CCME

2018 External Quality Review

MAGNOLIA HEALTH PLAN

Submitted: October 4, 2018

Prepared on behalf of the
Mississippi Division of Medicaid

Table of Contents

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 2018 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:

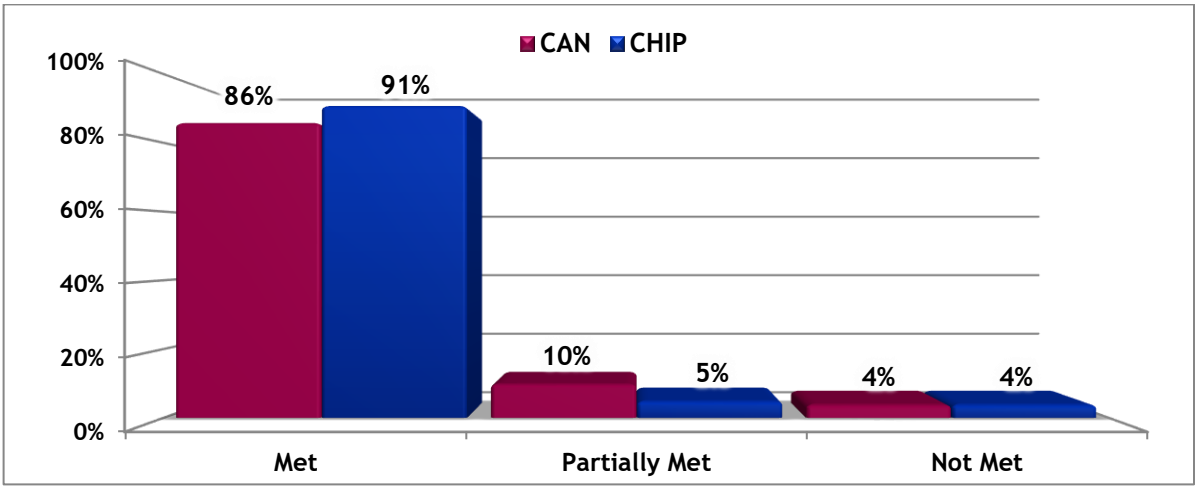
- Determine if Magnolia is in compliance with service delivery as mandated in the Coordinated Care Organization (CCO) contract with DOM.
- Provide feedback for potential areas of continued improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

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 MCO. The review includes a desk review of documents, results from a one-day onsite visit, a compliance review, validation of performance improvement projects and performance measures, member satisfaction survey and provider satisfaction survey validations, and an Information System Capabilities Assessment (ISCA) Audit.

OVERVIEW

The 2018 EQR review of the CAN program reflects Magnolia achieved "Met" scores for 86% of the standards reviewed. As the following chart indicates, 10% of the standards were scored as "Partially Met" and 4% of the standards were scored as "Not Met." For the CHIP program, 91% of the standards received a "Met" score, 5% of the standards were scored as "Partially Met," and 4% of the standards were scored as "Not Met."

Figure 1: 2018 Annual EQR Review Results for CAN & CHIP



Overall Findings

An overview of the findings for each section is included in this Executive Summary. Details of the review, including specific strengths, weaknesses, applicable corrective action items, and recommendations can be found in the respective sections and narrative of this report.

Management Information Systems

Magnolia's ISCA documentation indicates numerous internal audits are conducted to ensure the quality and accuracy of claims, and an internal Claims Operations Management Team monitors claims daily and monthly to ensure compliance with established benchmarks. Because Magnolia did not submit actual per-month clean claim payment statistics/reports, CCME could not verify Magnolia's processes to ensure accurate and timely claims handling.

Appropriate methods are used to uniquely identify enrollees, to identify duplicate members, and to correlate newborns with existing Medicaid members.

ISCA documentation indicates that Magnolia collects and stores data required to generate state-required reports. These indications are reinforced by a recent audit, which found Magnolia met all required Healthcare Effectiveness Data and Information Set (HEDIS®) standards.

Magnolia supplied a *Business Continuity and Recovery Response Plan* that included detailed vendor information, extensive team and staff contact information, and clear, understandable response processes. Additionally, Magnolia supplied a management summary of disaster recovery (DR) tests that were executed in June 2017 and August

2017. The DR test results reported successful recovery of datacenter infrastructure, health plan systems, and telecommunications systems.

Provider Services

The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. The committee meets monthly and committee minutes show a quorum is established at each meeting. The Credentialing Committee policy included outdated information that behavioral health credentialing is delegated to Envolve, formerly known as Cenpatico. Onsite discussion confirmed that behavioral health credentialing is no longer delegated.

Several policies address the credentialing program, which includes the standards and processes for conducting the functions of practitioner/organizational selection and retention. A common issue in the policies was not addressing the need to query the Medicaid MS Sanctioned Provider List.

The credentialing and recredentialing file review showed the files were organized but a few issues were identified in one or more files for CAN and CHIP regarding the following areas: proof of queries; collaborative agreements or protocols for NPs/PAs acting as PCPs; proof of malpractice insurance; incomplete ownership disclosure forms; and inconsistent information on the behavioral health checklist regarding OIG Compliance Now queries.

An area of concern related to Magnolia's lack of ability to provide proof of provider office site visits for initial credentialing. CCME only received copies of three provider office site reviews, and Magnolia indicated they were unable to locate where site evaluations prior to 2014 were documented. CCME received an excel spreadsheet showing some site visit tracking, but it appears that Magnolia neither tracks the final score nor documents review outcomes in credentialing files.

The Provider Satisfaction Survey validation was performed and met all requirements of the *CMS Survey Validation Protocol*. Suggestions to increase response rates were recommended to the plan because the survey initial sample (10.0%) had a low response rate and the latter sample had a response rate of 34.7%. This is just slightly below the National Committee for Quality Assurance (NCQA) target response rate for surveys of 40%.

Member Services

CCME identified issues in documentation of grievances processes and requirements in the CHIP grievance policy, draft *CAN* and *CHIP Member Handbooks*, the *CAN Provider Manual*, and the CAN and CHIP websites. Review of CAN grievance files revealed isolated issues related to the documented grievance resolution and untimely complaint processing. Issues of greater concern included two grievances that were not referred for review and investigation as potential quality of care concerns and seven files with evidence that the

health plan took no action to investigate or resolve the member's grievance and instead instructed the member to file a complaint with the provider/facility or with various state agencies/licensing boards. Review of CHIP grievance files revealed an isolated issue of a resolution letter dated prior to the date of the investigation. Two files lacked sufficient documentation of the grievance and investigation, which hindered CCME's ability to determine if the resolution was appropriate. Grievance data are reported to appropriate committees and used for quality improvement activities for both the CAN and CHIP products and membership.

CCME validated Member Satisfaction Surveys for both the CHIP and CAN populations using *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. Morpace, a National Committee for Quality Assurance (NCQA)-certified vendor, conducted both the CAN and CHIP Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. Low survey response rates resulted in difficulty discerning the generalizability of the surveys. CCME offered recommendations to focus on strategies that would help increase response rates for the populations. The survey results were presented and discussed in appropriate committee meetings, and interventions for improvement were included in applicable work plans.

Quality Improvement

CCME's Quality Improvement sections included a validation review of the HEDIS® and non-HEDIS® performance measures and validation of their performance improvement projects for the CAN and CHIP programs. Magnolia was found to be "Fully Compliant" and "Met" all the requirements for the CAN and CHIP HEDIS measures. When comparing the measure year (MY) 2015 CAN rates to the MY 2016 CAN rates, several measures had substantial improvements of greater than 10%, including Adult Body Mass Index (BMI) Assessments, BMI Percentile for children/adolescent, Counseling for Nutrition, Counseling for Physical Activity, Rotavirus immunizations, and several others. The only measure with a substantial decrease in rate was the Statin Adherence at 80% for Males and Females.

CCME did not completely validate CAN non-HEDIS measures due to issues with DOM's reporting template. The Excel formulas in the reporting template were incorrect and did not provide the measure rates in accordance with the DOM specifications. The non-HEDIS performance measure for the CHIP program: Developmental Screening in the First Three Years of Life was found to be "Fully Compliant."

Magnolia submitted four performance improvement projects for the CAN program. The topics included Congestive Heart Failure (CHF) Readmissions, Obesity, Diabetes, and Asthma. Three of the projects (3/4=75%) received a score of "High Confidence in Reported Results" and one received a score of "Confidence in Reported Results." For the CHIP program, four projects were submitted. The topics Magnolia selected included Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Obesity for Children,

Attention Deficit Hyperactivity Disorder (ADHD), and Use of Appropriate Medications for People with Asthma. One (25%) of the projects received a score of "Confidence in Reported Results" and the others (75%) received a score of "High Confidence in Reported Results." The primary issues across all PIPs were benchmark and baseline rate definitions. CCME provided recommendations to help improve some of the documentation in the project documents.

Utilization Management

CCME's assessment of the Utilization Management (UM) section includes reviews of the program description, program evaluation, policies, committee minutes, *Provider Manual*, *Member Handbook*, and case management and appeal files. The CAN and CHIP UM Program Descriptions outline the purpose, goals, objectives, and staff roles. Policies define how appeals and case management services are operationalized to service members.

CCME identified issues with appeals processes and requirements for CAN and CHIP and provided recommendations to address them. Specifically, review of CAN and CHIP appeal files revealed the start time for processing appeals submitted on the member's behalf begins with receipt of the member or member's guardian signed Authorized Representative Form (ARF) instead of the date the appeal request is received.

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

2018	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Management Information Systems						
CAN	4	0	0	0	0	4
CHIP	4	0	0	0	0	4
Provider Services						
CAN	46	2	4	0	0	52
CHIP	46	2	4	0	0	52
Member Services						
CAN	10	3	0	0	0	13
CHIP	12	1	0	0	0	13
Quality Improvement						
CAN	2	1	0	0	0	3
CHIP	2	1	0	0	0	3

2018	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Utilization Management						
CAN	24	4	0	0	0	28
CHIP	27	1	0	0	0	28

METHODOLOGY

On May 21, 2018, 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 purposes of offering Magnolia an opportunity to seek clarification on the review process and 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 June 20, 2018 for review at the CCME offices (see *Attachment 1*).

The second segment was a one-day onsite review conducted August 23, 2018, 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 is 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. In addition, the review included the optional activities of member and provider satisfaction survey validations.

FINDINGS

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

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

I. Management Information Systems

CCME's External Quality Review (EQR) for Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP) included an Information System Capabilities Assessment (ISCA) for Magnolia Health Plan (Magnolia). Documentation shows the plan conducts internal audits to ensure claim quality and accuracy. An internal Claims Operations Management Team monitors claims daily and monthly to ensure compliance with established benchmarks. Although documentation indicates reasonable processes are in place to ensure accurate and timely claims handling, this could not be verified because Magnolia did not submit actual per-month clean claim payment statistics/reports.

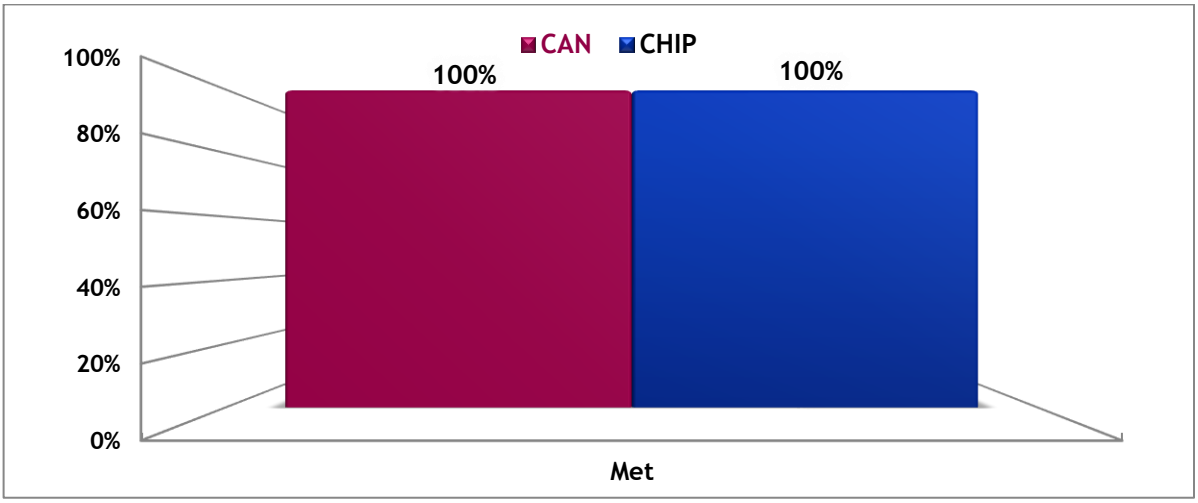
Magnolia uses member IDs included in the State's 834 files to uniquely identify enrollees and uses reports to identify duplicate members. Magnolia's claims system merges duplicates and retains membership history. Magnolia's claims system also correlates newborns with existing Medicaid members using reports generated by its inpatient authorization system. That same reporting process is used to track newborn enrollment.

ISCA documentation indicates that Magnolia collects and stores the data required to generate state-required reports. These indications are reinforced by a recent audit performed by Attest Health Care Advisors that evaluated Magnolia's Healthcare Effectiveness Data and Information Set (HEDIS®) standards, policies, and procedures, and found Magnolia met all required HEDIS standards.

Magnolia supplied a *Business Continuity and Recovery Response Plan* that included detailed vendor information, extensive team and staff contact information, and clear, understandable response processes. Additionally, Magnolia supplied a management summary of disaster recovery (DR) tests that were executed in June 2017 and August 2017, which reported successful recovery of datacenter infrastructure, health plan systems, and telecommunications systems.

As noted in *Figure 2, Management Information Systems Findings*, the CAN program received "Met" scores for 100% of the standards in Management Information Systems. For the CHIP program, the percentage of "Met" scores in Management Information Systems was 100%.

Figure 2: Management Information Systems Findings



Strengths

- Magnolia collects, stores, and reports HEDIS required data, and verified those capabilities with an audit.
- Magnolia demonstrated its ability to successfully recover key production systems in the case of a disaster.

II. Provider Services

CCME conducted a review of Magnolia Health Plan's (Magnolia) policies and procedures, credentialing and recredentialing processes and files, provider network information, and the Provider Satisfaction Survey for Provider Services.

The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. Additional voting members of the committee include the Vice President of Medical Affairs, two Magnolia Medical Directors and four participating providers with the specialties of pediatrics, family medicine, and psychiatry. The committee membership also includes one nurse practitioner. The Credentialing Committee meets monthly and a quorum is met with 50% of voting members in attendance. Committee minutes show a quorum is established at each meeting. The Credentialing Committee policy included outdated information that behavioral health credentialing is delegated to Envolve, formerly known as Cenpatico. Onsite discussion confirmed that behavioral health credentialing is no longer delegated.

Several policies address the credentialing program, which includes the standards and processes for conducting the functions of practitioner/organizational selection and retention. The policies are comprehensive and address state requirements through

footnotes and attachments. A common issue in the policies was not addressing the need to query the Medicaid MS Sanctioned Provider List.

The credentialing and recredentialing file review showed the files were organized. However, CCME identified a few issues in one or more files for CAN and CHIP regarding the following areas:

- Proof of queries such as the Medicaid MS Sanctioned Provider List, Office of Inspector General (OIG), Social Security Death Master File (SSDMF), and National Plan and Provider Enumeration System (NPPES)
- Collaborative agreements or protocols for NPs/PAs acting as PCPs are not documented in the file
- Proof of malpractice insurance
- Incomplete Ownership Disclosure Forms (only received page two of some Ownership Disclosure Forms)
- Inconsistent information on the behavioral health checklist regarding Office of Inspector General (OIG) Compliance Now queries

One area of concern related to Magnolia's inability to provide proof of provider office site visits for initial credentialing as required by the *CAN* and *CHIP Contracts, Section 7 E*. Provider office site visits were not included with the credentialing files received for the EQR desk review. The information was again requested for the onsite visit and CCME received copies of only three provider office site reviews. Magnolia indicated they were unable to locate where site evaluations prior to 2014 were documented. CCME received a spreadsheet showing some site visit tracking, but it does not appear that Magnolia tracks the final score nor documents site evaluation outcomes in credentialing files.

Provider Satisfaction Survey Validation

As a part of this EQR, CCME validated the Provider Satisfaction Survey using *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. The only element that did not meet the CMS protocol for validation was the low response rate. *Table 2, Provider Satisfaction Survey Validation Results* offers the section of the validation worksheet that needs improvement, the reason, and the recommendation. The complete worksheet is available as an attachment in this report.

Table 2: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Assess the response rate, potential sources of non-response and bias, and implications of the response	Initial sample (10.0%) had a low response rate and the latter sample had a response rate of 34.7%. This is just slightly below the NCQA target	Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.

Section	Reason	Recommendation
rate for the generalize ability of survey findings.	response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.	

As noted in *Figure 3, Provider Services Findings*, the CAN program received "Met" scores for 88% of the standards in Provider Services. For the CHIP program, the percentage of "Met" scores in Provider Services was 88%.

Figure 3: Provider Services Findings

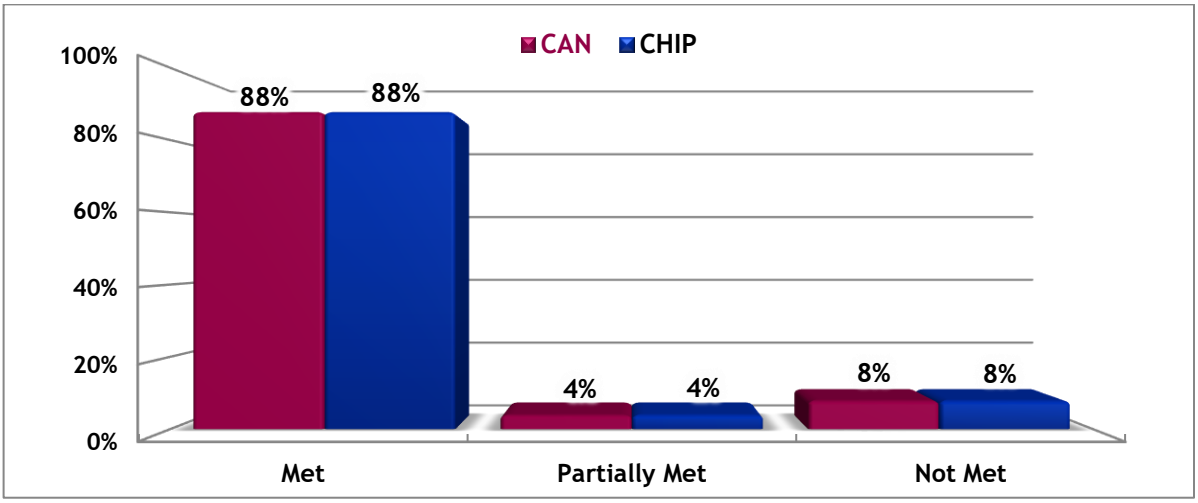


Table 3: CAN Provider Services

Section	Standard	CAN 2018 Review
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Partially Met
	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	Partially Met

Section	Standard	CAN 2018 Review
Credentialing and Recredentialing	Credentialing: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Not Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Not Met
	Recredentialing: Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Not Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Not Met

Table 4: CHIP Provider Services

Section	Standard	CHIP 2018 Review
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Partially Met
	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	Partially Met
	Credentialing: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Not Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Not Met
	Recredentialing: Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Not Met

Section	Standard	CHIP 2018 Review
Credentialing and Recredentialing	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Not Met

Strengths

- Onsite discussion confirmed that Magnolia recognized the need to do a telephone survey to assess appointment availability to identify which providers were noncompliant. Telephone surveys were implemented in Quarter 2, 2018 and Magnolia will assess the data and develop interventions.

Weaknesses

- Page 23 of Policy CC.CRED.01, Practitioner Credentialing & Recredentialing and Attachment B do not specify the Medicaid MS Sanctioned Provider List as a query requirement.
- Policy CC.CRED.03, Credentialing Committee, states, credentialing of behavioral health practitioners has been delegated to Envolve (formerly known as Cenpatico). However, onsite discussion confirmed that credentialing is no longer delegated to Envolve for MS behavioral health.
- The following weaknesses relate to the CAN and CHIP provider credentialing and recredentialing policy and file review:
  - For nurse practitioners acting as PCPs, Magnolia collects information regarding collaborating physicians but does not collect the nursing protocols or collaborative agreements.
  - Several behavioral health credentialing/recredentialing files had inconsistent information on the checklist that displays documents reviewed. Two files showed item 29 “Miscellaneous: OIG CN” as a category instead of displaying the various queries documented on the OIG CN query sheet, while other file checklist showed the category as “OIG Compliance Now Screening” with specific queries listed (SSDMF, etc.).
  - CCME found no evidence of query of the Medicaid MS Sanctioned Provider List in the credentialing or recredentialing files. Onsite discussion confirmed this list is not being queried.
  - One behavioral health recredentialing file lacked proof that an OIG Compliance Now query was performed, there was no evidence in the file of queries for the SSDMF or NPPES.
  - Policy CC.CRED.05, Practitioner Office Site Review, includes a statement that Cenpatico Behavioral Health monitors site visits for behavioral health in accordance

with Policy CC.CRED.12, Oversight of Delegated Credentialing. Onsite discussion confirmed that behavioral health credentialing is no longer delegated to Cenpatico.

- Provider office site visits were not included with the credentialing files received for review.

- The organizational policy and file review for CAN and CHIP reflected the following additional issues:
  - Policy CC.CRED.09, Organizational Assessment and Reassessment, Attachment E does not address the need to query the Medicaid MS Sanctioned Provider List. Evidence of query of the Medicaid MS Sanctioned Provider List was not in the organizational files reviewed. Onsite discussion confirmed this list is not being queried by the plan.
  - One credentialing file did not have proof of the OIG query and the application did not have a date by the signature.
  - One recredentialing file lacked proof of malpractice insurance.
  - Only received a copy of the second page of the Ownership Disclosure Form in two recredentialing files.
- GEO Access reports for CAN reflected the mileage standard for Rural Emergency Care providers was evaluated as "one within 60 miles," but the guideline is "one within 30 miles" for Rural.
- The Provider Satisfaction Survey initial sample had a low response rate of 10.0% and the latter sample had a response rate of 34.7%. This is just slightly below the NCQA target response rate of 40% for surveys.

Corrective Action

- Update Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to include the Medicaid MS Sanctioned Provider List as a query requirement.
- Update Policy CC.CRED.03, Credentialing Committee, to reflect that MS behavioral health credentialing is not delegated to Envolve.
- The following corrective action applies to the CAN and CHIP credentialing and recredentialing policy and file review:
  - Ensure the Medicaid MS Sanctioned Provider List is queried at credentialing and recredentialing. Include proof of query in the files.
  - Update Policy CC.CRED.05, Practitioner Office Site Review, to remove incorrect language regarding behavioral health being delegated to Cenpatico.
  - Review the provider office site review process to ensure all site reviews are being conducted in accordance with Policy MS.CONT.03. Ensure evidence of the provider office site reviews is included in the credentialing files.

- Update Policy CC.CRED.09, Organizational Assessment and Reassessment, Attachment E to indicate the Medicaid MS Sanctioned Provider List is queried at credentialing and recredentialing for organizational providers and proof of query is in the files.
- Ensure organizational files contain appropriate documentation, such as complete copy of the Ownership Disclosure Form, proof of malpractice insurance, proof of OIG query, and the date the application is signed.

Recommendations

- The following recommendations apply to the CAN and CHIP credentialing and recredentialing file review:
  - Ensure collaborative agreements or protocols are collected for all nurse practitioners/physician assistants acting as PCPs at credentialing and recredentialing.
  - The behavioral health credentialing/recredentialing file checklist should reflect a listing of all required queries conducted by the Plan or OIG Compliance Now.
  - Ensure all files contain proof of query of the SSDMF and NPPES.
- Ensure the quarterly CAN GEO Access reports reflect the correct mileage parameter for Rural Emergency Care providers.
- Regarding the Provider Satisfaction Survey, focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.

III. Member Services

CCME's review of Member Services for Magnolia encompassed policies, requirements, and internal processes for grievances, as well as review of grievance files for the CAN and CHIP lines of business.

Magnolia has developed policies to define requirements and processes for handling member grievances and complaints. In addition to the policies, information about grievances is found in the *CAN* and *CHIP Member Handbooks*, *Provider Manuals*, and on Magnolia's CAN and CHIP websites.

CCME found grievance terminology appropriately defined across all reviewed documents. CCME identified the following issues in documentation of grievance processes and requirements:

- Incomplete information regarding the timeframe to file a grievance in the draft *CAN Member Handbook*

- Incorrect timeframes to file a grievance on the CAN website and in CHIP documents, including Policy MS.MBRS.07.01, Member Grievance and Complaints Process, the *CHIP Member Handbook*, and on the CHIP website
- Lack of information regarding extensions of grievance resolution timeframes in the current and draft versions of the *CAN Provider Manual*
- Erroneous information regarding second-level and third-level grievance review processes in the draft *CAN Provider Manual*
- Incorrect information that a signed Authorization to Release Information Form is required to request additional information to review the member's grievance in the draft *CAN Member Handbook* and draft *CAN Provider Manual*

Review of CAN grievance files revealed one grievance resolution did not correspond with the documented grievance. In addition, it appears that one file was handled as a complaint but was not resolved within one calendar day as required. Of greater concern, CCME identified the following issues:

- Two grievances should have been referred for review and investigation as potential quality of care concerns, but the files contained no evidence that this occurred.
- Seven files revealed that Magnolia took no action to investigate or resolve the grievance—instead the members were informed they could file a complaint with the provider/facility or with various state agencies/licensing boards.

Review of CHIP grievance files revealed one resolution letter was dated prior to the date of the investigation, and two files lacked sufficient documentation of the grievance and investigation, which hindered CCME's ability to determine if the resolution was appropriate.

Grievance data are reported to appropriate committees and used for quality improvement activities for both the CAN and CHIP.

Member Satisfaction Survey Validation

Member Satisfaction Surveys for both the CHIP and CAN populations underwent validation by CCME using *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. Morpace, an NCQA-certified vendor, conducted both the CAN and CHIP Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

The validations revealed sufficient sampling sizes; however, low response rates resulted in difficulty discerning the generalizability of the surveys:

- CAN Adult survey—response rate 25%
- CAN Child survey—response rate 18%

- CAN Children with chronic conditions survey—response rates 28.49% (total) and 26.97% (general population)
- CHIP Child survey—response rate 20%
- CHIP Children with chronic conditions survey—response rates 22% (total) and 20% (general population)

CCME offered recommendations to focus on strategies that would help increase response rates for the populations, such as setting an internal response rate goal (i.e., receiving a 2% increase over the previous year's response rate) as opposed to the target rate set by the Agency for Healthcare Research and Quality (AHRQ).

The survey results were presented and discussed in appropriate committee meetings, and interventions for improvement were included in applicable work plans.

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

For CAN, Magnolia received "Met" scores for 77% of the standards for Member Services and 23% of standards received were scored as "Partially Met." For CHIP, the percentage standards scored as "Met" was 92% and 8% received "Partially Met" scores.

Figure 4: Member Services Findings

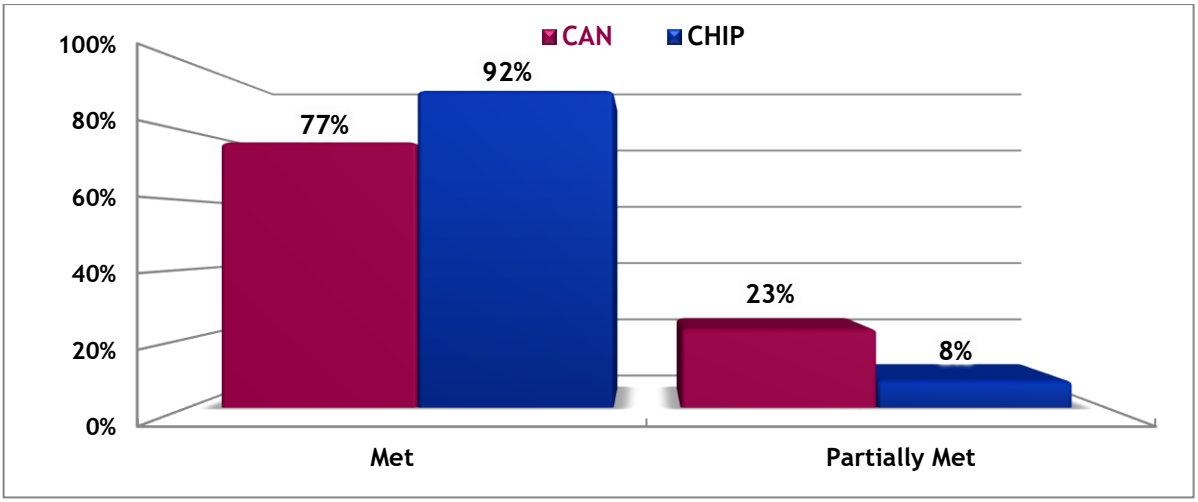


Table 5: CAN Member Services

Section	Standard	CAN 2018 Review
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner	Partially Met

Section	Standard	CAN 2018 Review
	consistent with contract requirements, including, but not limited to: the procedure for filing and handling a complaint/grievance	
Complaints/ Grievances	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Partially Met
	The CCO applies the complaint/grievance policy and procedure as formulated	Partially Met

Table 6: CHIP Member Services

Section	Standard	CHIP 2018 Review
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to the procedure for filing and handling a complaint/grievance	Partially Met

Strengths

- When interpreter or TTY/TDD services are used to file a grievance, Magnolia provides the resolution of the grievance using the same resource.

Weaknesses

- The generalizability of the survey results for the CAN and CHIP Member Satisfaction Surveys is difficult to discern due to low response rates.
- The draft *CAN Member Handbook* states complaints may be filed within 30 days of the date of the event causing dissatisfaction but does not expressly state that there is no time limit for filing grievances.
- Magnolia's CAN website contains an incorrect statement that grievances must be filed within 30 days of the date of the event causing dissatisfaction.
- CHIP Policy MS.MBRS.07.01, Member Grievance and Complaints Process, the *CHIP Member Handbook*, and the CHIP website incorrectly state the timeframe to file a grievance is within 45 calendar days of the incident causing the dissatisfaction.
- The draft *CAN Member Handbook* section titled, "How to File a Grievance or Complaint," references a requirement for a signed Authorization to Release Information Form to be submitted with a member's grievance. This information was

also noted in the draft *CAN Provider Manual*. Onsite discussion revealed this information is incorrect and should not have been included in the *CAN Member Handbook* and draft *CAN Provider Manual*.

- Policy MS.MBRS.07.01, Member Grievance and Complaints Process incorrectly defines three levels of grievance review and states the resolution timeframe is within 15 calendar days of the receipt date for each level. Onsite discussion revealed the policy is in the process of being updated with correct information.
- The current and draft versions of the *CAN Provider Manual* do not address extensions of the grievance resolution timeframe.
- The draft *CAN Provider Manual* contains erroneous information regarding second-level and third-level grievance review processes.
- Of 20 CAN grievance files reviewed, minor findings included one file with a resolution that did not correspond with the documented grievance and one file was handled as a complaint but was not resolved within one calendar day as required. Of greater concern, CCME identified the following issues in the grievance files:
  - Two grievances should have been referred for review and investigation as potential quality of care concerns, but the files contained no evidence that this occurred. Refer to Policy MS.MBRS.07, Member Grievance and Complaints Process, and Policy CC.QI.17, Potential Quality of Care Incidents.
  - Seven files contained evidence that Magnolia took no action to investigate or resolve the grievance—instead the members were informed they could file a complaint with the provider/facility or with various state agencies/licensing boards.
- CCME's review of 19 CHIP grievance files revealed one resolution letter dated prior to the documented date of investigation and two files with insufficient documentation regarding the services for which the member was being billed, resulting in the inability to determine if the resolution was appropriate.
- Page 11 of the 2018 *CHIP Quality Assessment and Performance Improvement Program Description* indicates the Performance Improvement Team (PIT) reviews grievance statistics and makes recommendations to the Grievance and Appeals team regarding interventions for improvement or educational opportunities. However, onsite discussion revealed grievance information is not reported to the PIT.

Corrective Action

- Revise the CAN website and draft *CAN Member Handbook* with information that grievances can be filed at any time.
- Correct the timeframe to file a grievance in CHIP Policy MS.MBRS.07.01, the *CHIP Member Handbook*, and on Magnolia's CHIP website.

- Revise the draft *CAN Provider Manual* to include information on extensions of grievance resolution timeframes.
- Remove the erroneous information regarding second-level and third-level grievance review from the draft *CAN Provider Manual*.
- Develop and document a training plan for grievance staff to ensure staff understand requirements for referring grievances containing possible quality of care concerns for investigation as stated in Magnolia policies. Also include in the training the processes to ensure all grievances are reviewed and appropriate activities are conducted to investigate and resolve the grievances rather than informing members to file their complaints with providers or state agencies/licensing boards. Include, if possible, the date the training is conducted and documentation of completion of the training.

Recommendations

- For the CAN and CHIP Member Satisfaction Surveys, focus on strategies that would help increase response rates. Set internal response rate goals (such as receiving a 2% increase over the previous year's response rate) as opposed to the target rate set by AHRQ.
- Remove the incorrect information about the requirement of a signed Authorization to Release Information Form from the draft *CAN Member Handbook* and draft *CAN Provider Manual*.
- Update Policy MS.MBRS.07.01 to remove the three-level grievance review process and ensure the grievance resolution timeframe is corrected.
- For grievances, ensure the following:
  - Grievance resolution corresponds with the documented grievance and incorporates all aspects of the grievance.
  - Complaints are transferred to the grievance process and processed as such if a complaint cannot be resolved within the required 24-hour timeframe.
  - Resolution letters are dated appropriately.
  - Grievance files contain enough documentation of the grievance and/or investigation findings to verify resolution is correct.
- Remove the erroneous information regarding reporting grievance data to the PIT from the 2018 CHIP *Quality Assessment and Performance Improvement Program Description*.

IV. Quality Improvement

As part of the 2018 External Quality Review (EQR) for Magnolia, CCME conducted a validation review of the Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS performance measures and validated their performance improvement projects

(PIPs) for the Mississippi CAN and Mississippi CHIP programs following CMS protocols. The following is an overview of that validation starting with the performance measure validation.

Performance Measure Validation

CCME reviewed and validated HEDIS measures following the HEDIS technical specifications for the reporting year 2016. Magnolia was found to be "Fully Compliant" and met all the requirements. All relevant HEDIS performance measures for Magnolia CAN for the current review year (MY 2016), as well as the previous year (MY 2015) and the change from 2015 to 2016 are reported in *Table 7: HEDIS CAN Performance Measure Results*. As shown, there were several measures that had substantial improvement of greater than 10%, including Adult Body Mass Index (BMI) Assessments, BMI Percentile for children/adolescent, Counseling for Nutrition, Counseling for Physical Activity, Rotavirus immunizations, and several others. The only measure with a substantial decrease in rate was the Statin Adherence at 80% for Males and Females.

Table 7: HEDIS CAN Performance Measure Results

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	69.47%	84.08%	14.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	24.04%	45.91%	21.87%
Counseling for Nutrition	25.48%	46.39%	20.91%
Counseling for Physical Activity	22.84%	34.38%	11.54%
Childhood Immunization Status (cis)			
DTaP	85.10%	79.33%	-5.77%
IPV	95.43%	92.07%	-3.36%
MMR	93.03%	90.38%	-2.65%
HiB	93.03%	88.46%	-4.57%
Hepatitis B	96.15%	91.11%	-5.04%
VZV	93.03%	89.90%	-3.13%
Pneumococcal Conjugate	83.17%	81.25%	-1.92%
Hepatitis A	80.05%	75.24%	-4.81%
Rotavirus	63.46%	75.72%	12.26%
Influenza	25.00%	27.88%	2.88%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Combination #2	83.17%	75.72%	-7.45%
Combination #3	78.85%	73.56%	-5.29%
Combination #4	67.79%	61.30%	-6.49%
Combination #5	56.73%	64.66%	7.93%
Combination #6	23.08%	24.52%	1.44%
Combination #7	46.88%	54.33%	7.45%
Combination #8	22.12%	22.60%	0.48%
Combination #9	15.87%	22.12%	6.25%
Combination #10	14.90%	20.43%	5.53%
Immunizations for Adolescents (ima)			
Meningococcal	48.56%	44.47%	-4.09%
Tdap/Td	73.32%	73.56%	0.24%
Combination #1	47.36%	42.79%	-4.57%
Combination #2	NR	5.29%	NA
Human Papillomavirus Vaccine for Female Adolescents (hpv)	12.06%	5.29%	-6.77%
Lead Screening in Children (lsc)	68.87%	68.57%	-0.30%
Breast Cancer Screening (bcs)	55.18%	57.57%	2.39%
Cervical Cancer Screening (ccs)	59.14%	60.34%	1.20%
Chlamydia Screening in Women (chl)			
16-20 Years	49.14%	48.00%	-1.14%
21-24 Years	62.39%	62.02%	-0.37%
Total	58.25%	50.86%	-7.39%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	51.62%	59.68%	8.06%
Appropriate Treatment for Children With URI (uri)	NR	NR	NA
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	NR	NR	NA
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.34%	27.87%	0.53%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	39.30%	38.15%	-1.15%
Bronchodilator	74.51%	74.01%	-0.50%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	44.52%	50.00%	5.48%
5-11 Years - Medication Compliance 75%	17.42%	19.26%	1.84%
12-18 Years - Medication Compliance 50%	43.57%	46.30%	2.73%
12-18 Years - Medication Compliance 75%	17.14%	19.44%	2.30%
19-50 Years - Medication Compliance 50%	46.42%	48.15%	1.73%
19-50 Years - Medication Compliance 75%	22.87%	22.96%	0.09%
51-64 Years - Medication Compliance 50%	66.10%	61.86%	-4.24%
51-64 Years - Medication Compliance 75%	41.53%	38.14%	-3.39%
Total - Medication Compliance 50%	48.73%	49.82%	1.09%
Total - Medication Compliance 75%	23.65%	22.73%	-0.92%
Asthma Medication Ratio (amr)			
5-11 Years	73.29%	76.28%	2.99%
12-18 Years	62.18%	53.94%	-8.24%
19-50 Years	39.90%	39.06%	-0.84%
51-64 Years	44.74%	40.99%	-3.75%
Total	50.54%	51.90%	1.36%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	32.23%	42.24%	10.01%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	59.52%	55.81%	-3.71%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	61.65%	69.92%	8.27%
Statin Adherence 80% - 21-75 years (Male)	72.38%	43.85%	-28.53%
Received Statin Therapy - 40-75 years (Female)	58.17%	60.00%	1.83%
Statin Adherence 80% - 40-75 years (Female)	61.16%	34.17%	-26.99%
Received Statin Therapy - Total	59.81%	64.59%	4.78%
Statin Adherence 80% - Total	66.62%	39.02%	-27.60%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	85.65%	86.16%	0.51%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
HbA1c Poor Control (>9.0%)	65.97%	57.04%	-8.93%
HbA1c Control (<8.0%)	26.62%	36.99%	10.37%
HbA1c Control (<7.0%)	NR	NQ	NA
Eye Exam (Retinal) Performed	65.74%	69.45%	3.71%
Medical Attention for Nephropathy	92.13%	91.65%	-0.48%
Blood Pressure Control (<140/90 mm Hg)	40.97%	NQ	NA
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	NR	NR	NA
Statin Adherence 80%	NR	NR	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	71.43%	NQ	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	36.91%	38.15%	1.24%
Effective Continuation Phase Treatment	23.07%	22.94%	-0.13%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	55.98%	56.71%	0.73%
Continuation and Maintenance (C&M) Phase	68.29%	66.37%	-1.92%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	39.06%	58.68%	19.62%
7-Day Follow-Up	20.73%	32.20%	11.47%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	NR	72.36%	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NR	70.11%	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NR	79.59%	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	NR	56.45%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NR	22.86%	NA

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
6-11 Years	NR	21.79%	NA
12-17 Years	NR	25.21%	NA
Total	NR	23.70%	NA
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	87.38%	88.81%	1.43%
Digoxin	50.37%	51.67%	1.30%
Diuretics	87.36%	88.57%	1.21%
Total	86.93%	88.29%	1.36%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	NQ	NA
Appropriate Treatment for Children With URI (uri)	63.25%	60.99%	-2.26%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	31.44%	32.35%	0.91%
Use of Imaging Studies for Low Back Pain (lbp)	73.14%	69.11%	-4.03%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NA	NA
6-11 Years	NR	0.43%	NA
12-17 Years	NR	0.85%	NA
Total	NR	0.65%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.04%	86.39%	0.35%
45-64 Years	92.29%	92.21%	-0.08%
65+ Years	76.47%	84.38%	7.91%
Total	88.34%	88.65%	0.31%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.04%	97.05%	1.01%
25 Months - 6 Years	88.89%	87.28%	-1.61%
7-11 Years	89.21%	90.73%	1.52%
12-19 Years	83.49%	96.68%	13.19%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Annual Dental Visit (adv)			
2-3 Years	41.43%	48.91%	7.48%
4-6 Years	67.82%	70.68%	2.86%
7-10 Years	67.20%	70.59%	3.39%
11-14 Years	59.09%	65.97%	6.88%
15-18 Years	49.33%	57.44%	8.11%
19-20 Years	33.40%	40.35%	6.95%
Total	56.34%	64.04%	7.70%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	NR	64.79%	NA
Engagement of AOD Treatment: 13-17 Years	NR	4.69%	NA
Initiation of AOD Treatment: 18+Years	NR	29.26%	NA
Engagement of AOD Treatment: 18+ Years	NR	4.47%	NA
Initiation of AOD Treatment: Total	NR	32.57%	NA
Engagement of AOD Treatment: Total	NR	4.49%	NA
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	88.21%	91.69%	3.48%
Postpartum Care	62.26%	62.95%	0.69%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 years	NR	65.71%	NA
6-11 years	NR	72.15%	NA
12-17 years	NR	66.62%	NA
Total	NR	68.93%	NA
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	11.27%	10.81%	-0.46%
21-40 Percent	4.74%	4.58%	-0.16%
41-60 Percent	7.33%	7.07%	-0.26%
61-80 Percent	13.94%	15.07%	1.13%
81+ Percent	62.72%	62.48%	-0.24%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	6.03%	5.21%	-0.82%
1 Visit	5.76%	5.24%	-0.52%
2 Visits	6.94%	6.01%	-0.93%
3 Visits	8.32%	7.96%	-0.36%
4 Visits	13.76%	13.75%	-0.01%
5 Visits	21.66%	24.39%	2.73%
6+ Visits	37.53%	37.43%	-0.10%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	50.94%	51.21%	0.27%
Adolescent Well-Care Visits (awc)	28.54%	34.03%	5.49%

NA: Indicates denominator was too small or not available; NR: Not reported. Green font for change in rate indicates a substantial (>10%) improvement; red font for change in rate indicates a substantial (>10%) decline.

CCME reviewed and validated the CHIP HEDIS measures following the HEDIS 2017 technical specifications for the reporting year 2016. All relevant HEDIS performance measures for Magnolia CHIP for the current review year (MY 2016) are reported in *Table 8: HEDIS CHIP Performance Measure Results* in addition to the MY 2015 rate and the change from 2015 to 2016. As shown, there were several measures that had substantial improvement of greater than 10%, including BMI percentile documentation, immunization rates, and dental visits. Measures with a substantial decrease in rate include prenatal and postpartum care and ongoing prenatal care.

Table 8: HEDIS CHIP Performance Measure Results

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment **and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)**			
BMI Percentile	36.54%	49.64%	13.10%
Counseling for Nutrition	37.98%	45.78%	7.80%
Counseling for Physical Activity	35.58%	38.07%	2.49%
Childhood Immunization Status (cis)			
DTaP	80.00%	87.26%	7.26%
IPV	90.00%	93.03%	3.03%
MMR	90.00%	93.75%	3.75%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
HiB	83.33%	91.35%	8.02%
Hepatitis B	90.00%	92.31%	2.31%
VZV	86.67%	93.27%	6.60%
Pneumococcal Conjugate	86.67%	85.58%	-1.09%
Hepatitis A	73.33%	78.37%	5.04%
Rotavirus	60.00%	83.17%	23.17%
Influenza	33.33%	33.41%	0.08%
Combination #2	73.33%	85.58%	12.25%
Combination #3	73.33%	82.69%	9.36%
Combination #4	63.33%	69.23%	5.90%
Combination #5	53.33%	75.72%	22.39%
Combination #6	30.00%	31.25%	1.25%
Combination #7	46.67%	63.46%	16.79%
Combination #8	26.67%	28.13%	1.46%
Combination #9	20.00%	29.57%	9.57%
Combination #10	16.67%	26.68%	10.01%
Immunizations for Adolescents (ima)			
Meningococcal	50.00%	49.52%	-0.48%
Tdap/Td	82.26%	78.61%	-3.65%
HPV	16.67%	9.62%	-7.05%
Combination #1	50.00%	48.32%	-1.68%
Combination #2		8.65%	NA
Lead Screening in Children (lsc)	66.67%	62.42%	-4.25%
Chlamydia Screening in Women (chl)			
16-20 Years	35.20%	43.25%	8.05%
*21-24 Years**	NA	NA	NA
Total	35.20%	43.25%	8.05%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	60.28%	66.70%	6.42%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	NA	45.45%	NA

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
5-11 Years: Medication Compliance 75%	NA	15.91%	NA
*12-18 Years: Medication Compliance 50%**	NA	41.67%	NA
*12-18 Years: Medication Compliance 75%**	NA	16.67%	NA
Total Medication Compliance 50%	NA	44.12%	NA
Total Medication Compliance 75%	NA	16.18%	NA
Effectiveness of Care: Behavioral			
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	NA	41.18%	NA
Continuation and Maintenance (C&M) Phase	NA	60.98%	NA
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-day follow-up	NB	55.29%	NA
7-day follow-up	NB	27.06%	NA
Effectiveness of Care: Respiratory Conditions			
Appropriate Treatment or Children with URI (uri)	NR	57.47%	NA
Access/Availability of Care			
Children and Adolscents' Access to Primary Care Practitioners (cap)			
12-24 Months	98.02%	98.83%	0.81%
25 Months-6 Years	82.19%	90.49%	8.30%
7-11 Years	NA	90.44%	NA
12- 19 Year	100.0%	96.24%	-3.76%
Annual Dental Visit (adv)			
2-3 Years	45.28%	47.40%	2.12%
4-6 Years	61.63%	70.45%	8.82%
7-10 Years	66.14%	74.65%	8.51%
11-14 Years	58.62%	69.13%	10.51%
15-18 Years	47.73%	58.67%	10.94%
19-20 Years	35.42%	59.65%	24.23%
Total	57.13%	66.05%	8.92%
Prenatal and Postpartum Care (ppc)			
*Timeliness of Prenatal Care**	80.00%	57.14%	-22.86%
*Postpartum Care**	60.00%	42.86%	-17.14%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
*<21 Percent**	0.00%	14.29%	14.29%
*21-40 Percent**	20.00%	28.57%	8.57%
*41-60 Percent**	0.00%	0.00%	0.00%
*61-80 Percent**	20.00%	14.29%	-5.71%
*81+ Percent**	60.00%	42.86%	-17.14%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	4.55%	2.88%	-1.67%
1 Visit	2.27%	2.47%	0.20%
2 Visits	3.41%	1.23%	-2.18%
3 Visits	3.41%	3.70%	0.29%
4 Visits	10.23%	9.88%	-0.35%
5 Visits	25.00%	29.63%	4.63%
6+ Visits	51.14%	50.21%	-0.93%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	43.18%	51.11%	7.93%
Adolescent Well-Care Visits (awc)	27.76%	34.01%	6.25%

**Small denominator for rate calculation; NR= Not Reported; NB= No Benefit; NA= not calculated*

Non-HEDIS Performance Measures

The non-HEDIS performance measures selected by DOM for the CAN program included: Asthma Related Emergency Room (ER) Visits, Asthma Related Readmissions, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screenings, Congestive Heart Failure (CHF) Readmissions, Pre/Post Natal Complications, and Pregnancy Outcomes. The non-HEDIS performance measure for CHIP was the Developmental Screening in the First Three Years of Life. The validation of the non-HEDIS measure required a review of the following for each measure:

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

This process assesses the production of these measures by the plan to ensure that what is submitted to DOM complies with DOM-defined measure specifications. Each CCO was provided a Microsoft® Excel (Excel) reporting template prepared by a DOM vendor for reporting their CAN non-HEDIS rates. During the Onsite, it was determined that the Excel formulas in the reporting template were incorrect and did not provide the measure rates following DOM's specifications. Based on this determination, CCME did not perform the validation of the CAN non-HEDIS measures for the current review cycle.

The non-HEDIS performance measure, as per the CHIP contract includes the Developmental Screening in the First Three Years of Life measure. The MY 2016 rates for the Non-HEDIS measure are reported in *Table 9: CHIP Non-HEDIS Performance Measure Report Rates*.

Table 9: CHIP Non-HEDIS Performance Measure Reported Rates

Measure	Reported Rates for MY 2016
Developmental Screening in the First Three Years of Life (DEV-CH)	
Age 12 months	0.00%
Age 24 months	3.36%
Age 36 months	1.17%
Total	2.07%

Magnolia CHIP was found to be "Fully Compliant" and "Met" all the requirements for the non-HEDIS measures as per the report by Attest Health Care Advisors. *Table 10: CHIP Non-HEDIS Performance Measure Validation Results* provides an overview of the validation scores for the CHIP measures.

Table 10: CHIP Non-HEDIS Performance Measure Validation Results

Measure	Validation Scores
Developmental Screening in the First Three Years of Life (DEV-CH)	100% FULLY COMPLIANT

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

Performance Improvement Project Validation

CCME conducted PIP validations following the CMS protocol titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates project components 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. The topics included CHF Readmissions, Obesity, Diabetes, and Asthma. *Table 11: CAN Performance Improvement Project Validation Scores* provides an overview of the previous and current validation scores.

Table 11: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Congestive Heart Failure (CHF) Readmissions	62/78 = 80% CONFIDENCE IN REPORTED RESULTS	78/85 = 92% HIGH CONFIDENCE IN REPORTED RESULTS
Obesity	62/62 = 100% HIGH CONFIDENCE IN REPORTED RESULTS	96/111 = 86% CONFIDENCE IN REPORTED RESULTS
Diabetes	62/62 = 100% HIGH CONFIDENCE IN REPORTED RESULTS	95/97 = 98% HIGH CONFIDENCE IN REPORTED RESULTS
Asthma	67/78 = 86% CONFIDENCE IN REPORTED RESULTS	84/85 = 99% HIGH CONFIDENCE IN REPORTED RESULTS

As shown, three of the projects (3/4=75%) received a score of "High Confidence in Reported Results" and one received a score of "Confidence in Reported Results." The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 12: Congestive Heart Failure (CHF) Readmissions

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly	Annual results are presented in the 2017 PDF report in the indicator section, not in the results section. The comparison on results to baseline goal and benchmark is not clearly written as the Results Table format was not utilized.	Include all measurement periods in the report in the Results section, not the indicator section.
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?	Analyses of baseline data and remeasurements are not provided in report.	Analysis of rates at each measurement period, whether the goal was met or not, and action plans in response to the findings should be included in the report.
Was there any documented, quantitative improvement in processes or outcomes of care?	Rate increased whereas the goal is to decrease CHF readmissions.	Initiate new interventions to improve rate toward goal.

Table 13: Asthma

Section	Reasoning	Recommendation
Was there any documented, quantitative improvement in processes or outcomes of care?	There was no improvement in the rate.	Continue interventions and initiate new ideas to improve the rate.

Table 14: Diabetes

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The denominators suggest that members with unavailable data are included in the percentage. The denominator should include only those members where pre and post data are available for evaluation. The results should clearly identify the number of records for each measurement year, and the number of members who have records available that	Ensure reporting of eligible members and denominator for rate is accurate in PIP report. Check labels for Table on page A-17.

Section	Reasoning	Recommendation
	met the A1C < 8 goal. Also, the Table on page A-17 is labeled 2016 and it should be labeled 2017.	
Was there any documented, quantitative improvement in processes or outcomes of care?	There was no improvement in rate.	Initiate new interventions to increase rate

Table 15: Obesity

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Baseline goal and benchmark are the same. The baseline goal should be an initial goal that is set for baseline measurement only. The benchmark is the goal that will be utilized to consider the study to be complete.	Adjust benchmark rate to the be the best practice rate.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are difficult to interpret. If only 60 members had a documented BMI before and after, then 60 should be the denominator. For the baseline results, interpretation was not given in the report to determine how a denominator of 20 was obtained.	Ensure the denominator includes only those patients where data can be obtained for pre and post. Interpretation of baseline and all remeasurements should be included in the analysis section.

For CHIP, Magnolia submitted four projects for review. As per the contract, a PIP regarding obesity should be selected annually for continuous evaluation. The topics Magnolia selected included EPSDT, Obesity for Children, Attention Deficit Hyperactivity Disorder (ADHD), and Use of Appropriate Medications for People with Asthma. The results of the validation for the CHIP program PIPs follow.

Table 16: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
EPSDT	78/78 = 100% High Confidence in Reported Results	86/91 = 95% HIGH CONFIDENCE IN REPORTED RESULTS

Project	Previous Validation Score	Current Validation Score
Obesity for Children	82/82 = 100% High Confidence in Reported Results	87/104 = 84% CONFIDENCE IN REPORTED RESULTS
ADHD	62/62 = 100% High Confidence in Reported Results	86/91 = 95% HIGH CONFIDENCE IN REPORTED RESULTS
Use of Appropriate Medications for People with Asthma	62/62 = 100% High Confidence in Reported Results	86/91 = 95% HIGH CONFIDENCE IN REPORTED RESULTS

As shown, one (25%) of the projects received a score of "Confidence in Reported Results"; 3/4=75% received a score of "High Confidence in Reported Results." The primary issues across all four PIPs were benchmark and baseline rate definitions. The table that follows lists the specific errors by project and includes recommendations to correct the errors.

Table 17: EPSDT

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measures are defined under the measurable goal section. Results should not be presented in the quantifiable measures Table	Omit results in quantifiable measures section.

Table 18: Obesity for Children

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measure is defined under the measurable goal section. The baseline goal and the benchmark rate are the same. The benchmark should be the absolute best practice rate, and will likely be lower than the baseline goal rate	Review the baseline goal and benchmark to determine if reduction of 5 points in 50% of eligible population is an appropriate benchmark. For example, the baseline goal might be 50% of eligible members and the benchmark is 80% or higher of the eligible members will have a reduction of 5 percentile points.

Section	Reasoning	Recommendation
Did the sample contain a sufficient number of enrollees?	The sample is extremely small for baseline and remeasurement 1. With such small samples, this PIP does not appear to have an impact on the health status of a broad spectrum of members.	Interventions should be implemented to determine ways to reach the individuals that are eligible, but unable to be reached.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are clearly presented in Table format, but the interpretation of the baseline data are not provided in the report. The denominators appear to include all eligible members, although data were not available for all eligible members	Interpretation should be included for all measurements. Also, the records were only available for 21 individuals, thus, the denominator should be 21 as those are the members with available data.

Table 19: ADHD

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measures are defined under the measurable goal section. The baseline goal and the benchmark rates are the same. The benchmark should be the absolute best practice rate and will likely be higher than the baseline goal rate.	Review the baseline goal and benchmark, and set a best practice rate for the benchmark, and a short-term goal for the baseline goal.

Table 20: Use of Appropriate Medications for People with Asthma

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measures are defined under the measurable goal section. The baseline goal is higher than the benchmark. As increases in the rate suggest improvement, the benchmark should be higher and considered the best practice rate. The baseline goal is the short- term goal. Table on page A-19 should be titled 2017 instead of 2016.	Review the baseline goal and benchmark, and set a best practice rate for the benchmark, and a short-term goal for the baseline goal. Adjust the label for the Table on page A-19.

Details of the validation activities for the performance measures and PIPs, and specific outcomes related to each activity, may be found in *Attachment 3, EQR Validation Worksheets*.

Figure 5, Quality Improvement Findings indicates that for the CAN program, 67% of the standards received a "Met" score, and 33% received a "Partially Met" score. For the CHIP program, 67% of the standards received a "Met" score, and 33% received a "Partially Met" score.

Figure 5: Quality Improvement Findings

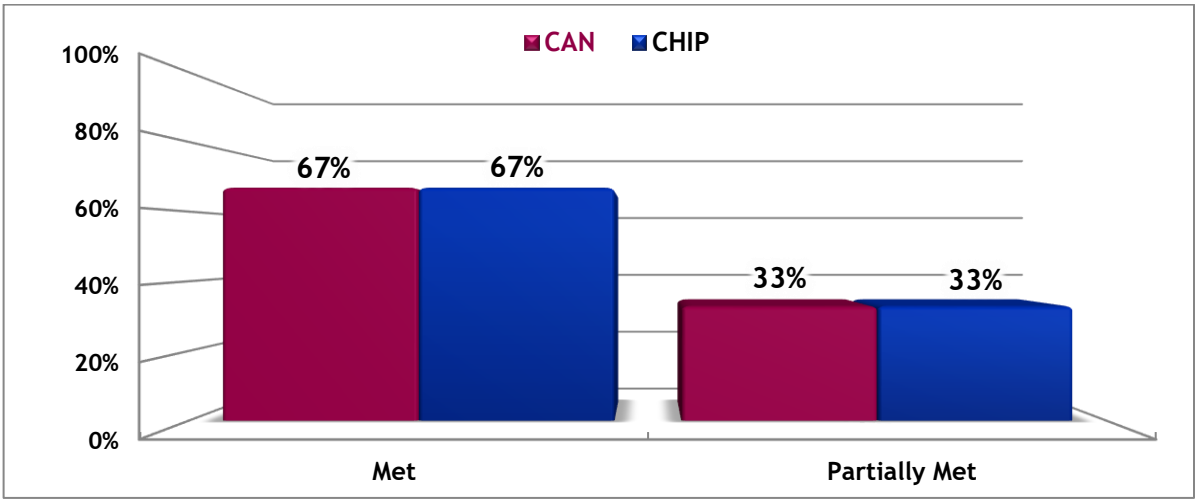


Table 21: CAN Quality Management

Section	Standard	CAN 2018 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met

Table 22: CHIP Quality Management

Section	Standard	CHIP 2018 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met

Strengths

- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented.
- 75% of PIPs were validated in the High Confidence range.
- HEDIS performance measures were "Fully Compliant."

Weaknesses

- PIPs have areas needing improvements including presenting the findings clearly and the lack of improvement in rates.
- CHIP PIP reports had issues with benchmark and baseline rate definitions.

Corrective Action

- Correct the specific errors identified in the PIPs.

V. Utilization Management

CCME's review of Utilization Management (UM) includes Appeals, Care Management, and Transitional Care Management, and encompasses a review of policies, program descriptions, program evaluations, committee minutes, and appeal and care management files.

Magnolia has established policies that explain appeal requirements and processes for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP) programs. Appeals requirements and processes are also found in *Member Handbooks* and *Provider Manuals*. Review of all information provided revealed many instances of outdated language to define appeals terminology in both CAN and CHIP materials. Incorrect or missing information about timeframes for appeal acknowledgement were noted in the CAN and CHIP Appeal Acknowledgement Letter templates, Policy MS.UM.08, CAN Appeal of UM Decisions, *CAN Member Handbook*, and the *CAN Provider Manual*.

Review of CAN and CHIP appeal files revealed that Magnolia begins the resolution timeframe for appeals on the date the signed Authorized Representative Form is received from the member. This practice is not consistent with CAN and CHIP appeal policies, *42 CFR § 438.408 (b)(2)*, and the *CAN* and *CHIP Contracts*.

The CAN and CHIP Case Management (CM) policies and procedures, as well as the Program Descriptions, provide guidance to staff performing CM activities. The review of CAN and CHIP Care Management files reflect Magnolia staff conduct appropriate CM activities for the members' conditions and assigned risk levels. The review of CAN and CHIP

Transitional Care Management programs and documentation reflect appropriate collaboration of the interdisciplinary care team in managing members' needs.

As noted in *Figure 6, Utilization Management Findings*, Magnolia received "Met" scores for 86% of the standards in the UM section of the review for CAN and 96% of the standards in the UM section of the review for CHIP.

Figure 6: Utilization Management Findings

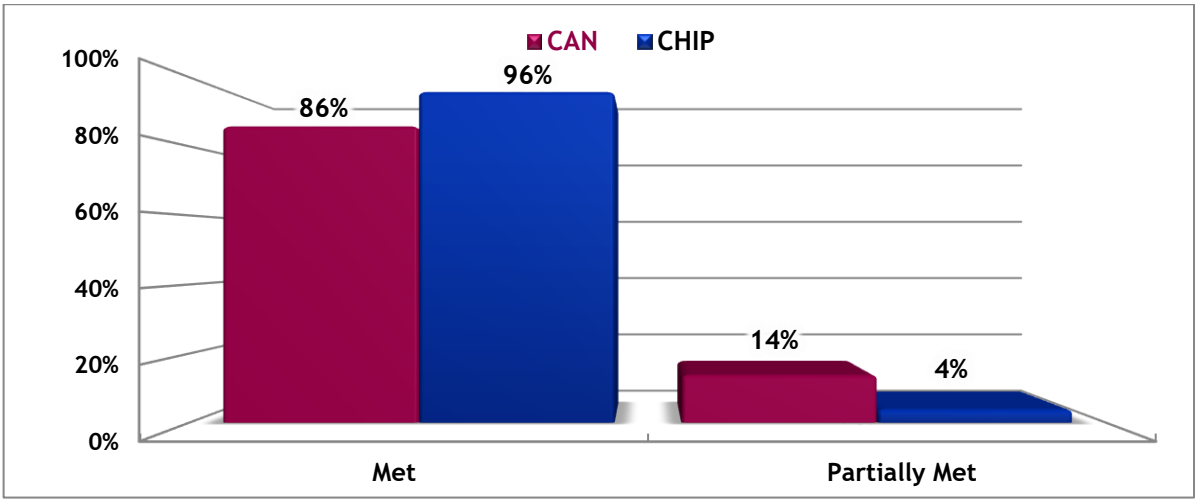


Table 23: CAN Utilization Management

Section	Standard	CAN 2018 Review
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 adverse benefit determination and an appeal and who may file an appeal	Partially Met
	The procedure for filing an appeal	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met
	The CCO applies the appeal policies and procedures as formulated	Partially Met

Table 24: CHIP Utilization Management

Section	Standard	CHIP 2018 Review
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 adverse benefit determination and an appeal and who may file an appeal	Partially Met
	The CCO applies the appeal policies and procedures as formulated	Partially Met

Strengths

- CM files reflect Magnolia uses available resources to provide quality services to members.

Weaknesses

- *42 CFR § 438.400 (b)* provides definitions of appeal terminology. The following documents use the term "action" or "adverse decision" instead of "adverse benefit determination":
  - Pages 1, 2, 3, 5, 8, 10, and 11 of the CAN Policy MS.UM.08, Appeal of UM Decisions ("action"); and pages 1, 2, 5, 7, and 11 ("adverse decision")).
  - Pages 51 and 52 of the *CAN Provider Manual*.
  - Page 29 of the *CHIP Member Handbook* ("adverse action").
  - Pages 73 through 75 of the *CHIP Provider Manual* uses both "action" and "adverse action."
- CCME identified the following issues with instructions for filing an appeal:
  - Policy MS.UM.08, Appeal of UM Decisions, indicates members can file an appeal request within 30 days. The *CAN Contract, Exhibit D* allows 60 days for a member to file an appeal.
  - The instructions on the provider section of the CAN website do not indicate written permission from the member is required for the provider to file an appeal on the member's behalf.
  - The member section of the CAN website states "Magnolia will include a form with the Adverse Benefit Determination letter," but it does not clearly indicate the purpose of the form.

- Appeal instructions located on the provider section of the CHIP website do not indicate written permission from the member is required for the provider to file an appeal on the member's behalf, and appeal information for providers was difficult to locate on the website.
- The CAN and CHIP Appeal Acknowledgement Letter templates do not define timeframes for appeal resolutions.
- CCME identified the following omitted language for appeal resolution timeframes, as specified in the *CAN Contract, Exhibit D*:
  - For a standard appeal extension requested by the plan, page 3 of Policy MS.UM.08, Appeal of UM Decisions, does not indicate Magnolia will give the member written notice of the extension and the reason for the extension within 2 calendar days.
  - Page 52 of the CAN *Provider Manual* and page 68 of the *CAN Member Handbook* do not indicate Magnolia will make reasonable efforts to provide and document verbal notice of an expedited appeal resolution.
- Five CAN appeal files and two CHIP appeal files indicated the appeals resolution timeframe began when Magnolia received a signed Authorized Representative Form from the member. Onsite discussion confirmed this is the process Magnolia follows. This practice is not consistent with page 4 of Policy MS. UM.08, Appeal of UM Decisions, page 3 of Policy MS. UM.08.01, Appeal of UM Decisions, 42 CFR *§ 438.408 (b)(2),* and the *CAN* and *CHIP Contracts*.

Corrective Actions

- Update the draft *CAN Provider Manual*, Policy MS.UM.08, the *CHIP Provider Manual*, and the *CHIP Member Handbook* to use the correct term of "adverse benefit determination."
- Update Policy MS.UM.08, Appeal of UM Decisions, to define the correct timeframe for members to file an appeal.
- Update the provider section of the CAN website to indicate written permission from the member is required for the provider to file an appeal on the member's behalf.
- Update Policy MS.UM.08, Appeal of UM Decisions, to indicate Magnolia will give the member written notice of a plan-requested extension and the reason for the extension within 2 calendar days.
- Update the *CAN Provider Manual* and *CAN Member Handbook* to indicate Magnolia will make reasonable efforts to provide and document verbal notice of an expedited appeal resolution.
- Ensure the timeframe for appeal resolution begins with receipt of the appeal request, as required in *42 CFR § 438.408 (b)(2)*, the *CAN Contract, Section C and Exhibit D*, and Policies MS.UM.08 and MS.UM.08.01.

Recommendations

- Update the member section of the CAN website to include instructions for the use of the form which is included with the Adverse Benefit Determination letter.
- Edit the providers' section of the CHIP website to communicate that a member's consent is required for the provider to file an appeal on the member's behalf.
- Ensure appeals information is easily identifiable on the provider section of the CHIP website.
- Update the CAN and CHIP Appeal Acknowledgement Letter templates to include appeal resolution timeframes.

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

I. 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

May 21, 2018

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 2018 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 **August 23, 2018** for the MississippiCAN Program and the Mississippi CHIP Program.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Requested for Desk Review** and **Mississippi CHIP Materials Requested for Desk Review** lists should be provided to CCME no later than **June 20, 2018**.

Please upload all the desk materials electronically to CCME through our secure file transfer website. 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. We will also send 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 2018 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 that support the adequacy of the provider base for the MSCAN program. Include copies of the most recent Network Geographic Access (GeoAccess) reports (complete reports), provider network assessment, enrollee demographic studies, and population needs assessments. Please include any provider identified limitations on panel size considered in the network assessment.

5. Reports of any assessments made of provider compliance with the appointment and after-hours standards for the MSCAN Program.

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

9. The Quality Improvement work plans for MSCAN for 2017 and 2018.

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

11. 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.

12. Minutes of all committee meetings in the past year (May 2017 through April 2018) 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.

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

14. A complete list of all members for MSCAN enrolled in the Care Management program from May 2017 through April 2018. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

16. 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, final report provided by the subcontractor, and any other documentation of the requested scope of work.

17. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of May 2017 through April 2018.

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

19. A list of physicians for the MSCAN and CHIP programs currently available for utilization consultation/review and their specialty.

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

21. 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.

22. 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.

23. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (including signed Ownership Disclosure Forms and provider office site visits as appropriate) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. 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 behavioral health providers

v. Two network hospitals; and
vi. One file for each additional type of facility in the network.

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://eqro.thecarolinascenter.org**
- **should be submitted in the categories listed.**

Magnolia Health Plan

External Quality Review 2018 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 that support the adequacy of the provider base for the CHIP program. Include copies of the most recent Network Geographic Access (GeoAccess) reports (complete reports), provider network assessment, enrollee demographic studies, and population needs assessments. Please include any provider identified limitations on panel size considered in the network assessment.

5. Reports of any assessments made of provider compliance with the appointment and after-hours standards for the CHIP Program.

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

9. The Quality Improvement work plans for CHIP for 2017 and 2018.

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

11. 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.

12. Minutes of all committee meetings in the past year (May 2017 through April 2018) 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.

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

14. A complete list of all members for CHIP enrolled in the Care Management program from May 2017 through April 2018. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

16. 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, final report provided by the subcontractor, and any other documentation of the requested scope of work.

17. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of May 2017 through April 2018.

18. Copies of all letter templates for documenting 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.

19. A list of physicians for the MSCAN and CHIP programs currently available for utilization consultation/review and their specialty.

20. A copy of the provider handbook or manual for the CHIP program.

21. 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.

22. 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.

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

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://eqro.thecarolinascenter.org**
- **should be submitted in the categories listed.**

II. Attachment 2: Materials Requested for Onsite Review

Magnolia Health Plan – MississippiCAN

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Member response letter for complaint/grievance file number XXXXXXXXX.
3. Non-HEDIS Performance Measure 2017 Rates.
4. Programming logic and State specifications for Pregnancy Outcome performance measure.
5. Proof of provider office site reviews for all credentialing provider files received in the Desk Materials in accordance with Policy MS.CONT.03.
6. Copy of the Office Site Evaluation tool.
7. 2017 Annual results of Primary Care Provider's appointment and after-hours accessibility.
8. Copy of the 2017 Annual QI Program Evaluation.

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 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Newsletter to Providers that display the Member Satisfaction Survey results for 2017.
3. Proof of provider office site reviews for all credentialing provider files received in the Desk Materials in accordance with Policy MS.CONT.03.

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

III. 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 CHIP
- 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	**UHC CHIP/CAN**
Survey Validated	**PROVIDER SATISFACTION SURVEY**
Validation Period	2017
Review Performed	2018

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**	-Used Provider Satisfaction Survey developed by vendor and plan *Documentation:* *-2017 Market Strategies Physician Scorecard*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	- Used Provider Satisfaction Survey developed by vendor and plan *Documentation:* *-2017 Market Strategies Physician Scorecard*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Used Provider Satisfaction Survey developed by vendor and plan *Documentation:* *-2017 Market Strategies Physician Scorecard*

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 based on NCQA standards criteria. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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 based on NCQA standards criteria. *Documentation:* *-2017 Market Strategies Physician Scorecard*

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. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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. *Documentation:* *-2017 Market Strategies Physician Scorecard*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	-Sampling strategy was noted. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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. *Documentation:* *-2017 Market Strategies Physician Scorecard*

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. *Documentation:* *-2017 Market Strategies Physician Scorecard*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rates were calculated appropriately. *Documentation:* *-2017 Provider Satisfaction Survey Results*

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 Market Strategies, an experienced survey organization. Its standard procedures were used for this survey. *Documentation:* *-2017 Statement of Work*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-2017 Provider Satisfaction Survey Results*
5.3	Were confidentiality procedures followed?	**MET**	- Confidentiality procedures were appropriate. *Documentation:* *-2017 Provider Satisfaction Survey Results*

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. *Documentation:* *-2017 Provider Satisfaction Survey Results*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	- Appropriate statistical tests used and applied correctly. *Documentation:* *-2017 Market Strategies Physician Scorecard*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions supported by the data and analysis. *Documentation:* *-2017 Provider Satisfaction Survey Results*

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 Market Strategies allows for a standardized and audited approach to the implementation and analysis of the surveys. - Market Strategies, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report. Documentation: *-2017 Market Strategies Physician Scorecard*
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?	Response rate of the 2017 survey was approximately 4.7% (*n*=117) which is decreased from prior year (6.6%, *n*=130) and slightly below the historical national response range of 5.0%-11.4% (2017 National range was not available at the time of completing this report). ***Recommendation:*** *Focus on strategies that help increase response rates for this population. Solicit the help of the survey vendor and set an internal goal for response rate increase from the previous year.* *Documentation:* *-2017 Provider Satisfaction Survey Results*
7.4	What conclusions are drawn from the survey data?	The 2017 results yielded significant overall improvements in NPS drivers (*overall*) and all ten domains. These improvements were favorable to last year and the prior four years' results. Of the 41 items, only two saw declines from prior year (exchanging information with behavioral health providers (-4) and availability of disease management programs (-3)). Both domains over these items saw improvements. The most significant improvements were noted in the domains of Customer Service (+15), Claims Processing (+14), and Overall Image (+17). *Documentation:* *-2017 Provider Satisfaction Survey Results*
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.
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	2017
Review Performed	07/2018

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*

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: Morpace*
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: Morpace*

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. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
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. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
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. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*

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. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	-Uses standard CAHPS for measurement via a certified vendor, which uses the protocols established by the National Committee for Quality Assurance (NCQA) in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) Volume Three Technical Update Specifications. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA-certified CAHPS vendor, who adheres to the approved confidentiality processes and procedures. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*

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 *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*

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.	- Using a CAHPS certified vendor promotes a standardized and audited approach to the implementation and analysis of the surveys. - Morpace 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 the 2016 Adult Medicaid Quality Compass®
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
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 low response rate (25%). ***RECOMMENDATION:*** *Focus on strategies that would help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by Agency for Healthcare Research and Quality (AHRQ) (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
7.4	What conclusions are drawn from the survey data?	Rating of Specialist was at the 90th percentile; Care Coordination, Customer Service, Shared Decision Making, and Rating of Health Care were below the 50th percentile; Getting Care Quickly, How Well Doctors Communicate, Getting Needed Care, Rating of Personal Doctor, and Rating of Health plan were between the 50th and 90th percentile. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
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 the report. *Documentation:* *-Morpace 2017 CAHPS Adult Medicaid Survey Summary Report for Magnolia Health: July 2017*
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	2017
Review Performed	07/2018

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*

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: Morpace*
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: Morpace*

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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*

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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	-Uses standard CAHPS for measurement via a certified vendor, which uses the protocols established by the National Committee for Quality Assurance (NCQA) in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) Volume Three Technical Update Specifications. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA-certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*

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 *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*

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.	- Using a CAHPS certified vendor promotes a standardized and audited approach to the implementation and analysis of the surveys. - Morpace 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 the 2016 Child Medicaid Quality Compass® - General Population Results
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
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 low response rate (19% for the total sample and 18% for the general population). ***RECOMMENDATION:*** *Focus on strategies that would help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by Agency for Healthcare Research and Quality (AHRQ) (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	Getting Care Quickly and Getting Needed Care were above the 90th percentile; Care Coordination and Rating of Personal Doctor were below the 50th percentile; How Well Doctors Communicate, Customer Service, Shared Decision Making, Rating of Health Care, Rating of Specialist, and Rating of Health Plan were between 50th and 90th percentile. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
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 the report. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid with CCC Survey Summary Report for Magnolia Health: July 2017*
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	2017
Review Performed	07/2018

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*

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: Morpace*
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: Morpace*

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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*

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. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	-Uses standard CAHPS for measurement via a certified vendor, which uses the protocols established by the National Committee for Quality Assurance (NCQA) in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) Volume Three Technical Update Specifications. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA-certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*

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 *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*

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.	- Using a CAHPS certified vendor promotes a standardized and audited approach to the implementation and analysis of the surveys. - Morpace 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 the 2016 Child Medicaid Quality Compass®
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
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 low response rate (18%). ***RECOMMENDATION:*** *Focus on strategies that would help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by Agency for Healthcare Research and Quality (AHRQ) (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
7.4	What conclusions are drawn from the survey data?	Getting Care Quickly, How Well Doctors Communicate, Rating of Specialist were above the 90th percentile; Shared Decision Making was below the 50th percentile; Care Coordination, Getting Needed Care, Customer Service, Rating of Health Care, Rating of Personal Doctor, and Rating of Health Plan were between 50th and 90th percentile. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
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 the report. *Documentation:* *-Morpace 2017 CAHPS Child Medicaid Survey Summary Report for Magnolia Health: July 2017*
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	2017
Review Performed	07/2018

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*

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: Morpace*
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: Morpace*

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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*

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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	- Uses standard CAHPS for measurement via a certified vendor, which uses the protocols established by National Committee for Quality Assurance (NCQA) in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) Volume Three Technical Update Specifications. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA-certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*

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 *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documentation:* -Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*

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.	- Using a CAHPS certified vendor promotes a standardized and audited approach to the implementation and analysis of the surveys. - Morpace 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 the 2016 Child Medicaid Quality Compass® General Population and 2016 Child Medicaid Quality Compass® CCC Population Rates.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
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 low response rate (22% for total sample and 20% for general population). ***Recommendation:*** *Focus on strategies that would help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by Agency for Healthcare Research and Quality (AHRQ) (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	In comparison to Quality Compass General Population Results, the composites of Getting Care Quickly, How Well Doctors Communicate, Getting Needed Care and Customer Services were above the 90th percentile. Shared Decision Making was below the 10th percentile. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
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 the report. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Children with Chronic Conditions for Magnolia Health 2017*
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	2017
Review Performed	07/2018

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*

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: Morpace*
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: Morpace*

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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*

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. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by the National Committee for Quality Assurance (NCQA) in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set (HEDIS®) Volume Three Technical Update Specifications. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA-certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*

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 *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*

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.	- Using a CAHPS-certified vendor promotes a standardized and audited approach to the implementation and analysis of the surveys. - Morpace 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 the 2016 Child Medicaid Quality Compass®
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
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 low response rate (20%). ***Recommendation:*** *Focus on strategies that would help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by Agency for Healthcare Research and Quality (AHRQ) (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child with Chronic Conditions for Magnolia Health 2017*

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	How Well Doctors Communicate, Care Coordination, Getting Needed Care were at or above the 90th percentile. Getting Care Quickly, Customer Service, Rating of Health Care, Rating of Personal Doctor, and Rating of Specialist were above the 50th percentile but below the 90th percentile. Shared Decision Making and Rating of Health Plan were below the 50th percentile. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
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 the report. *Documentation:* *-Morpace CAHPS Summary Report MS Children's Health Insurance Program Child for Magnolia Health 2017*
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 2016**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2017

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 National Committee for Quality Assurance (NCQA)-certified software, Inovalon. Documentation review requirements are 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. Denominator data sources review requirements are met.
D1. 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. Denominator calculation review requirements are 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. Numerator data sources review requirements are met.

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**	Plan uses NCQA-certified software, Inovalon. Numerator calculation review requirements are 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.
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. Reporting review requirements are 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 2016**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2017

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 National Committee for Quality Assurance (NCQA)-certified software, Inovalon. Documentation review requirements are 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. Denominator data sources review requirements are 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. Denominator calculation review requirements are 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. Numerator data review requirements are met.

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**	Plan uses NCQA-certified software, Inovalon. Numerator calculation review requirements are 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.
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. Reporting review requirements are 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:	**DEV (DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE)**
Reporting Year:	**Measurement Year 2016**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHIPRA Core Set 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**	Documentation is appropriate as per Attest Health report.

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 are accurate as per Attest Health report.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator is adhering to the appropriate specifications dictated by the State.

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

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**	Calculations of measures adhered to specifications and are accurate as per Attest Health report.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method 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**	Hybrid method 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**	Sampling was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Sampling was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Sampling was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was approved as reported as per Attest Health report.
R2. Reporting	Was the measure reported according to technical specifications?	**MET**	Measure was reported according to Children's Health Insurance Program Reauthorization Act (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	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	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:	**2017**
Review Performed:	**2018**

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 not used.
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 used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.

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 documented for 2016 and 2017.
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)**	**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)**	**MET**	Initial and repeat measurements are 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 results was documented. Information on follow-up activities was documented in section VIIb.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was the same at baseline and remeasurement 1.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	There was improvement in the rate. ***Recommendation:*** *Continue interventions and initiate new ideas to improve the rate.*
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**	No improvement to assess.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.

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**	No improvement to assess.

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	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	**84**
Project Possible Score	**85**
Validation Findings	**99%**

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:	**CONGESTIVE HEART FAILURE READMISSIONS**
Reporting Year:	**2017**
Review Performed:	**2018**

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**	Congestive Heart Failure (CHF) was the most prevalent and 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)**	**MET**	The indicator is defined according to the State specifications.
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 change 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 used.
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 used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

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 in report.
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 in report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Data analysts used programming logic to calculate rate.
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 in 2016 and 2017.
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 annually.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Annual results are presented in the 2017 PDF report in the indicator section, not in the results section. The comparison on results to baseline goal and benchmark is not clearly written as the Results Table format was not used. ***Recommendation:*** *Include all measurement periods in the Results section of the report, not the indicator section*.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurement is 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**	Analyses of baseline data and remeasurements are not provided in report. ***Recommendation:*** *Include analyses of rates at each measurement period, whether the goal was met or not, and action plans in response to the findings in the report.*

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)**	**MET**	Methodologies were similar across measurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate increased whereas the goal is to decrease CHF readmissions. ***Recommendation**: Initiate new interventions to improve rate toward goal.*
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 was no improvement reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	There was no improvement reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Only one remeasurement at this point.

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	5
8.3	1	1
8.4	1	0
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	78
Project Possible Score	85
Validation Findings	92%

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:	**DIABETES**
Reporting Year:	**2017**
Review Performed:	**2018**

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)**	**MET**	Sampling conducted according to Healthcare Effectiveness Data and Information Set (HEDIS®) technique.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Sampling was based on A1C level.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sampling used entire eligible population.

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 were identified for 2016 and 2017.
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 performed according to the plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	The denominators suggest that members with unavailable data are included in the percentage. The denominator should include only those members where pre and post data are available for evaluation. The results should clearly identify the number of records for each measurement year, and the number of members who have records available that met the A1C < 8 goal. Also, the Table on page A-17 is labeled 2016 and it should be labeled 2017. ***Recommendation:*** *Ensure reporting of eligible members and denominator for rate is accurate in performance improvement project (PIP) report. Check labels for Table on page A-17.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements are 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 the results is documented.

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)**	**MET**	The methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	There was no improvement in rate. ***Recommendation:*** *Initiate new interventions to increase rate.*
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 was no improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was conducted.
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	5	5
8.2	1	0
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	1	1
Step 10		
10.1	NA	NA
Verify		

Project Score	**95**
Project Possible Score	**97**
Validation Findings	**98%**

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:	**2017**
Review Performed:	**2018**

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)**	**PARTIALLY MET**	Baseline goal and benchmark are the same. The baseline goal should be an initial goal that is set for baseline measurement only. The benchmark is the goal used to consider the study as complete. ***Recommendation:*** *Adjust benchmark rate to be the best practice rate.*
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.

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)**	**MET**	Sampling used Healthcare Effectiveness Data and Information Set (HEDIS®) technique.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Sampling conducted based on body mass index (BMI).
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sample contained all members that were eligible.
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 in the report.
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 in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Medical record audits are performed; personnel involved are documented in the report.

Component / Standard (Total Points)	Score	Comments
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 and noted for 2016 and 2017.
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**	Baseline analysis and remeasurement 1 were conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	Results are difficult to interpret. If only 60 members had a documented BMI before and after, then 60 should be the denominator. For the baseline results, interpretation was not given in the report to determine how a denominator of 20 was obtained. ***Recommendation:*** *Ensure the denominator includes only those patients where data can be obtained for pre and post study. Interpretation of baseline and all remeasurements should be included in the Analysis section.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements were 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 study results is provided in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement was demonstrated.
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)**	**MET**	Improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was conducted, although improvement was not significant.

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**	Too early to judge.

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	5
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	5	5
8.2	10	0
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify		

Project Score	**96**
Project Possible Score	**111**
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 HEALTH CHIP**
Name of PIP:	**ADHD**
Reporting Year:	2016-2017
Review Performed:	2018

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**	Attention Deficit Hyperactivity Disorder (ADHD) incidence is more than double the national rate 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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measures are defined under the measurable goal section. The baseline goal and the benchmark rates are the same. The benchmark should be the absolute best practice rate and will likely be higher than the baseline goal rate. ***Recommendation:*** *Review the baseline goal and benchmark, set a best practice rate for the benchmark, and a short-term goal for the baseline goal.*
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**	Measure is related to functional status and processes of care.
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**	Population is clearly 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**	Population studied was the intended population.

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**	
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Entire eligible population was used.
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 were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Manual data were not used for this performance improvement project (PIP). Audit personnel are noted in the document.
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 documented for 2016 and 2017.
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)**	**Met**	Results are clearly presented in narrative and Table format.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and remeasurement data are presented.
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**	Conclusions were offered and revisions were made to continue recent improvement in rates.

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)**	**Met**	Methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement was noted.
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)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical testing was conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

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	5
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	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**86**
Project Possible Score	**91**
Validation Findings	**95%**

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 HEALTH CHIP**
Name of PIP:	**ASTHMA - CLINICAL**
Reporting Year:	2016-2017
Review Performed:	2018

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**	Asthma emergency department (ED) rate increased 23% from 2003 to 2008.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measures are defined under the Measurable Goal section. The baseline goal is higher than the benchmark. As increases in the rate suggest improvement, the benchmark should be higher and considered the best practice rate. The baseline goal is the short-term goal. Table on page A-19 should be titled 2017 instead of 2016. ***Recommendation:*** *Review the baseline goal and benchmark, and set a best practice rate for the benchmark, and a short-term goal for the baseline goal. Adjust the label for the Table on page A-19.*
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**	Measure is related to health status.

Component / Standard (Total Points)	Score	Comments
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**	Population is clearly 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**	Population studied was the intended population.
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**	
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Entire eligible population was used.
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 were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Audit personnel involved are documented in the report.
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**	Barriers and interventions were documented.
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 for the baseline year and remeasurement 1.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are clearly presented in narrative and Table format.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Repeat measurements are conducted.

Component / Standard (Total Points)	Score	Comments
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**	Conclusions were offered and revisions were made to continue improvement in rates.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rate improved from baseline to remeasurement 1.
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)**	**Met**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical testing was conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

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	5
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	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	86
Project Possible Score	91
Validation Findings	95%

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 HEALTH CHIP**
Name of PIP:	**EPSDT SERVICES FOR CHILDREN UP TO 19 YEARS OF AGE- CLINICAL**
Reporting Year:	2015-2017
Review Performed:	2018

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**	Information on importance of well-child visits is provided.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measures are defined under the Measurable Goal section. Results should not be presented in the quantifiable measures Table. ***Recommendation*: *Omit results in Quantifiable Measures section*.**
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**	Measure is related to 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**	Population is clearly 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**	Population studied was the intended population.

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**	*Note.* If you did not use sampling, this section of the report should contain N/A. Activity V is confusing because the sample size says 100%, but the sample size is a number, not a percentage. If using the entire population, leave this section blank or place N/A in the Table.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Entire eligible population was used.
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 were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Manual data were not used for this performance improvement project (PIP). Audit personnel are noted in the report.
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**	Barriers and interventions were documented.
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 the plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are clearly presented in narrative and Table format.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeated measures are analyzed.
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**	The study data analysis offered conclusions and made revisions to sustain recent rate improvements.

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)**	**Met**	Methodology was the same across measurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement occurred for all three measures.
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)**	**Met**	Interventions appear to impact well child visit rates.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical testing was conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Sustainment unable to be judged.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

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	5
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	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**86**
Project Possible Score	**91**
Validation Findings	**95%**

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 HEALTH CHIP**
Name of PIP:	**OBESITY FOR CHILDREN**
Reporting Year:	2017
Review Performed:	2018

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**	Rate of obesity was 35.5 for 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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measure is defined under the Measurable Goal section. The baseline goal and the benchmark rate are the same. The benchmark should be the absolute best practice rate and will likely be lower than the baseline goal rate. ***Recommendation:*** *Review the baseline goal and benchmark to determine if reduction of 5 points in 50% of eligible population is an appropriate benchmark. For example, a baseline goal of 50% of eligible members and a benchmark of 80% or higher of the eligible members will yield a reduction of 5 percentile points.*
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**	Measure is related to health status.

Component / Standard (Total Points)	Score	Comments
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**	The Plan clearly defined the population.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The Plan studied the intended population.
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**	The sampling technique was adjusted based on ability to contact individuals.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	The Plan used hybrid sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Partially Met**	The sample is extremely small for baseline and remeasurement 1. With such small samples, this performance improvement project (PIP) does not appear to impact the health status of a broad spectrum of members. ***Recommendation:*** *Implement interventions to determine ways to reach the individuals that are eligible, but unable to be reached.*
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	The data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The data sources were clearly specified in Data Collection section.
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**	The method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	The study design documented the data sources.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	The study design indicated an annual data analysis.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel used to collect data were qualified and documented in the performance improvement project (PIP) report.

Component / Standard (Total Points)	Score	Comments
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 documented for 2016 and 2017.
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**	The Plan conducted analyses for the baseline year.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	Results are clearly presented in table format, but the interpretation of the baseline data are not provided in the report. The denominators appear to include all eligible members, although data were not available for all eligible members. ***Recommendation:*** *Include interpretations for all measurements. Also, the records were only available for 21 individuals, thus, the denominator should be 21 since those are the members with available data*.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	The analysis identified initial and repeat measurements.
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**	The study data analysis offered conclusions and made revisions to sustain recent rate improvements.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Due to reporting issues, this will not be evaluated.
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**	Due to reporting issues, this will not be evaluated.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Due to reporting issues, this will not be evaluated.

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**	Unable to judge using only one available remeasurement.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

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	5
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	3
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	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**87**
Project Possible Score	**104**
Validation Findings	**84%**

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.*

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**Magnolia Health Plan MS CAN**
Review Performed:	2018

I. Management Information Systems

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. Information Systems Capabilities Assessment (ISCA)						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia's ISCA documentation indicates numerous internal audits are conducted to ensure the quality and accuracy of claims. The materials also indicate that an internal "Claims Operations Management" Team monitors claims daily and monthly to ensure compliance with the following benchmarks: •100% of clean claims finalized to a paid or denied status within 30 calendar days from receipt •99% of non-clean claims finalized to a paid or denied status within 60 calendar days from receipt •100% of all claims, including adjustments, processed and paid within 90 calendar days from receipt The documentation indicates Magnolia uses established and reasonable processes to ensure accurate and timely claims handling; however, this could not be verified because Magnolia did not submit actual per-month clean claim payment statistics/reports.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia uses the member IDs included in the State's 834 files to uniquely identify enrollees and uses reports to identify duplicate members. If duplicates are found, Magnolia merges the duplicate records and retains the membership history. According to Magnolia, newborns are correlated with existing Medicaid members using reports generated by its inpatient authorization system. That same reporting process is used to track newborn enrollment. Finally, ISCA documentation indicates Magnolia monitors member, claims, and encounter data stored within aggregate systems and can provide that data to the state for tracking purposes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					ISCA documentation indicates that Magnolia collects and stores the data required to generate state-required reports. These indications are reinforced by a recent audit performed by Attest Health Care Advisors that evaluated Magnolia's Healthcare Effectiveness Data and Information Set (HEDIS®) standards, policies, and procedures. The audit found Magnolia met all the required HEDIS standards.
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 supplied a business continuity and recovery response plan that included detailed vendor information, extensive team and staff contact information, and clear, understandable response processes. Additionally, Magnolia also supplied a management summary of disaster recovery (DR) tests that were executed in June 2017 and August 2017. The DR management summary reports successful recovery of datacenter infrastructure, health plan systems, and telecommunications systems. The provider also noted, "Gaps and problem logs were recorded for follow-up in ServiceNow while the exercise was in progress and an owner was assigned to be responsible for tracking and resolving issues."

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				Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, defines the process for conducting the functions of practitioner selection and retention. The policy is detailed and includes state requirements for MS in footnotes and in Attachment B of the document. However, page 23 of the policy and Attachment B do not specify the Medicaid MS Sanctioned Provider List as a query requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Update Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to include the Medicaid MS Sanctioned Provider List as a query requirement.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.		X				The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. Additional voting members of the committee include the Vice President of Medical Affairs, two Magnolia Medical Directors and four participating providers with the specialties of pediatrics, family medicine, and psychiatry. The committee membership also includes one nurse practitioner. The committee meets monthly and a quorum is met with 50% of voting members in attendance. Committee minutes show a quorum is established at each meeting. Policy CC.CRED.03, Credentialing Committee, defines the Credentialing Committee procedures and states the Quality Improvement Committee (QIC) oversees the plan Credentialing Committee. The QIC is the vehicle through which credentialing, monitoring, and reporting mechanisms are communicated to the Board of Directors. The policy states credentialing of behavioral health practitioners, including the Credentialing Committee, has been delegated to Envolve (formerly known as Cenpatico). However, onsite discussion confirmed that for MS behavioral health, credentialing is no longer delegated to Envolve. *Corrective Action Plan: Update Policy CC.CRED.03, Credentialing Committee, to reflect that MS behavioral health credentialing is not delegated to Envolve.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized; however, several issues are discussed in the following section. It was also noted that for nurse practitioners acting as primary care physicians (PCPs), Magnolia collects information regarding collaborating physicians but does not collect the nursing protocols or collaborative agreements. CCME informed Magnolia they should be collecting the nursing protocols or collaborative agreements. The two behavioral health files received for credentialing had inconsistent information on the checklist that displays documents reviewed. One file showed item 29 "Miscellaneous: OIG CN" as a category instead of displaying the various queries documented on the OIG CN query sheet and the other file checklist showed the category as "OIG Compliance Now

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Screening" with specific queries listed (Social Security Death Master File (SSDMF), etc.). Magnolia needs to ensure the checklist displays <u>all</u> the required queries performed by OIG Compliance Now. *Recommendation: Ensure collaborative agreements or protocols are collected for all nurse practitioners/physician assistants acting as PCPs at credentialing. The behavioral health credentialing file checklist should reflect a listing of all required queries being performed by the plan or OIG Compliance Now.*
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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			Evidence of query of the Medicaid MS Sanctioned Provider List was not in the credentialing files reviewed. Onsite discussion confirmed this list is not being queried. *Corrective Action Plan: Ensure the Medicaid MS Sanctioned Provider List is queried at credentialing and proof of query is in the credentialing files.*
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 Query of the Social Security Administration's Death Master File (SSDMF)	X					The Magnolia credentialing files reviewed contained appropriate documentation. The Cenpatico behavioral health credentialing files contained proof of query of the SSDMF through searches performed via OIG Compliance NOW, LLC. Magnolia indicated during onsite discussion that the SSDMF is included in the search and provided a page from the contract showing a listing of searchable items. A copy of an OIG Compliance Now search specific to each behavioral health provider was in the credentialing files showing the Social Security number was searched.
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.15 Ownership Disclosure Form.	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Policy CC.CRED.05, Practitioner Office Site Review, defines the process of conducting provider office site visits regarding member complaints, and Attachment B (Magnolia Unique Site Visits Requirements) refers to Policy MS.CONT.03 for site visits relating to new provider contracts. However, Policy CC.CRED.05 has a statement that Cenpatico Behavioral Health monitors site visits for behavioral health in accordance with Policy CC.CRED.12, Oversight of Delegated Credentialing. Onsite discussion confirmed that behavioral health credentialing is no longer delegated to Cenpatico. Policy MS.CONT.03, Site Assessments for New Provider Contracts, states initial visits to the office of all new potential primary care practitioners, OB/GYNs, cardiologists and newly designated RHCs and FQHCs are conducted prior to making the credentialing decision for that provider. Magnolia provided a work process document for Policy MS.CONT.03 that states once the Site Evaluation tool is completed, the Contract Audit Specialist will e-mail the Site Evaluation tool to the Credentialing team. However, provider office site visits were not included with the credentialing files received for the EQR desk review. The information was again requested for the onsite and CCME received copies of only three provider office site reviews. Magnolia indicated they were unable to locate where site evaluations prior to 2014 were documented. CCME received a spreadsheet showing some site visit tracking, but it does not appear that Magnolia tracks the final score nor documents site evaluation outcomes in credentialing files. *Corrective Action Plan: Update Policy CC.CRED.05, Practitioner Office Site Review, to remove incorrect language regarding behavioral health being delegated to Cenpatico. Review the provider office site review process to ensure all site reviews are being conducted in accordance with Policy MS.CONT.03. Ensure evidence of the provider office site reviews is included in the credentialing files.*

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 were organized; however, several issues are discussed in the following section. It was also noted that for nurse practitioners acting as PCPs, Magnolia collects information regarding collaborating physicians but does not collect the nursing protocols or collaborative agreements. CCME informed Magnolia they should be collecting the nursing protocols or collaborative agreements. Of the two recredentialing behavioral health files, one file reflected a query for OIG Compliance Now, but the checklist did not specify which queries had been performed. It only showed "#29 Miscellaneous: OIGCN". There was no indication on the checklist of the queries for SSDMF, etc. *Recommendation: Ensure collaborative agreements or protocols are collected for all nurse practitioners/physician assistants acting as PCPs at recredentialing. The behavioral health recredentialing file checklist should reflect a listing of all required queries being performed by the plan or OIG Compliance Now and proof of queries should be in the files.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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			Evidence of query of the Medicaid MS Sanctioned Provider List was not in the recredentialing files reviewed. Onsite discussion confirmed this list is not being queried by the plan. *Corrective Action Plan: Ensure the Medicaid MS Sanctioned Provider List is queried at recredentialing and proof of query is in the recredentialing files.*
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 Query of the Social Security Administration's Death Master File (SSDMF);	X					One recredentialing behavioral health file did not contain proof an OIG Compliance Now check had been performed and there was no evidence of query for the SSDMF. *Recommendation: Ensure all recredentialing files contain proof of query of the SSDMF.*
4.2.11 Query of the National Plan and Provider Enumeration (NPPES);	X					One recredentialing behavioral health file did not contain proof of query of the NPPES even though the checklist indicated the search had been performed. *Recommendation: Ensure all recredentialing files contain proof of query of the NPPES.*
4.2.12 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 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					
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO.	X					Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, states the plan may implement practitioner disciplinary actions, up to and including suspension, restriction, or termination of a practitioner's participation status with the plan network, based on non-compliance with minimum administrative credentialing requirements or if imminent harm to patient health, fraud, or malfeasance is suspected. The process ensures participating practitioners are treated equitably, that any actions taken against a practitioner for quality reasons are reported to the appropriate authorities, and the practitioner is offered a formal appeal process (see 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			Policy CC.CRED.09, Organizational Assessment and Reassessment, defines the process for conducting the functions of provider selection and retention of organizational providers. The policy defines provider types and processes for assessing compliance to the credentialing and recredentialing requirements. Attachment E of the policy does not address the need to query the Medicaid MS Sanctioned Provider List and evidence of query of the Medicaid MS Sanctioned Provider List was not in the organizational files reviewed. Onsite discussion confirmed this list is not being queried by the plan. The organizational file review reflected the following additional issues:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•One credentialing file did not have proof of the OIG query and the application did not have a date by the signature. •One recredentialing file did not have proof of malpractice insurance. •Only received a copy of the second page of the ownership disclosure form in two recredentialing files. *Corrective Action Plan: Update Policy CC.CRED.09, Attachment E to include the Medicaid MS Sanctioned Provider List is queried at credentialing and recredentialing for organizational providers and proof of query is in the files. Ensure organizational files contain appropriate documentation such as complete copy of the Ownership Disclosure Form, proof of malpractice insurance, proof of OIG query, and the date the application is signed.*
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.09, Verification of Member Eligibility, states the plan will notify the PCP for members assigned to them within five business days of receipt of the Enrollee Listing Report from DOM. The Provider Relations team, or their designee, will ensure PCPs are notified of the members assigned to them via surface mail, web portal, or by telephone. If a notification is provided via web portal, the plan will confirm that the PCP acknowledges receipt of the list of members assigned to the PCP.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MS.PRVR.09, Verification of Member Eligibility, states all providers may contact the toll-free telephone number printed on the member's Plan ID card and utilize the plan's interactive voice response (IVR) system, available 24 hours a day, seven (7) days a week to verify member eligibility. The IVR is updated daily. In addition, all providers may contact the toll-free telephone number printed on the member's Plan ID card to speak with a Plan Provider Services Representative during normal business hours to verify member eligibility.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					The *Provider Manual* addresses member panel capacity and the importance of contacting Magnolia if the practice wants to make a change to their defined provider panel. Magnolia tracks limitations on panel size and the *Provider Directory* search option on the website has an option for selecting providers that are 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					Policy MS.QI.04, Evaluation of Practitioner Availability, states Magnolia assesses the availability of PCPs within the health care deliver-service area. The established standards defined in the policy for the geographic distribution comply with contract guidelines and GEO access reports received match defined parameters. The *Magnolia Health Medicaid and CHIP Availability of Practitioners Analysis – 2018* report shows availability goals were met 100% for primary care providers.
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 that comply with contract requirements. CCME received GEO Access reports for review and noted the following for MS CAN: •Rural Emergency Care providers were assessed using “one within 60 miles,” but the guideline is “one within 30 miles” for Rural. *Recommendation: Ensure the quarterly CAN GEO Access reports reflect the correct mileage parameter for Rural Emergency Care providers.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Policy MS.QI.04, Evaluation of Practitioner Availability, states practitioner type and availability is measured quarterly.
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					Policy MS.QI.04, Evaluation of Practitioner Availability, states 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MS.QI.22, Cultural Competency, states Magnolia has a comprehensive linguistic and cultural competency plan describing how it will meet the linguistic and cultural needs of members. Staff training is held on an as-needed basis, and subcontractors and providers receive training through quarterly provider trainings or onsite visits upon request.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					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 grievances/complaints, provider audits/surveys, and through the member satisfaction survey. At least annually, Magnolia analyzes appointment accessibility including routine, urgent, and after-hours care against the standards it has defined. The *2017 MSCAN QI Program Evaluation* showed Medicaid primary care routine appointments measured through the CAHPS Member Satisfaction Survey as not meeting the 75th percentile goal (results at 81.11%, 70th percentile); primary care urgent appointments not meeting goal (82.79%, 46th percentile); and the telephone survey for primary care after-hours care not meeting goal with providers only 50.6% having an acceptable method of providing after-hours access for members. Barriers and interventions were discussed in the report. Onsite discussion confirmed that Magnolia recognized the need to do a telephone survey to assess appointment availability to identify which providers were noncompliant. They implemented telephone surveys in Quarter 2, 2018 and will assess the data and develop interventions.
II C. Provider Satisfaction Survey						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.	X					A Provider Satisfaction Survey validation was performed using a validation worksheet based on the *CMS Survey Validation Protocol*. The initial sample had a low response rate (10.0%) and the latter sample had a response rate of 34.7%. This is just slightly below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey. The complete worksheet is available as an attachment in this report. *Recommendation: Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The survey results were analyzed by the Plan. As a result, the plan developed a focus group to improve provider satisfaction.
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 Quality Improvement Committee (QIC) in October 2017, and discussion continued in the December QIC meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. 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 generalizability of the survey results is difficult to discern due to low response rate. The response rates were: •Adult survey—25% •Child survey—18% •Children with chronic conditions survey—19% (total sample) and 18% (general population)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Focus on strategies that would help increase response rates. Set internal response rate goals (such as receiving a 2% increase over the previous year's response rate) as opposed to the target rate set by AHRQ.
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 April. A workplan was developed to implement actions to increase member satisfaction.
3. The CCO reports the results of the member satisfaction survey to providers.	X					Survey results were reported to providers in the 2018 Winter Provider Newsletter.
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 8/30/17 and opportunities to improve were documented. In the QIC minutes, documentation was provided regarding the response rates and general results and the 2017 CAHPS work plan was generated based on the results.
III B. 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 requirements and processes for receiving, handling, and responding to member requests for complaints and grievances.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, defines a complaint as an expression of dissatisfaction received orally or in writing that is of less serious or formal nature that is resolved within 1 calendar day of receipt. The term "grievance" is appropriately defined in Policy MS.MBRS.07, Member Grievance and Complaints Process, the CAN website, the draft *CAN Member Handbook*, and *CAN Provider Manual* (current and draft versions). Appropriate information regarding who can file a grievance is found in Policy MS.MBRS.07, the draft *CAN Member Handbook*, the *CAN Provider Manual* (current and draft versions), and on the CAN website.
1.2 The procedure for filing and handling a complaint/grievance;		X				As stated in Policy MS.MBRS.07, Member Grievance and Complaints Process, grievances may be filed at any time;

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						however, the filing timeframe to file a complaint is limited to within 30 calendar days of the event causing the dissatisfaction. The draft *CAN Member Handbook* states complaints may be filed within 30 days of the date of the event causing dissatisfaction but does not state that there is no time limit for filing grievances. Also, the "How to File a Grievance or Complaint" section of the draft *CAN Member Handbook* states, "To review your request, we may need to obtain additional information. If a signed Authorization to Release Information Form is not included with your grievance, a form will be sent to you for signature. If a signed authorization is not provided within 30 business days of the request, Magnolia may issue a decision on the grievance without review of some or all of the information." This information was also noted in the draft *CAN Provider Manual*. Onsite discussion revealed this information is incorrect and should not have been included in the *CAN Member Handbook* and draft *CAN Provider Manual*. Magnolia's CAN website contains an incorrect statement that grievances must be filed within 30 days of the date of the event causing dissatisfaction *Corrective Action: Revise the CAN website with information that grievances can be filed at any time. Update the draft CAN Member Handbook to include that there is no time limit on filing a grievance.* *Recommendation: Remove the incorrect information about the requirement of a signed Authorization to Release Information Form from the draft CAN Member Handbook and draft CAN Provider Manual.*
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;		X				Policy MS.MBRS.07, Member Grievance and Complaints Process, defines resolution and notification timeframes for complaints and grievances. Appropriate information regarding extensions of standard grievance resolution timeframes is included as well. Appropriate information regarding grievance and complaint resolution timeframes and extensions is noted in the draft CAN *Member Handbook* and on the Magnolia CAN website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The current and draft versions of the *CAN Provider Manual* reference the 30-day grievance resolution and notification timeframe. However, neither the draft nor the current version of the *CAN Provider Manual* address extensions of the grievance resolution timeframe. In addition, the draft *CAN Provider Manual* contains erroneous information regarding second-level and third-level grievance review processes. *Corrective Action: Revise the draft CAN Provider Manual to include information on extensions of grievance resolution timeframes. Remove the erroneous information regarding second-level and third-level grievances review from the draft CAN Provider Manual.*
1.4 Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, states Magnolia ensures individuals who make decisions on grievances are not involved in any previous level of review or decision making. Magnolia also ensures healthcare professionals with appropriate clinical expertise shall make decisions on grievances that involve clinical issues.
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					
2. The CCO applies the complaint/grievance policy and procedure as formulated.		X				CCME reviewed 20 of Magnolia's CAN grievance files. Of these, one file reflected a grievance resolution that did not correspond with the documented grievance and one file appeared to have been handled as a complaint but was not resolved within 1 calendar day, as required. Of greater concern, CCME identified the following issues in the 20 files reviewed: •Two grievances should have been referred for review and investigation as a potential quality of care concern, but the files contained no evidence that this occurred. Refer to Policy MS.MBRS.07, Member Grievance and Complaints Process, and Policy CC.QI.17, Potential Quality of Care Incidents. •Seven files contained evidence that Magnolia took no action to investigate or resolve the grievance—instead the members were

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						informed they could file a complaint with the provider/facility or with various state agencies/licensing boards. *Corrective Action: Develop and document a training plan for grievance staff to ensure staff understand requirements for referring grievances containing possible quality of care concerns for investigation as stated in Magnolia policies. Also include the processes to ensure all grievances are reviewed and appropriate activities are conducted to investigate and resolve the grievances rather than informing members to file their complaints with providers or state agencies/licensing boards. Include, if possible, the date the training is conducted and documentation of completion of the training.* *Recommendation: Ensure the grievance resolution corresponds with the documented grievance and incorporates all aspects of the grievance. Ensure that if a complaint cannot be resolved within the required 24-hour timeframe it is transferred to the grievance process and processed as such.*
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 quarterly summaries of complaint and grievance actions, trends, and root causes are reported to the Quality Improvement Committee (QIC). The QIC uses the reports to look for opportunities to improve quality of care/service. Findings are reported to the Board of Directors. Review of QIC minutes confirms grievance information is reported and discussed.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV B. 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					Magnolia submitted four PIPs for the CAN program. The topics included Congestive Heart Failure (CHF) Readmissions, Obesity, Diabetes, and Asthma.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects".		X				Three of the projects (3/4=75%) received a score of "High Confidence in Reported Results" and one received a score of "Confidence in Reported Results." PIPs have areas needing improvements including presenting the findings clearly and the lack of improvement in rates *Corrective Action: Correct the specific errors identified in the performance improvement projects.*

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. 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					Magnolia's appeal process for CAN members described in Policy MS.UM.08 Appeal of UM Decisions, indicated on the Magnolia CAN website, and communicated in the *CAN Provider Manual* and *CAN Member Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Refer to *42 CFR § 438.400 (b)* for the definitions of appeal terminology. The following documents use the term "action" or "adverse decision" instead of "adverse benefit determination." •Pages 1, 2, 3, 5, 8, 10, and 11 of the CAN Policy MS.UM.08, Appeal of UM Decisions ("action") and pages 1, 2, 5, 7, and 11; ("adverse decision") •Pages 51 and 52 of the *CAN Provider Manual* *Corrective Action: Update the Provider Manual (Draft 2018) and Policy MS.UM.08 to use the correct term of "adverse benefit determination" instead of "action" or "adverse decision."*
1.2 The procedure for filing an appeal;		X				Instructions for filing an appeal are listed in Policy MS.UM.08, Appeal of UM Decisions, the *CAN Member Handbook*, *CAN Provider Manual*, and on the Magnolia website. CCME identified the following issues with instructions for filing an appeal: •Pages 1 through 5 of the Policy MS.UM.08, Appeal of UM Decisions, indicates members can file an appeal request within 30 days. The *CAN Contract, Exhibit D* allows 60 days for a member to file an appeal. •The instructions on the provider section of the CAN website do not indicate written permission from the member is required for the provider to file an appeal on the member's behalf. •The member section of the CAN website states "Magnolia will include a form with the Adverse Benefit Determination letter", but it does not clearly indicate the purpose of the form. During onsite discussion. Magnolia staff reported Policy MS.UM.08, Appeal of UM Decisions, was updated and that the most recent version will be forwarded to CCME. An updated policy was not received. *Corrective Action: Update Policy MS.UM.08, Appeal of UM Decisions, to define the correct timeframe for members to file an appeal. Update the provider section of the CAN website to indicate written permission from the member is required for the provider to file an appeal on the member's behalf.* *Recommendation: Update the member section of the CAN website to include instructions for the use of the form which is included with the Adverse Benefit Determination letter.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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				Standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt as documented in Adverse Benefit Determination letter templates, Policy MS.UM.08, Appeal of UM Decisions, the *CAN Member Handbook*, the *CAN Provider Manual*, and on Magnolia's CAN website. The Appeal Acknowledgement Letter template does not define timeframes for appeal resolutions. CCME identified the following omitted language for appeal resolution timeframes, as specified in the *CAN Contract, Exhibit D*: •For a standard appeal extension requested by the plan, page 3 of the Policy MS.UM.08, Appeal of UM Decisions, does not indicate Magnolia will give the member written notice of the extension and the reason for the extension within 2 calendar days. •Page 52 of the *CAN Provider Manual*, and page 68 of the *CAN Member Handbook* do not indicate Magnolia will make reasonable efforts to provide and document verbal notice of an expedited appeal resolution. *Recommendation: Update the Appeal Acknowledgement Letter template to include appeal resolution timeframes.* *Corrective Action: Update Policy MS.UM.08, Appeal of UM Decisions, to indicate Magnolia will give the member written notice of a plan-requested extension and the reason for the extension within 2 calendar days. Update the CAN Provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Manual and CAN Member Handbook to indicate Magnolia will make reasonable efforts to provide and document verbal notice of an expedited appeal resolution.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				Appeal files reflect required acknowledgements, appropriate physician reviewers, and timely resolutions and notifications. However, 5 files indicate the beginning of the appeals response time starts when Magnolia receives signed Authorized Representative Form (ARF) from the member. During the onsite, Magnolia staff indicated the appeal process begins when a signed ARF is received from the member and not when the appeal request is received from the provider. This practice is not consistent with page 4 of Policy MS. UM.08, Appeal of UM Decisions, *42 CFR § 438.408 (b)(2)*, and the *CAN Contract Section C* and *Exhibit D*. *Corrective action: Ensure staff are applying appeals policies and procedures to reflect the timeframe for appeal resolution begins with receipt of the appeal request, as required in 42 CFR § 438.408 (b)(2), the CAN Contract Section C and Exhibit D, and Policy MS.UM.08.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeal results for medical and behavioral health are tracked, trended, analyzed, and reported to the Quality Improvement Committee (QIC) quarterly as described in Policy MS.UM.08, Appeal of UM Decisions. Annual results were reported during the QIC meeting in February 2018. Interventions were created to address identified barriers and several recommendations were made.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. B Care Management						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO assess the varying needs and different levels of care management needs of its member population.	X					Policy MS.CM.01, Care Management Program and Program Description, defines the Care Management program including but not limited to, medical services, behavioral health/substance use disorder services, hospital discharge planning, and social services. The Care Management Program Description describes the program goals, objectives, lines of responsibility, and operations provided by Centene and Magnolia. The Program Description lists and describes the levels of care management as Low, Moderate, High Complex, and High Transitional Care. The Care Management Program is communicated in the *CAN Member Handbook* and the *CAN Provider Manual*.
2. The CCO uses varying sources to identify and evaluate members' needs for care management.	X					Policy MS.CM.01, Care Management Program and Program Description, lists sources used to identify and risk stratify members for Care Management such as predictive modeling, reviewing administrative and UM data, referral sources, and health risk screenings. Identification of members for behavioral health services and high-risk pregnancy needs are also described.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					The Care Management Program Description notes member outreach is initiated by phone as early as possible, but in all cases within 30 days of identification as potential candidates for Complex Case Management. Based on results from the initial screening, the Care Manager completes a Health Risk Assessment (HRA) no later than 30 days of referral for members identified in High, Moderate, and Low risk levels.
4. The detailed health risk assessment includes:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					

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					The CAN Program Description addresses the time frame for completing treatment plans as within 30 days of the HRA and notes the Care Management teams may include, but are not limited to, Care Managers, Program Coordinators, and Behavioral Health Specialists. Sampled files reflect qualified professionals complete HRAs via telephone or in person visits.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Sampled files indicate HRAs are completed within a 30-day timeframe and updated appropriately.
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high-risk and medium risk categories are assigned to a specific Care Management Team member and provided instructions on how to contract their assigned team;						
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the member requests otherwise;						
7.3 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health and those identified through EPSDT;						
7.4 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.5 Monitoring and treatment of members with ongoing medical conditions according to appropriate standards of medical practice;						
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.7 Coordination of discharge planning;						
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;						
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;						
7.11 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						
7.14 The Contractor must produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The member and/or authorized family member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					CAN Members assigned to the medium risk level receive all services provided to members in the low risk level as outlined in the *Care Management Program Description*. The criteria used for assigning members to risk levels and services provided are clearly described.
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					The *Care Management Program Description* appropriately describes the assessment process for and the services provided to high-risk pregnant members. Magnolia Care Managers collaborate with Mississippi State Department of Health (MSDH), who implements the Perinatal High-risk Management/Infant Services System (PHRM/ISS), to provide case management services for high-risk pregnant members.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Page 17 of the *Care Management Program Description* indicates 6 months of claims history, case management history, and other pertinent information must be forwarded to DOM when a member disenrolls from the health plan. Page 2 of the Policy MS.UM.24, Continuity and Coordination of Services, provides instructions for when a member terminates from the plan and describes the role of the Integrated Care Team (ICT) designee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy MS.CM.02, Disease Management Programs, clearly describes the purpose of the disease management program and the key components. Magnolia delegates management of asthma, diabetes, hypertension, obesity (weight management), and congestive heart failure to Envolve People Care Disease Management and retains disease management for organ transplants and high-risk pregnancy. Disease management processes were adequately noted during the case management file review.
V C. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and other service providers.	X					
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					Policy MS.CM.99, Transitional Care Management Process, describes transition of care services for new members and for members moving from an inpatient setting or psychiatric residential treatment facility (PRTF) back to the member's home or other community setting.
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					Policy MS.CM.99, Transitional Care Management Process, indicates an interdisciplinary transition of care team provides oversight and management of care processes. When applicable, appropriate transitional care staff, such as nurses, pharmacists, and medical and behavioral health team members were identified during the case management file review.

CCME CHIP Data Collection Tool

Plan Name:	**Magnolia Health Plan CHIP**
Review Performed:	2018

I. MANAGEMENT INFORMATION SYSTEMS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. Information Systems Capabilities Assessment (ISCA)						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia's ISCA documentation indicates numerous internal audits are conducted to ensure the quality and accuracy of claims. The materials also indicate claims are monitored by an internal "Claims Operations Management" team on a daily and monthly basis to ensure compliance with the following benchmarks: •100% of clean claims finalized to a paid or denied status within 30 calendar days from receipt •99% of non-clean claims finalized to a paid or denied status within 60 calendar days from receipt •100% of all claims, including adjustments, processed and paid within 90 calendar days from receipt The documentation indicates Magnolia uses established reasonable processes to ensure accurate and timely claims handling; however, this could not be verified because Magnolia did not submit actual per-month clean claim payment statistics/reports.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia uses the member IDs included in the State's 834 files to uniquely identify enrollees and uses reports to identify duplicate members. If duplicates are found, Magnolia merges the duplicate records and retains the membership history. According to Magnolia, newborns are correlated with existing Medicaid members using reports generated by its inpatient authorization system. That same reporting process is used to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						track newborn enrollment. Finally, ISCA documentation indicates Magnolia monitors member, claims, and encounter data stored within aggregate systems and can provide that data to the state for tracking purposes.
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					ISCA documentation indicates that Magnolia collects and stores the data required to generate state-required reports. These indications are reinforced by a recent audit performed by Attest Health Care Advisors that evaluated Magnolia's HEDIS standards, policies, and procedures. The audit found Magnolia met all the required HEDIS standards.
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 supplied a business continuity and recovery response plan that included detailed vendor information, extensive team and staff contact information, and clear, understandable response processes. Additionally, Magnolia also supplied a management summary of DR tests that were executed in June 2017 and August 2017. The DR management summary reports successful recovery of datacenter infrastructure, health plan systems, and telecommunications systems. The provider also noted, "Gaps and problem logs were recorded for follow-up in ServiceNow while the exercise was in progress and an owner was assigned to be responsible for tracking and resolving issues."

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				Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, defines the process for conducting the functions of practitioner selection and retention. The policy is detailed and includes state requirements for MS in footnotes and in Attachment B of the document. However, page 23 of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy and Attachment B do not specify the Medicaid MS Sanctioned Provider List as a query requirement. *Corrective Action Plan: Update Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to include the Medicaid MS Sanctioned Provider List as a query requirement.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.		X				The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. Additional voting members of the committee include the Vice President of Medical Affairs, two Magnolia Medical Directors four participating providers with the specialties of pediatrics, family medicine, and psychiatry. The committee membership also includes one nurse practitioner. The committee meets monthly and a quorum is met with 50% of voting members in attendance. Committee minutes show a quorum is established at each meeting. Policy CC.CRED.03, Credentialing Committee, defines the Credentialing Committee procedures and states the QIC oversees the plan Credentialing Committee. The QIC is the vehicle through which credentialing, monitoring and reporting mechanisms are communicated to the Board of Directors. The policy states credentialing of behavioral health practitioners, including the Credentialing Committee, has been delegated to Envolve (formerly known as Cenpatico). However, onsite discussion confirmed that for MS, behavioral health credentialing is no longer delegated to Envolve. *Corrective Action Plan: Update Policy CC.CRED.03, Credentialing Committee, to reflect that for MS, behavioral health is not delegated to Envolve.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized; however, several issues are discussed in the following section. It was also noted that for nurse practitioners acting as PCPs, Magnolia collects information regarding collaborating physicians but does not collect the nursing protocols or collaborative agreements. CCME informed Magnolia they should be collecting the nursing protocols or collaborative agreements. The two behavioral health files received for credentialing had inconsistent information on the checklist that displays documents reviewed. One file showed item 29 "Miscellaneous:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						OIG CN" as a category instead of displaying the various queries documented on the OIG CN query sheet and the other file checklist showed the category as "OIG Compliance Now Screening" with specific queries listed (SSDMF, etc.). Magnolia needs to ensure the checklist displays <u>all</u> the required queries performed by OIG Compliance Now. *Recommendation: Ensure collaborative agreements or protocols are collected for all nurse practitioners/physician assistants acting as PCPs at credentialing. The behavioral health credentialing file checklist should reflect a listing of all required queries being performed by the plan or OIG Compliance Now.*
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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			Evidence of query of the Medicaid MS Sanctioned Provider List was not in the credentialing files reviewed. Onsite discussion confirmed this list is not being queried. *Corrective Action Plan: Ensure the Medicaid MS Sanctioned Provider List is queried at credentialing and proof of query is in the credentialing files.*
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 Query of the Social Security Administration's Death Master File (SSDMF)	X					The Magnolia credentialing files reviewed contained appropriate documentation. The Cenpatico behavioral health credentialing files contained proof of query of the SSDMF through searches performed via OIG Compliance NOW, LLC. Magnolia indicated during onsite discussion that the SSDMF is included in the search and provided a page from the contract showing a listing of searchable items. A copy of an OIG Compliance Now search specific to each behavioral health provider was in the credentialing files showing the Social Security number was searched.
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.13 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	
3.1.14 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					
3.1.15 Ownership Disclosure Form.	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Policy CC.CRED.05, Practitioner Office Site Review, defines the process of conducting provider office site visits regarding member complaints, and Attachment B (Magnolia Unique Site Visits Requirements) refers to Policy MS.CONT.03 for site visits relating to new provider contracts. However, Policy CC.CRED.05 has a statement that Cenpatico Behavioral Health monitors site visits for behavioral health in accordance with Policy CC.CRED.12, Oversight of Delegated Credentialing. Onsite discussion confirmed that behavioral health credentialing is no longer delegated to Cenpatico. Policy MS.CONT.03, Site Assessments for New Provider Contracts, states initial visits to the office of all new potential primary care practitioners, OB/GYNs, cardiologists and newly designated RHCs and FQHCs are conducted prior to making the credentialing decision for that provider. Magnolia provided a work process document for Policy MS.CONT.03 and it states that once the Site Evaluation tool is completed, the Contract Audit Specialist will e-mail the Site Evaluation tool to the Credentialing team. However, provider office site visits were not included with the credentialing files received for the EQR desk review. The information was again requested for the onsite and CCME received copies of only three provider office site reviews. Magnolia indicated they were unable to locate where site evaluations prior to 2014 were documented. CCME received a spreadsheet showing some site visit tracking, but it does not appear that Magnolia tracks the final score or documents site evaluation outcomes in credentialing files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Update Policy CC.CRED.05, Practitioner Office Site Review, to remove incorrect language regarding behavioral health being delegated to Cenpatico. Review the provider office site review process to ensure all site reviews are being conducted in accordance with Policy MS.CONT.03. Ensure evidence of the provider office site reviews is included in the credentialing files.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files were organized; however, several issues are discussed in the following section. It was also noted that for nurse practitioners acting as PCPs, Magnolia collects information regarding collaborating physicians but does not collect the nursing protocols or collaborative agreements. CCME informed Magnolia they should be collecting the nursing protocols or collaborative agreements. Of the two recredentialing behavioral health files received, one file reflected a query for OIG Compliance Now but the checklist did not specify which queries had been performed. It only showed "#29 Miscellaneous: OIGCN". There was no indication on the checklist of the queries for SSDMF, etc. *Recommendation: Ensure collaborative agreements or protocols are collected for all nurse practitioners/physician assistants acting as PCPs at credentialing. The behavioral health credentialing file checklist should reflect a listing of all required queries being performed by the plan or OIG Compliance Now and proof of queries should be in the files.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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			Evidence of query of the Medicaid MS Sanctioned Provider List was not in the recredentialing files reviewed. Onsite discussion confirmed this list is not being queried by the plan. *Corrective Action Plan: Ensure the Medicaid MS Sanctioned Provider List is queried at recredentialing and proof of query is in the recredentialing files.*
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 Query of the Social Security Administration's Death Master File (SSDMF);	X					One recredentialing behavioral health file did not contain proof an OIG Compliance Now check had been performed and there was no evidence of query for the SSDMF. *Recommendation: Ensure all recredentialing files contain proof of query of the SSDMF.*
4.2.11 Query of the National Plan and Provider Enumeration (NPPES);	X					One recredentialing behavioral health file did not contain proof of query of the NPPES even though the checklist indicated the search had been performed. *Recommendation: Ensure all recredentialing files contain proof of query of the NPPES.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 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					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 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					
4.4 Review of practitioner profiling activities.	X					
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 CC.CRED.07, Practitioner Disciplinary Action and Reporting, states the plan may implement practitioner disciplinary actions, up to and including suspension, restriction, or termination of a practitioner's participation status with the plan network, based on non-compliance with minimum administrative credentialing requirements or if imminent harm to patient health, fraud, or malfeasance is suspected. The process ensures participating practitioners are treated equitably, that any actions taken against a practitioner for quality reasons are reported to the appropriate authorities, and the practitioner is offered a formal appeal process (see 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			Policy CC.CRED.09, Organizational Assessment and Reassessment, defines the process for conducting the functions of provider selection and retention of organizational providers. The policy defines provider types and processes for assessing compliance to the credentialing and recredentialing requirements. Attachment E of the policy does not address the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						need to query the Medicaid MS Sanctioned Provider List and evidence of query of the Medicaid MS Sanctioned Provider List was not in the organizational files reviewed. Onsite discussion confirmed this list is not being queried by the plan. The organizational file review reflected the following additional issues: •One credentialing file did not have proof of the OIG query and the application did not have a date by the signature. •One recredentialing file did not have proof of malpractice insurance. •Only received a copy of the second page of the ownership disclosure form in two recredentialing files. *Corrective Action Plan: Update Policy CC.CRED.09, Attachment E to include the Medicaid MS Sanctioned Provider List is queried at credentialing and recredentialing for organizational providers and proof of query is in the files. Ensure organizational files contain appropriate documentation such as complete copy of the Ownership Disclosure Form, proof of malpractice insurance, proof of OIG query, and the date the application is signed.*
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.09, Verification of Member Eligibility, states the plan will notify the PCP for members assigned to them within five business days of receipt of the Enrollee Listing Report from DOM. The Provider Relations team, or their designee, will ensure PCPs are notified of the members assigned to them via surface mail, web portal, or by telephone. If a notification is provided via web portal, the plan will confirm that the PCP acknowledges receipt of the list of members assigned to the PCP.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MS.PRVR.09, Verification of Member Eligibility, states all providers may contact the toll-free telephone number printed on the member's Plan ID card and utilize the plan's interactive voice response (IVR) system, available 24 hours a day, seven

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						days a week to verify member eligibility. The IVR is updated daily. In addition, all providers may contact the toll-free telephone number printed on the member's Plan ID card to speak with a Plan Provider Services Representative during normal business hours to verify member eligibility.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					The *Provider Manual* addresses member panel capacity and the importance of contacting Magnolia if the practice wants to make a change to its defined provider panel. Magnolia tracks limitations on panel size and the *Provider Directory* search option on the website has an option for selecting providers that are 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					Policy MS.QI.04, Evaluation of Practitioner Availability, states Magnolia assesses the availability of PCPs within the health care deliver-service area. The established standards defined in the policy for the geographic distribution comply with contract guidelines and GEO access reports received match defined parameters. The *Magnolia Health Medicaid and CHIP Availability of Practitioners Analysis – 2018* report shows availability goals were met 100% for primary care providers.
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 that comply with contract requirements. GEO Access reports received for CHIP followed contract requirements.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Policy MS.QI.04, Evaluation of Practitioner Availability, states, practitioner type and availability is measured quarterly.
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					Policy MS.QI.04, Evaluation of Practitioner Availability, states 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MS.QI.22, Cultural Competency, states, Magnolia has a comprehensive linguistic and cultural competency plan describing how it will meet the linguistic and cultural needs of their Members. Staff training is held on an as-needed basis, and subcontractors and providers receive training through quarterly provider trainings or onsite visits upon request.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					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. At least annually, Magnolia analyzes appointment accessibility including routine, urgent, and after-hours care against the standards it has defined. The *Annual QI Program Evaluation MSCHIP 2017* showed Medicaid primary care routine appointments measured through the CAHPS Member Satisfaction Survey as meeting the 75th percentile goal (results at 90.91%, 78th percentile); primary care urgent appointments not meeting goal (95.52%, 62nd percentile); and the telephone survey for primary care after-hours care not meeting goal with only 58% of providers having an acceptable method of providing after-hours access for members. Barriers and interventions were discussed in the report. Onsite discussion confirmed that Magnolia recognized the need to do a telephone survey to assess appointment availability to identify which providers were noncompliant. They implemented telephone surveys in Quarter 2, 2018 and will assess the data and develop interventions.
II C. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.	X					A Provider Satisfaction Survey validation was performed using a validation worksheet based on the *CMS Survey Validation Protocol*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The initial sample had a low response rate (10.0%) and the latter sample had a response rate of 34.7%. This is just slightly below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey. The complete worksheet is available as an attachment in this report. *Recommendation: Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The survey results were analyzed by the Plan. As a result, the plan developed a focus group to improve provider satisfaction.
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 in October 2017, and discussion continued in the December QIC meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. 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 generalizability of the survey results is difficult to discern due to low response rate. The response rates were: •Child survey—20% •Children with chronic conditions survey—22% (total sample) and 20% (general population) Recommendation: Focus on strategies that would help increase response rates. Set internal response rate goals (such as receiving a 2% increase over the previous year's response

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 August 2017 and discussed again in April 2018.
3. The CCO reports the results of the member satisfaction survey to providers.	X					Survey results were reported to providers in the 2018 Winter Provider Newsletter.
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					QIC minutes for April 2018 reflect the documentation was provided regarding the response rates and general results. A work plan based on the results was provided.
III B. 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 Complaints Process, defines requirements and processes for receiving, handling, and responding to member requests for complaints and grievances.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;	X					The following documents appropriately define grievance terminology and who can file a grievance: •Policy MS.MBRS.07.01, Member Grievance and Complaints Process •*CHIP Member Handbook* •*CHIP Provider Manual* •CHIP website
1.2 The procedure for filing and handling a complaint/grievance;		X				Onsite discussion confirmed grievances can be filed at any time, as stated in the draft *CHIP Provider Manual*. The following documents incorrectly state the timeframe is within 45 calendar days of the incident causing the dissatisfaction: •Policy MS.MBRS.07.01, Member Grievance and Complaints Process •*CHIP Member Handbook* •CHIP website *Corrective Action: Correct the timeframe to file a grievance in Policy MS.MBRS.07.01, the CHIP Member Handbook, and on Magnolia's CHIP website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;	X					Onsite discussion confirmed the grievance resolution timeframe is within 30 calendar days of receipt of the grievance, as stated in the *CHIP Member Handbook*, draft *CHIP Provider Manual*, and the CHIP website. Policy MS.MBRS.07.01, Member Grievance and Complaints Process, however, defines three levels of grievance review and incorrectly states the resolution timeframe is within 15 calendar days of the receipt date. Onsite discussion revealed the policy is in the process of being updated with correct information. *Recommendation: Update Policy MS.MBRS.07.01 to remove the three-level grievance review process and ensure the grievance resolution timeframe is corrected.*
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 states individuals who make decisions on grievances are not involved in any previous level of review or decision making, and healthcare professionals with appropriate clinical expertise make decisions on grievances that involve clinical issues. Grievances that involve potential clinical or quality of care issues are referred to the Quality Improvement Department for review and investigation by appropriate clinical staff.
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					
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					CCME's review of 19 CHIP grievance files revealed the following: •One resolution letter was dated prior to the date of investigation documented in the notes •Two files had insufficient documentation regarding the services for which the member was being billed, resulting in the inability to determine if the resolution was appropriate *Recommendation: Ensure resolution letters are dated appropriately. Ensure grievance files contain enough documentation of the grievance and/or investigation findings to verify resolution is correct.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The 2018 CHIP *Quality Assessment and* ***Performance Improvement Program Description*** confirms grievances related to quality of care and service are tracked, classified according to severity, reviewed by the Chief Medical Director, categorized by the QI Department, and reported and analyzed on a routine basis by the QIC. The QIC then recommends specific physician/provider improvement activities. In addition, all administrative member grievance data are tracked and reported to/analyzed by the QIC at least quarterly to identify trends and to recommend performance improvement activities as appropriate. CCME's review of QIC minutes confirms the routine presentation, review, and discussion of grievance data. According to page 11 of the 2018 CHIP *Quality Assessment and Performance Improvement Program Description,* the Performance Improvement Team (PIT) reviews grievance statistics and makes recommendations to the Grievance and Appeals team regarding interventions for improvement or educational opportunities. However, CCME's review of PIT minutes did not reflect this. There was no indication of review or discussion of grievance data reflected in the minutes. Onsite discussion revealed the information is reported to a QIC subcommittee and not the PIT. *Recommendation: Remove the erroneous information regarding reporting grievance data to the PIT from the 2018 CHIP Quality Assessment and Performance Improvement Program Description.*
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV B. 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					For CHIP, Magnolia submitted four projects for review. As per the contract, a PIP regarding obesity should be selected annually for continuous evaluation. The topics Magnolia selected included EPSDT, Obesity for Children, Attention Deficit Hyperactivity Disorder (ADHD), and Use of Appropriate Medications for People with Asthma.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				One (25%) of the projects received a score of "Confidence in Reported Results"; 3/4=75% received a score of "High Confidence in Reported Results." The primary issues across all four PIPs were benchmark and baseline rate definitions. *Corrective Action: Correct the specific errors identified in the performance improvement projects.*

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. 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					Magnolia has an appeal process for CHIP members described in Policy MS.UM.08.01, Appeal of UM Decisions, indicated on their website and communicated in the *Provider Manual* and *Member Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Refer to *42 CFR §438.400 (b)* for definitions of appeal terminology. The following documents use the term "action" or "adverse action" instead of "adverse benefit determination": •Page 29 of the *CHIP Member Handbook* uses "adverse action" • Pages 73 through 75 of the *CHIP Provider Manual* (uses both "action" and "adverse action." *Corrective Action: Ensure the CHIP Provider Manual and the CHIP Member Handbook use current terminology.*
1.2 The procedure for filing an appeal;	X					Instructions for filing an appeal are appropriately described in Policy MS.UM.08.01, Appeal of UM Decisions, the draft *CHIP Member Handbook*, and the draft *CHIP Provider Manual*. Appeal instructions located on the provider section of the CHIP website did not indicate written permission from the member is required for the provider to file an appeal on the member's behalf, and it was difficult to locate on the website. *Recommendation: Edit the providers' section of the CHIP website to communicate that a member's consent is required for the provider to file an appeal on the member's behalf. Ensure appeals information is easily identifiable on the provider section of the CHIP website.*
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, appropriately describes individuals who can review appeals involving medical necessity.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					The process for expedited appeals is described in Policy MS.UM.08.01, Appeal of UM Decisions, the *CHIP Member Handbook,* the *CHIP Provider Manual*, and on Magnolia's CHIP website.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Standard appeals are resolved within 30 calendar days and expedited appeals are resolved within 72 hours as documented in Policy MS.UM.08.01, Appeal of UM Decisions, the CHIP *Member Handbook*, the CHIP *Provider Manual*, and the Adverse Benefit Determination letter templates. The Appeal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Acknowledgement Letter template does not define timeframes for appeal resolutions. *Recommendation: Update the Appeal Acknowledgement Letter template to include appeal resolution timeframes.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				Appeal files reflect required acknowledgements, appropriate physician reviewers, and timely resolutions and notifications. However, 2 files indicate the appeal resolution timeframe begins when Magnolia receives the signed Authorized Representative Form (ARF) from the member. During the onsite, Magnolia confirmed the appeal process begins when a signed ARF is received from the member and not when the appeal request is received from the provider. This practice is not consistent with page 3 of Policy MS. UM.08.01, Appeal of UM Decisions, and *42 CFR §438.408 (b) (2)*. *Corrective action: Ensure staff are applying appeals policies and procedures to reflect the start of the appeals process begins with receipt of an appeal request, as required in 42 CFR § 438.408 (b)(2) and Policy MS.UM.08.01, Appeal of UM Decisions.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeal results for medical and behavioral health are tracked, trended, analyzed, and reported to QIC quarterly as described in Policy MS.UM.08.01, Appeal of UM Decisions. Annual results were reported during the QIC meeting in February 2018. Interventions were created to address identified barriers and several recommendations were made.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. B Care Management						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO assess the varying needs and different levels of care management needs of its member population.	X					Policy MS.CM.01, Care Management Program and Program Description, defines the Care Management program including but not limited to, medical services, behavioral health/substance use disorder services, hospital discharge planning and, social services. The *Care Management Program Description* describes the program goals, objectives, lines of responsibility, and operations provided by Centene and Magnolia. The Program Description lists and describes the levels of care management as Low, Moderate, High Complex, and High Transitional Care. The Care Management Program is communicated in the *Member Handbook* and the *Provider Manual*.
2. The CCO uses varying sources to identify and evaluate members' needs for care management.	X					Policy MS.CM.01, Care Management Program and Program Description, and the *Provider Manual* describe various methods by which eligible members can be referred into case management. The HRA tool is primarily used to screen and identify new members. Activities such as data mining, provider or member referrals and medical management program referrals are used for ongoing identification of members for CM.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					The *Care Management Program Description* notes member outreach is initiated by phone as early as possible, but in all cases within 30 days of identification as potential addresses the assessment process for newly assigned high or medium risk level members. The *Provider Manual* gives a description of the low, moderate and high-risk levels to which a member can be assigned based on their HRA results.
4. The detailed health risk assessment includes:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.4 Member's current treatment provider and treatment plan if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments.	X					The *CHIP CM Program Description* addresses the timeframe for completing treatment plans as within 30 days of the HRA and notes the Care Management teams may include, but are not limited to, Care Managers, Program Coordinators, and Behavioral Health Specialists. Sampled files reflect qualified professionals complete HRAs via telephone or in person visits.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Sampled files indicate HRAs are completed within a 30-day timeframe and updated appropriately.
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members through the following minimum functions:	X					Magnolia uses care management techniques for CHIP members to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process as it applies to continual care, transitional care, and discharge planning.
7.1 Members in the high-risk and medium risk categories are assigned to a specific Care Management Team member and provided instructions on how to contract their assigned team;						
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the member requests otherwise;						
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;						
7.4 Documentation of referral services and medically indicated follow-up care in each member's medical record;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
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;						
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;						
7.11 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member;						
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						
7.14 The Contractor must produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The member and/or authorized family member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					CHIP members assigned to the medium risk level receive all services provided to members in the low risk level as outlined in the *Care Management Program Description*. The criteria used for assigning members to risk levels and services provided are clearly described.
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					The *Care Management Program Description* appropriately describes the assessment process for and the services provided to high-risk pregnant members. Magnolia Care Managers collaborate with Mississippi State Department of Health (MSDH), who implements the Perinatal High-risk Management/Infant Services System (PHRM/ISS), to provide case management services for high-risk pregnant members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					The *CM Program Description* indicates 6 months of claims history, case management history, and other pertinent information must be forwarded to the MS Division of Medicaid when a member disenrolls from the health plan. Policy MS.UM.24, Continuity and Coordination of Services, provides instructions for when a member terminates from the plan and the role of the Integrated Care Team (ICT) designee.
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					Policy MS.CM.02, Disease Management Programs clearly describes the purpose of the disease management program and the key components. Magnolia delegates management of asthma, diabetes, hypertension, obesity (weight management) and congestive heart failure to Envolve People Care Disease Management and retains disease management for organ transplants, and high-risk pregnancy. Disease management processes were adequately noted during the case management file review.
V C. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and other service providers.	X					
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					