	16.54%	17.42%	0.88%	
12-18 Years - Medication Compliance 50%	44.53%	43.57%	-0.96%	
12-18 Years - Medication Compliance 75%	17.19%	17.14%	-0.05%	
19-50 Years - Medication Compliance 50%	46.42%	46.42%	0.00%	
19-50 Years - Medication Compliance 75%	20.75%	22.87%	2.12%	
51-64 Years - Medication Compliance 50%	65.22%	66.10%	0.88%	
51-64 Years - Medication Compliance 75%	40.00%	41.53%	1.53%	
Total - Medication Compliance 50%	49.14%	48.73%	-0.41%	
Total - Medication Compliance 75%	22.62%	23.65%	1.03%	
Asthma Medication Ratio (amr)				
5-11 Years	72.46%	73.29%	0.83%	
12-18 Years	61.27%	62.18%	0.91%	
19-50 Years	36.53%	39.90%	3.37%	
51-64 Years	44.81%	44.74%	-0.07%	
Total	48.29%	50.54%	2.25%	

Measure/Data Element	2014 CAN Rates	2015 CAN Rates	Change from 2014 to 2015 CAN Rates	2015 CHIP Rates
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (cbp)	46.36%	32.23%	-14.13%	
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	65.79%	59.52%	-6.27%	
Statin Therapy for Patients With Cardiovascular Disease (spc)				
Received Statin Therapy - 21-75 years (Male)	NR	61.65%	NA	
Statin Adherence 80% - 21-75 years (Male)	NR	72.38%	NA	
Received Statin Therapy - 40-75 years (Female)	NR	58.17%	NA	
Statin Adherence 80% - 40-75 years (Female)	NR	61.16%	NA	
Received Statin Therapy - Total	NR	59.81%	NA	
Statin Adherence 80% - Total	NR	66.62%	NA	
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (cdc)				
Hemoglobin A1c (HbA1c) Testing	81.90%	85.65%	3.75%	
HbA1c Poor Control (>9.0%)	56.61%	65.97%	9.36%	
HbA1c Control (<8.0%)	31.09%	26.62%	-4.47%	
HbA1c Control (<7.0%)	NR	NR	NA	
Eye Exam (Retinal) Performed	61.72%	65.74%	4.02%	
Medical Attention for Nephropathy	85.15%	92.13%	6.98%	
Blood Pressure Control (<140/90 mm Hg)	47.10%	40.97%	-6.13%	
Effectiveness of Care: Musculoskeletal Conditions				
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	71.73%	71.43%	-0.30%	
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (amm)				
Effective Acute Phase Treatment	42.39%	36.91%	-5.48%	
Effective Continuation Phase Treatment	25.84%	23.07%	-2.77%	
Follow-Up Care for Children Prescribed ADHD Medication (add)				
Initiation Phase	56.72%	55.98%	-0.74%	
Continuation and Maintenance (C&M) Phase	65.45%	68.29%	2.84%	
Follow-Up After Hospitalization for Mental Illness (fuh)				
30-Day Follow-Up	NR	39.06%	NA	
7-Day Follow-Up	NR	20.73%	NA	

Measure/Data Element	2014 CAN Rates	2015 CAN Rates	Change from 2014 to 2015 CAN Rates	2015 CHIP Rates
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	68.68%	NR	NA	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	62.34%	NR	NA	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	51.35%	NR	NA	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	59.96%	NR	NA	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)				
1-5 Years	NA	NR	NA	
6-11 Years	10.37%	NR	NA	
12-17 Years	18.44%	NR	NA	
Total	14.98%	NR	NA	
Effectiveness of Care: Medication Management				
Annual Monitoring for Patients on Persistent Medications (mpm)				
ACE Inhibitors or ARBs	86.84%	87.38%	0.54%	
Digoxin	52.41%	50.37%	-2.04%	
Diuretics	86.13%	87.36%	1.23%	
Total	86.06%	86.93%	0.87%	
Effectiveness of Care: Overuse/Appropriateness				
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	11.69%	NR	NA	
Appropriate Treatment for Children With URI (uri)	63.08%	63.25%	0.17%	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	27.02%	31.44%	4.42%	
Use of Imaging Studies for Low Back Pain (lbp)	74.11%	73.14%	-0.97%	100.00%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)				
1-5 Years	NA	NR	NA	
6-11 Years	NA	NR	NA	
12-17 Years	4.55%	NR	NA	
Total	2.70%	NR	NA	
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (aap)				
20-44 Years	86.17%	86.04%	-0.13%	
45-64 Years	92.35%	92.29%	-0.06%	

Measure/Data Element	2014 CAN Rates	2015 CAN Rates	Change from 2014 to 2015 CAN Rates	2015 CHIP Rates
65+ Years	88.57%	76.47%	-12.10%	
Total	88.41%	88.34%	-0.07%	
Children and Adolescents' Access to Primary Care Practitioners (cap)				
12-24 Months	97.05%	96.04%	-1.01%	98.02%
25 Months - 6 Years	89.80%	88.89%	-0.91%	82.19%
7-11 Years	87.19%	89.21%	2.02%	
12-19 Years	80.52%	83.49%	2.97%	100.00%
Annual Dental Visit (adv)				
2-3 Years	37.46%	41.43%	3.97%	45.28%
4-6 Years	51.31%	67.82%	16.51%	61.63%
7-10 Years	49.32%	67.20%	17.88%	66.14%
11-14 Years	42.55%	59.09%	16.54%	58.62%
15-18 Years	34.85%	49.33%	14.48%	47.73%
19-20 Years	24.76%	33.40%	8.64%	35.42%
Total	39.76%	56.34%	16.58%	57.13%
Prenatal and Postpartum Care (ppc)				
Timeliness of Prenatal Care	88.57%	88.21%	-0.36%	80.00%
Postpartum Care	60.00%	62.26%	2.26%	20.00%
Utilization				
Frequency of Ongoing Prenatal Care (fpc)				
<21 Percent	11.36%	11.27%	-0.09%	0.00%
21-40 Percent	4.37%	4.74%	0.37%	20.00%
41-60 Percent	7.04%	7.33%	0.29%	0.00%
61-80 Percent	14.19%	13.94%	-0.25%	20.00%
81+ Percent	63.05%	62.72%	-0.33%	60.00%
Well-Child Visits in the First 15 Months of Life (w15)				
0 Visits	1.25%	6.03%	4.78%	4.55%
1 Visit	2.50%	5.76%	3.26%	2.27%
2 Visits	13.75%	6.94%	-6.81%	3.41%
3 Visits	13.75%	8.32%	-5.43%	3.41%
4 Visits	20.00%	13.76%	-6.24%	10.23%
5 Visits	26.25%	21.66%	-4.59%	25.00%
6+ Visits	22.50%	37.53%	15.03%	51.14%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	53.52%	50.94%	-2.58%	43.18%
Adolescent Well-Care Visits (awc)	24.56%	28.54%	3.98%	27.76%
CHIPRA Measures				
Behavioral Health Risk Assessment (BHRA)				
Depression Screening				0.00%
Alcohol Use Screening				0.00%
Tobacco Use Screening				0.00%

Measure/Data Element	2014 CAN Rates	2015 CAN Rates	Change from 2014 to 2015 CAN Rates	2015 CHIP Rates
Drug Use				0.00%
Intimate Partner Violence				0.00%
Total				0.00%
Developmental Screening in the first Three Years of Life (DEV)				
Age 12 months				0%
Age 24 months				3.50%
Age 36 months				1.58%
Total (All Ages)				2.07%

NA: Indicates denominator was too small; NR: Not reported

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

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

Three of the four non-HEDIS measures for the CAN program were found to be "Fully Compliant" and one measure was "Substantially Compliant" as noted in *Table 8: MSCAN Non-HEDIS Performance Measure Validation Results*.

Table 8: CAN Non-HEDIS Performance Measure Validation Results

Measure	CAN Validation Scores
Asthma Related Readmissions	100% FULLY COMPLIANT
Asthma Related ER Visits	100% FULLY COMPLIANT
CHF Rehospitalizations	100% FULLY COMPLIANT
Pre Post Natal Complications	73% SUBSTANTIALLY COMPLIANT

For the non-HEDIS measures, queries were submitted for all four measures with three of the four scoring "Fully Compliant". There are concerns regarding the logic used to calculate the pre- and post-natal complications measure. Although the specifications and the programming logic used matched up, it appears the specifications used were inconsistent with DOM's specifications. This occurs, specifically, for the fourth digit of the 640-649 codes. The codes should include a one or three in the fifth digit, but the fourth digit can be any numeric value from 0 to 9. In the programming logic and specifications, only codes with zero as the fourth digit were included.

All of the non-HEDIS measures for the CHIP program met the protocol guidelines and were considered "Fully Compliant" as shown in *Table 9, CHIP Non-HEDIS Performance Measure Validation Results*.

Table 9: CHIP Non-HEDIS Performance Measure Validation Results

Measure	CHIP Validation Scores
BHRA (Behavioral Health Risk Assessment)	100% FULLY COMPLIANT
DEV (Developmental Screening in the First Three Years of Life)	100% FULLY COMPLIANT

The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*.

Performance Improvement Project Validation

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

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

Magnolia submitted four PIPs for the CAN program and four PIPS for the CHIP program. The tables below display the current validation scores for each project submitted, any errors, and recommendations identified. The tables start with the CAN PIP results.

Table 10: CAN Performance Improvement Project Validation Scores

Project	Current Validation Score
Congestive Heart Failure Readmissions	62/78 = 80% Confidence in Reported Results
Obesity	62/62 = 100% High Confidence in Reported Results
Diabetes	62/62 = 100% High Confidence in Reported Results
Asthma	67/78 = 86% Confidence in Reported Results

As shown, two of the projects received a score of "High Confidence in Reported Results" and two received a score of "Confidence in Reported Results". The following tables list specific errors, by project, and include recommendations to correct the errors.

Table 11: Congestive Heart Failure

Section	Reasoning	Recommendation
3.1 Did the study use objective, clearly defined, measurable indicators?	The indicator description mentions DOM performance measure as the source, but the description and baseline goal do not match in type of measurement.	Correct documentation to match the study indicator description and DOM specification description. The numerator is correct. The denominator is 1,000 member months. Also, the study indicator is described as a "percentage" when the indicator is not a percentage, but a numeric value.
6.6 Were qualified staff and personnel used to collect the data?	Qualifications of personnel were not documented.	Include qualifications of personnel working with data on page A-7 or A-13.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis of baseline data and whether or not it met baseline goal was not provided on page A-15.	Include narrative for the rate of the current measurement period and whether it meets the baseline goal on page A-15.

Table 12: Asthma

Section	Reasoning	Recommendation
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented on page A-16. The numerator and denominator appear to be switched.	Revise the numeric values on page A-16 to correct the numerator and denominator.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	The analysis does not indicate interpretation of the baseline rate in comparison to the baseline goal.	Although only baseline data have been collected, a narrative regarding the baseline rate in comparison with the baseline goal should be included on page A-16.

There were four CHIP performance improvement projects submitted for desk review. The topics included Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Obesity, ADHD, and Asthma. Each of the four PIPs provided a data-based rationale for the project as well as information regarding the study indicators, data sources, and planned data analysis. Barriers and interventions to address those barriers were documented. Analysis of findings was provided for the baseline data from the EPSDT project. The results of the validation for the CHIP program Performance Improvement Projects follows.

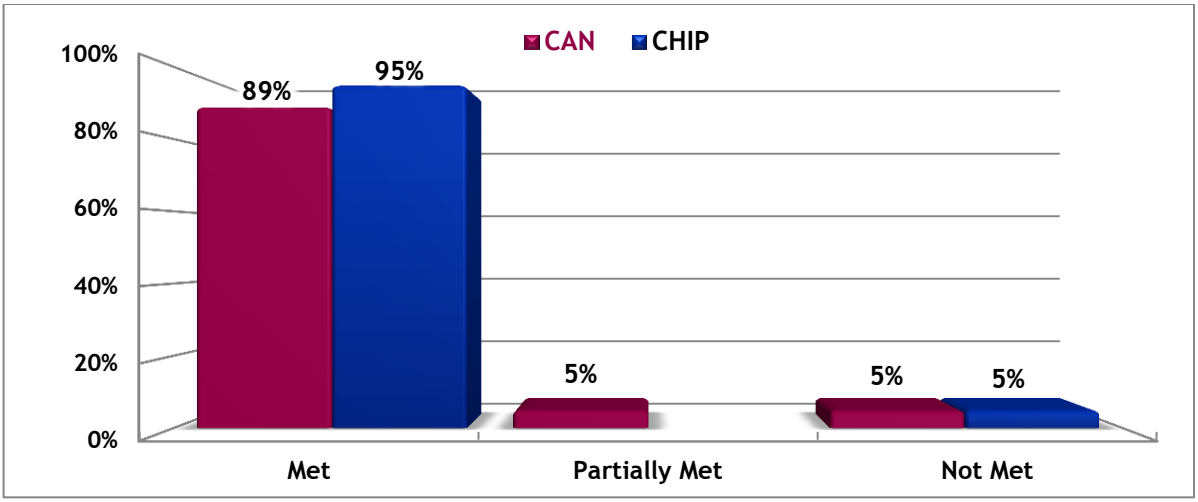
Table 13: CHIP Performance Improvement Project Validation Scores

Project	Validation Score
EPSDT	78/78 = 100% High Confidence in Reported Results
Obesity for Children	82/82 = 100% High Confidence in Reported Results
ADHD	62/62 = 100% High Confidence in Reported Results
Asthma	62/62 = 100% High Confidence in Reported Results

As shown, all of the projects received a score of "High Confidence in Reported Results". Details of the validation activities for the performance measures and PIPs, along with specific outcomes related to each activity, are found in *Attachment 3, CCME EQR Validation Worksheets*.

Figure 5, Quality Improvement Findings indicate that for the CAN program, 89% of the standards received a "Met" score, 5% received a "Partially Met" score, and 5% received a "Not Met" score. For the CHIP program, 95% of the standards received a "Met" score and 5% received a "Not Met" score. The "Partially Met" score was related to documentation in the CAN performance improvement projects. The "Not Met" scores for CAN and CHIP were related to the tracking of any diagnoses identified during EPSDT screenings, Well-Baby and Well-Child assessments and treatments, or the referrals provided as a result of the assessments.

Figure 5: Quality Improvement Findings



Percentages may not total 100% due to rounding

Table 14: Quality Management

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met
Provider Participation in Quality Improvement Activities	The CCO tracks provider compliance with EPSDT service provision requirements for: The diagnosis and/or treatment for children	Not Met	N/A
	The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: The diagnosis and/or treatment for children	N/A	Not Met

N/A = Standard is Not Applicable

Strengths

- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented.
- 50% of CAN PIPs and all of the CHIP PIPS were validated in the "High Confidence" range.
- HEDIS performance measures were fully compliant.

Weaknesses

- The monitoring of services furnished to members with special health care needs and health care disparities was not included as part of the scope of work listed in the CAN and CHIP quality improvement program descriptions.
- The charter for the Quality Improvement Committee indicates the membership will include two nurse practitioners. Magnolia recruited one nurse practitioner, but she does not attend regularly.
- Non-HEDIS measure programming logic for the pre- and post-natal complications measure did not abide by DOM's specifications.
- Areas needing improvements in project documentation for the CAN program include presenting the findings in a clear and accurate manner with an interpretation of the results for each measurement period, including baseline.
- The health plan does not track any diagnoses identified during EPSDT screenings, Well-Baby and Well-Child assessments and treatments, or the referrals provided as a result of the assessments.

Corrective Action

- Correct the errors identified in the CAN performance improvement project documents.
- 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.

Recommendations

- Include in the scope of work listed in the CAN and CHIP quality improvement program descriptions the monitoring of services furnished to members with special health care needs and health care disparities.
- Continue to recruit nurse practitioners to serve on the Quality Improvement Committee.
- Include the fourth digit in the ICD – 9 codes used to calculate the pre- and post-natal complications measure.

E. Utilization Management

Magnolia's *Utilization Management Program Descriptions* for the CAN and CHIP products describe the UM Program for each, including the program's purpose, goals, scope, and implementation information. Departmental policies and procedures provide guidance for staff in the performance of various functions for the CAN and CHIP UM Programs.

The CAN and CHIP *UM Program Descriptions* indicate the UM Programs are evaluated at least annually. Findings and recommendations are submitted to the Utilization Management Committee (UMC) for review, action and follow-up. Ultimate approval for the UM Programs is given by the Quality Improvement Committee (QIC) and Magnolia's Board of Directors. The 2015 *UM Program Evaluation* for CAN included highlights of the UM Program's status and progress for 2015, identified barriers and opportunities for improvement, and included recommendations for further actions to continue improvement. A copy of the *UM Program Evaluation* for CHIP was not received.

UM criteria are reviewed annually and updated, as appropriate, by the UMC and/or QIC. All clinical policies are reviewed, updated, and approved annually by the Clinical Policy Committee (CPC) with input from local practitioners with professional knowledge or clinical expertise in the areas reviewed.

Magnolia's vice president of medical affairs is Dr. Rebecca Waterer. The chief medical director, Dr. Jeremy Erwin, has operational responsibility for and provides support to the UM Program. Behavioral health aspects of the program are overseen by a behavioral health practitioner. A pharmacist oversees pharmacy services.

Policy MS.UM.04, Appropriate UM Professionals, states a physician or other appropriately licensed health care professionals (as indicated by case type) review all medical necessity denials of healthcare services offered under the Plan's medical benefits, and per State contract, "denials can only be issued by a Mississippi licensed physician." However, review of UM files for CAN membership indicated pharmacists are issuing denials for medications. Onsite discussion revealed that Magnolia allows pharmacists to issue denial determinations without referring the review to a medical director. This is not in compliance with requirements of the *CAN Contract, Section 5 (J) (1), CHIP Contract, Section 5 (H) (1)*, and Policy MS.UM.04, Appropriate UM Professionals.

Appeals processes are defined in CAN Policy MS.UM.08, Appeal of UM Decisions, and CHIP Policy MS.UM.08.01, Appeal of UM Decisions. Along with these policies, appeals information is found in the *Member Handbooks*, *Provider Manuals*, letter templates, and on the Magnolia CAN and CHIP websites. Errors were noted in documentation of the following appeals requirements and processes:

- Incorrect, incomplete, and/or missing definitions of the terms, "appeal" and "action" (CAN and CHIP)
- Missing information regarding the member's ability to present evidence and/or examine the appeal case file (CAN and CHIP)
- Incomplete documentation of appeals filing requirements (CHIP)
- Incomplete information regarding appeal resolution timeliness and/or timeframe extensions (CAN and CHIP)

- Ambiguous information in the *CHIP Provider Manual* does not differentiate between grievances and appeals

CAN and CHIP appeals files reflected timely determinations issued by appropriate reviewers. However, several appeal resolution letters did not reference the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based.

Magnolia's *Care Management Program Description* defines processes to identify, plan, coordinate, and monitor appropriate, cost-effective services for members. Additional processes and requirements are defined in various CM policies and procedures. Care Management (CM) programs are available to all members, but specifically target members with catastrophic or complex health conditions. CM files confirm appropriate processes and functions are being performed for the CAN and CHIP populations.

As noted in *Figure 6, Utilization Management Findings*, Magnolia received "Met" scores for 91% of the standards in the UM section of the review for CAN and 83% of the standards in the UM section of the review for CHIP. Scores of "Partially Met" were related to allowing inappropriate reviewers to issue pharmacy denial determinations (CAN and CHIP), errors and/or omissions in documentation of appeals requirements and processes (CAN and CHIP), documentation of authorization determination timeliness requirements (CHIP), and lack of policies addressing inter-rater reliability processes and pharmacy authorization requirements (CHIP). The "Not Met" and "Not Applicable" scores for CHIP were related to lack of a formal, written UM Program evaluation.

Figure 6: Utilization Management Findings

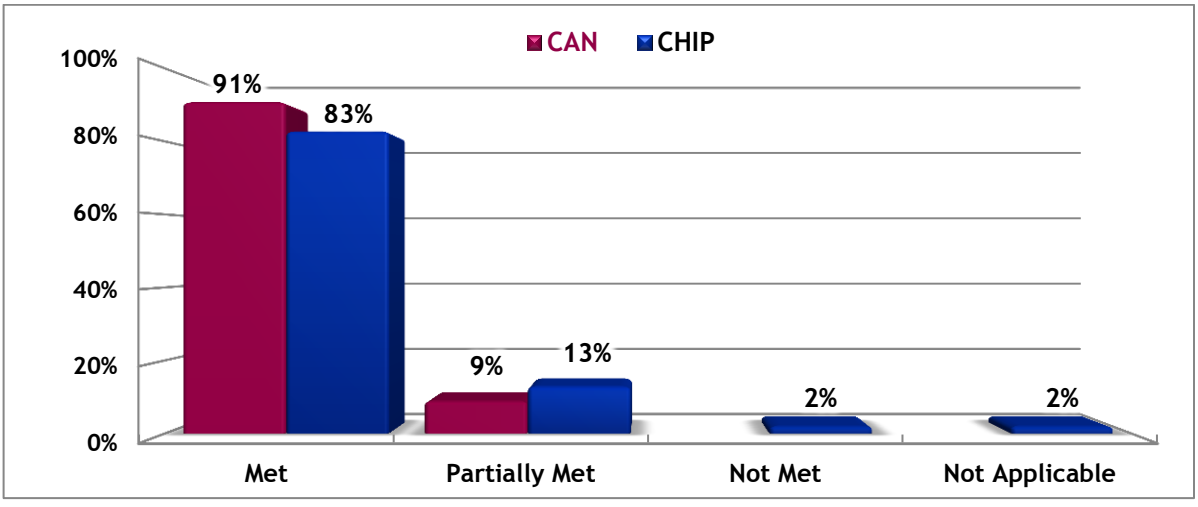


Table 15: Utilization Management

Section	Standard	CAN 2016 Review	CHIP 2016 Review
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 timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Partially Met
	The CCO has established policies and procedures for the prior authorization of medications	Met	Partially Met
	Utilization management decisions are made by appropriately trained reviewers	Partially Met	Partially Met
	All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Partially 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 the definitions of an action and an appeal and who may file an appeal	Partially Met	Partially Met
	The procedure for filing an appeal	Partially Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Partially Met
Annual Evaluation of the Utilization Management Program	A written summary and assessment of the effectiveness of the UM program is prepared annually	Met	Not Met
	The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	N/A

Strengths

- Varied specialists throughout Centene Corporation and AMR are available for consultation for medical necessity determinations.
- The Magnolia website contains a prior authorization pre-screening tool to allow providers to quickly determine if an authorization is required for a service or procedure.
- An electronic *Health Information Form,* available via the website, allows members to submit information regarding health conditions and specific needs. Members receive CentAccount rewards for completing the form.

Weaknesses

- The *CAN Member Handbook*, page 42, and the *CAN Provider Manual*, pages 13 and 21, incorrectly state a hospital/provider must notify of a member's admission within one business day of the admission.
- The *CHIP Member Handbook* does not define the authorization determination timeframe for urgent, pre-service, outpatient authorization requests and does not provide information on extensions of the timeframe.
- Issues related to inter-rater reliability testing for CHIP include:
    - Magnolia has not created a policy defining inter-rater reliability (IRR) testing processes and requirements for staff who issue medical necessity determinations for the CHIP product.
    - Review of QIC minutes for 12/17/16 included reporting of IRR results for "Medicaid" with no mention of the results for CHIP staff. Onsite discussion confirmed the results reported for "Medicaid" included those for both CAN and CHIP reviewers.
- Policy CC.PHAR.10, Preferred Drug List, does not include that Magnolia uses the most current version of the *Mississippi Medicaid Program Preferred Drug List*, as required by the *DOM Contract, Section 5 (F)*.
- Policy MS.PHAR.09, Pharmacy Program, does not define the product/line of business to which it applies. Onsite discussion confirmed this policy applies to both the CAN and CHIP products.
- No policy addressing details of the pharmacy authorization process for the CHIP product was provided. Onsite discussion revealed the processes are the same as those described in CAN Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria. The policy is not updated to indicate it applies to both the CAN and CHIP products.
- Two of three CAN UM denial files for pharmacy authorization requests showed denial determinations rendered by clinical pharmacists. Onsite discussion found pharmacists are permitted to issue denial determinations without referring the review to a medical director. This is not compliant with requirements documented in Policy MS.UM.04, Appropriate UM Professionals, the *CAN Contract, Section 5 (J) (1),* or the *CHIP Contract, Section 5 (H) (1)*.
- The *CAN Provider Manual*, page 44, definition of an action is incomplete. It is missing:
    - The denial, in whole or part, of payment for a service
    - The denial for a resident of a rural area with only one CCO to obtain services outside the network

- The *CHIP Member Handbook*, page 56, defines an appeal as "a request for Magnolia to review a Magnolia Notice of Adverse Action." This is not compliant with the definition of an appeal found in *Federal Regulation §438.400 (b)* and the *CHIP Contract, Section 2 (A)*.
- The *CHIP Provider Manual* does not define an appeal or an action and does identify who can file an appeal.
- Issues noted regarding procedures for filing an appeal include:
    - The timeframe to file an appeal is not specified in the *CHIP Provider Manual*.
    - The *CHIP Member Handbook*, *CHIP Provider Manual*, and initial CHIP denial letter template do not indicate that oral expedited appeal requests do not require written follow-up.
    - The *CAN Member Handbook* and *CAN Provider Manual* do not include that the member may present evidence and examine the case file and other documents related to the appeal.
    - The *CHIP Member Handbook* and *CHIP Provider Manual* do not include that the member may present evidence and examine the case file and other documents related to the appeal.
- Issues noted regarding timeliness guidelines for appeal resolution and timeframe extensions include:
    - Policy MS.UM.08, Appeal of UM Decisions (CAN), and Policy MS.UM.08.01, Appeal of UM Decisions (CHIP), do not specify the appeal resolution timeframe begins when the appeal request is received.
    - The *CAN Member Handbook*, the *CHIP Member Handbook*, and the *CAN Provider Manual* do not indicate members may request an extension of the standard appeal resolution timeframe.
    - The *CHIP Provider Manual*, pages 62-64, does not define the various levels of appeals (I, II, III) or provide information on the timeliness requirements for each. There is no information on extensions of timeframes.
- One CAN appeal resolution letter and one CHIP appeal resolution letter did not reference the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based, as required by CAN Policy MS. UM.08, Appeal of UM Decisions, and CHIP Policy MS. UM.08.01, Appeal of UM Decisions.
- Per the *UM Program Description* for CHIP, the UM Program is evaluated annually and modifications made as necessary; however, a copy of the written *UM Program Evaluation* for CHIP was not received.

Corrective Actions

- Revise the *CHIP Member Handbook* to include the determination timeframe and information on extensions of the timeframe for urgent, pre-service outpatient authorization requests.
- Develop a policy to define IRR processes for CHIP or update the CAN policy to indicate it also applies to CHIP.
- Ensure IRR results reported to the QIC clearly reflect the results for CHIP.
- Develop and implement a policy defining the pharmacy authorization processes for CHIP or revise CAN Policy CC.PHAR.08 to reflect it applies to both the CAN and CHIP products.
- Update pharmacy review processes to ensure pharmacy denials are issued only by Mississippi-licensed physicians as required by Policy MS.UM.04, the *CAN Contract, Section 5 (J) (1),* and the *CHIP Contract, Section 5 (H) (1).*
- Revise the *CAN Provider Manual* to include the complete definition of an action. Refer to the *CAN Contract, Section 2 (A).*
- Revise the definition of an appeal in the *CHIP Member Handbook* to be compliant with *Federal Regulation § 438.400 (b)* and the *CHIP Contract, Section 2 (A).*
- Update the *CHIP Provider Manual* to include definitions of the terms “action” and “appeal”. Define who can file an appeal.
- Add the timeframe to file an appeal to the *CHIP Provider Manual*. Refer to the *CHIP Contract, Exhibit E.*
- Revise the *CHIP Member Handbook*, *CHIP Provider Manual*, and initial denial letter template to indicate oral expedited appeal requests do not require written follow-up. Refer to *Federal Regulation § 438.402 (b) (3) (ii).*
- Revise the *CAN Member Handbook*, *CAN Provider Manual*, *CHIP Member Handbook*, and *CHIP Provider Manual* to inform that member may present evidence and examine the case file and other documents related to the appeal. Refer to *Federal Regulation § 438.406 (b) (2) and (3).*
- Revise Policy MS.UM.08, Appeal of UM Decisions, and Policy MS.UM.08.01, Appeal of UM Decisions, to specify the appeal resolution timeframe begins when the appeal request is received.
- Revise the *CAN Member Handbook*, the *CHIP Member Handbook*, and the *CAN Provider Manual* to include members may request an extension of the standard appeal resolution timeframe.

- Revise the *CHIP Provider Manual* to clearly define the member appeals processes and requirements, including the various levels of appeals, timeframes for resolution of each, and information on extensions of the timeframes.
- Ensure a written evaluation of the effectiveness of the UM Program for CHIP is produced annually.

Recommendations

- Revise the *CAN Member Handbook*, page 42, and the *CAN Provider Manual*, pages 13 and 21, to reflect the timeframe for a provider/facility to notify Magnolia of a member's inpatient admission is within two business days of admission.
- Revise Policy CC.PHAR.10 to indicate Magnolia uses the most current version of the *Mississippi Medicaid Program Preferred Drug List*. See the *DOM Contract, Section 5 (F)*.
- Revise Policy MS.PHAR.09 to define the product/line of business to which it applies.
- Ensure all appeal resolution letters contain a reference to the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based.

F. Delegation

Magnolia has delegation agreements with the entities identified in *Table 16, Delegated Entities and Services*.

Table 16: Delegated Entities and Services

Delegated Entities	Delegated Services
Cenpatico	Behavioral Health claims, network, utilization management, credentialing, and quality management
Dental Health & Wellness	Dental claims, network, utilization management, credentialing, and quality management
MTM (CAN Only)	Non-emergency transportation claims, network, utilization management, and quality management
NIA	Radiology utilization management
NurseWise	Nurse call center
Nurtur	Disease management
OptiCare	Vision services claims, network, utilization management, credentialing, and quality management
US Script	Pharmacy claims, network, utilization management, credentialing, and quality management

Magnolia has established policies defining the requirements for delegation including monitoring and oversight of the delegated vendors' performance. The *Master Services Agreement* and *Attachment B, Delegated Services Agreement*, specify the activities to be performed by delegates, and address performance standards as well as penalties and sanctions for sub-standard performance.

Policy MS.QI.14, Oversight of Delegated Credentialing, contains ambiguous information regarding oversight requirements. Page seven of the policy indicates for NCQA certified or accredited entities, the health plan may omit the annual evaluation and only require reporting from the delegate. The policy also states, the "Plan's State Contract may not acknowledge this automatic credit." As written, this could create confusion regarding the requirement that an annual evaluation must be conducted for each credentialing delegate. Refer to the *CAN Contract, Section 14 (B)*.

Magnolia retains accountability for all delegated services. Onsite discussion confirmed Centene (corporate) staff conducts credentialing delegation oversight, and both corporate and local plan staff conducts oversight for non-credentialing delegation. Delegate performance is monitored via review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings, and an annual evaluation. When deficiencies are identified, corrective action plans are developed, as warranted. Information regarding delegation oversight activities and reports of ongoing corrective action plans, if any, are presented to the QIC at least quarterly. When deficiencies are severe or unable to be resolved, the delegation arrangement may be revoked. Adequate evidence of delegation oversight was provided for each delegated entity.

As indicated in *Figure 7, Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met." Each line of business received a score of "Partially Met" due to inaccurate oversight documentation in the Oversight of Delegated Credentialing policy.

Figure 7: Delegation Findings

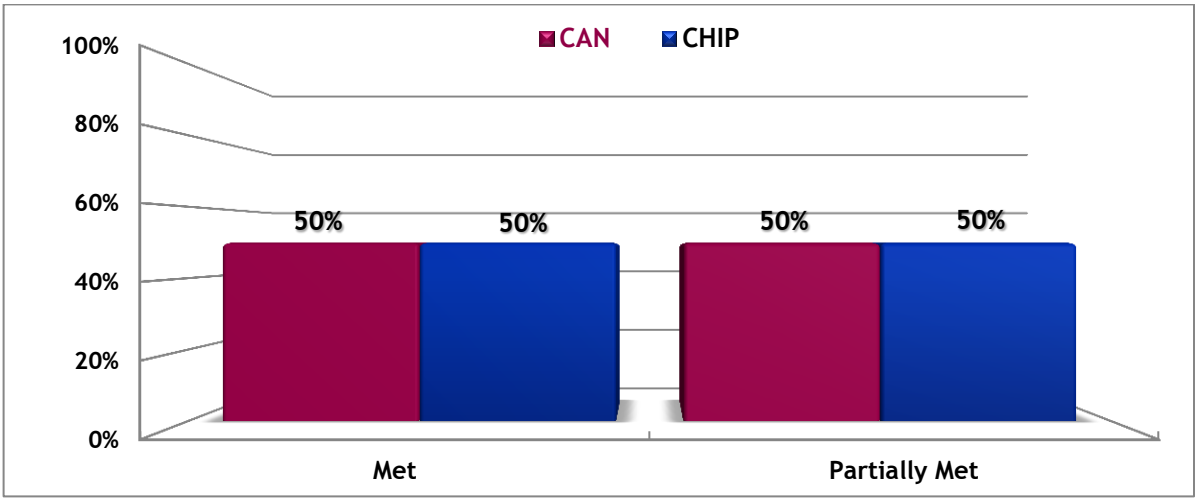


Table 17: Delegation

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Delegation	The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.	Partially Met	Partially Met

Weaknesses

- Policy CC.CRED.12, Oversight of Delegated Credentialing, page seven, contains incorrect information regarding Magnolia omitting the annual audit or evaluation when a delegate is NCQA Certified or Accredited. This is not compliant with requirements of the *CAN Contract, Section 14 (B)* or the *CHIP Contract, Section 14 (B)*.

Corrective Action

- Revise Policy CC.CRED.12, page seven, to remove the following statements:
    - "Per NCQA standards, in the instance where the delegate is NCQA Certified or Accredited, Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and omit the annual audit or evaluation."
    - "Once delegation occurs, Plan must only ensure that the delegate provides the appropriate reports as determined by Plan to ensure the delegate is compliant with the needs of Plan."

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
12040 Regency Parkway, Suite 100, Cary, NC 27518-8597 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

November 1, 2016

Mr. Aaron Sisk
Plan President & CEO
Magnolia Health Plan
111 East Capitol Street, Suite 500
Jackson, MS 39201

Dear Mr. Sisk:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2016 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN and Mississippi Children's Health Insurance Program (CHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The onsite visit will be conducted at Magnolia Health Plan's office on **February 7, 2017 through February 9, 2017 for the MississippiCAN Program and the Mississippi CHIP Program.**

In preparation for the desk review, the items on the enclosed **MississippiCAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **December 5, 2016**.

Submission of all the desk materials will be different than in the past. This year we have a new secure file transfer website for uploading desk materials electronically to CCME. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will simultaneously be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance.

We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site and we have included written desk instructions on how to use the file transfer site as well. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support. Of course, additional information and technical assistance will be provided as needed.

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DOM, to describe the review process and answer any questions prior to the onsite visit, is being offered as well.

Please contact me directly at 919-461-5588 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Karen Smith
Project Manager

Enclosure(s)
cc: DOM

Magnolia Health Plan

External Quality Review 2016 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MSCAN program, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence for the MSCAN program.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the MSCAN program. Please include any provider identified limitations on panel size considered in the network assessment.

5. A complete list of network providers for the MississippiCAN members. The lists should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. This list will be used to select a sample of providers for our telephone access study. The provider addresses and phone numbers should be current.

6. The total number of unique specialty providers for MSCAN as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

7. A current provider list/directory as supplied to MSCAN members.

8. A copy of the current Fraud, Waste & Abuse/Compliance plan for the MSCAN program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy programs for MSCAN.

10. The Quality Improvement work plans for MSCAN for 2015 and 2016.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Care Management programs for MSCAN.

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of

the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

a. For all projects with NON-HEDIS measures:
    - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
b. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction, and
    - 15 sample records from those abstracted charts.
c. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP, and
    - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

13. Minutes of all committee meetings in the past year for all committees reviewing or taking action on MSCAN related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

14. Membership lists and a committee matrix for all MSCAN committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include committee charters if available.

15. Any data for the MSCAN program collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities for the MSCAN program conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews. Please identify which reviews were conducted for a MSCAN provider.

18. A complete list of all members for MSCAN enrolled in the Care Management program from October 1, 2015 through September 30, 2016. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the MSCAN program and changes.

20. A copy of the MSCAN member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction surveys for the MSCAN program with a copy of the tool, and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the MSCAN program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the MSCAN program.

24. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of October 1, 2015 through September 30, 2016.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the MSCAN program.

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the MSCAN program. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment access monitoring.

27. Preventive health practice guidelines for the MSCAN program recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

28. Clinical practice guidelines for the MSCAN program for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

29. A list of physicians for the MSCAN program currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual for MSCAN program.

31. A sample provider contract for the MSCAN program.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A description of the data security policy with respect to email and PHI.

33. A listing of all MSCAN delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

34. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

36. All performance measures calculated and required to be reported to the state for the MSCAN program. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen, and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/10 and/or CPT-4 codes, member months/years calculation, other specified parameters);
    d. if non HEDIS, programming specifications that include data sources such as files/databases and fields with definitions, programming logic, and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

37. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.

c. Twenty-five medical necessity denial files for the MSCAN program made in the months of October 1, 2015 through September 30, 2016. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of October 1, 2015 through September 30, 2016, including any medical information and approval criteria used in the decision.

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

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at** https://egro.thecarolinascenter.org
- **should be submitted in the categories listed.**

Magnolia Health Plan

External Quality Review 2016 for Mississippi CHIP

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the CHIP program, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence for the CHIP program.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the CHIP program. Please include any provider identified limitations on panel size considered in the network assessment.

5. A complete list of network providers for the Mississippi CHIP members. The lists should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. This list will be used to select a sample of providers for our telephone access study. The provider addresses and phone numbers should be current.

6. The total number of unique specialty providers for CHIP as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

7. A current provider list/directory as supplied to the CHIP members.

8. A copy of the current Fraud, Waste & Abuse/Compliance plan for the CHIP program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy programs for CHIP.

10. The Quality Improvement work plans for CHIP for 2015 and 2016.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Care Management programs for CHIP.

12. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement

definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

a. For all projects with NON-HEDIS measures:
    - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
b. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction, and
    - 15 sample records from those abstracted charts.
c. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP, and
    - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

13. Minutes of all committee meetings in the past year for all committees reviewing or taking action on Mississippi CHIP related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

14. Membership lists and a committee matrix for all CHIP committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include committee charters if available.

15. Any data for the CHIP program collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities for the CHIP program conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews. Please identify which reviews were conducted for a CHIP provider.

18. A complete list of all members for CHIP enrolled in the Care Management program from October 1, 2015 through September 30, 2016. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the CHIP program and changes.

20. A copy of the CHIP member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction surveys for the CHIP program with a copy of the tool, and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the CHIP program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the CHIP program.

24. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of October 1, 2015 through September 30, 2016.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements. For the CHIP program. Please also include the letter template used to notify CHIP members that their annual out-of-pocket maximum has been met.

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the CHIP program. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment access monitoring.

27. Preventive health practice guidelines for the CHIP program recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

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31. A sample provider contract for the CHIP program.

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    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

g. A description of the data security policy with respect to email and PHI.

33. A listing of all CHIP delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

34. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

36. All performance measures calculated and required to be reported to the state for the CHIP program. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen, and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/10 and/or CPT-4 codes, member months/years calculation, other specified parameters);
    d. if non HEDIS, programming specifications that include data sources such as files/databases and fields with definitions, programming logic, and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

37. Provide electronic copies of the following files for the CHIP program:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
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v. One file for each additional type of facility in the network.

c. Twenty-five medical necessity denial files for the CHIP program made in the months of October 1, 2015 through September 30, 2016. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP program made in the months of October 1, 2015 through September 30, 2016, including any medical information and approval criteria used in the decision.

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

These materials:

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- **should be submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

Magnolia Health Plan – MississippiCAN

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Policy CP.MP.68, Medical Necessity Criteria
3. Policy CC.CRED.04, Nondiscriminatory Credentialing and Recredentialing, if applicable.
4. An example of all the materials mailed in the New Member Packet.
5. Please provide a print version of the CAN Member Handbook.
6. Please provide the following policies if still active:
    a. CC.CLMS.10.94
    b. CC.HUMR.17
    c. Attachment A of Policy CC.LEGL.01- Records Retention Schedules
7. Please provide the following documents that were not received as part of the Credentialing Files:
    a. Provider Office evaluations for all initial credentialing files as defined in policy MS.CONT.03, Site Assessments for New Provider Contracts.
    b. Cierra Colbert, MD PCP – Proof of malpractice insurance
    c. Radha Alur, PCP MD –CLIA is not addressed on application or verified on the checklist.
    d. Michael Williams, NP PCP - Proof of malpractice insurance; please advise why the checklist is not in file as the date application was received could not be determined.
    e. Brandy Parker, NP Specialist – copy of DEA
    f. Shimeka Banks, OB/GYN PCP – Proof of malpractice insurance
    g. Jessica Moran, NP PCP – Could not establish when provider was notified of credentialing committee approval; ownership disclosure form was signed but there was no date by the signature. Please advise.
8. Please provide the following documents that were not received as part of the Recredentialing Files:

a. Parry Wilson, MD Specialist – Physician profiling results not addressed in the file. The checklist shows a date of 12/20/13 for Quality Data.
b. Bernard De As, MD PCP – Application shows received date 1/27/16 and not approved by committee until 7/21/16, please advise why it took so long. Could not locate date of initial/prior credentialing.
c. Jeffrey Burns, MD Specialist - Could not locate date of initial/prior credentialing.
d. Thomas Barkley, MD PCP – Application (page 20 in file) says Baptist Memorial Hospital -Union County for hospital privileges but verification (page 37 in file) shows only that he can order outpatient diagnostic tests. Please provide explanation. Also please provide the NPPES search.

9. Please provide the following documents for organizational providers that were not received as part of the Credentialing/Recredentialing Files:
    a. The following credentialing files did not show proof of queries for OIG or SAM. Please provide documents or explanation: Children's Hospital; Pearl River County; Vicksburg Convalescent; Winston Medical Center; and BNB Healthcare.
    b. Recredentialing for UMC Dialysis – Ownership Disclosure Form
10. Please provide reports for measuring provider adherence to the appointment access standards for 2015 and 2016.
11. Please provide reports for measuring provider adherence to medical record standards for 2015 and 2016.
12. The name of reviewer who issued the initial denials for all appeal files that were submitted to CCME.

Materials should be uploaded to the secure CCME EQR File Transfer site at https://egro.thecarolinascenter.org

Magnolia Health Plan – Mississippi CHIP

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Policy CP.MP.68, Medical Necessity Criteria
3. Policy CC.CRED.04, Nondiscriminatory Credentialing and Recredentialing, if applicable.
4. Please provide the following documents that were not received as part of the Credentialing Files:
    a. Provider Office evaluations for all initial credentialing files as defined in policy MS.CONT.03, Site Assessments for New Provider Contracts.
    b. Cierra Colbert, MD PCP – Proof of malpractice insurance
    c. Radha Alur, PCP MD –CLIA is not addressed on application or verified on the checklist.
    d. Michael Williams, NP PCP - Proof of malpractice insurance; please advise why the checklist is not in file as the date application was received could not be determined.
    e. Brandy Parker, NP Specialist – copy of DEA
    f. Shimeka Banks, OB/GYN PCP – Proof of malpractice insurance
    g. Jessica Moran, NP PCP – Could not establish when provider was notified of credentialing committee approval; ownership disclosure form was signed but there was no date by the signature. Please advise.
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    b. Bernard De As, MD PCP – Application shows received date 1/27/16 and not approved by committee until 7/21/16, please advise why it took so long. Could not locate date of initial/prior credentialing.
    c. Jeffrey Burns, MD Specialist - Could not locate date of initial/prior credentialing.

d. Thomas Barkley, MD PCP – Application (page 20 in file) says Baptist Memorial Hospital -Union County for hospital privileges but verification (page 37 in file) shows only that he can order outpatient diagnostic tests. Please provide explanation. Also please provide the NPPES search.

6. Please provide the following documents for organizational providers that were not received as part of the Credentialing/Recredentialing Files:
    a. The following credentialing files did not show proof of queries for OIG or SAM. Please provide documents or explanation: Children's Hospital; Pearl River County; Vicksburg Convalescent; Winston Medical Center; and BNB Healthcare.
    b. Recredentialing for UMC Dialysis – Ownership Disclosure Form
7. Please provide reports for measuring provider adherence to the appointment access standards for 2015 and 2016.
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9. The name of reviewer who issued the initial denials for all appeal files that were submitted to CCME.

Materials should be uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN and CHIP
- Member Satisfaction Survey Validation CAN
  - Adult
  - Child with CCC
  - Child
- Member Satisfaction Survey Validation CHIP
  - Child CCC
  - Child
- HEDIS PM Validation CAN
- HEDIS PM Validation CHIP
- Non-HEDIS PM Validation CAN
  - PRE AND POST NATAL COMPLICATIONS
  - ASTHMA RELATED ER VISITS
  - CHF READMISSIONS
  - ASTHMA READMISSIONS
- Non-HEDIS PM Validation CHIP
  - BHRA (BEHAVIORAL HEALTH RISK ASSESSMENT)
  - DEV (DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE)
- PIP Validation CAN
  - ASTHMA
  - CONGESTIVE HEART FAILURE READMISSIONS
  - DIABETES
  - OBESITY
- PIP Validation CHIP
  - ADHD
  - ASTHMA
  - EPSDT SERVICES FOR CHILDREN UP TO 19 YEARS OF AGE
  - OBESITY FOR CHILDREN

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA CAN AND CHIP**
Survey Validated	**PROVIDER SATISFACTION SURVEY**
Validation Period	2016
Review Performed	01/2017

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Uses 2015 SPHA Provider Satisfaction Survey *Documented:* 2015 Provider Satisfaction Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses 2015 SPHA Provider Satisfaction Survey *Documented:* 2015 Provider Satisfaction Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Uses 2015 SPHA Provider Satisfaction Survey *Documented:* 2015 Provider Satisfaction Report

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**NOT MET**	Information on reliability of the SPHA Provider Satisfaction Survey was not provided. **RECOMMENDATION**: Include information and appropriate statistical values regarding reliability of the survey.
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**NOT MET**	Information on validity of the SPHA Provider Satisfaction Survey was not provided in documentation. **RECOMMENDATION**: Include information and appropriate statistical values regarding validity of the survey.

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was clearly identified. *Documented:* 2015 Provider Satisfaction Report
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined and appropriate. *Documented:* 2015 Provider Satisfaction Report
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy was noted. *Documented:* 2015 Provider Satisfaction Report
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Sample size is sufficient. *Documented:* 2015 Provider Satisfaction Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documented:* 2015 Provider Satisfaction Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Response rate calculation was provided in the documentation and was appropriate. *Documented:* 2015 Provider Satisfaction Report
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	Initial sample (6.4%) had a low response rate and the later sample had a response rate of 36.7%. This is slightly below the NCQA target response rate for surveys of 40%. The low response rate may affect the generalizability of the survey. **RECOMMENDATION:** Work to increase response rates to avoid biases and lack of generalizability of results. *Documented:* 2015 Provider Satisfaction Report

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Survey instrument was administered by SPH Analytics, an NCQA certified, experienced survey organization. Their standard procedures were used for this survey. *Documented:* 2015 Provider Satisfaction Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Based on the timelines provided, the survey followed the planned approach. *Documented:* 2015 Provider Satisfaction Report
5.3	Were confidentiality procedures followed?	**MET**	Survey instrument was administered by SPH Analytics, an NCQA certified, experienced survey organization. Their standard procedures were used for this survey. *Documented:* 2015 Provider Satisfaction Report

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. *Documented:* 2015 Provider Satisfaction Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were used and applied correctly. *Documented:* 2015 Provider Satisfaction Report
6.3	Were all survey conclusions supported by the data and analysis?	**NOT MET**	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. **RECOMMENDATION:** Work to increase response rates to avoid biases and lack of generalizability of results. *Documented:* 2015 Provider Satisfaction Report

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of an NCQA certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report. All measures are compared to 2013, 2014, 2015 trend years and the 2014 SPH Analytics Medicaid Book of Business are also provided for comparison.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were identified.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate is low and may impact the generalizability of the results.
7.4	What conclusions are drawn from the survey data?	The 2015 rates for overall satisfaction with Magnolia Health Plan were higher in 2015 (63.2%) than 2014 (53.9%). There were several items increasing from 2014 to 2015, including Finance Issues, Utilization and Quality Management, Network/Coordination of Care, Pharmacy, and Recommend to Other Physicians' Practices. There were two measures which decreased from last year: Health Plan Call Center Service Staff and Provider Relations. Several of Magnolia's composite and key attribute measure rates were below the 2014 SPHA Medicaid Book of Business 50th and 75th percentile rates. *Documented:* 2015 Provider Satisfaction Report
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Not Applicable for this survey.
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA CAN**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID ADULT)**
Validation Period	2016
Review Performed	01/2017

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Uses CAHPS and its standardized purpose. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses CAHPS and its standardized objectives. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended use for survey findings is identified *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Survey is reliable. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Survey is valid. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population clearly identified. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for the sample frame clearly defined and appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy is appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Sample size is sufficient for the use of the survey. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Uses standard NCQA definition for response rate calculation by their certified vendor. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report

Survey Element		Element Met / Not Met	Comments And Documentation
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The results met the minimum number of responses considered by NCQA necessary for a valid survey (n=432), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent, respectively) at 24.2%. Alternative approaches are needed to increase the response rates. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for this population. Solicit the help of your survey vendor.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Uses standard CAHPS for measurement via a certified vendor using the protocols established by NCQA in their HEDIS® 2015 CAHPS® 5.0H guidelines and HEDIS® 2016 Volume Three Technical Update Specifications. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Based on the timelines provided, the survey followed the planned approach. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were used and applied correctly. *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report
6.3	Were all survey conclusions supported by the data and analysis?	**NOT MET**	The response rate for the Medicaid adult population was low. Response rate bias is a concern because the generalizability of the results can be affected by low response rates. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for the Medicaid adult population.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Adult 5.0H Final Report

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. SPH Analytics provides a full report of process and results meeting the necessary requirements and expectations of a survey report. All measures are compared to the 2016 SPH Analytics Book of Business benchmark and the 2015 Quality Compass® All Plans Medicaid Adult benchmark.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Response rate was below the response rate target (see Element 4.2 for recommendations).

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	For composite questions: • Getting Needed Care: The rate increased and met the goal. • Getting Care Quickly: The rate decreased and did not meet the goal. • How Well Doctors Communicate: The rate increased and met the goal. • Customer Service: The rate increased and met the goal. The goal rates for these composite questions for 2016 were based on the 2015 Quality Compass All Plans benchmark. “Getting Care Quickly” was 0.10% from the goal. *Documentation:* 2016 MSCAN CAHPS Executive Summary
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in QIC meeting minutes and *Accessing the Network* report. *Documentation:* Assessment of Member Experience Accessing the Network Report 10.6.16 QIC Meeting Minutes
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA CAN**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD WITH CCC)**
Validation Period	2016
Review Performed	01/2017

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Uses CAHPS and its standardized purpose. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objectives are clear and measurable. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended use and audience is identified. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	CAHPS survey is reliable.
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	CAHPS survey is valid.

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was clearly identified. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined and appropriate. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy was noted. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Sample size is sufficient, based on population size. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures used to select sample were appropriate. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	It could not be determined which respondents of the sample qualify as having a chronic condition, thus, the response rate is not provided for the CCC population. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NA**	Response rate is not provided for the CCC population. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Uses standard CAHPS for measurement via a certified vendor using the protocols established by NCQA in their HEDIS® 2015 CAHPS® 5.0H guidelines and HEDIS® 2016 Volume Three Technical Update Specifications. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Based on the timelines provided, the survey followed the planned approach. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Uses standard CAHPS for measurement via a certified Vendor *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Uses standard CAHPS for measurement via a certified Vendor *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report
6.3	Were all survey conclusions supported by the data and analysis?	**NA**	The generalizability of the results is undetermined due to lack of response rate information. It is difficult to determine if survey conclusions are supported by data and analysis. *Documented:* SPH Analytics 2016 Medicaid Child with CCC Measurement Set CAHPS 5.0H Final Report

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of surveys. SPH Analytics provides a full report of process and results meeting the necessary requirements and expectations of a survey report. All measures are compared to the 2016 SPH Analytics Book of Business benchmark and the 2015 Quality Compass® All Plans benchmark.
7.2	Identify the technical weaknesses of the survey and its documentation.	The generalizability of the results is undetermined due to lack of response rate information. It is difficult to determine if survey conclusions are supported by data and analysis. ***RECOMMENDATION*** *Identify methods to determine if response rate can be calculated and if denominator can be calculated using member data.*
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate is unable to be reported, affecting the ability to generalize the findings to the CCC population.
7.4	What conclusions are drawn from the survey data?	The 2015 Quality Compass All Plans benchmark was used as the 2016 goal for the Children with Chronic Conditions survey. Seven questions did not meet the goal. Four of these were 1% or less than the goal. Rating of health plan was 2.8% point lower than the goal. Doctors spending enough time with members was 20.2% lower than the goal. All other questions and composites met the goal for 2016. For 2016, there were not any statistically significant increases or decreases in the rates for the CCC population. *Documentation:* 2016 MSCAN CAHPS Executive Summary
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in CAHPS executive summary document. *Documentation:* 2016 MSCAN CAHPS Executive Summary
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA CAN**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD)**
Validation Period	2016
Review Performed	01/2017

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Uses CAHPS and its standardized purpose. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses CAHPS and its standardized objectives. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Uses standard CAHPS for measurement and use. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was clearly defined. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy was appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Sample size was sufficient for intended use of the survey. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are documented. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

Survey Element		Element Met / Not Met	Comments And Documentation
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The results met the minimum number of responses considered by NCQA necessary for a valid survey (n=557), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively) at 20.9%. Alternative approaches are needed to increase the response rates. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for this population. Solicit the help of your survey vendor.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Uses standard CAHPS for measurement via a certified vendor using the protocols established by NCQA in their HEDIS® 2015 CAHPS® 5.0H guidelines and HEDIS® 2016 Volume Three Technical Update Specifications. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Based on the timelines provided, the survey followed the planned approach. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Uses standard CAHPS for measurement via a certified vendor *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Uses standard CAHPS for measurement via a certified vendor *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report
6.3	Were all survey conclusions supported by the data and analysis?	**NOT MET**	The response rate for the Medicaid Child population was low. Response rate bias is a concern because the generalizability of the results can be affected by low response rates. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for the Medicaid Child population.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. SPH Analytics as a vendor provides a full report of process and results meeting necessary requirements and expectations of a survey report. All measures are compared to the 2016 SPH Analytics Book of Business benchmark and the 2015 Quality Compass® All Plans benchmark.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Response rate was below the response rate target. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for this population. Solicit the help of your survey vendor.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	Two key questions did not meet the goal for 2016. Rating of Health Care was 3.5% lower than goal and Rating of Health Plan was 1.5% lower than the goal for 2016. All other composites and key questions met the 2016 goal. Ten of the questions improved since 2015 and seven questions are improving year over year. For 2016, there were neither statistically significant increases nor decreases in the rates for the child population. *Documentation:* 2016 MSCAN CAHPS Executive Summary
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in CAHPS executive summary document. *Documentation:* 2016 MSCAN CAHPS Executive Summary
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA CHIP**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD CCC)**
Validation Period	2016
Review Performed	01/2017

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Uses CAHPS and its standardized purpose. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses CAHPS and its standardized objectives. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Uses standard CAHPS for measurement and use. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Uses standard CAHPS for measurement via a certified vendor *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was clearly defined. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy was appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Sample size was sufficient for intended use of the survey. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are documented. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NA**	There were 294 child members identified as children with Chronic conditions in the CAHPS survey responses. It cannot be determined which respondents of the sample qualify as having a chronic condition, thus, response rate cannot be provided. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Uses standard CAHPS for measurement via a certified vendor using protocols established by NCQA in their HEDIS® 2015 CAHPS® 5.0H guidelines and HEDIS® 2016 Volume Three Technical Update Specifications. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Based on the timelines provided, the survey followed the planned approach. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor adhering to the approved confidentiality processes and procedures. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Uses standard CAHPS for measurement via a certified vendor *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Uses standard CAHPS for measurement via a certified vendor *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
6.3	Were all survey conclusions supported by the data and analysis?	**NA**	The generalizability of the survey results is difficult to discern due to lack of information regarding the response rate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. SPH Analytics provides a full report of process and results meeting the necessary requirements and expectations of a survey report. All measures are compared to the 2016 SPH Analytics Book of Business benchmark and the 2015 Quality Compass® All Plans benchmark.
7.2	Identify the technical weaknesses of the survey and its documentation.	The response rate was unable to be calculated. ***RECOMMENDATION*** *Revisit the inability to calculate a response rate for this population. Generate a method to determine the denominator, if possible.*
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to lack of information regarding the response rate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child CCC 5.0H Final Report for Magnolia CHIP
7.4	What conclusions are drawn from the survey data?	Customer Service Composite did not meet the 2015 Quality Compass All Plans benchmark by 0.9% percentage points. The Customer Service key question Treated with courtesy and respect by the customer service staff was 2.4% below the goal. All other composites and key questions met or exceeded the established goal except Rating of Health Plan, 4.9% below the benchmark. *Documentation:* 2016 CHIP CAHPS Executive Summary
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in CAHPS executive summary document. *Documentation:* 2016 CHIP CAHPS Executive Summary
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA CHIP**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD)**
Validation Period	2016
Review Performed	01/2017

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Uses CAHPS and its standardized purpose. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses CAHPS and its standardized objectives. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Uses standard CAHPS for measurement and use. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Survey version 5.0H administrated Vendor: SPH Analytics

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was clearly defined. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy was appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Sample size was sufficient for intended use of the survey. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are documented. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

Survey Element		Element Met / Not Met	Comments And Documentation
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The results met the minimum number of responses considered by NCQA necessary for a valid survey (n=522), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively) at 20.0%. Alternative approaches are needed to increase the response rates. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for this population. Solicit the help of your survey vendor.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Uses standard CAHPS for measurement via a certified vendor using protocols established by NCQA in their HEDIS® 2015 CAHPS® 5.0H guidelines and HEDIS® 2016 Volume Three Technical Update Specifications. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Based on the timelines provided, the survey followed the planned approach. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor adhering to approved confidentiality processes and procedures. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP
6.3	Were all survey conclusions supported by the data and analysis?	**NOT MET**	The response rate for the Medicaid Child population was low. Response rate bias is a concern because the generalizability of the results can be affected by low response rates. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for the Medicaid Child population.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. SPH Analytics as a vendor provides a full report of process and results meeting the necessary requirements and expectations of a survey report. All measures are compared to the 2016 SPH Analytics Book of Business benchmark and the 2015 Quality Compass® All Plans benchmark.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Response rate was below the response rate target. ***RECOMMENDATION*** *Focus on strategies to help increase response rates for this population. Solicit the help of the survey vendor.* *Documented:* SPH Analytics 2016 CAHPS Medicaid Child 5.0H Final Report for Magnolia CHIP

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	Four key questions did not meet the *2015 Quality Compass All Plans* benchmark: • Obtained appointment with a specialist as soon as needed was 1.9% below the goal. • Getting information/help from customer service was 0.4% below the goal. • Rating of health care was 0.2% below the goal. • Rating of the health plan was 5.7% below benchmark. All other key questions and composites were above the goal for 2016. *Documentation:* 2016 CHIP CAHPS Executive Summary
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in CAHPS executive summary document. *Documentation:* 2016 CHIP CAHPS Executive Summary
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CAN**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2015**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2016

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator data sources have been met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator calculation have been met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan uses Altegra for medical record abstraction.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses Altegra for medical record abstraction. On page 26 of *Attest Health Care Advisors Audit Report,* it was noted the final MRRV (medical record review validation) resulted in required administrative reporting for WCCB & CDC DRE. On page 9, however, both measures were considered a PASS for validation.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses Altegra for medical record abstraction.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Sampling methods passed audit.
S2. Sampling	Sample treated all measures independently.	**MET**	Sampling methods passed audit.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sampling methods passed audit.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to technical specifications?	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for reporting have been met.

VALIDATION SUMMARY

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

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

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CHIP**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2015**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2016

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for documentation have been met.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for denominator data sources have been met.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for denominator calculation have been met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator data sources have been met.
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator calculation have been met.
N8. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan uses Altegra for medical record abstraction.
N9. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses Altegra for medical record abstraction. On page 26 of *Attest Health Care Advisors Audit Report,* it was noted the final MRRV (medical record review validation) resulted in required administrative reporting for WCCB & CDC DRE. On page 9, however, both measures were considered a PASS for validation.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses Altegra for medical record abstraction.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**MET**	Sampling methods passed audit.
S5. Sampling	Sample treated all measures independently.	**MET**	Sampling methods passed audit.
S6. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sampling methods passed audit.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately.
R4. Reporting	Was the measure reported according to technical specifications?	**MET**	Plan uses NCQA certified software, Inovalon. Review requirements for reporting have been met.

VALIDATION SUMMARY

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

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

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CAN**
Name of PM:	**PRE AND POST NATAL COMPLICATIONS**
Reporting Year:	**Measurement Year 2015**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS DOM Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G3. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D5. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources are accurate.
D6. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator adheres to appropriate specifications dictated by the State.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N11. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Data sources are complete and accurate.
N12. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	Prenatal complications should only be in the range of 640-649 and include all.01 and .03 sub codes. (For example 640.01, 640.03, 640.81, 640.83, 640.91, 640.93, 641.01, 641.03 etc.…). The programming logic only includes fourth digits of "0" and should include all applicable digits. ***RECOMMENDATION*** *Correct issues and include all codes required by the specifications.*
N13. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N14. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N15. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Hybrid method not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S7. Sampling	Sample was unbiased.	**NA**	Sampling was not utilized.
S8. Sampling	Sample treated all measures independently.	**NA**	Sampling was not utilized.
S9. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Sampling was not utilized.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R5. Reporting	Was the measure reported accurately?	**NOT MET**	Deviations from the specifications were found, calling into question the accuracy of the reported rates. ***RECOMMENDATION*** *Correct the issues so the measure complies with State specifications and recalculate the measures.*
R6. Reporting	Was the measure reported according to technical specifications?	**MET**	Measure was reported according to all State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
SUBSTANTIALLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CAN**
Name of PM:	**ASTHMA RELATED ER VISITS**
Reporting Year:	Measurement Year 2015
Review Performed:	2017

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS DOM Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculation was in place.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Data sources used to calculate numerator values were complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

Plan's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CAN**
Name of PM:	**CHF READMISSIONS**
Reporting Year:	Measurement Year 2015
Review Performed:	2017

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS DOM Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Data sources used to calculate numerator values were complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

Plan's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CAN**
Name of PM:	**ASTHMA READMISSIONS**
Reporting Year:	Measurement Year 2015
Review Performed:	2017

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS DOM Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Data sources used to calculate numerator values were complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

Plan's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CHIP**
Name of PM:	**BHRA (BEHAVIORAL HEALTH RISK ASSESSMENT)**
Reporting Year:	**Measurement Year 2015**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHIPRA Core Set Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G4. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate per *Attest Health Report*.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D7. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources are accurate per *Attest Health Report*.
D8. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator adheres to the appropriate specifications dictated by the State.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N16. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Data sources are complete and accurate, per *Attest Health Report*.
N17. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculations of measures adhered to specifications and are accurate per I.
N18. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N19. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N20. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Hybrid method not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S10. Sampling	Sample was unbiased.	**NA**	Sampling was not utilized.
S11. Sampling	Sample treated all measures independently.	**NA**	Sampling was not utilized.
S12. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Sampling was not utilized.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R7. Reporting	Was the measure reported accurately?	**MET**	Measure was approved as reported per *Attest Health Report*.
R8. Reporting	Was the measure reported according to technical specifications?	**MET**	Measure was reported according to all CHIPRA specifications.

VALIDATION SUMMARY

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

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

Plan's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA CHIP**
Name of PM:	**DEV (DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE)**
Reporting Year:	**Measurement Year 2015**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHIPRA Core Set Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G5. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate as per Attest Health report.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D9. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources are accurate as per Attest Health report.
D10. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator is adhering to the appropriate specifications dictated by the State.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N21. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**MET**	Data sources are complete and accurate as per Attest Health report.
N22. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculations of measures adhered to specifications and are accurate as per Attest Health report.
N23. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N24. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N25. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Hybrid method not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S13. Sampling	Sample was unbiased.	**NA**	Sampling was not utilized.
S14. Sampling	Sample treated all measures independently.	**NA**	Sampling was not utilized.
S15. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Sampling was not utilized.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R9. Reporting	Was the measure reported accurately?	**MET**	Measure was approved as reported as per Attest Health report.
R10. Reporting	Was the measure reported according to technical specifications?	**MET**	Measure was reported according to all CHIPRA specifications.

VALIDATION SUMMARY

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

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

Plan's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CAN)**
Name of PIP:	**ASTHMA**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	10.4% of Mississippi children ages 0-17 years and 7.5% of adults ages 18 and above currently have asthma.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-4.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-8.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-9.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed on page A-8.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are identified on pages A-10 to A-12.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	Results are presented on page A-16. The numerator and denominator are switched. The baseline rate is the same as the baseline goal. **Recommendation:** Revise the numeric values on page A-16 so that numerator and denominator are correct.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	The analysis does not indicate interpretation of the baseline rate in comparison to the baseline goal. **Recommendation**: Although only baseline data have been collected, a narrative regarding the baseline rate in comparison with the baseline goal should be included on page A-16.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance are the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	0
8.3	NA	NA
8.4	1	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	**67**
Project Possible Score	**78**
Validation Findings	**86%**

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CAN)**
Name of PIP:	**CONGESTIVE HEART FAILURE READMISSIONS**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	CHF was most prevalent and most costly disease in Mississippi in 2010.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-3 of documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**NOT MET**	The indicator description mentions DOM performance measure as the source, but the description and baseline goal do not match measurement type. **Recommendation:** Correct documentation so that the study indicator description matches the DOM specification description. The numerator is correct; the denominator is 1,000 member months. Also, the study indicator is described as a "percentage" when the indicator is not a percentage, but a numeric value.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-7.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-8.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NOT MET**	Qualifications of personnel not documented. **Recommendation**: Include qualifications of personnel working with data on page A-7 or A-13.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified on pages A-9 to A-11.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline data and whether or not it met the baseline goal was not provided on page A-15. **Recommendation:** Include narrative of the rate for the current measurement period and whether or not it met the baseline goal on page

Component / Standard (Total Points)	Score	Comments
		A-15.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	0
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	0
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	**62**
Project Possible Score	**78**
Validation Findings	**80%**

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CAN)**
Name of PIP:	**DIABETES**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Mississippi ranks second in Diabetes prevalence.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-3 of documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined on page A-4.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not yet conducted.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not yet conducted.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not yet conducted.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-7.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-8.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are on page A-7.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers identified on pages A-9 to A-11.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No analysis to present.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	No results to present.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	No analysis to present.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	NA	NA
8.2	NA	NA
8.3	NA	NA
8.4	NA	NA
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	62
Project Possible Score	62
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CAN)**
Name of PIP:	**OBESITY**
Reporting Year:	**2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Mississippi ranks first in adult obesity.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is stated clearly in documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Baseline goal and benchmark are the same. The baseline goal is an initial goal set for baseline measurement only. The benchmark is the goal used to consider the study to be complete.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not yet conducted.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not yet conducted.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not yet conducted.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-8.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-9.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are not listed on page A-8.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers identified on pages A-10 to A-11.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No analysis to present.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	No results to present.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	No analysis to present.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	NA	NA
8.2	NA	NA
8.3	NA	NA
8.4	NA	NA
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	**62**
Project Possible Score	**62**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CHIP)**
Name of PIP:	**ADHD**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Mississippi has an 11% incidence of children with ADHD.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-8.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-9.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed on page A-8.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers identified on pages A-10 to A-11.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Analyses have not yet been conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Analyses have not yet been conducted.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Analyses have not yet been conducted.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	NA	NA
8.2	NA	NA
8.3	NA	NA
8.4	NA	NA
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	62
Project Possible Score	62
Validation Findings	100%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CHIP)**
Name of PIP:	**ASTHMA**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	10.4% of MS children ages 0-17 have asthma.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-7.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-8.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed on page A-7.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers identified on pages A-9 to A-10.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Analyses have not yet been conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Analyses have not yet been conducted.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Analyses have not yet been conducted.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	NA	NA
8.2	NA	NA
8.3	NA	NA
8.4	NA	NA
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	62
Project Possible Score	62
Validation Findings	100%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CHIP)**
Name of PIP:	**EPSDT SERVICES FOR CHILDREN UP TO 19 YEARS OF AGE**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Well-child visits are vital for reducing morbidity and mortality from childhood diseases and conditions.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-4.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-10.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-11.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed on page A-10.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers identified on pages A-12 to A-15.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Interpretation of findings is noted on page A-18.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	1
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	78
Project Possible Score	78
Validation Findings	100%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA (CHIP)**
Name of PIP:	**OBESITY FOR CHILDREN**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	The rate of obesity exceeds 35% in Mississippi.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page A-4.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sampling is based on specific criteria being met.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Sample will contain only children meeting specific criteria.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sample includes all enrollees meeting criteria.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted on page A-8.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted on page A-9.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed on page A-8.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers identified on pages A-10 to A-12.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Analyses have not yet been conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Analyses have not yet been conducted.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Repeat measurements are not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Analyses have not yet been conducted.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	There were no repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	There were no repeat measurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There were no repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There were no repeat measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There were no repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	NA	NA
8.2	NA	NA
8.3	NA	NA
8.4	NA	NA
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	82
Project Possible Score	82
Validation Findings	100%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**Magnolia Health Plan MS CAN**
Review Performed:	2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Magnolia Health Plan (Magnolia) for MSCAN has a comprehensive set of policies and procedures that are generally specific to Mississippi or contain Mississippi addendums. Some policies did not clearly indicate the line of business to which they applied. Because Magnolia serves CHIP, CAN, and a marketplace insurance plan, policies need to clearly indicate the line(s) of business to which they apply. Policies are reviewed annually and updated as needed. Employees have access to policies on a shared drive. Magnolia underwent full NCQA Accreditation in 2016 and is awaiting the final determination. *Recommendation: Ensure all Magnolia policies for CAN indicate the line of business to which the policy applies.*
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. At a minimum, this includes designated staff performing in the following roles:						Magnolia Health has sufficient administrative and clinical staff to ensure members have access to required benefits and services as determined by the State of Mississippi. The Leadership Team is in place with no vacancies noted.
1.1 Full time Chief Executive Officer;	X					Aaron Sisk serves as plan president and CEO. He is located in Mississippi and is responsible for the day-to-day business activities of Magnolia Health Plan. He reports to Jason Dees, the regional vice president of health plan operations. The Board of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Directors has ultimate authority and accountability for the oversight of the quality of services provided to members. Magnolia Health Plan is part of the Centene Corporation, located in St. Louis, Missouri.
1.2 Chief Operations Officer;	X					Trip Peeples is the senior vice president of operations.
1.3 Chief Financial Officer;	X					Michael Ruffin is the vice-president of finance.
1.4 Chief Information Officer: A professional who will oversee information technology and systems to support CCO operations, including submission of accurate and timely encounter data;	X					Magnolia has a local IT support person in Mississippi with Centene Corporate staff supporting local Mississippi IT functions. The Finance department assumes the responsibility for submission of required encounter data reporting.
1.4.1 Information Systems personnel;	X					
1.5 Claims Administrator;	X					Debra Merchant is the manager of claims.
1.6 Provider Services Manager;	X					Cynthia Douglas is the senior director, network development & contracting. Her responsibilities include claims, provider contracting, and local credentialing.
1.6.1 Provider credentialing and education;	X					The Provider Relations department is charged with conducting overall provider education. The Quality Improvement department educates providers on quality measures, such as HEDIS, and involves providers in quality projects. Credentialing is conducted by the Centene Corporate Credentialing department.
1.7 Member Services Manager;	X					Lucretia Causey serves as director of customer service and oversees call center performance.
1.7.1 Member services and education;	X					Member education is conducted in multiple ways across several departments. For example, member education can be provided through written materials, brochures, newsletters, call center encounters, face to face meetings, and the *Member Handbook.*
1.8 Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals;	X					Complaints, grievances, and appeals are handled by the Quality Improvement department.
1.9 Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions;	X					Paula Whitfield is the vice president of medical management and Amanda Smith is the director of utilization management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9.1 Medical/Care Management Staff	X					
1.10 Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities;	X					Carrie Mitchell is senior director of quality improvement
1.11 Marketing and/or Public Relations;	X					Mary Anna McDonnieal is the director of marketing and communications.
1.12 Medical Director: A physician licensed and actively practicing in the state of Mississippi, providing substantial oversight of the medical aspects of operation, including quality assurance activities, the functions of the Credentialing Committee, and serves as Chair of the Credentialing Committee;	X					Dr. Jeremy Erwin (OB/GYN) serves as the chief medical director and Dr. Rebecca Waterer (internal medicine) is the vice president of medical affairs. Magnolia is in the process of redefining these roles. Dr. Erwin is more involved with UM and the Quality Improvement area. Dr. Waterer oversees pharmacy functions and provider education. Dr. Bri May (pediatrics) and Dr. Leigh Campbell (pediatrics/neonatology) support UM functions along with both Dr. Erwin and Dr. Waterer. Behavioral health practitioners oversee the behavioral health aspects of the UM Program. Michael Todero, PharmD is the vice president of pharmacy operations and is supported by Conor Smith, RPh.
1.13 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.	X					Terrica Miller is the vice president of compliance and serves as the privacy officer. Policy CC.COMP.05, Prohibiting Retaliation Against Employees, Individuals, or Others, states, “The Corporation will maintain an “open-door policy” at all levels of management to encourage employees to report problems and concerns.” The compliance officer has a direct reporting path to the plan president or the Centene Corporate Compliance department.
2. Operational relationships of CCO staff are clearly delineated.	X					The organizational chart depicts the operational relationships for Magnolia.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions.	X					
4. A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week.	X					Magnolia utilizes NurseWise to provide a nurse advice line with 24/7/365 availability. It is accessible via a toll-free number and TTY.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia has systems and guidelines in place to ensure benchmarks are met and metrics are monitored to ensure compliance. The CCO reported actual financial accuracy percentages and expected 30-day and 90-day clean claims processing percentages. The CCO provided data samples indicating actual 30/90-day clean claim payment percentages surpassing CAN and CHIP contract minimums.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia performs extensive analysis of the demographics and enrollment of members. Detailed membership information is tracked and compared against the provider database to ensure adequate coverage is provided.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Magnolia stores claims and member data in a data warehouse environment comprised of redundant servers and storage systems used for HEDIS reporting. An analytics application is used to track data and generate quality and utilization reports.
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Magnolia has an extensive disaster recovery (DR) plan addressing resources, tasks, personnel, and recovery strategy. In May 2016, a systems recoverability test was performed and all recovery goals were met.
I D. Compliance/Program Integrity						
1. The CCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.		X				A toll-free hotline number has been established to report potential fraud, waste, or abuse activities. The hotline is operated by an independent third party and all referrals are sent directly to a member of the SIU management team at Centene. The hotline is well publicized at the plan and in the *Member Handbook* and *Provider Manual.* Compliance staff members receive at least 2 hours of compliance and fraud, waste, and abuse training per year. Terrica Miller also attends annual training sponsored by the American Contract Compliance Association. All staff receive compliance training within the first 4 days of orientation and annually thereafter. The Centene Corporate *Fraud, Waste, and Abuse/Compliance Plan* with a Mississippi addendum was submitted with desk materials. *The Fraud, Waste and Abuse/Compliance Plan*, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						multiple policies were reviewed for compliance to federal and regulations and contract requirements. The following requirements were not found in the *Fraud, Waste, and Abuse Plan*: •Enforcement of standards through well-publicized guidelines (*Federal Regulation § 438.608 (a) (1) (vi) and CAN Contract, Section 11 (B) (5) and CHIP Contract, Section 11 (B) (4))* •Prompt responses to detected offenses. *(Federal Regulation § 438.608 (2), CAN Contract, Section 11 (B) (6), and CHIP Contract, Section 11 (B) (5))* •The Contractor shall not knowingly have a relationship with an individual, or entity that is debarred, suspended, or otherwise excluded from Federal participation in procurement activities under the Federal Acquisition Regulation. *(Federal Regulation § 438.610 (a) (1),* and *CAN and CHIP Contracts, Section 1 (I))* The *CAN Contract, Section 11 (A)* states the Contractor shall comply with all federal and state requirements regarding fraud, waste, and abuse including, but not limited to, *42 C.F.R. § 455, Section 1902 (a)(68) of the Social Security Act, and 42 C.F.R. §438.608. Section 1902 (a) (68). Federal Regulation § 438.600 (6)* requires entities receiving payments of $5M or more to establish certain minimum written policies relating to the Federal False Claims Act. This was not found in a policy. *Corrective Action: Include the previously noted bulleted list of requirements in the Fraud, Waste, and Abuse Plan. Develop a policy for the CAN line of business defining how Magnolia instructs on and implements the provisions of the Federal False Claims Act.*
2. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					Magnolia's Compliance Committee is chaired by the compliance officer and meets on a quarterly basis or as needed. The committee minutes reflect good attendance with a quorum consisting of 50% of voting members present. The committee reports to the Board of Directors. Membership of this committee is found in the committee charter and the committee matrix. The charter includes a finance officer/CFO as a member; however, this position is not included in the membership list attached to the charter or in the committee matrix document.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the listing of compliance committee membership is consistent across all documentation.
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					The *UM Program Description*, page 9, lists the various means Magnolia uses to ensure confidentiality in all processes and seeks to abide by all federal and state laws governing confidentiality. Policy CC.COMP.04, Confidentiality and Release of Protected Health Information (PHI), defines the use and protection of PHI, along with several policies that address privacy and security. Policy CC.COMP.PRVC.10, Privacy Notice-Provision, states the Notice of Privacy Practices will be provided to new members upon enrollment and within 60 days of a material revision to the notice. If NCQA accredited, members will be notified annually of their right to obtain a copy of the notice. The Notice of Privacy Practices is included in the *Member Handbook* for CAN and CHIP.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The Centene Corporate Credentialing Program has been adopted by Magnolia for the CAN and CHIP programs. Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, addresses the credentialing and recredentialing process for practitioners, and Policy CC.CRED.09, Organizational Assessment and Reassessment, addresses the organizational provider credentialing and recredentialing process. The policies are detailed with state specific requirements addressed via footnotes and attachments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					Policy CC.CRED.03, Credentialing Committee, outlines the structure, protocols, and peer-review process the Credentialing Department and Magnolia uses to make recommendations regarding credentialing decisions. The Credentialing Committee is currently chaired by Dr. Becky Waterer, vice president of medical affairs. Dr. Waterer was formerly the chief medical director; however, this position is currently held by Dr. Jeremy Erwin who also serves on the committee. Additional voting members of the committee include two Magnolia medical directors and six participating providers with the specialties of pediatrics, family medicine, nurse practitioner, hospital medicine, and psychiatry. The Credentialing Committee meets at least 10 times per year and a quorum is established with 50% of voting members in attendance. A review of Credentialing Committee minutes reflected good participation by the voting members. A quorum established at the beginning of each meeting. During the onsite visit, CCME recommended Magnolia consider having the chief medical director chair the Credentialing Committee, as this is a requirement for both the *CAN* and *CHIP Contracts, Sections 1 (L)*, item 4. Magnolia was very receptive to implementing this change. *Recommendation: Consider having the chief medical director chair the Credentialing Committee.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files reviewed were organized and contained appropriate documentation. Two issues are discussed in the following section.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.12 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	X					
3.1.13 Ownership Disclosure Form.	X					One credentialing file contained the signed ownership disclosure form but the form was not dated. Magnolia indicated it was not their practice to accept forms without a date, and the other forms reviewed were signed and dated. *Recommendation: Ensure ownership disclosure forms contain a date beside the signature.*
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Policy MS.CONT.03, Site Assessment for New Provider Contracts, defines the procedure for provider office site review to ensure patient care is delivered in an accessible, safe environment with adequate examination and waiting areas. Magnolia conducts an initial office visit to all new potential PCPs, OB/GYNs, and all high volume specialists prior to making the credentialing decision for that provider. For sites that do not meet an overall minimum score of 80 percent, follow-up action plans are developed and revisits are scheduled at least every six months until performance standards are met. The *Practitioner Office Site Evaluation Tool* received at the onsite has incorrect appointment availability information as follows: •It states the timeframe for a preventive health exam or routine, non-symptomatic visit is 45 calendar days, but the requirement is “not to exceed 30 calendar days.” This is an uncorrected issue from the previous EQR. •It states the timeframe for routine, non-urgent symptomatic visits is within 10 calendar days, but the requirement is “not to exceed 7 calendar days.” This is an uncorrected issue from the previous EQR. •It states the timeframe for urgent visits is within 48 hours, but the requirement is “not to exceed 24 hours.” (Reference the *CAN Contract, Section 7 (B) (2)*) The uncorrected issues from the previous EQR contributed to the “Not Met” score.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A review of the credentialing files showed PCP office site visits were not received in the initial desk materials requested. The information was requested again at the onsite visit and three PCP site visits were not received. Magnolia should requirements of Policy MS.CONT.03, Site Assessment for New Provider Contracts, are followed. *Corrective Action: Update the Practitioner Office Site Evaluation Tool to reflect correct appointment availability timeframes. Ensure provider office site visits are conducted in accordance with Policy MS.CONT.03, Site Assessment for New Provider Contracts.*
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files reviewed were organized and contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Requery the System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	X					
4.2.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.12 Ownership Disclosure form.	X					
4.3 Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met.	X					Policy MS.CONT.03, Site Assessment for New Provider Contracts, defines the procedure to monitor deficiencies related to a practitioner's office by monitoring member complaints/ grievances and/or member survey information. Upon identification of complaints related to quality of a practitioner's office site, Provider Relations staff performs an onsite visit within 45 days of identification the complaint threshold has been met. Sites must receive a passing score of greater than 80 percent in any category. For providers not meeting the standard, a corrective action plan is presented to the office and is to be fully implemented within six months of the initial visit. Plan staff revisits the site at least every six months until the performance standards have been met, or until the Credentialing Committee recommends terminating the provider, if applicable.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.4 Review of practitioner profiling activities.	X					Policy MS.QI.23, Provider Profiling Program, states Magnolia increases provider awareness of performance through the continual use of the Provider Profiling Program. The goals of this program are to improve the health outcomes of members and to appropriately recognize providers for delivering quality care. Provider profiling is conducted through a review of claims and outcomes data. Specific aspects of a provider's profile will be shared with that provider. The Provider Profiling Program extends to Primary Care Physicians (PCPs) and Specialists, with each PCP and Specialist receiving an annual, individualized profile report. Evidence of PCP Patterns of Care reports were received in the desk materials.
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy MS.QI.18, Quality of Care Investigations, defines the procedure for receiving, investigating, and addressing potential quality of care issues. All potential quality of care issues are routed to the Quality Improvement Department. Severity levels are assigned, and the medical director reviews all cases with a severity level above zero. All cases with a severity level 3 or 4 are referred to the Peer Review Committee for review and action. If a practitioner's network participation is to be suspended or terminated for reasons relating to the practitioner's competence or professional conduct, appropriate authorities will be notified. The number and severity level of quality of care investigations may be used by the Credentialing Committee at the time of physician recredentialing. Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, defines the process of suspension and/or termination from the Magnolia network and states the practitioner is offered a formal appeal process. The appeal hearing process is addressed in Policy CC.CRED.08, Practitioner Appeal Hearing Process.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					The credentialing and recredentialing guidelines for organizational providers are addressed in Policy CC.CRED.09, Organizational Assessment and Reassessment.
II B. Adequacy of the Provider Network						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.09, Verification of Member Eligibility, defines the procedure for ensuring that providers have access to the PCP Panel/Patient List within five business days of receipt of enrollment from DOM. The information is available for eligibility verification via the Secure Provider Portal on the website. Providers may contact and use the interactive voice response (IVR) system, available 24/7. Providers may also speak with Provider Services Representatives during normal business hours to verify member eligibility.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Magnolia tracks limitations on panel size and the *Provider Directory* search option on the website has an option for selecting providers accepting new patients. Evidence of Open Panel and Closed Panel PCP reports were received in the desk materials.
1.4 Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties.		X				MS.QI.04, Evaluation of Practitioner Availability, defines the process used to monitor the type, number, and geographic distribution of network providers to determine how effectively the network meets the needs, preferences, and diversity of Magnolia's membership. Policy MS.CONT.01, Provider Network, provides general information regarding network development. Both policies define the geographic definitions that comply with contract requirements. GEO access reports received match defined parameters in compliance with the *CAN* and *CHIP Contract*s. The CAN 2015 *QI Program Evaluation* (page 26) states the standard member-to-provider ratio for PCPs is 1:1,500 while Policies MS QI.04 and MS.CONT.01 define the ratio as 1:2,500. *Corrective Action: Ensure the CAN 2016 QI Program Evaluation*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Policies MS.QI.04 and MS.CONT.01 contain consistent information regarding the PCP member-to-provider ratio.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MS.QI.04, Evaluation of Practitioner Availability, defines the geographic access standards for hospitals, specialists, dental providers, behavioral health providers, pharmacy, urgent care, dialysis, and emergency service providers in compliance with contract requirements.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Practitioner type and availability is measured quarterly by the Magnolia Provider Relations, Network Development, and Contracting Departments as defined in Policy MS.QI.04, Evaluation of Practitioner Availability.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Magnolia assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts practitioner availability within its network. They assist in connecting members with practitioners who can meet their needs and analyze member surveys and grievance data to identify areas for improvement as defined in Policy MS.QI.04, Evaluation of Practitioner Availability. Free access to interpreter services is provided for members. Magnolia has a *Cultural Competency Plan* serving as a process to follow for multicultural principles and practices throughout organizational systems of services and programs. Magnolia's goal is to reduce healthcare disparities and increase access to care by providing quality, culturally competent healthcare through strong doctor-patient relationships. The *Cultural Competency Plan* is reviewed annually and is loaded to the provider portal section of the website. The *Provider Manual* addresses responsibilities for the providers regarding cultural competency and Policy MS.QI.22, Cultural Competency, defines guidelines for how Magnolia meets the cultural competency needs of members.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MS. PRVR.10, Evaluation of the Accessibility of Services states the Provider Relations Department measures access to primary care services at least annually. Policy MS.QI.05, Evaluation of the Accessibility of Services, states Magnolia measures appointment and telephone access to primary care services on an ongoing basis through member grievance/ complaints, provider audits/surveys, and through the member satisfaction survey. Trend analysis is conducted with comparison to established standards at least annually. Results are reported and reviewed by the Quality Improvement Committee (QIC). Policies MS. PRVR.10 and MS.QI.05 define appointment timeframes for "Medically necessary initial high-risk prenatal care (For High-risk pregnancy OB/GYN providers only)." However, the appointment criteria listed on the website states the criteria is for "Pregnant Women Care" and the CAN *Provider Manual* states the appointment timeframes are for "OB/GYN Access". The information is not listed in the CHIP *Provider Manual*. There was confusion among Magnolia staff during the onsite discussion as to whether the standards applied only to high-risk prenatal care or pregnant women. *Corrective Action: Update documents addressing appointment standards for OB/GYN such as Policies MS.PRVR.10 and MS.QI.05, Provider Manuals, and the website to reflect consistent information. Indicate whether the standards apply to high risk OB/GYN or pregnant women care.* A review of Magnolia's provider appointment and after-hours evaluations indicates possible member access issues. •Results of the PCP Appointment Access monitoring reported in both the CAN and CHIP 2015 Program Evaluations that only 3 out of 8 measures met the performance goal of ≥90%. Failed standards included emergent visit, medically necessary initial high-risk prenatal care, EPSDT initial health check within 90 calendar days of enrollment, after-hours coverage 24/7, and patient wait time within 30 minutes of appointment. •*The Magnolia Health Medicaid and Ambetter Practitioner Access Analysis* (July 1, 2015 – June 30, 2016) reported access measures as not meeting goal for PCP routine and urgent appointments, PCP after-hours care, behavioral health follow-up

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						routine care appointments, and oncology urgent appointments. Barriers and implemented actions such as provider education were discussed. CCME recommends a continued focus on member access to providers. Identify the non-compliant providers and work to improve compliance to the provider access measures. *Recommendation: Continue to focus on member access to providers. Identify the non-compliant providers and work to improve compliance to the access measures.*
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			Results of the *Telephonic Provider Access and Availability Study* conducted by CCME showed calls were successfully answered by personnel at the correct practice for 38% (99 out of 258) of calls, which estimates between 36% and 41% for the entire population, based on a 95% confidence interval. In comparison to last year, which had a 54% (168 out of 310 calls) success rate, this is a statistically significant decrease, $Z = 3.81$, $p < .001$. For those not answered successfully, 60% of physicians were no longer at the practice or phone number listed. Magnolia members may not be receiving correct provider information so there could be an access problem. *Corrective Action: Implement interventions to address the member access issues identified in the Provider Access and Availability Study conducted by CCME.*
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Newly contracted providers receive an orientation within 30 days of execution of a new provider contract. The orientation presentation includes core elements and all provider office staff are encouraged to attend as specified in Policy CC.PRVR.13, Provider Orientations. The provider portal on the website also contains training videos and a Practice Improvement Resource Center (PIRC) containing resource information for CAN and CHIP. A toll-free provider telephone hotline is also available to provide support through the provider services call center. Policy MS.PRVR.03, Toll-free Provider Telephone Hotline, defines call

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						center standards and procedures for call tracking and resolution. Policy CC.PRVR.02, Provider Manual, states the *Provider Manual* will be referenced during orientation visits performed by the Provider Relations Department. Magnolia has *Provider Manuals* for both the CAN and CHIP programs serving as good resource documents for navigating the plan. The CAN *Provider Manual* was loaded to the provider portal on the website.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communication the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;		X				The *Provider Manual* for CAN states it is a member's right to receive oral interpretation services for all non-English languages free of charge; however, it does not provide any guidance to providers regarding what translation services are available and what a provider should do if a member needs translation services. *Corrective Action: Update the Provider Manual for CAN to include information regarding what translation services are available and what a provider should do if a member needs translation services.*
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.	X					Policy MS.PRVR.19, Provider Directory, defines the procedure for maintaining a web-based, searchable *Provider Directory* that includes a listing of all providers in Magnolia's network. The web-based data is refreshed nightly from the Enterprise Data Warehouse (EDW) system to keep all information current. *Provider Directory* data is sourced from the credentialing system in a live feed providing immediate updates. Printed *Provider Directories* are updated annually or more often if there are significant network changes.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider training includes regularly scheduled meetings with in-network providers based on assignment and Plan initiatives. The provider portal on the website includes a "Provider Resources" section for reference materials, training information, and provider newsletters. Magnolia recently added a "secure email messaging" function to the secure portal. Providers can also communicate via phone. Policy MS.PRVR.14, Provider Visit Schedule, defines the procedures for establishing regularly scheduled face to-face meetings with providers.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, establishes the process for adoption and distribution of preventive health and clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The guidelines are reviewed and adopted by the Quality Improvement Committee. They are updated upon significant new scientific evidence or change in the national standards and will be reviewed at least every two years.
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO members to providers.		X				Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines, states a listing of adopted preventive health guidelines is maintained in the *Provider Manual* with a notation the links and/or full guidelines are available on the Magnolia website or hard copy, upon request. The *CAN Provider Manual* does not contain information on the practice guidelines. There are a few references but no information specific to providers about using the guidelines and where to find them. The preventive guidelines are loaded to the provider portal of the website and the information on the website matches the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy. *Corrective Action: Update the Provider Manual for CAN to include information regarding preventive health guidelines, the expectation that they will be followed, and where to find them.*
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and Adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					
3.7 Behavioral Health	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, establishes the process for adoption and distribution of preventive health and clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The guidelines are reviewed and adopted by the Quality Improvement Committee. They are updated upon significant new scientific evidence or change in the national standards, and will be reviewed at least every two years.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.		X				Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines, states that a listing of adopted clinical practice is maintained in the *Provider Manual* with a notation that the links and/or full guidelines are available on the Magnolia website or hard copy, upon request. The *CAN Provider Manual* does not contain information for the practice guidelines. There are a few references, but no information specific to providers about using the guidelines and where to find them. The clinical practice guidelines are loaded to the provider portal of the website and the information on the website matches the policy. *Corrective Action: Update the Provider Manual for CAN to include information regarding clinical practice guidelines, the expectation that they will be followed, and where to find them.*
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.		X				Policy MS.QI.13, Medical Record Review, outlines the process for monitoring network providers for medical record documentation. Minimum standards are defined in the policy and the *CAN Provider Manual* specifies detailed requirements for medical record documentation and review. The policy states the most current version of the medical record standards is maintained on Magnolia's website; however, the information could not be found. *Corrective Action: Update the provider portal on the website to include the most current version of the medical record standards as defined in Policy MS.QI.13, Medical Record Review.*
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Policy MS.QI.13, Medical Record Review, states PCPs and high-volume specialists (OB/GYN) are monitored for compliance to medical record standards. A score below 80% is considered deficient. Providers are notified of the audit results and a follow-up audit is conducted within six months. Medical record reviews are trended by the QI Department and presented to the QI Committee quarterly. The *CAN Provider Manual* states Magnolia will conduct random medical record audits as part of its QI program to monitor compliance with the medical record documentation standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion confirmed Magnolia conducts the medical record reviews as an ongoing process for only 15 – 16 providers, annually. Results for 2016 showed no provider fell below the 80% goal. *Recommendation: Consider conducting medical record reviews on a larger sample of providers to ensure they are adhering to Magnolia's medical record standards.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.		X				For the *Provider Satisfaction Survey*, the initial sample had a low response rate (6.4%) with the latter sample having a better response rate of 36.7%. This is slightly below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey. Finding ways to increase the response rate is recommended. Additionally, information on reliability and validity of the *SPHA Provider Satisfaction Survey* was not provided in the documentation. *Corrective Action: Implement interventions to increase the response rate in the Provider Satisfaction Survey and improve survey documentation. Provide information regarding whether or not reliability and validity have been assessed on the survey, and, if assessed, the values associated with the reliability and validity findings.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QIC committee in February of 2016 and continued discussion occurred in June of 2016.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MS.MBRS.25, Member Rights and Responsibilities, states a written description of the rights and responsibilities will be included in the member information materials provided to new members. Member rights are found in the *CAN Member Handbook.*
2. Member rights include, but are not limited to, the right:		X				The score of "Partially Met" is due to issues noted in the standards below.
2.1 To be treated with respect and dignity;						The right to be treated with respect and dignity is documented in Policy MS.MBRS.25, Member Rights and Responsibilities, the *CAN Provider Manual,* and website. However, it was not found in the *CAN Member Handbook* list of member rights. Refer to the *CAN Contract, Section 6 (I) (b).* *Corrective Action: Include the right to be treated with respect and with due consideration for his or her dignity and privacy in the CAN Member Handbook listing of member rights.*
2.2 To privacy and confidentiality, both in their person and in their medical information;						The member's right to privacy and confidentiality in their person and in their medical information is documented in Policy MS.MBRS.25, Member Rights and Responsibilities, the *CAN Provider Manual,* and on the website. However, it is not found in the *CAN Member Handbook* list of member rights. The Notice of Privacy Practices is included in the *CAN Member Handbook.* Refer to the *CAN Contract, Section 6 (I)* and *Federal Regulation § 438.100 (d).* *Corrective Action: Include the right to privacy and confidentiality both in their person and medical information in the CAN Member Handbook listing of member rights.*
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member Responsibilities include the responsibility;	X					Located in the *CAN Member Handbook* and Policy MS.MBRS.25, Member Rights and Responsibilities.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff.						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education						
1. Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:		X				Policy MS.MBRS.01, New Member Packet/Member ID Card, states new member packets and ID cards are issued for members prior to the first day of the month in which enrollment starts, and no later than 14 days after the plan receives notice of the member's enrollment. The *CAN Member Handbook* lists the locations where provider directories can be found and states members may contact Member Services for a printed copy. It includes a description of the search for provider feature on the Magnolia Website. The score of "Partially Met" is due to missing information in the standards that follow.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The benefit list in the *CAN Member Handbook* is thorough and provides complete benefit information. The *Provider Manual* does include benefit exclusions and non-covered services. Providers are instructed to call Provider Relations for additional benefit information. Providers could be better served by having a list defining member benefits in an organized fashion. *Recommendation: Include a list of member benefits for quick reference in the CAN Provider Manual, the CAN Provider website, or a separate document.*
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary;						
1.2 Limits of coverage, maximum allowable benefits and claim submission procedures; including that no cost is passed on to the member for out-of-network services;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						Policy MS.UM.24, Continuity and Coordination of Care, describes the functions of coordinated care, including appropriate referrals. The *CAN Member Handbook* includes self-referrals, in-network referrals, and that prior authorization may be required for out-of-network providers.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						Policy MS.PHAR.09, Pharmacy Program, contains a description of the Pharmacy Program to promote the appropriate use of the pharmacy benefit. Magnolia has policies addressing emergency supply, utilization of the pharmacy benefit, over-the-counter medications, the Preferred Drug List (PDL), pharmacy lock-in program, and prior authorization. The *CAN Member Handbook* includes this information along with a description of step therapy, and age and quantity limitations. It states in-network providers should not charge any fees or copays for any care offered as part of the health plan.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Policy MS.MBRS.12, Member Notification of Plan Changes, and the member letter template advising of changes and selecting a new PCP contain the appropriate timeframes for notification. Policy MS.MBRS.27, Member Advisory of Provider Termination, defines the process to notify members when a provider leaves

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or is terminated from the plan. Both policies apply to CAN and CHIP.
1.9 A description of the member's identification card and how to use the card;						A thorough description of the Member ID card and how to use it is in the *CAN Member Handbook*.
1.10 Primary care provider's role and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, the nurse advice line, and the member portal;						The *CAN Member Handbook* provides the toll-free telephone, TTY/TDD, and Mississippi Relay numbers. Magnolia's Member Services Department is open from 8 a.m. to 8 p.m. on Monday, Tuesday-Friday from 8 a.m. to 5 p.m., and the second weekend of the month from 8 a.m. to 5 p.m. Calls received after business hours are sent directly to NurseWise. NurseWise staff are available 24 hours a day, 7 days a week, including holidays. The *CAN Member Handbook* includes a list of information that can be accessed on the website. However, it does not include a description of the member portal, what is included, or how to access it. This information was not located in any other member information provided for review. See the *CAN Contract, Section 5 (G) (1).* *Corrective Action: Include information regarding the member portal, what it includes, and how to access it in the CAN Member Handbook or other member documentation.*
1.13 A description of the EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals, including the right to request a Fair Hearing						The *CAN Member Handbook* includes the procedures and timeframe for filing and who may file a grievance or appeal. It further describes how to request a State Fair Hearing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						The provider search feature on the Magnolia CAN website includes the requirements of the contract and federal regulations and is referenced in the *CAN Member Handbook*. Members can call Member Services for additional assistance.
1.17 Instructions on reporting suspected cases of Fraud and Abuse;						The Hotline phone number is provided in the *CAN Member Handbook* in addition to examples of things that could fall into the category of fraud, waste, or abuse.
1.18 Information regarding the Care Management Program and how to contact the Care Management Team;						Members are informed about Care Management and Disease Management Programs offered by Magnolia in the *CAN Member Handbook*. The Start Smart for Your Baby Program is described; however, it does not mention high-risk OB care management. The high-risk pregnancy program is discussed in the *CAN Provider Manual.* Refer to the *CAN Contract, Section 8 (A) (3).* *Corrective Action: Include a description of high-risk OB care management services in the CAN Member Handbook.*
1.19 Information on advance directives;						
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.		X				The *CAN Member Handbook*, page 3, states Magnolia's practices, policies, and benefits may be modified or discontinued from time to time and every attempt will be made to inform members within 30 days of any changes as they occur. This is compliant with *Federal Regulation § 438.10 (g) (4).* The *CAN Member Handbook* states if the member's primary care provider is planning to leave the provider network, Magnolia will send a notice at least 15 days before this date occurs; however, the *CAN Contract, Section 7 (D) (3)* states this timeframe is within 15 calendar days of notice or issuance of termination of a provider. The timeframe is also incorrect in the *CAN Provider Manual*, page 16. *Corrective Action: Correct the CAN Member Handbook and the CAN Provider Manual to reflect the correct timeframe for written*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						notice to members if their PCP leaves the network.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy MS.MBRS.06, Member Materials and Readability and Translation, verifies member materials are written in a clear and concise manner, at appropriate reading levels, and are available in prevalent languages. Documents are written to a Flesch-Kincaid readability level of no greater than the 6th grade. (Per policy, DOM accepts 6.4 or lower.) Translation and interpretations services are available at no cost to the member. TTY services are available. The *CAN Member Handbook* informs members about alternative formats available and other interpretation services.
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					*The CAN Contract, Section 6 (D) (13) (b)*, states the CCO must have "A multilingual notice that describes translation services that are available and provides instructions explaining how members can access those translation services." Onsite discussion determined the 1557 rule regarding this is pending approval at DOM. *Recommendation: Develop a multilingual notice describing translation services available and provide instructions for members to access those translation services.*
5. Member complaints/grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					The *QI Program Description* states grievance and appeals statistics are reviewed and recommendations are made to the grievance and appeals team regarding interventions for improvement or educational opportunities. Data is reported to and analyzed by the QIC quarterly to identify trends and to recommend performance improvement activities, as appropriate.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					Magnolia adheres to contract requirements for materials used to market to potential members, as defined in Policy MS.COMM.01, Marketing: General Guidelines for Marketing Activities.
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					Members and providers receive one toll-free number to contact Magnolia with questions. Dedicated staff are trained to address member calls with others trained to address provider inquiries.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Call Center scripts are in-place and staff receives training as required by the contract.	X					Call scripts are in place and call center staff is alerted when members need preventive, screening, or PCP visits to meet identified care gaps. CCME conducted a review of recent call-center calls from members during the onsite visit. Issues identified during this process included: •Staff did not consistently complete the HIPAA verification process •Staff rushed calls creating the appearance of impolite treatment of the members •Several calls brought attention to system issues requiring a member to call back to enter a change of PCP. According to the *CAN Contract, Section 6 A (4),* call center trainings must include education about Medicaid, the MississippiCAN Program, appropriate instances for transferring a Member to a Care Manager, and customer service. Staff must also receive updates about Medicaid changes or requirements. Onsite discussion confirmed training does occur regularly and attendance is tracked. This is not documented in a policy or training materials. *Recommendation: Continue to provide additional training and follow-up audits for call center staff not meeting expectations when handling phone calls. The requirement that Magnolia conduct quarterly scheduled training for call center staff should be documented in a policy or other document and include the frequency and general content of these trainings.*
3. Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee.	X					Magnolia's call-center standards for performance are defined in Policy MS.PRVR.03. Performance is measured monthly and reported to the QIC. Magnolia documented abandonment rates of < 5% for all months reported in 2016 (9 months less than 1%). Answer speeds of < 30 seconds were noted for all months reported. This data meets contract specifications. Magnolia evaluates at least 3% of call center calls each month for compliance to customer care guidelines.
III D. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Policy MS.ELIG.03, Primary Care Providers Selection and Change, defines PCP selection process. Member Services staff assist members to select or change a PCP upon request. Policies MS.ELIG.01, Primary Care Provider, and MS.ELIG.08, PCP Notification, state PCP assignment is accomplished within 60 days of enrollment if the member has not chosen a PCP within the first 30 days of enrollment.
2. The CCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Preventive Health Guidelines are found in the *CAN Member Handbook* for men, women, and children, including EPSDT. Magnolia's Member Connections program promotes preventive health and the *CAN Member Handbook* addresses available Care Management and Disease Management services. The use of these benefits and services is encouraged. Magnolia mails preventive health reminders, educates members via a quarterly newsletter, and facilitates wellness programs.
3. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					Magnolia's Start Smart for Your Baby program offers educational materials on pregnancy, pre- and post-natal care, and caring for babies. Magnolia uses multiple sources to identify women who are pregnant. Magnolia opens a care management file on each pregnant woman until the need for care management or care coordination is determined. Contact with high-risk members is conducted within 7 days and within 14 days for medium risk members. Onsite discussion confirmed members are informed about WIC during this process. The *CAN Member Handbook* includes thorough information about pregnancy and the importance of pre-natal care.
4. The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					The Healthcare Effectiveness Data and Information Set Steering Committee (HSC) is responsible for monitoring, evaluating, and improving HEDIS outcomes. The Committee reports directly to the Quality Improvement Committee (QIC). Policy MS.QI.20, EPSDT, states Magnolia is committed to providing preventive health screenings and improving the overall health of enrolled children. Although monitoring and implementing interventions related to the EPSDT program is a multi-disciplinary collaborative project across Magnolia, the Quality Improvement designee maintains lead responsibility for the EPSDT management program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The key aspects of the program include monitoring reports, employee education, and provider- and member-level interventions including a periodic notification system to facilitate compliance with the periodicity schedule. Magnolia provides incentives for members by rewarding healthy behaviors and receiving immunizations through the CentAccount program. Providers may also benefit from profiling activities and pay-for-performance programs.
5. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Onsite discussion confirms Magnolia provides numerous educational opportunities for members. Events are typically located in areas familiar to and convenient for members. The Communication department develops the Annual Health Educations and Prevention Work-plan.
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The results met the minimum number of responses considered by NCQA to be necessary for a valid survey (n=432), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively) at 24.2%. Alternative approaches may be needed to increase the response rates. Low response rates may contribute to response rate bias. *Recommendation: Focus on strategies to help increase response rates for the Medicaid Adult population to be more representative of the entire member population. Solicit the help of your survey vendor. Set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate). Based on this year's child survey response rate of 20.9%, a 3% increase would be statistically significant if a similar sample size of 2,665 was used. For the adult survey, the most recent response rate was 24.2%. A 4% increase in the response rate would be statistically significant, based on a similar sample size of 1,787. Any member incentive program must be approved by DOM prior to implementation.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Results were presented and analyzed to assess barriers and create interventions regarding the satisfaction results in October 2016 and in the program evaluation for 2015.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO reports the results of the member satisfaction survey to providers.	X					
4. The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QIC on August 25, 2016 along with documented opportunities for improvement. In the QIC meeting minutes on October 6, 2016, documentation was provided regarding the response rates, general results, and how to generate a work plan based on the results.
III G. Complaints/Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, defines the process Magnolia uses to receive, acknowledge, investigate, and resolve member grievances. Magnolia has a process that includes complaints resolved in one business day. Grievances involving clinically urgent or quality of care issues are resolved within 72 hours. A second-level review of a grievance is conducted by committee. Magnolia demonstrated the systems used to log and track grievances and appeals during the onsite visit.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;		X				The *CAN Contract, Section 6 (J) (5)* defines a grievance as, "An expression of dissatisfaction received orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Action as defined in this contract." Documents containing an incomplete or missing definition of grievance include: •Policy MS.MBRS.07, Member Grievance and Complaints Process •The *CAN Member Handbook* •The Magnolia website •The *CAN Provider Manual* The following documents include who may file a grievance in accordance with the contract: •Policy MS.MBRS.07, Member Grievance and Complaints Process •The *CAN Member Handbook* •The *CAN Provider Manual* •The Magnolia website

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the definition of a grievance in the policy, CAN Member Handbook, CAN Provider Manual, and the website to match the definition found in the CAN Contract or federal regulations.
1.2 The procedure for filing and handling a complaint/grievance;	X					The following requirements are included in all policies, handbooks, manuals, and on the website: •How to file a grievance •The timeframe to file •Magnolia will assist members to file •Acknowledging grievances within contract guidelines •Timeframe for resolution
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;		X				The *CAN Contract* states grievances must be resolved within 30 calendar days of receipt of the grievance with a possible 14 day extension as defined in *Federal Regulation § 438.408 (c).* Magnolia also has a process to resolve expedited, clinically-urgent grievances within 72 hours. The following documents fail to include that a member may request an extension of the timeframe for grievance resolution: •The *CAN Provider Manual* •The Magnolia CAN website. Grievance resolution letter templates were compliant with contract requirements. *Corrective Action: Update the Magnolia website and the Provider Manual to include that members may also request to extend the timeframe for grievance resolution.*
1.4 Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, states individuals who make decisions on grievances were not involved in any previous level of review and healthcare professionals with appropriate clinical expertise shall make decisions on grievances involving clinical issues. Onsite discussion confirmed this is the Medical Director. This also applies to any grievance regarding quality of care. This policy does not address the requirement found in *Federal Regulation § 438.406 (b) (ii) (B)* that individuals deciding a grievance regarding the denial of an expedited appeal must have the appropriate expertise, as determined by the state, in treating the enrollees disease or condition. *Recommendation: Include in Policy MS.MBRS.07 that decision*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						makers on grievances related to the denial of an expedited appeal are decided by individuals who have the appropriate expertise, as determined by the state, in treating the enrollee's disease or condition.
1.5 Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract.		X				The *CAN Member Handbook* states grievance records are retained for a period of 7 years. Policy MS.MBRS.07, Member Grievance and Complaints Process, states the retention timeframe is 5 years. Onsite discussion confirmed the timeframe for retention is 10 years. This is documented in Attachment A of Policy CC.LEGL.01, Records Retention Schedule. *Corrective Action: Ensure the timeframe for retention of grievance records is consistent across all documentation.*
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					As part of the EQR process, 21 grievance files were reviewed. Only 1 file was completed beyond the 30-day resolution timeframe. This file was completed in 63 days. It was mistakenly filed as a complaint and not converted to a grievance, therefore, acknowledgement and resolution letters were not sent. A few grievances could not be completed due to inability to contact the grievant. Onsite discussion confirmed the call center always verifies contact information on calls. Acknowledgement and resolution notices were sent within the required timeframe. A few resolution notices did not include the steps taken to resolve or contained language that did not explain the resolution. Possible quality of care issues were discussed with the medical director when appropriate. *Recommendation: Develop a process to review member grievance resolution letters prior to mailing to ensure letter content is accurate and easy to understand.*
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, states Magnolia uses grievance data for quality improvement. QIC meeting minutes documented tracking and trending. Onsite discussion revealed Magnolia tracks the top 5 grievance categories more diligently.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Onsite discussion confirmed there is a process in place to investigate grievances related to requests to change PCPs due to dissatisfaction. However, this process is not documented. *Recommendation: Document the process for investigating all requests for change of PCP due to dissatisfaction as grievances in an existing or new policy.*
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Magnolia presented the *Quality Assessment and Performance Improvement Program Description 2016* for their CAN program in the desk materials. The program description is reviewed, updated as needed, and presented to the Quality Improvement Committee and to the Board of Directors for approval at least annually.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Monitoring and identifying opportunities to access health care disparities as required by the *DOM Contract, Section 9* is not included in the scope of the *Quality Improvement Program Description*. Health care disparities is a standing agenda item for the Quality Improvement Committee. During the onsite visit, the Quality Staff discussed several initiatives underway for tracking and monitoring health care disparities such as sickle cell. *Recommendation: Include in the scope of work listed in the quality improvement program description the monitoring of services furnished to members with special health care needs*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and health care disparities.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					The *2015* and *2016 Annual QI Work Plan* developed by Magnolia contained all requirements.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia's Quality Improvement Committee is the designated committee charged with providing oversight of all quality improvement activities. This committee is responsible for establishing standards and criterial for delivery of care and services.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Quality Improvement Committee is a senior level committee which actively involves participating network practitioners. A review of the committee's participant roster indicates there are five network providers serving as voting members. Their specialties include pediatrics, family medicine, hospital medicine, and psychiatry. The committee charter indicates the membership will also include two nurse practitioners. Magnolia recruited one nurse practitioner but she does not attend regularly. *Recommendation: Continue to recruit nurse practitioners to serve on the Quality Improvement Committee.*
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded at each meeting. Magnolia's Quality Improvement Committee meeting minutes reflect the attendance and committee discussions for each item and timeline for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						completing any follow-up items.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All HEDIS measures met the protocol guidelines and were considered "Fully Compliant". For non-HEDIS measures, three of the four measures were found to be "Fully Compliant" and one measure was "Substantially Compliant." There are concerns regarding the logic used to calculate the pre and post-natal complications measure. Although the specifications and programming logic used matched up, the specifications used and DOM's specifications are inconsistent. This occurs, specifically, for the fourth digit of the 640-649 codes. The codes should include a one or three in the fifth digit, with the fourth digit being any numeric value from zero to nine. In the programming logic and specifications, only codes with zero as the fourth digit were included. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.* *Recommendation: Include the fourth digit in the ICD – 9 codes used to calculate the pre and post-natal complications measure.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Two of the projects received a validation score of "High Confidence in Reported Results" and two received a score of "Confidence in Reported Results". Areas needing improvements include presenting the findings in a clear and accurate manner with an interpretation of the results for each measurement period, including baseline. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Correct the errors identified in the performance improvement project documents.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					One of the goals listed in the *CAN Quality Improvement Program Description*, page 2, states "Magnolia will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistent in compliance."
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			The *CAN Contract, Section 5 D,* requires the health plan to establish a tracking system for reporting all screening results, diagnosis, and/or treatment for members. Magnolia has systems in place for tracking EPSDT screenings. However, the health plan does not track any diagnoses identified during the assessments, treatments, or referrals provided as a result of the assessments. *Corrective Action: Develop a system for tracking any diagnoses identified during an EPSDT screening, treatment, and/or referrals provided.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Annually Magnolia conducts an evaluation of the effectiveness of their quality improvement program. For this EQR, the *Annual Quality Improvement Program Evaluation 2015* was provided. This evaluation includes an overview of all QI activities conducted during 2015, the results for each activity, if the goals were met, any potential barriers identified for goals not met, and interventions.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *2016 Magnolia Health Plan Utilization Management (UM) Program Description* contains the program's purpose, scope, goals, implementation information, and all contractually-required elements. Departmental policies and procedures guide staff in performance of UM functions.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					UM determination timeliness requirements are documented in the *UM Program Description,* Policy MS.UM.05, Timeliness of UM Decisions and Notifications, the *CAN Member Handbook*, and the *CAN Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Discrepancies were noted in the timeframe for the provider or hospital to notify Magnolia of an admission: •The *CAN Member Handbook*, page 42, and the *CAN Provider Manual*, pages 13 and 21, state the notification requirement is within 1 business day of admission. •The *CAN Provider Manual*, page 22, indicates the timeframe is within 2 business days of admission. Onsite discussion confirmed the requirement is within 2 business days of admission. *Recommendation: Revise the CAN Member Handbook, page 42, and the CAN Provider Manual, pages 13 and 21, to reflect the timeframe for a provider/facility to notify Magnolia of a member's inpatient admission is within 2 business days of admission.*
1.5 Consideration of new technology;	X					Level I reviews are referred for Level II (medical director) review for new technology/procedures and services or procedures not addressed in InterQual criteria and for which no local criteria or policy exists.
1.6 The appeal process, including a mechanism for expedited appeal;	X					Appeals processes are defined in Policy MS.UM.08, Appeal of UM Decisions.
1.7 The absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The vice president of medical affairs is Dr. Rebecca Waterer and the chief medical director is Dr. Jeremy Erwin. Dr. Erwin has operational responsibility for and provides support to the UM Program, and along with the vice president of medical management and/or any designee assigned by Magnolia's president and CEO, is responsible for implementing the UM Program. A behavioral health practitioner is involved in implementing, monitoring, and directing behavioral health aspects of the UM Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually with modifications made as necessary. The evaluation includes all aspects of the UM Program (member/provider complaint, grievance, and appeal data, member satisfaction/disenrollment surveys, UM data, practitioner profiles, and drug utilization review profiles. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the QIC and Board of Directors for approval. UM criteria are reviewed annually and updated, as appropriate, by the UMC and/or QIC. All clinical policies are reviewed, updated, and approved annually by the Clinical Policy Committee (CPC) with input from local practitioners possessing professional knowledge or clinical expertise in the area being reviewed.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, indicates Magnolia uses the following criteria: •InterQual Level of Care and Care Planning Criteria •Centene clinical policies •Magnolia Medical Management Guidelines for therapies and rehabilitation •Local state and/or regulatory guidelines, where applicable Policy CP.MP.68, Medical Necessity Criteria, defines the hierarchy for use of available criteria.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files for the CAN population confirmed appropriate criteria are used in the determination of medical necessity. Information is requested, when needed, to render a determination.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, confirms Level I reviews are conducted using InterQual criteria or other applicable criteria or clinical policy. Other factors considered are the individual member's needs (age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable) at the time of the request along with the local delivery system available for care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Level II reviews are conducted using InterQual criteria or other applicable criteria or policy with consideration given to continuity of care, individual member needs at the time of the request, and the local delivery system available for care.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy CC.UM.02.05, Interrater Reliability, describes Magnolia's processes for verifying consistency in medical necessity decision-making. Annual testing is performed of all physician and non-physician clinical staff, trainers, and managers. New staff members are tested within 90 days of initial InterQual training. The scoring benchmark is 90%. Follow-up processes for scores below the benchmark are defined in the policy.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Policy CC.PHAR.10, Preferred Drug List, defines the processes used by the Centene Pharmacy and Therapeutics (P&T) Committee for approving changes to the PDL, in cooperation with and approval from Magnolia's local P&T Committee. This policy does not indicate Magnolia uses the most current version of the *Mississippi Medicaid Program Preferred Drug List*, as required by the *DOM Contract, Section 5 (F)*. Policy MS.PHAR.09, Pharmacy Program, states that Envolve (formerly US Script), Magnolia's PBM, implements the pharmacy program, including use of the Universal Preferred Drug List (UPDL). The policy further states the UPDL is a listing of covered pharmacy services approved by the MS-DOM P&T Committee. The policy does not define the product/line of business to which it applies. Onsite discussion confirmed the policy applies to both the CAN and CHIP products. *Recommendation: Revise Policy CC.PHAR.10 to indicate Magnolia uses the most current version of the Mississippi Medicaid Program PDL, as required by the DOM Contract, Section 5 (F). Revise Policy MS.PHAR.09 to define the line of business to which it applies.*
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, describes the processes for prior authorization of medications and states a 72-hour supply of medication is available when there is a delay in the review process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CAN *Member Handbook* and CAN *Provider Manual* include appropriate information regarding the emergency supply of medication.
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy MS.UM.12, Emergency Services, defines appropriate processes for emergency and post-stabilization services.
7. Utilization management standards/criteria are available to providers.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, states treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting the Medical Management department or may discuss the UM decision with the medical director. The availability of criteria is addressed in the *CAN Member Handbook, CAN Provider Manual,* and the initial notice of action letter template.
8. Utilization management decisions are made by appropriately trained reviewers.		X				Policy MS.UM.04, Appropriate UM Professionals, states: •A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under the Plan's medical benefits. Per State contract, denials may be issued only by a Mississippi licensed physician. •Appropriate practitioners may review and make recommendations to the medical director. •Qualified, licensed health professionals appropriately trained in utilization and medical necessity review conduct authorization and/or concurrent reviews. •Prior authorization nurses and concurrent review nurses conduct Level I review for medical necessity. Onsite discussion revealed Magnolia permits pharmacists to issue denial determinations without referring the review to a medical director. This is not compliant with requirements of the *CAN Contract, Section 5 (J) (1),* and Policy MS.UM.04, Appropriate UM Professionals. *Corrective Action: Update review processes so denials are only issued by Mississippi-licensed physicians, as required by the CAN Contract, Section 5 (J) (1) and Policy MS.UM.04.*
9. Initial utilization decisions are made promptly after all necessary information is received.	X					UM approval files reflect timely determinations and notifications.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files contained evidence of appropriate attempts to obtain necessary clinical information prior to rendering a denial determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.		X				Two of three denial files for pharmacy authorization requests reflected denial determinations rendered by clinical pharmacists. This is not compliant with the requirement that denials can only be issued by a Mississippi-licensed physician, as required by the *CAN Contract, Section 5 (J) (1),* and documented in Policy MS.UM.04, Appropriate UM Professionals. *Corrective Action: Ensure that all denials for medications are issued by a Mississippi-licensed physician.*
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					UM denial files reflected timely decision-making and notification of the determination to members and providers.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					Policy MS.UM.08, Appeal of UM Decisions, defines Magnolia's processes for handling appeals of UM actions for the CAN membership.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Policy MS.UM.08, Appeal of UM Decisions, the *CAN Member Handbook,* and the *CAN Provider Manual* contain appropriate information on who may file an appeal. Policy MS.UM.08, Appeal of UM Decisions, and the *CAN Member Handbook* appropriately define an appeal and an action. The *CAN Provider Manual,* page 44, adequately defines an appeal; however, the definition of an action is incomplete. It is missing: •the denial, in whole or part, of payment for a service •the denial for a resident of a rural area with only one CCO to obtain services outside the network

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Revise the CAN Provider Manual to include the complete definition of an action. Refer to the CAN Contract, Section 2 (A).
1.2 The procedure for filing an appeal;		X				Procedures for filing an appeal are documented in Policy MS.UM.08, Appeal of UM Decisions, the *CAN Member Handbook*, the *CAN Provider Manual*, and the initial denial letter template. The *CAN Member Handbook* and *CAN Provider Manual* do not indicate the member may present evidence and examine the case file and other documents related to the appeal. *Corrective Action: Revise the CAN Member Handbook and CAN Provider Manual to state the member may present evidence and examine the case file and other documents related to the appeal. Refer to Federal Regulation § 438.406 (b) (2) and (3) and the CAN Contract, Exhibit D, Section C.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Policy MS.UM.08, Appeal of UM Decisions, states the final decision of all appeals will be made by a physician. It further defines qualifications for appeal reviewers as*:* •A physician or other appropriate clinical peer of a same-or-similar specialty, not supervised by the individual nor involved in the initial adverse decision; and •A practitioner with the appropriate clinical expertise in treating the member's condition or disease.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Appeal resolution timeframe requirements and information on extensions of the timeframes are documented in Policy MS.UM.08, Appeal of UM Decisions, the *CAN Member Handbook*, and the *CAN Provider Manual*. Issues noted regarding timeliness guidelines for appeal resolution and extensions include: •Policy MS.UM.08, Appeal of UM Decisions, does not specify the appeal resolution timeframe begins when the appeal request is received. •The *CAN Member Handbook*, page 63, does not indicate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members may request an extension of the standard appeal resolution timeframe. •The *CAN Provider Manual* does not indicate members may request an extension of the standard appeal resolution timeframe. *Corrective Action: Revise Policy MS.UM.08, Appeal of UM Decisions, to specify the appeal resolution timeframe begins when the appeal request is received. Revise the CAN Member Handbook, page 63, to include members may request an extension of the standard appeal resolution timeframe. Update the CAN Provider Manual to indicate members may request an extension of the standard appeal resolution timeframe.*
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy MS.UM.08, Appeal of UM Decisions, specifies the required components of appeal resolution letters.
1.7 Other requirements as specified in the contract.	X					Policy MS.UM.08, Appeal of UM Decisions, contains appropriate information regarding continuation of benefits.
2. The CCO applies the appeal policies and procedures as formulated.	X					Appeals files reflected appeals are reviewed and resolved following established processes and contractual requirements. One appeal file resolution letter did not reference the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based, as required by Policy MS. UM.08, Appeal of UM Decisions. *Recommendation: Ensure all appeal resolution letters contain a reference to the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Per Policy MS.UM.08, Appeal of UM Decisions, summaries of appeal actions, trends, and root causes are reported quarterly to the QIC. Reports are used to identify opportunities to improve quality of care and/or service. Findings are reported to the Board of Directors. Review of QIC minutes confirm reporting and discussion of appeals data.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. D Care Management						
1. The CCO assess the varying needs and different levels of care management needs of its member population.	X					The *Care Management Program Description* defines Magnolia's Care Management (CM) processes to identify, plan, coordinate, and monitor appropriate, cost-effective services for members. CM programs are available to all members, but specifically to members with indications of complex or catastrophic health conditions, including, but not limited to, multiple comorbidities, end-stage disease, head injury, organ transplants, members with complex health needs, and members at risk for potential complications.
2. The CCO uses varying sources to identify and evaluate members' needs for care management.	X					A key objective of Magnolia's CM program is early identification of members who have the greatest need for CM services. Multiple data sources are used for member identification. Additionally, direct referrals for CM may come from other sources. Reports identifying members for CM are reviewed at least monthly and forwarded to the CM team for outreach and further review.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Per the *CM Program Description*, member outreach is initiated telephonically at the earliest possible opportunity, but always within 30 days of identifying the member as a potential candidate for CM. Based on application of the criteria in the initial screening evaluation, care managers contact the members in order of risk level, from highest to lowest.
4. The detailed health risk assessment includes:						The comprehensive *Health Risk Assessment (HRA)* includes health status, condition–specific issues, comorbidities, clinical history, key events such as inpatient stays, treatment history, current and past medications, compliance with current and past therapies and monitoring, and mental health status.
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments.	X					Per the *CM Program Description*, the member's care plan is completed within 30 days of completion of the *HRA*. Participants in the development of the care plan include the Care Management team consisting of care managers, program coordinators, social services specialists, behavioral health specialists, and member connections representatives. Each team member contributes different skills and functions to the management of the member's care. Each must work within their scope of practice. Other key participants in the development of the care plan may include: •The member, member's authorized representative, or guardian •The member's PCP and specialty providers •Magnolia's medical directors •Hospital discharge planners •Ancillary providers •Behavioral health providers •Representatives from community social service, civic, and religious based organizations •Other non-health care entities
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Care plans are monitored at least monthly and revised as necessary, (e.g. when the member's condition progresses or regresses, when goals are reached, etc.). A schedule for continuous review and revision, which includes follow-up and monitoring of the member's progress, is developed using the intervals defined by priority level and current needs. Reassessments are completed for significant changes in condition, and care plan revisions are made as needed and shared with the PCP or specialist, as appropriate.
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management Team member and provided instructions on how to contract their assigned team;						Each member enrolled in CM is assigned to a specific care manager. Certain care managers specialize in specific conditions, such as sickle cell disease, high risk obstetrics, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the member requests otherwise;						
7.3 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health and those identified through EPSDT;						Care managers assist members with referrals and scheduling for specialty care.
7.4 Documentation of referral services and medically indicated follow-up care in each member's medical record;						Onsite discussion confirmed care managers document referrals and follow-up care in each member's care management record.
7.5 Monitoring and treatment of members with ongoing medical conditions according to appropriate standards of medical practice;						
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						Processes for discharge planning coordination and post-discharge follow-up are documented in Policy CC.UM.01.09, Discharge Planning, Policy MS.UM.24.04, Post Discharge Member Outreach, and Work Process MS.UM.24.05, Post Discharge Member Outreach Calls.
7.8 Determination of the need for non-covered services and referral of members to the appropriate service setting, utilizing assistance as needed from the Division;						Policy MS.UM.24, Continuity and Coordination of Services, describes the process for ensuring that appropriate referrals and linkages for both covered and non-covered services are made.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.9 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.10 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						Policy MS.UM.24, Continuity and Coordination of Services, addresses requirements for continued access to terminated providers for up to 90 calendar days or until the member can be transferred to a network provider.
7.11 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						Policy MS.UM.24, Continuity and Coordination of Services, describes coordination of care when a PCP change occurs.
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member;						
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						Policy MS.UM.24, Continuity and Coordination of Services, addresses requirements for care to be provided by an out-of-network provider when the services are unavailable from a network provider.
7.14 The Contractor must produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The member and/or authorized family member or guardian must						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
be involved in the development of the plan;						
7.15 Monitor and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MS.UM.24, Continuity and Coordination of Services, addresses requirements for continuity of care for members who disenroll from Magnolia.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and other service providers.	X					Transitional Care Management is performed by Care Management staff for members with needs for discharge planning and outpatient coordination of services to prevent unnecessary readmission. Policy MS.UM.24, Continuity and Coordination of Services, addresses processes for facilitating coordination of care between various providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. 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.	X					
3. 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.	X					
V. F Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The *2015 UM Program Evaluation* included highlights of the UM Program's status and progress for 2015; identified barriers and opportunities for improvement; and recommendations for further actions to continue improvement. Each goal was listed individually along with its status, outcomes, and opportunities for improvement.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					QIC minutes from June30, 2016 contained documentation of discussion of the 2015 Medicaid UM Evaluation.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The *Master Services Agreement* and *Attachment B, Delegated Services Agreement*, specify the activities to be performed by delegates and address performance standards, as well as penalties and sanctions for sub-standard performance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				Policy MS.QI.14, Oversight of Delegated Vendor Services, defines processes for oversight of delegated entities. Magnolia retains accountability for delegated services and monitors the delegate's performance through review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings with each delegate, and annual evaluation. Corrective action plans are developed, as warranted, when deficiencies are identified. Reports regarding ongoing corrective action plans are presented to the QIC at least quarterly. When deficiencies are severe or unable to be resolved, the delegation arrangement may be revoked. Policy CC.CRED.12, Oversight of Delegated Credentialing, defines processes for oversight of delegated credentialing. Page 7 states, "Per NCQA standards, in the instance where the delegate is NCQA Certified or Accredited, Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and omit the annual audit or evaluation. On pre-delegation, Plan must evaluate the compatibility of the delegate's Credentialing Program with Plan's Credentialing Program. Once delegation occurs, Plan must only ensure that the delegate provides the appropriate reports as determined by Plan to ensure the delegate is compliant with the needs of Plan. Plan's State Contract may not acknowledge this automatic credit." The *CAN Contract*, *Section 14 (B)*, states, "The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in Annual Quality Management Program Evaluation." The contract does not allow plans to eliminate annual oversight for NCQA Certified or Accredited delegates. Evidence of appropriate oversight was provided for each of Magnolia's delegated entities. Committee minutes reflected that summaries of oversight meetings and reporting are presented to the QIC for review and comment. *Corrective Action: Revise Policy CC.CRED.12, page 7, to remove the following statements:* • *"Per NCQA standards, in the instance where the delegate is*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						NCQA Certified or Accredited, Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and omit the annual audit or evaluation." • *"Once delegation occurs, Plan must only ensure that the delegate provides the appropriate reports as determined by Plan to ensure the delegate is compliant with the needs of Plan."*

CCME CHIP Data Collection Tool

Plan Name:	**Magnolia Health Plan CHIP**
Review Performed:	2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Magnolia Health Plan (Magnolia) for CHIP has a comprehensive set of policies and procedures specific to Mississippi or containing Mississippi addendums. Some policies do not clearly indicate the line of business to which they apply. Because Magnolia serves MSCHIP, MSCAN, and a marketplace insurance plan, policies need to clearly indicate the line of business to which they apply. Policies are reviewed annually and updated as needed. Employees have access to policies on a shared drive. Magnolia underwent full NCQA Accreditation in 2016 and is awaiting the final determination. *Recommendation: Ensure that all Magnolia policies for CHIP indicate the line of business the policy applies to.*
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. At a minimum, this includes designated staff performing in the following roles:						Magnolia has sufficient administrative and clinical staff to ensure members have access to required benefits and services as determined by the State of Mississippi. The Leadership Team is in place with no vacancies noted in this area.
1.1 Full time Chief Executive Officer;	X					Aaron Sisk serves as plan president and CEO. He is located in Mississippi and is responsible for the day-to-day business

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						activities of Magnolia Health Plan. He reports to Jason Dees, the regional VP of health plan operations. The Board of Directors has ultimate authority and accountability for oversight of the quality of services provided to members. Magnolia Health Plan is part of Centene Corporation, located in St. Louis, Missouri.
1.2 Chief Operations Officer;	X					Trip Peeples is the senior vice president of operations.
1.3 Chief Financial Officer;	X					Michael Ruffin the vice president of finance.
1.4 Chief Information Officer: A professional who will oversee information technology and systems to support CCO operations, including submission of accurate and timely encounter data;	X					Magnolia has a local IT support person in Mississippi and Centene Corporate staff support local Mississippi IT functions. The Finance department assumes responsibility for submission of required encounter data reporting.
1.4.1 Information Systems personnel;	X					
1.5 Claims Administrator;	X					Debra Merchant is the manager of claims.
1.6 Provider Services Manager;	X					Cynthia Douglas is the senior director, network development & contracting. Her responsibilities include claims, provider contracting, and local credentialing.
1.6.1 Provider credentialing and education;	X					The Provider Relations department is charged with conducting provider education. The Quality Improvement department educates providers on quality measures, such as HEDIS, and involves providers in quality projects. Credentialing is conducted by the Centene Corporate Credentialing department.
1.7 Member Services Manager;	X					Lucretia Causey serves as director of customer service and oversees call center performance.
1.7.1 Member services and education;	X					Member education is conducted in multiple ways across several departments. For example, Magnolia member education can be provided through written materials, brochures, newsletters, call center, face to face meetings, and the *Member Handbook.*
1.8 Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals;	X					Complaints, grievances, and appeals are handled by the Quality Improvement department.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions;	X					Paula Whitfield is the vice president of medical management and Amanda Smith is the director of utilization management.
1.9.1 Medical/Care Management Staff	X					
1.10 Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities;	X					Carrie Mitchell is senior director of quality improvement.
1.11 Marketing and/or Public Relations;	X					Mary Anna McDonnieal is the director of marketing and communications.
1.12 Medical Director: A physician licensed and actively practicing in the state of Mississippi, providing substantial oversight of the medical aspects of operation, including quality assurance activities, the functions of the Credentialing Committee, and serves as Chair of the Credentialing Committee;	X					Dr. Jeremy Erwin (OB/GYN) serves as the chief medical director and Dr. Rebecca Waterer (internal medicine) is the vice president of medical affairs. Magnolia is in the process of redefining these roles. Dr. Erwin is more involved with UM and the Quality Improvement area and Dr. Waterer oversees pharmacy functions and provider education. Dr. Bri May (pediatrics) and Dr. Leigh Campbell (pediatrics/neonatology) support UM functions along with both Dr. Erwin and Dr. Waterer. Behavioral health practitioners oversee the behavioral health aspects of the UM program. Michael Todero, PharmD is the vice president of pharmacy operations and is supported by Conor Smith, RPh.
1.13 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.	X					Terrica Miller is the vice president of compliance and serves as the privacy officer. Policy CC.COMP.05, Prohibiting Retaliation Against Employees, Individuals or Others, states, “The Corporation will maintain an “open-door policy” at all levels of management to encourage employees to report problems and concerns.” The compliance officer has a direct reporting path to the plan president or the Centene Corporate Compliance department.
2. Operational relationships of CCO staff are clearly delineated.	X					The organizational chart depicts the operational relationships for Magnolia.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week.	X					Magnolia utilizes NurseWise to provide a nurse advice line with 24/7/365 availability. It is accessible via a toll-free number and TTY.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia has systems and guidelines in place to confirm benchmarks are met and metrics are monitored to ensure compliance. The CCO reported actual financial accuracy percentages and expected 30-day and 90-day clean claims processing percentages. The CCO provided data samples indicating actual 30/90-day clean claim payment percentages surpassing CAN and CHIP contract minimums.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia performs extensive analysis of the demographics and enrollment of members. Detailed membership information is tracked and compared against the provider database to ensure adequate coverage is provided.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Magnolia stores claims and member data in a data warehouse environment comprised of redundant servers and storage systems that are used for HEDIS reporting. An analytics application is used to track that data to generate quality and utilization reports.
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Magnolia has an extensive disaster recovery (DR) plan that addresses resources, tasks, personnel, and recovery strategy. In May 2016 a systems recoverability test was performed and all recovery goals were met.
I D. Compliance/Program Integrity						
1. The CCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.		X				A toll-free hotline number has been established to report potential fraud, waste or abuse activities. The hotline is operated by an independent third party and all referrals are sent directly to a member of the SIU management team at Centene. The hotline is well publicized at the plan and in the *CAN and CHIP Member Handbooks* and *Provider Manuals.* Compliance staff receive at least 2 hours of compliance and fraud, waste, and abuse training per year. Terrica Miller also attends annual training sponsored by the American Contract Compliance Association. All staff receive compliance training within the first 4 days of orientation and annually thereafter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *Centene Corporate Fraud, Waste, and Abuse/Compliance Plan* with a Mississippi addendum was submitted with the desk materials. *The Fraud, Waste and Abuse/Compliance Plan*, and multiple policies were reviewed for compliance to federal and regulations and contract requirements. The following requirements were not found in the Fraud, Waste, and Abuse Plan: •Enforcement of standards through well-publicized guidelines (*Federal Regulation § 438.608 (a) (1) (vi), CAN Contract, Section 11 (B) (5),* and *CHIP Contract, Section 11 (B) 4)).* •Prompt response to detected offenses. *(Federal Regulation § 438.608 (2), CAN Contract, Section 11 (B) (6),* and *CHIP Contract, Section 11 (B) (5)).* •The Contractor shall not knowingly have a relationship with an individual, or entity that is debarred, suspended, or otherwise excluded from Federal participation in procurement activities under the Federal Acquisition Regulation. *(Federal Regulation § 438.610 (a) (1) and CAN* and *CHIP Contracts, Section 1 (I)).* *Corrective Action: Include in the Fraud, Waste, and Abuse/Compliance Plan the 3 items noted above.*
2. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					Magnolia's Compliance Committee is chaired by the compliance officer and meets on a quarterly basis and as needed. The committee minutes reflect good attendance and a quorum consists of 50% of voting members present. The committee reports to the Board of Directors. Membership of this committee is found in the committee charter and the committee matrix. The charter includes a finance officer/CFO as a member; however, this position is not included in the membership list attached to the charter or in the committee matrix document submitted. *Recommendation: Ensure the listing of compliance committee membership is the same across all documentation.*
I E. Confidentiality						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					The *UM Program Description*, page 9, lists the various means Magnolia uses to ensure confidentiality in all processes and seeks to abide by all federal and state laws governing confidentiality. Policy CC.COMP.04, Confidentiality and Release of Protected Health Information (PHI), defines the use and protection of PHI, along with several policies that address privacy and security. Policy CC.COMP.PRVC.10, Privacy Notice-Provision states the notice will be provided to new members upon enrollment and within 60 days of a material revision to the notice. If *NCQA* accredited, member will be notified annually of their right to obtain a copy of the notice. The Notice of Privacy Practices is included in the *Member Handbook* for CAN and CHIP.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Centene Corporate Credentialing Program* has been adopted by Magnolia for the CAN and CHIP programs. Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, addresses the credentialing and recredentialing process for practitioners and Policy CC.CRED.09, Organizational Assessment and Reassessment, addresses the organizational provider credentialing and recredentialing process. The policies are detailed with state-specific requirements addressed via footnotes and attachments.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the	X					Policy CC.CRED.03, Credentialing Committee, outlines the structure, protocols, and peer-review process the Credentialing Department and Magnolia uses to make recommendations regarding credentialing decisions. The Credentialing Committee is currently chaired by Dr. Becky

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
CCO.						Waterer, vice president of medical affairs. Dr. Waterer was formerly the chief medical director, and the position is currently held by Dr. Jeremy Erwin who also serves on the committee. Additional voting members of the committee include two Magnolia medical directors and six participating providers with the specialties of pediatrics, family medicine, nurse practitioner, hospital medicine, and psychiatry. The Credentialing Committee meets at least 10 times per year and a quorum is established with 50% of voting members in attendance. A review of Credentialing Committee minutes reflected good participation by voting members. A quorum established at the beginning of each meeting. During the onsite visit, CCME recommended Magnolia consider having the chief medical director chair the Credentialing Committee, as this is a requirement of both the *CAN* and *CHIP Contracts, Section 1 (L),* item 4). Magnolia was very receptive to implementing this change. *Recommendation: Consider having the chief medical director chair the Credentialing Committee.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files reviewed were organized and contained appropriate documentation. Two issues are discussed in the following section.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.12 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	X					
3.1.13 Ownership Disclosure Form.	X					One credentialing file contained the signed ownership disclosure form but the form was not dated. Magnolia indicated it was not their practice to accept forms without a date. Other forms reviewed were signed and dated.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure ownership disclosure forms contain a date beside the signature.
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.		X				Policy MS.CONT.03, Site Assessment for New Provider Contracts, defines the procedure for provider office site review to ensure patient care is delivered in an accessible, safe environment with adequate examination and waiting areas. Magnolia conducts an initial office visit to all new potential PCPs, OB/GYNs, and all high volume specialists prior to making the credentialing decision for that provider. For sites that do not meet an overall minimum score of 80 percent, follow-up action plans are developed and revisits are scheduled at least every six months until performance standards are met. The *Practitioner Office Site Evaluation Tool* received at the onsite has incorrect appointment availability information as follows: •It states the timeframe for a preventive health exam or routine, non-symptomatic visit is 45 calendar days, but the requirement is “not to exceed 30 calendar days.” •It states the timeframe for routine, non-urgent symptomatic visits is within 10 calendar days, but the requirement is “not to exceed 7 calendar days.” •It states the timeframe for urgent visits is within 48 hours, but the requirement is “not to exceed 24 hours.” *(*Reference the *CHIP Contract, Section 7 (B) (2))* A review of the credentialing files showed PCP office site visits were not received in the initial desk materials requested. The information was requested again at the onsite visit and three PCP site visits were not received. Magnolia needs to ensure they are following Policy MS.CONT.03, Site Assessment for New Provider Contracts. *Corrective Action: Update the Practitioner Office Site Evaluation Tool to reflect correct appointment availability timeframes. Ensure provider office site visits are conducted in accordance with Policy MS.CONT.03, Site Assessment for New Provider Contracts.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files reviewed were organized and contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery the System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	X					
4.2.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.12 Ownership Disclosure form.	X					
4.3 Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met.	X					Policy MS.CONT.03, Site Assessment for New Provider Contracts, defines the procedure to monitor deficiencies related to a practitioner's office by monitoring member complaints/ grievances and/or member survey information. Upon identification of complaints related to quality of a practitioner's office site, Provider Relations performs an onsite visit within 45 days of identification that the complaint threshold has been met. Sites must receive a passing score of greater than 80 percent in any category. For providers not meeting the standard, a corrective action plan is presented to the office and is to be fully implemented within six months of the initial visit. Plan staff revisit the site at least every six months until the performance standards have been met, or until the Credentialing Committee recommends terminating the provider, if applicable.
4.4 Review of practitioner profiling activities.	X					Policy MS.QI.23, Provider Profiling Program, states Magnolia increases provider awareness of performance through the continual use of the Provider Profiling Program. The goals of this program are to improve the health outcomes of members and to appropriately recognize providers for delivering quality care. Provider profiling is conducted through a review of claims and outcomes data. Specific aspects of a provider's profile will be shared with that provider. The Provider Profiling Program

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						extends to Primary Care Physicians and Specialists, with each PCP and Specialist receiving an annual, individualized profile report. Evidence of PCP Patterns of Care reports were received in the desk materials.
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy MS.QI.18, Quality of Care Investigations, defines the procedure for receiving, investigating, and addressing potential quality of care issues. All potential quality of care issues are routed to the Quality Improvement Department. Severity levels are assigned with the medical director review of all cases with a severity level above zero. All cases with a severity level 3 or 4 are referred to the Peer Review Committee for review and action. If a practitioner's network participation is to be suspended or terminated for reasons relating to the practitioner's competence or professional conduct, appropriate authorities will be notified. The number and severity level of quality of care investigations may be used by the Credentialing Committee at the time of physician recredentialing. Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, defines the process of suspension and/or termination from the Magnolia network and states the practitioner is offered a formal appeal process. The appeal hearing process is addressed in Policy CC.CRED.08, Practitioner Appeal Hearing Process.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					The credentialing and recredentialing guidelines for organizational providers are addressed in Policy CC.CRED.09, Organizational Assessment and Reassessment.
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.09, Verification of Member Eligibility, defines the procedure for ensuring that providers have access to the PCP Panel/Patient List within five business days of receipt of enrollment from DOM. The information is available for eligibility verification via the Secure Provider Portal on the website. Providers may contact and use the interactive voice response (IVR) system, available 24/7. Providers may also speak with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Services Representatives during normal business hours to verify member eligibility.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Magnolia tracks limitations on panel size and the *Provider Directory* search option on the website has an option for selecting providers accepting new patients. Evidence of Open Panel and Closed Panel PCP reports were received in the desk materials.
1.4 Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties.		X				MS.QI.04, Evaluation of Practitioner Availability, defines the process used to monitor the type, number, and geographic distribution of network providers to determine how effectively the network meets the needs, preferences, and diversity of Magnolia's membership. Policy MS.CONT.01, Provider Network, provides general information regarding network development. Both policies define the geographic definitions that comply with contract requirements. GEO access reports received match defined parameters in compliance with the *CAN and CHIP Contracts*. The CHIP 2015 *QI Program Evaluation* (page 37) states the standard member-to-provider ratio for PCPs is 1:1,500 while Policies MS QI.04 and MS.CONT.01 define the ratio as 1:2,500. *Corrective Action: Ensure the CHIP 2016 QI Program Evaluation and Policies MS.QI.04 and MS.CONT.01 contain consistent information regarding the PCP member-to-provider ratio.*
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MS.QI.04, Evaluation of Practitioner Availability, defines the geographic access standards for hospitals, specialists, dental providers, behavioral health providers, pharmacy, urgent care, dialysis, and emergency service providers in compliance with contract requirements.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at	X					Practitioner type and availability is measured quarterly by the Magnolia Provider Relations, Network Development, and Contracting Departments as defined in Policy MS.QI.04,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
least quarterly.						Evaluation of Practitioner Availability.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Magnolia assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts practitioner availability within its network. They assist in connecting members with practitioners who can meet their needs and analyze member surveys and grievance data to identify areas for improvement as defined in Policy MS.QI.04, Evaluation of Practitioner Availability. Free access to interpreter services is provided for members. Magnolia has a *Cultural Competency Plan* serving as a process to follow for multicultural principles and practices throughout organizational systems of services and programs. Magnolia's goal is to reduce healthcare disparities and increase access to care by providing quality, culturally competent healthcare through strong doctor-patient relationships. The *Cultural Competency Plan* is reviewed annually and is loaded to the provider portal section of the website. The *Provider Manual* addresses responsibilities for the providers regarding cultural competency and Policy MS.QI.22, Cultural Competency, defines guidelines for how Magnolia meets the cultural competency needs of members.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MS. PRVR.10, Evaluation of the Accessibility of Services states the Provider Relations Department measures access to primary care services at least annually. Policy MS.QI.05, Evaluation of the Accessibility of Services, states Magnolia measures appointment and telephone access to primary care services on an ongoing basis through member grievance/ complaints, provider audits/surveys, and through the member satisfaction survey. Trend analysis is conducted with comparison to established standards at least annually. Results are reported and reviewed by the Quality Improvement Committee (QIC). Policies MS. PRVR.10 and MS.QI.05 define appointment timeframes for "Medically necessary initial high-risk prenatal care (For High-risk pregnancy OB/GYN providers only)." However, the appointment information listed on the website states the criteria is for "Pregnant Women Care" and in the CAN *Provider Manual* it states the appointment timeframes are for "OB/GYN Access". The information is not listed in the CHIP *Provider Manual*. There was confusion among Magnolia staff during the onsite discussion as to whether the standards applied to only high-risk prenatal care or pregnant women. *Corrective Action: Update documents addressing appointment standards for OB/GYN such as Policies MS.PRVR.10 and MS.QI.05, Provider Manuals, and the website to reflect consistent information. Do the standards apply to high risk OB/GYN or pregnant women care?* A review of Magnolia's provider appointment and after-hours evaluations indicates possible member access issues. •Results of the PCP Appointment Access monitoring reported in both the CAN and CHIP 2015 Program Evaluations that only 3 out of 8 measures met the performance goal of ≥90%. Failed standards included emergent visit, medically necessary initial high-risk prenatal care, EPSDT initial health check within 90 calendar days of enrollment, after-hours coverage 24/7, and patient wait time within 30 minutes of appointment. •The *Magnolia Health Medicaid and Ambetter Practitioner Access Analysis (July 1, 2015 – June 30, 2016)* reported access measures as not meeting goal for PCP routine and urgent

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appointments, PCP after-hours care behavioral health follow-up routine care appointments, and oncology urgent appointments. Barriers and implemented actions such as provider education were discussed. CCME recommends a continued focus on member access to their providers; identifying the non-compliant providers and working to improve compliance to the provider access measures. *Recommendation: Continue to focus on member access to providers. Identify the non-compliant providers and work to improve compliance to the access measures.*
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.				X		Results of the *Telephonic Provider Access and Availability Study* conducted by CCME showed calls were successfully answered by personnel at the correct practice for 39% (104 out of 265) of calls, which estimates between 36% and 42% for the entire population, based on a 95% confidence interval. For those not answered successfully, 51% of physicians were no longer at the practice or phone number listed. Since this is the first *Telephonic Provider Access and Availability Study* conducted by CCME for CHIP, this standard is being scored as “Not Applicable”.
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.		X				Newly contracted providers receive an orientation within 30 days of execution of a new provider contract. The orientation presentation includes core elements and all provider office staff are encouraged to attend as specified in Policy CC.PRVR.13, Provider Orientations. The provider portal on the website also contains training videos and a Practice Improvement Resource Center (PIRC) containing resource information for CAN and CHIP. A toll-free provider telephone hotline is also available to provide support through the provider services call center. Policy MS.PRVR.03, Toll-free Provider Telephone Hotline, defines call center standards and procedures for call tracking and resolution. Policy CC.PRVR.02, Provider Manual, states the *Provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Manual will be referenced during orientation visits which are performed by the Provider Relations Department. Magnolia has *Provider Manuals* for both the CAN and CHIP programs serving as good resource documents for navigating the plan. At the time of the EQR, the *CHIP Provider Manual* was not loaded to the provider portal on the website. *Corrective Action: Ensure the CHIP Provider Manual is loaded to the provider portal on the website.*
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					
2.2 Billing and reimbursement practices;	X					
2.3 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;	X					
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					
2.7 Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					
2.8 Medical record handling, availability, retention and confidentiality;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communication the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;		X				The *Provider Manual* for CHIP states it is a member's right to receive oral interpretation services for all non-English languages free of charge; however, it does not provide any guidance to providers regarding what translation services are available and what a provider should do if a member needs translation services. *Corrective Action: Update the Provider Manual for CHIP to include information regarding what translation services are available and what a provider should do if a member needs translation services.*
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
lines of business.						
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.	X					Policy MS.PRVR.19, Provider Directory, defines the procedure for maintaining a web-based searchable *Provider Directory* that includes a listing of all providers in Magnolia's network of contracted providers. The web-based data is refreshed nightly from the Enterprise Data Warehouse (EDW) system to keep all information current. *Provider Directory* data is sourced from the credentialing system in a live feed providing immediate updates. Hard copy *Provider Directories* are updated annually or more often if there are significant network changes.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider training includes regularly scheduled meetings with in-network providers based on assignment and Plan initiatives. The provider portal on the website includes a "Provider Resources" section for reference materials, training information, and provider newsletters. Magnolia recently added a "secure email messaging" function to the secure portal and providers can also communicate via phone. Policy MS.PRVR.14, Provider Visit Schedule, defines the procedures for establishing regularly scheduled face to-face meetings with providers.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, establishes the process for adoption and distribution of preventive health and clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The guidelines are reviewed and adopted by the Quality Improvement Committee. They are updated upon significant new scientific evidence or change in the national standards and will be reviewed at least every two years.
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO members to providers.		X				Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines, states a listing of adopted preventive health guidelines is maintained in the *Provider Manual* with a notation the links and/or full guidelines are available on the Magnolia website or hard copy, upon request. The *CHIP Provider Manual* contains an outdated list of adopted practice guidelines and does not contain information specific to providers about using the guidelines or where to find them.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The preventive guidelines are loaded to the provider portal of the website and the information on the website matches the policy. *Corrective Action: Update the Provider Manual for CHIP to include accurate information regarding preventive health guidelines, the expectation they will be followed, and where to find them.*
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and Adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to member high-risk groups.	X					
3.5 Behavioral Health	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, establishes the process for adoption and distribution of preventive health and clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The guidelines are reviewed and adopted by the Quality Improvement Committee. They are updated upon significant new scientific evidence or change in the national standards, and will be reviewed at least every two years.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be		X				Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines, states that a listing of adopted clinical practice is maintained in the *Provider Manual* with a notation that the links and/or full guidelines are available on the Magnolia website or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
followed for CCO members.						hard copy, upon request. The *CHIP Provider Manual* contains an outdated list of adopted practice guidelines and does not contain information specific to providers about using the guidelines or where to find them. The clinical practice guidelines are loaded to the provider portal of the website and the information on the website matches the policy. *Corrective Action: Update the Provider Manual for CHIP to include accurate information regarding clinical practice guidelines, the expectation they will be followed, and where to find them.*
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.		X				Policy MS.QI.13, Medical Record Review, outlines the process for monitoring network providers for medical record documentation. Minimum standards are defined in the policy and the *CHIP Provider Manual* specifies detailed requirements for medical record documentation and review. The policy states the most current version of the medical record standards is maintained on Magnolia's website; however, the information could not be found. *Corrective Action: Update the provider portal on the website to include the most current version of the medical record standards as defined in Policy MS.QI.13, Medical Record Review.*
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Policy MS.QI.13, Medical Record Review, states PCPs and high-volume specialists (OB/GYN) are monitored for compliance to medical record standards. A score below 80% is considered deficient. Providers are notified of the audit results and a follow-up audit is conducted within six months. Medical record reviews are trended by the QI Department and presented to the QI Committee quarterly. The *CHIP Provider Manual* states Magnolia will conduct random medical record audits as part of its QI program to monitor compliance with the medical record documentation standards. Onsite discussion confirmed Magnolia conducts the medical record reviews as an ongoing process for only 15 – 16 providers, annually. Results for 2016 showed no provider fell

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						below the 80% goal. *Recommendation: Consider conducting medical record reviews on a larger sample of providers to ensure they are adhering to Magnolia's medical record standards.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.		X				For the *Provider Satisfaction Survey*, the initial sample had a low response rate (6.4%) with the latter sample having a better response rate of 36.7%. This is slightly below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey. Finding ways to increase the response rate is recommended. Additionally, information on reliability and validity of the *SPHA Provider Satisfaction Survey* was not provided in the documentation. *Corrective Action: Implement interventions to increase the response rate in the provider satisfaction survey and improve survey documentation. Provide information regarding whether or not reliability and validity have been assessed on the survey, and, if assessed, the values associated with the reliability and validity findings.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Survey was analyzed by the plan.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QIC committee in February 2016 and continued discussion occurred in June of 2016.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MS.MBRS.25, Member Rights and Responsibilities, states a written description of the rights and responsibilities will be included in the member information materials provided to new members. Member rights are found in the *CHIP Member Handbook*.
2. Member rights include, but are not limited to, the right:		X				The overall score of "Partially Met" is based issues identified in the following standards.
2.1 To be treated with respect and dignity;						Found in Policy MS.MBRS.25, Member Rights and Responsibilities, the *CHIP Member Handbook*, the CHIP website, and the *CHIP Provider Manual*.
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline,						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						The *CHIP Member Handbook* fails to include the right of members to freely exercise their rights and that exercising their rights will not affect the way providers or the health plan treats them. Refer to the *CHIP Contract, Section 6 (I) (1) (g).* *Corrective Action: Include in the CHIP Member Handbook a member's right to freely exercise rights, and that the free exercise of their rights will not affect the way providers or the health plan treats them.*
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member Responsibilities include the responsibility;	X					Member responsibilities are included in the *CHIP Member Handbook* and Policy MS.MBRS.25, Member Rights and Responsibilities. See the recommendations in the standards below.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff.						This responsibility is partially defined in the *CHIP Member Handbook.* *Recommendation: Include in the CHIP Member Handbook that members are asked to show courtesy and respect to providers and their staff.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education						
1. Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:		X				Policy MS.MBRS.01, New Member Packet/Member ID Card, states new member packets and ID cards are issued prior to the first day of the month in which enrollment starts, and no later than 14 days after the plan receives notice of the member's enrollment. The *CHIP Member Handbook* lists the locations where provider directories are located. Members can also call member services to request a printed copy. It includes a description of the search for provider feature on the Magnolia Website. The "Partially Met" score is due to missing information in the following standards.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The benefit lists in the *CHIP Member Handbook* and the *CHIP Provider Manual* are thorough. Both documents contain minor inconsistencies: •The *CHIP Member Handbook* does not include disposable medical supplies as a benefit. •The *CHIP Provider Manual* fails to include chiropractic care, air ambulance fixed wing, and diabetes training. *Corrective Action: Update the CHIP Member Handbook and the CHIP Provider Manual with the missing information noted above.*
1.1.1 Benefits include family planning and direct access for female Members to a women's health specialist in addition to a PCP;						The *CHIP Member Handbook* does not include that female members may have direct access to a women's health specialist in addition to a PCP. See *Federal Regulation § 438.206 (b) (2) and CHIP Contract, Section 7(A).* *Corrective Action: Include in the CHIP Member Handbook that women may have direct access to a women's health specialist in addition to a PCP.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary;						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						Policy MS.UM.24, Continuity and Coordination of Care, describes the functions of coordinated care and include appropriate referrals and linkages are made for the member. The *CHIP Member Handbook* includes self-referrals and in-network referrals, and that prior authorization may be required for out-of-network providers.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						Policy MS.PHAR.09, Pharmacy Program, contains a description of the Pharmacy Program. Magnolia has policies addressing emergency supply, utilization of the pharmacy benefit, over-the-counter medications, the Preferred Drug List (PDL), and prior authorization. The *CHIP Member Handbook* includes this information and, additionally, a description of step therapy, age limits, and quantity limitations. Copayments required for some of the CHIP population apply to doctor or emergency room visits. Copayments are explained in the *CHIP Member Handbook*.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Policy MS.MBRS.12, Member Notification of Plan Changes, and the member letter template advising of changes and selecting a new PCP contain the appropriate timeframes for notification. Policy MS.MBRS.27, Member Advisory of Provider Termination, defines the process to notify members when a provider leaves or is terminated from the plan. Errors in other documents are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addressed in a standard to follow.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's role and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, the nurse advice line, and the member portal;						The *CHIP Member Handbook* provides the toll-free telephone, TTY/TDD, and Mississippi Relay numbers. Magnolia's Member Services Department is open from 8 a.m. to 8 p.m. on Monday, Tuesday-Friday from 8 a.m. to 5 p.m., and the second weekend of the month from 8 a.m. to 5 p.m. Calls received after business hours are sent directly to NurseWise. NurseWise staff are available 24 hours a day, 7 days a week, including holidays. Information on the member portal is provided in the *CHIP Member Handbook*.
1.13 A description of the Well-Baby and Well-Child services that includes;						The *CHIP Member Handbook* explains Well-Baby and Well-Child services. There are missing elements that need to be addressed and they are defined in the following standards.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						Federally required blood lead screening is not found in the list of laboratory tests on page 26 of the *CHIP Member Handbook.* *Recommendation: Include blood level testing in the description of Well-Baby and Well-Child services in the CHIP Member Handbook.*
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/Education and referral for identified problems.						Referral for identified problems is not found in the list of Well-Baby and Well-Child services, on page 26 of the *CHIP Member Handbook.* See *CHIP Contract, Section 5 (D) (10).* *Recommendation: Include referrals for identified problems in the description of Well-Baby and Well-Child services.*
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals, including the right to request an independent external review;						The *CHIP Member Handbook* includes the procedures for filing a grievance, who may file a grievance or appeal, and how to request second and third levels of review, including review by an external reviewer.
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate						The provider search feature on the *Magnolia CHIP website* includes the requirements of the contract and federal regulations. It is also referenced in the *CHIP Member Handbook*. Members/parents can call Member Services for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
languages spoken by the provider's office;						additional assistance.
1.17 Instructions on reporting suspected cases of Fraud and Abuse;						The Hotline phone number is provided in the *CHIP Member Handbook* along with examples of things that could fall into the category of fraud, waste, or abuse.
1.18 Information regarding the Care Management Program and how to contact the Care Management Team;						Members are informed of the Care Management and Disease Management Programs offered by Magnolia in the *CHIP Member Handbook*. The Start Smart for Your Baby Program is described; however, the *Member Handbook* does not mention high-risk OB care management for the CHIP population. The high-risk pregnancy program is discussed in the *CHIP Provider Manual.* *Recommendation: Include a description of high-risk OB care management services in the CHIP Member Handbook.*
1.19 Information on advance directives;						
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.		X				The *CHIP Member Handbook*, page 3, states, "The practices, policies, and benefits described herein may be modified or discontinued from time to time. Magnolia will make every effort to keep you informed of the changes. You may receive notice of the changes by secure portal, fax or regular mail. You will receive notification of changes at least 30 days before the changes are effective." This is compliant with *Federal Regulation § 438.10 (g) (4).* The *CHIP Member Handbook*, page 34, states, "if the child's PCP leaves the network, Magnolia will send a notice at least 15 days before this date occurs." However, the *CHIP Contract, Section 7 (D) (3)* states this timeframe Is within 15 calendar of notice or issuance of termination. The timeframe is also incorrect in *CHIP Provider Manual*, page 17. *Corrective Action: Correct the CHIP Provider Manual and CHIP Member Handbook to reflect the correct timeframe for written*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						notice to members if their PCP leaves the network.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy MS.MBRS.06, Member Materials and Readability and Translation, verifies materials are written in a clear and concise manner, are at appropriate reading levels, and are available in prevalent languages. Documents are written to a Flesch-Kincaid readability level of no greater than the 6th grade. (Per policy, DOM accepts 6.4 or lower.) Translation and interpretations services are available at no cost to the member. TTY services are available. The *CHIP Member Handbook* informs members about alternative formats available and other interpretation services.
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					The *CHIP Member Handbook* informs that the Member Services area is available and that after hours calls are directed to NurseWise, the 24-hour nurse advice line. TTY and translation services are available for all calls. The *CHIP Contract, Section 6 (D) (14) (b)*, states the CCO must have "A multilingual notice that describes translation services that are available and provides instructions explaining how members can access those translation services." Onsite discussion determined the 1557 rule regarding this is pending approval at DOM. *Recommendation: Develop a multilingual notice describing translation services available and provide instructions explaining how members can access those translation services.*
5. Member complaints/grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Call Center scripts are in-place and staff receives training as required by the contract.	X					Call scripts are in place and call center staff is alerted when members need preventive, screening, or PCP visits to meet identified care gaps. CCME conducted a review of recent call-center calls from members during the onsite visit. Issues identified during this process included the following: •Staff did not consistently complete the HIPAA verification process. •Staff members were rushing calls, having the appearance of impolite treatment of the members. •Several calls brought attention to systems issues requiring a member to call back to enter a change of PCP. According to *CHIP Contract, Section 6 A (4),* call center trainings must include education about Medicaid, the MississippiCHIP Program, appropriate instances for transferring a Member to a Care Manager, and customer service. Staff must also receive updates about CHIP Program changes or requirements. Onsite discussion confirmed training does occur regularly and attendance is tracked. This is not documented in a policy or training materials. *Recommendation: Continue to provide additional training and follow-up audits for call center staff not meeting expectations when handling phone calls. The requirement that Magnolia conduct quarterly scheduled training for call center staff should be documented in a policy or other document to include the frequency and general content of these trainings.*
3. Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee.	X					
III D. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Policy MS.ELIG.03, Primary Care Providers Selection and Change, defines the PCP selection process. Member Services staff assist members to select or change a PCP upon request. Policies MS.ELIG.01, Primary Care Provider, and MS.ELIG.08, PCP Notification, both state PCP assignment is accomplished within 60 days of enrollment if the member has not chosen a PCP within the first 30 days of enrollment.
2. The CCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Magnolia adopts clinical and preventive health guidelines. Preventive Health Guidelines are found in the *CHIP Member Handbook,* including guidelines for men, women, and children, including Well-Baby and Well-Child. Magnolia's Member Connections program promotes preventive health and the *CHIP Member Handbook* explains Care Management and Disease Management services. The use of these benefits and services are encouraged. Magnolia mails preventive health reminders and educates members via a quarterly newsletter. Information is also found on the CHIP Member website.
3. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					Magnolia's Start Smart for Your Baby Program offers educational materials on pregnancy, pre- and post-natal care, and caring for babies. Magnolia uses multiple sources to identify women who are pregnant and opens a care management file on each pregnant woman until the need for care management or care coordination is determined. Contact with high-risk members is conducted within 7 days and with medium risk members within 14 days following the health risk assessment. Onsite discussion confirmed members are informed about WIC in Start Smart materials and during this process. The *CHIP Member Handbook* includes helpful information about pregnancy and the importance of pre-natal care. CHIP membership may be changed to Medicaid, if applicable, and per notice received from DOM.
4. The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages Members to utilize these benefits.	X					Policy MS.QI.20, EPSDT, states Magnolia is committed to providing preventive health screenings and improving the overall health of children. The PCP and the health plan are responsible for identifying and tracking compliance to the Well-Baby and Well-Child program, and outreach is performed to encourage member compliance. The key aspects of the program include monitoring and tracking provider and member compliance,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reminders and outreach including a periodic notification system to support compliance with the periodicity schedule. Magnolia implemented the CentAccount program that rewards members for healthy behaviors such as well child visits and immunizations.
5. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Onsite discussion confirms Magnolia provides numerous educational opportunities for members. Events are typically located in areas familiar and convenient to members. The Communication department develops the Annual Health Educations and Prevention Work Plan.
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					*Member Satisfaction Survey* results met the minimum number of responses considered by NCQA to be necessary for a valid survey (n=557), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively) at 20.9%. Alternative approaches may be needed to increase the response rates. Due to the low response rates, it is difficult to determine if survey conclusions are supported by the data. *Recommendation: Focus on strategies to help increase response rates for this population. Solicit the help of your survey vendor. Identify methods to determine if response rates can be calculated and if the denominator can be calculated using member data. For the CHIP Member Satisfaction Survey, set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate). Based on Magnolia CHIP's most recent response rate of 20%, a 3% increase would be statistically significant if a similar sample size of 2608 was utilized.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Results were presented and analyzed to assess barriers and create interventions regarding the satisfaction results in October 2016 and in the program evaluation for 2015.
3. The CCO reports the results of the member satisfaction survey to providers.	X					The CAHPS results are reported to providers in a newsletter, including the 2014 and 2015 rates for composite variables that had high ratings in these areas: •Customer services •Getting needed care •Rating of personal doctor •Rating of health plan

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The newsletter also offered rates for items with needed improvement including: •Doctors explained things in an understandable way and •Child's doctor listens carefully to you
4. The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QIC on August 25, 2016 with documented opportunities for improvement. In the QIC meeting minutes on October 6, 2016, documentation was provided regarding the response rates, general results, and how to generate a work plan based on the results.
III G. Complaints/Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07.01, Member Grievance and Complaint Process, defines the process Magnolia uses to receive, acknowledge, investigate, and resolve CHIP member grievances. It includes a three-step review for members not satisfied with the first grievance resolution.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;		X				Several documents with the definition of a grievance are incomplete because they do not include the definition of a grievance as found in *Federal Regulation § 438.400*, "An expression of dissatisfaction received orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Action as defined in this contract." •Policy MS.MBRS.07.01, Member Grievance and Complaints Process •The *CHIP Member Handbook* •The Magnolia CHIP website The *CHIP Provider Manual* defines a grievance correctly as an expression received orally or in writing of dissatisfaction about any matter other than an action. Who may file a grievance is correct in the following documents: •Policy MS.MBRS.07.01, Member Grievance and Complaints Process •The *CHIP Provider Manual* •The *CHIP Member Handbook* •The Magnolia website *Corrective Action: Update the definition of a grievance in the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy, CHIP Member Handbook, and the website to match the definition found in the federal regulation.
1.2 The procedure for filing and handling a complaint/grievance;	X					
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;		X				The *CHIP Contract* states standard member grievance procedures must provide for completion of the entire three-step process within 90 calendar days and completion of expedited review within 72 hours. Policy MS.MBRS.07.01, Member Grievance and Complaints Process, states grievances are resolved within 15 calendar days of receipt and no more than 90 days from receipt. It includes the three step process. The timeframes found in the following documents do not agree with the following policies: •The *CHIP Provider Manual* states resolution timeframe is 15 days from receipt but does not include the three-step process for review of a grievance resolution. •The Magnolia CHIP website states grievance resolution is within 30 calendar days of receipt and fails to include the three-step process for review of a grievance. •The *CHIP Member Handbook* states the timeframe for resolution is 30 calendar days from receipt and no more than 90 days in total. It does define the three-step process for review when the member is dissatisfied with the grievance resolution. •The *CHIP Member Handbook* does not address a clinically-urgent grievance process or that a member can request an extension of timeframe for resolution. Grievance resolution letters do include the three-step process for review. The third level grievance acknowledgement and resolution letters refer members to a Chancery Court. Onsite discussion confirmed this is no longer applicable and should be removed. *Corrective Action: Update the CHIP website, CHIP Provider Manual, and CHIP Member Handbook to align with contract*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements for grievance resolution. Remove the reference to Chancery Court from final resolution grievance letter template. Update the CHIP Member Handbook regarding the urgent grievance process and member extensions.
1.4 Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Policy MS.MBRS.07.01, Member Grievance and Complaints Process, states individuals who make decisions on grievances were not involved in any previous level of review, and healthcare professionals with appropriate clinical expertise make decisions on grievances involving clinical issues. Onsite discussion confirmed this is the Medical Director. This also applies to any grievance regarding quality of care.
1.5 Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract.		X				The *CHIP Member Handbook* states grievance records are retained for a period of 7 years. Policy MS.MBRS.07.01, Member Grievance and Complaints Process, states this period is 5 years. Onsite discussion confirmed the timeframe for retention is 10 years and this is documented in Attachment A of Policy CC.LEGL.01, Records Retention Schedule. *Corrective Action: Ensure the timeframe for retention of grievance logs is consistent across all documentation.*
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					As part of the EQR process, 20 CHIP grievance files were reviewed. The files demonstrated grievances were addressed and closed within a 15-day timeframe. Acknowledgement and resolution notices were timely and resolution notices contained appropriate information.
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MS.MBRS.07.01, Member Grievance and Complaints Process, states Magnolia uses grievance data for quality improvement. QIC meeting minutes documented trending and tracking. Onsite discussion revealed Magnolia tracks the top 5 grievance categories more diligently.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Onsite discussion confirmed there is a process in place to investigate grievances related to requests to change PCPs due to dissatisfaction; however, this process is not documented. *Recommendation: Document the process for investigating all*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requests for change of PCP due to dissatisfaction as grievances in an existing or new CHIP policy.
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Magnolia has a dedicated program description for the CHIP line of business. The Q*uality Assessment and Performance Improvement Program Description 2016* for CHIP was provided in the desk materials. This program description is reviewed, updated as needed, and presented to the Quality Improvement Committee and to the Board of Directors for approval at least annually.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Monitoring and identifying opportunities to access health care disparities as required by the *DOM Contract, Section 9* is not included in the scope of the quality improvement program. Health care disparities are a standing agenda item for the Quality Improvement Committee. During the onsite visit, the Quality Staff spoke of several initiatives underway tracking and monitoring health care disparities such as sickle cell. *Recommendation: Include in the scope of work listed in the quality improvement program description the monitoring of services furnished to members with special health care needs and health care disparities.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia's Quality Improvement Committee is the designated committee charged with providing oversight of all quality improvement activities. This committee is responsible for establishing standards and criterial for delivery of care and services.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Quality Improvement Committee is a senior level committee which actively involves participating network practitioners. A review of the committee's participant roster indicates there are five network providers serving as voting members. Their specialties include pediatrics, family medicine, hospital medicine, and psychiatry. The committee charter indicates membership will also include two nurse practitioners. Magnolia recruited one nurse practitioner but she does not attend regularly. *Recommendation: Continue to recruit nurse practitioners to server on the Quality Improvement Committee.*
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are maintained for each meeting. The committee's discussions are clearly documented and indicated which line of business (CAN, CHIP, and Ambetter) is being discussed.
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All HEDIS and non-HEDIS measures for the CHIP program met the protocol guidelines and were considered "Fully Compliant". The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					There were four CHIP performance improvement projects submitted for desk review. The topics included Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Obesity, ADHD, and Asthma.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All PIPs provided a data-based rationale for the project, as well as, information regarding the study indicators, data sources, and planned data analysis. Barriers and interventions to address those barriers were documented with analysis of findings provided for the baseline data of the EPSDT project. All projects received a score of "High Confidence in Reported Results". The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						
4.1 Initial visits for newborns;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2 Well-Baby and Well-Child screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			The *CHIP Contract, Section 5 (D)* requires the health plan to establish a tracking system for reporting all screening results, diagnosis, and/or treatment for members. Magnolia has systems in place for tracking Well-Baby and Well-Care screenings. However, the health plan does not track any diagnoses identified during the assessments, treatments, or the referrals provided as a result of the assessments. *Corrective Action: Develop a system for tracking any diagnoses identified during a Well-Baby and Well-Child screening, treatment, and/or referrals provided.*
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					For the CHIP program, Magnolia conducts an evaluation of the effectiveness of their QI program. The program evaluation provided contained the results of the QI activities conducted for CHIP. Because 2015 was the inaugural year for Magnolia's CHIP program, there were results that could not be calculated or reported on. Otherwise, the evaluation was complete.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. The Utilization Management (UM) Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *CHIP Utilization Management (UM) Program Description* contains the program's purpose, scope, goals, implementation information, and all contractually-required elements. Departmental policies and procedures guide staff in performance of UM functions.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The *CHIP UM Program Description,* Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications, the *CHIP Member Handbook*, and the *CHIP Provider Manual* include determination timeliness requirements. However, the *CHIP Member Handbook* does not define the authorization determination timeframe for urgent pre-service outpatient authorization requests. Page 37 of the handbook states, "urgent requests can be handled sooner." It also does not include information on extensions of the timeframe. *Corrective Action: Revise the CHIP Member Handbook to include the determination timeframe and information on extensions of the timeframe for urgent pre-service outpatient authorization requests.*
1.5 Consideration of new technology;	X					Reviews for new technology/procedures and services/procedures not addressed in InterQual criteria, local criteria, or policy are referred for Level II medical director review.
1.6 The appeal process, including a mechanism for expedited appeal;	X					Appeals processes are defined in Policy MS.UM.08.01, Appeal of UM Decisions.
1.7 The absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The vice president of medical affairs is Dr. Rebecca Waterer and the chief medical director is Dr. Jeremy Erwin. Dr. Erwin has operational responsibility for and provides support to the UM Program, and along with the vice president of medical management and/or any designee assigned by Magnolia's president and CEO, is responsible for implementing the UM Program. A behavioral health practitioner is involved in implementing, monitoring, and directing behavioral health aspects of the UM Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy services.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions.	X					Per the *CHIP UM Program Description*, the UM Program is evaluated at least annually with modifications made as necessary. The evaluation includes all aspects of the UM Program including member/provider complaint, grievance, and appeal data, member satisfaction/disenrollment surveys, UM data, practitioner profiles, and drug utilization profiles. Problems and/or concerns are identified and recommendations for removing barriers are provided. The evaluation and recommendations are submitted to the UMC for review, action, and follow-up. The final document is then submitted to the QIC and Board of Directors for approval. Policy MS.UM.02, Clinical Decision Criteria and Application, states UM criteria are reviewed annually and updated, as appropriate, by the UMC and/or QIC. All clinical policies are reviewed, updated, and approved annually by the Clinical Policy Committee (CPC) with input from local practitioners with professional knowledge or clinical expertise in the areas being reviewed.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, indicates Magnolia uses the following criteria: •InterQual Level of Care and Care Planning Criteria •Centene clinical policies •Magnolia Medical Management Guidelines for therapies and rehabilitation •Local state and/or regulatory guidelines, where applicable Policy CP.MP.68, Medical Necessity Criteria, defines the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						hierarchy for use of the available criteria.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files for the CHIP population confirmed appropriate criteria are used to determine medical necessity and information is requested when needed to render a decision.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, confirms Level I reviews are conducted using established criteria while considering the individual member's needs including age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment, and the local delivery system available for care. Level II reviews are conducted using established criteria with consideration given to continuity of care, individual member needs at the time of the request, and the local delivery system available for care.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.		X				Onsite discussion confirmed Magnolia does not have a policy defining inter-rater reliability (IRR) testing processes and requirements for staff who issue medical necessity determinations for the CHIP product. It was confirmed the processes are identical to those used for the CAN product. Staff members for all lines of business were included in the most recent IRR testing. Review of QIC minutes for December 17, 2016 included reporting of IRR results for "Medicaid" with no mention of the results for CHIP staff. Onsite discussion revealed this was not clearly reported to the QIC and the results reported for "Medicaid" included those for both CAN and CHIP reviewers. *Corrective Action: Develop a policy to define IRR processes for the CHIP product or update the CAN policy which defines IRR processes to indicate it also applies to the CHIP product. Ensure IRR results reported to the QIC clearly reflect the results for the CHIP product.*
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Policy MS.PHAR.09, Pharmacy Program, states that Envolve (formerly US Script), Magnolia's PBM, implements the pharmacy program including use of the Universal Preferred Drug List (UPDL). The policy further states the UPDL is a listing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of covered pharmacy services approved by the MS-DOM P&T Committee. The policy does not define the product/line of business to which it applies. Onsite discussion confirmed this policy applies to both the CAN and CHIP products. *Recommendation: Revise Policy MS.PHAR.09 to define the product/line(s) of business to which it applies.*
5.2 The CCO has established policies and procedures for the prior authorization of medications.		X				Policy MS.PHAR.09, Pharmacy Program, provides an overview of the pharmacy prior authorization process. However, no policy providing detailed information on pharmacy authorization processes was included in the CHIP review materials. Onsite discussion revealed the processes are the same as those described in CAN Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, and the policy has not been updated to indicate it applies to both the CAN and CHIP products. Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, describes the processes for prior authorization of medications and states a 72-hour supply of medication is available when there is a delay in the review process. The CHIP *Member Handbook* and CHIP *Provider Manual* indicate pharmacies are authorized to provide a 72-hour supply of medication to any patient needing acute treatment, as well as those members awaiting a prior authorization determination to avoid interruption of current therapy or a delay in the initiation of therapy. *Corrective Action: Develop and implement a policy defining the pharmacy authorization processes for the CHIP product or revise CAN Policy CC.PHAR.08 to indicate it applies to both the CAN and CHIP products.*
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy MS.UM.12, Emergency Services, defines processes for emergency and post-stabilization services.
7. Utilization management standards/criteria are available to providers.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, states treating providers may request UM criteria pertinent to a specific authorization by contacting the Medical Management department or may discuss the UM decision with the medical director. The *CHIP Member Handbook, CHIP Provider Manual,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and the initial notice of action letter template notify of the availability of clinical criteria.
8. Utilization management decisions are made by appropriately trained reviewers.		X				Policy MS.UM.04, Appropriate UM Professionals, states: •Prior authorization nurses and concurrent review nurses conduct Level I review for medical necessity. •A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under the Plan's medical benefits. Per State contract, denials can only be issued by a Mississippi licensed physician. •Appropriate practitioners may review and make recommendations to the medical director. •Qualified, licensed health professionals appropriately trained in utilization and medical necessity review conduct authorization and/or concurrent reviews. Onsite discussion revealed pharmacists are permitted to issue denial determinations without referring the review to a medical director. This is not compliant with requirements documented in the *CHIP Contract, Section 5 (H) (1)* and Policy MS.UM.04, Appropriate UM Professionals. *Corrective Action: Update review processes such that denials are only issued by Mississippi-licensed physicians, as required by the CAN Contract, Section 5 (H) (1) and Policy MS.UM.04.*
9. Initial utilization decisions are made promptly after all necessary information is received.	X					UM approval files reflect timely determinations and notifications.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files contain evidence of appropriate attempts to obtain necessary clinical information prior to rendering a denial determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					UM denial files reflect determinations issued by appropriate physician reviewers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					UM denial files reflect timely decision-making and notification of the determination to members and providers.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					Policy MS.UM.08.01, Appeal of UM Decisions, defines Magnolia's processes for handling appeals of UM actions for the CHIP membership. Appeals processes and requirements are also documented in the *CHIP Member Handbook* and the *CHIP Provider Manual*.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Policy MS.UM.08.01, Appeal of UM Decisions, appropriately defines an action and appeal. The CHIP *Member Handbook*, page 56, defines an appeal as "a request for Magnolia to review a Magnolia Notice of Adverse Action." This is not compliant with the definition of an appeal as found in *Federal Regulation §438.400 (b),* and the *CHIP Contract, Section 2 (A)*, which define an appeal as a request for review of an action. Magnolia reviews the decision in the notice, not the notice itself. The CHIP *Provider Manual* does not define an appeal or an action and does not provide information about who can file an appeal. *Corrective Action: Revise the definition of an appeal in the CHIP Member Handbook to be compliant with Federal Regulation §438.400 (b) and the CHIP Contract, Section 2 (A). Update the CHIP Provider Manual to include definitions of action and appeal. Update the CHIP Provider Manual to define who can file an appeal.*
1.2 The procedure for filing an appeal;		X				Issues noted regarding procedures for filing an appeal include: •The timeframe to file an appeal is not specified in the *CHIP Provider Manual*. •The *CHIP Member Handbook*, *CHIP Provider Manual*, and initial denial letter template do not indicate that oral expedited appeal requests do not require written follow-up. •The *CHIP Member Handbook* and *CHIP Provider Manual* do not indicate the member may present evidence and examine the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						case file and other documents related to the appeal. Refer to *Federal Regulation § 438.406 (b) (2) and (3) and the CHIP Contract, Exhibit D, Section C.* *Corrective Action: Add the timeframe to file an appeal to the CHIP Provider Manual. Revise the CHIP Member Handbook, CHIP Provider Manual, and initial denial letter template to indicate oral expedited appeal requests do not require written follow-up. Update the CHIP Member Handbook and CHIP Provider Manual to indicate the member may present evidence and examine the case file and other documents related to the appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Policy MS.UM.08.01, Appeal of UM Decisions, states the final decision of all appeals will be made by a physician. It further defines qualifications for appeal reviewers as*:* •A physician or other appropriate clinical peer of a same-or-similar specialty not supervised by the individual nor involved in the initial adverse decision, and •A practitioner with the appropriate clinical expertise in treating the member's condition or disease.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Appeal resolution timeframe requirements and information on timeframe extensions are documented in Policy MS.UM.08.01, Appeal of UM Decisions, the *CHIP Member Handbook*, and the *CHIP Provider Manual*. Issues noted regarding timeliness guidelines for appeal resolution and extensions include: •Policy MS.UM.08.01, Appeal of UM Decisions, does not specify the appeal resolution timeframe begins when the appeal request is received. •The *CHIP Member Handbook*, page 57, addresses plan-requested extensions of standard appeal resolution timeframes, but does not indicate members may request an extension of the timeframe. •The *CHIP Provider Manual*, pages 62-64, does not clearly define the differences between appeals and grievances, and uses the words interchangeably. It does not define the various

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						levels of appeals (I, II, III) or provide information on the timeliness requirements for each. Also, there is no information on extensions of timeframes. *Corrective Action: Revise Policy MS.UM.08.01, Appeal of UM Decisions, to specify the appeal resolution timeframe begins when the appeal request is received. Update the CHIP Member Handbook to specify members may request an extension of the appeal resolution timeframe. Revise the CHIP Provider Manual to clearly define the member appeals processes and requirements, including the various levels of appeals, timeframes for resolution of each, and information on extensions of the timeframes.*
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy MS.UM.08.01, Appeal of UM Decisions, specifies the required components of appeal resolution letters.
1.7 Other requirements as specified in the contract.	X					Policy MS.UM.08.01, Appeal of UM Decisions, contains appropriate information regarding continuation of benefits.
2. The CCO applies the appeal policies and procedures as formulated.	X					Appeals files reflected appeals are reviewed and resolved following established processes and contractual requirements. One appeal file resolution letter did not reference the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based, as required by Policy MS. UM.08.01, Appeal of UM Decisions. *Recommendation: Ensure all appeal resolution letters contain a reference to the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Per Policy MS.UM.08.01, Appeal of UM Decisions, summaries of appeal actions, trends, and root causes are reported quarterly to QIC. Reports are used to identify opportunities to improve quality of care and/or service. Findings are reported to the Board of Directors. Review of QIC minutes confirm reporting and discussion of appeals data.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. D Care Management						
1. The CCO assess the varying needs and different levels of care management needs of its member population.	X					The *Care Management (CM) Program Description* defines Magnolia's processes to identify, plan, coordinate, and monitor appropriate, cost-effective services for members. CM programs are available to all members, but specifically to members with complex or catastrophic health conditions including, but not limited to, multiple comorbidities, end-stage disease, head injury, organ transplants, members with complex health needs, and members at risk for potential complications.
2. The CCO uses varying sources to identify and evaluate members' needs for care management.	X					A key objective of Magnolia's CM Program is early identification of members who have the greatest need for CM services. Multiple data sources are used for member identification. Additionally, direct referrals for CM may come from other sources. Reports identifying members for CM are reviewed at least monthly and forwarded to the CM team for outreach and further review.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Per the *CM Program Description*, member outreach is initiated telephonically at the earliest possible opportunity, but always within 30 days of identifying the member as a potential candidate for CM. Based on application of the criteria in the initial screening evaluation, care managers contact the members in order of risk level, from highest to lowest.
4. The detailed health risk assessment includes:						The comprehensive *Health Risk Assessment (HRA)* includes health status, condition-specific issues, comorbidities, clinical history, key events such as inpatient stays, treatment history, current and past medications, compliance with current and past therapies, and mental health status.
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments.	X					Per the *CM Program Description*, the member's care plan is completed within 30 days of completion of the *HRA*. Participants in the development of the care plan include the CM team (care managers, program coordinators, social services specialists, behavioral health specialists, and member connections representatives). Each team member contributes different skills and functions to the management of the member's care and each must work within their scope of practice. Other key participants in the development of the care plan may include: •the member •the member's authorized representative or guardian •the member's PCP and specialty providers •Magnolia's medical directors •hospital discharge planners •ancillary providers •behavioral health providers •community social service, civic, and religious based organizations •other non-health care entities
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Care plans are monitored at least monthly and revisions made as needed, such as when the member's condition progresses or regresses, or when goals are reached. A schedule for continuous review and revision including follow-up and monitoring of the member's progress is developed, using the intervals defined according to priority level and current needs. Reassessments are completed when there is a significant change in the member's condition. The care plan is then updated and shared with the PCP or specialist, as appropriate.
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management Team member and provided instructions on how to contract their assigned team;						Each member enrolled in Care Management is assigned to a specific care manager. Certain care managers specialize in specific conditions, such as sickle cell disease or high risk obstetrics.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the member requests otherwise;						
7.3 Appropriate referral and scheduling assistance for Members needing specialty health care services, including behavioral health, and those identified through Well-Baby and Well-Child screening;						Care managers assist members with referrals and scheduling for specialty care.
7.4 Documentation of referral services and medically indicated follow-up care in each member's medical record;						Onsite discussion confirmed care managers document referrals and follow-up care in each member's care management record.
7.5 Monitoring and treatment of members with ongoing medical conditions according to appropriate standards of medical practice;						
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						Processes for discharge planning coordination and post-discharge follow-up are documented in Policy CC.UM.01.09, Discharge Planning, Policy MS.UM.24.04, Post Discharge Member Outreach, and Work Process MS.UM.24.05, Post Discharge Member Outreach Calls.
7.8 Determination of the need for non-covered services and referral of members to the appropriate service setting, utilizing assistance as needed from the Division;						Policy MS.UM.24, Continuity and Coordination of Services, describes the process for ensuring appropriate referrals and linkages for both covered and non-covered services are made.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.9 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.10 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						Policy MS.UM.24, Continuity and Coordination of Services, addresses requirements for continued access to terminated providers for up to 90 calendar days or until the member can be transferred to a network provider.
7.11 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						Policy MS.UM.24, Continuity and Coordination of Services, details coordination of care when a PCP change occurs.
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member;						
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						Policy MS.UM.24, Continuity and Coordination of Services, addresses requirements for care to be provided by an out-of-network provider when the services are unavailable from a network provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.14 The Contractor must produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The member and/or authorized family member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MS.UM.24, Continuity and Coordination of Services, addresses requirements for continuity of care for members who disenroll from Magnolia.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.	X					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and other service providers.	X					Transitional Care Management is performed for members with needs for discharge planning and outpatient coordination of services to prevent unnecessary readmission. Policy MS.UM.24, Continuity and Coordination of Services, addresses processes for supporting coordination of care between various providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. 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.	X					
3. 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.	X					
V. F Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.			X			Per the CHIP *UM Program Description*, the UM Program is evaluated annually and modifications are made as necessary. A copy of the *UM Program Evaluation* for CHIP was not received. *Corrective Action: Ensure a written evaluation of the effectiveness of the UM Program for CHIP is produced annually.*
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.				X		

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The *Master Services Agreement* and *Attachment B, Delegated Services Agreement*, specify the activities to be performed by the delegate and address performance standards, as well as penalties and sanctions for sub-standard performance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				Policy MS.QI.14, Oversight of Delegated Vendor Services, defines processes for oversight of delegated entities. Magnolia retains accountability for delegated services and monitors the delegate's performance through review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings with each delegate, and annual evaluation. Corrective action plans are developed, as warranted, when deficiencies are identified. Reports regarding ongoing corrective action plans are presented to the QIC at least quarterly. When deficiencies are severe or unable to be resolved, the delegation arrangement may be revoked. Policy CC.CRED.12, Oversight of Delegated Credentialing, defines processes for oversight of delegated credentialing. Page 7 states, "Per NCQA standards, in the instance where the delegate is NCQA Certified or Accredited, Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and omit the annual audit or evaluation. On pre-delegation, Plan must evaluate the compatibility of the delegate's Credentialing Program with Plan's Credentialing Program. Once delegation occurs, Plan must only ensure that the delegate provides the appropriate reports as determined by Plan to ensure the delegate is compliant with the needs of Plan. Plan's State Contract may not acknowledge this automatic credit." The *CHIP Contract*, *Section 14 (B)*, states, "The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in Annual Quality Management Program Evaluation." The contract does not allow plans to eliminate annual oversight for NCQA Certified or Accredited delegates. Evidence of appropriate oversight was provided for each of Magnolia's delegated entities. Committee minutes reflected summaries of oversight meetings and reporting are presented to the QIC for review and comment. *Corrective Action: Revise Policy CC.CRED.12, page 7, to remove the following statements:* •*"Per NCQA standards, in the instance where the delegate is*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						NCQA Certified or Accredited, Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and omit the annual audit or evaluation." • *"Once delegation occurs, Plan must only ensure that the delegate provides the appropriate reports as determined by Plan to ensure the delegate is compliant with the needs of Plan."*