2019 External Quality Review

MAGNOLIA HEALTH

Submitted: November 21, 2019

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Magnolia Health (Magnolia). This report contains a description of the process and the results of the 2019 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 were 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 two-day onsite visit, a compliance review, validation of performance improvement projects (PIPs) and performance measures, *Member Satisfaction Survey* and *Provider Satisfaction Survey* validations, and an *Information System Capabilities Assessment* (ISCA) Audit.

OVERVIEW

The 2019 EQR review of the CAN program reflects Magnolia achieved "Met" scores for 93% of the standards reviewed. As the following chart indicates, 6% of the standards were scored as "Partially Met" and 1% of the standards was scored as "Not Met." For the CHIP program, 91.4% of the standards received a "Met" score, 8.1% of the standards scored as "Partially Met," and 0.5% of the standards scored as "Not Met."

Figure 1: 2019 Annual EQR Review Results for CAN & CHIP

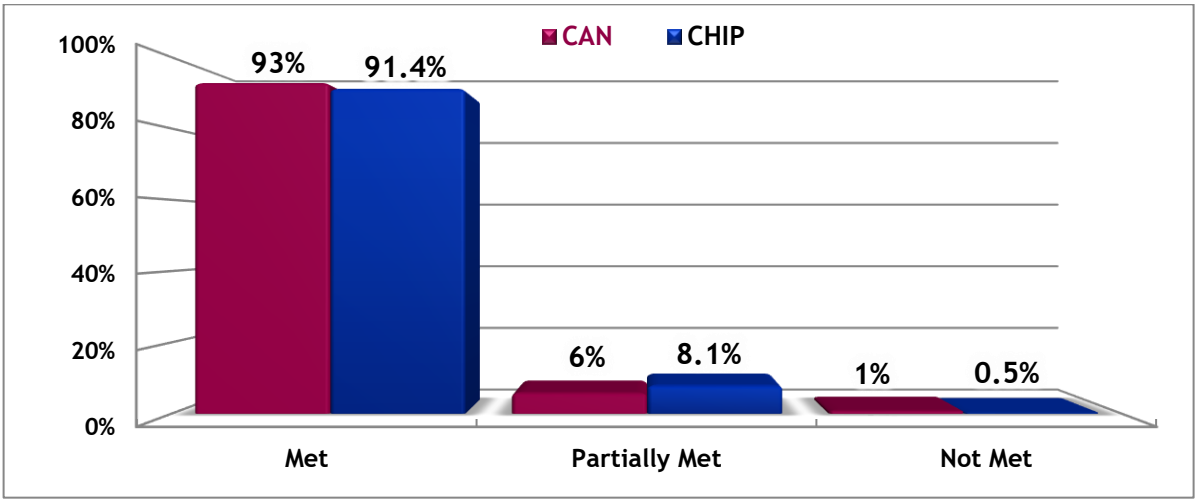


Table 1, Scoring Overview provides an overview of the scores for each review section for the CAN and the CHIP Programs.

Table 1: Scoring Overview

2019	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
CAN	30	1	0	0	0	31
CHIP	30	1	0	0	0	31
Provider Services						
CAN	80	7	0	0	0	87
CHIP	76	9	0	0	0	85
Member Services						
CAN	31	2	0	0	0	33
CHIP	28	4	0	0	0	32
Quality Improvement						
CAN	19	0	0	0	0	19
CHIP	19	0	0	0	0	19
Utilization Management						
CAN	48	3	2	0	0	53
CHIP	48	4	1	0	0	53
Delegation						
CAN	2	0	0	0	0	2

2019	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
CHIP	2	0	0	0	0	2

Overall Findings

An overview of the findings for each section is included in this Executive Summary. Details of the review, as well as specific strengths, weaknesses, any applicable corrective action items, and recommendations, are found in the respective sections of the narrative.

Administration

Policies are organized by department or functional area within the organization and are centrally housed in RSA Archer® for staff access. Policies are reviewed at least annually and more frequently as needed. CCME reminded Magnolia staff that, according to a directive from DOM, all policies and procedures should clearly indicate the line(s) of business to which they apply.

Magnolia closely monitors and reports on claims processing monthly. Magnolia did not provide exact claims statistics but documentation stated internal claims audits ensure 100% of clean claims are finalized within 30 calendar days, 99% of non-clean claims are finalized within 60 calendar days, and 100% of all claims, including adjustments, are finalized 90 calendar days from receipt. Magnolia's multi-tiered IT infrastructure is regularly maintained, frequently audited, and capable of being recovered after a disaster. Magnolia's infrastructure controls have been assessed by an independent third-party who found the infrastructure controls to be effective at controlling data access. Recent disaster recovery test results indicate Magnolia's ability to successfully recover systems and meet recovery time objectives.

Magnolia's *Compliance and Ethics Program Description* and a separate *Fraud, Waste and Abuse Plan* detail processes to guard against fraud, waste, and abuse (FWA). The corporate *Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace* defines expectations for ethical behavior for all employees of Centene Corporation and its subsidiaries. Appropriate processes are in place for training and educating staff and providers about compliance and FWA requirements, laws, and regulations. Documented processes for monitoring the exclusion status of any subcontractors and persons with an ownership or control interest or who are agents or managing employees of the health plan do not address the requirements to conduct routine checks of the Social Security Administration's Death Master File (SSDMF) and the National Plan and Provider Enumeration System (NPPES).

Provider Services

The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. The voting committee members also include the Vice President of Medical Affairs, two Magnolia Medical Directors, one participating nurse practitioner, and five participating providers with specialties in pediatrics, family medicine, and psychiatry. The committee meets monthly and a quorum of 50% of voting members in attendance was established at every meeting.

Policies define the process for conducting the functions of practitioner selection and retention for network participation, and attachments address state-specific credentialing requirements. Two policies that address provider office site review had incorrect or insufficient information regarding site reviews at initial credentialing. A review of credentialing and recredentialing files showed issues such as missing proof of query of the DOM *Sanctioned Provider List*, behavioral health files missing proof that provider profiling was considered at recredentialing, missing Clinical Laboratory Improvement Amendments (CLIA) certificate for an organizational file, and incomplete or outdated Ownership Disclosure forms.

Additional issues included updating the *Evaluation of Practitioner Availability Policy* to reflect Magnolia's established measurement goals, updating the CAN and CHIP *Provider Manuals* to correct a few issues/inconsistencies, and correcting some broken clinical practice guidelines weblinks on Magnolia's website.

Member Services

Magnolia has policies and procedures for CAN and CHIP that define and describe member rights and responsibilities as well as methods for notifying members of their rights and responsibilities. Information is included in the *Member Handbook*, *Provider Manual*, on Magnolia's website, and in member newsletters; however, CCME identified issues with documentation of member's rights and responsibilities.

Magnolia provides the toll-free contact information and descriptions for CAN and CHIP Member Services and the 24-Hour Nurse Advice Line in the *Member Handbook* and on the website and encourages members to use the services. CAN and CHIP members are also encouraged to obtain recommended preventive services (including well-child services) via the website, the *Member Handbook,* and through mailings.

Review of the grievance policies and related information in member handbooks, provider manuals, and on Magnolia's CAN and CHIP websites revealed issues such as incomplete definitions of grievance terminology, use of outdated terminology, and incomplete and incorrect information about requirements for grievance acknowledgement and grievance resolution timeframes. Issues identified in grievance resolution letters included incorrectly stating the grievance in the resolution letter and resolution letters that contained outdated information, typographical errors, incorrect dates, and incomplete

sentences. All the identified issues could result in confusion for the reader. CCME suggested implementing a quality review process for member letters to address these issues. Magnolia appropriately retains grievance and complaint data for the contractually required timeframe and uses the data for quality improvement activities.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continue to be conducted annually via a third-party vendor. Members satisfaction validation for Magnolia CAN and CHIP was performed based on the *CMS Survey Validation Protocol*. Generalizability of the survey results is difficult to discern due to low response rates and recommendations were provided to address this issue.

Quality Improvement

Magnolia has implemented a Quality Improvement (QI) Program designed to monitor and improve the clinical care and quality of services provided to CAN and CHIP members. Program descriptions were provided for the CAN, CHIP, and Behavioral Health (BH) programs. The program descriptions are reviewed, updated as needed, and presented to the Quality Improvement Committee (QIC) and to the Board of Directors (BOD) for approval at least annually. Workplans are developed to help guide and track the QI activities. The activities or scope of work on the BH workplans were identical to the CAN and CHIP and not specific to behavioral health. For example, the Performance Improvement Projects (PIPs) state at least one project is related to obesity.

Magnolia's BOD has authority, responsibility, and oversight of the Quality Program. The BOD delegates the operating authority to the QIC. This committee is responsible for implementing, monitoring, and directing the QI activities. Other committees involved in quality improvement activities include the Performance Improvement Team and the Quality Task Force.

Annually, Magnolia evaluates the effectiveness of the QI program. The *Annual Quality Improvement Program Evaluation MississippiCAN 2018* and the *Annual Quality Improvement Behavioral Health Program Evaluation 2018* were reviewed. Both program evaluations included the QI activities conducted in 2018, the results of those activities, any barriers identified, interventions, and recommendations for 2019. There were several issues identified in the program evaluations regarding analysis of coordination between providers, access and availability audit tables, appointment and afterhours accessibility monitoring, and monitoring of practitioner compliance with adopted BH guidelines.

The CAN and CHIP performance measures and PIPs met the CMS validation requirements. The CAN HEDIS performance measures comparison from the 2016 measurement year to the 2018 measurement year revealed a substantial improvement (>10%) in BMI Percentile for Children/Adolescent, Counseling for Physical Activity, HPV Vaccines, Well Child Visits in the First 15 Months of Life, and several others. The only measure with a substantial decrease in rate was Cardiovascular Monitoring for People with Cardiovascular Disease

and Schizophrenia. *Table 2: CAN HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from 2016 to 2018.

Table 2: CAN HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Substantial Increase in Rate (>10% improvement)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	45.91%	57.42%	11.51%
Counseling for Physical Activity	34.38%	47.45%	13.07%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	5.29%	20.19%	14.90%
Asthma Medication Ratio (amr)			
12-18 Years	53.94%	66.32%	12.38%
Total	51.90%	67.23%	15.33%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 40-75 years (Female)	60.00%	70.19%	10.19%
Well-Child Visits in the First 15 Months of Life (w15)			
6+ Visits	37.43%	52.45%	15.02%
Substantial Decrease in Rate (>10% decrease)			
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	79.59%	64.15%	-15.44%

All relevant CHIP HEDIS performance measures for the current review year (MY 2018) were compared to the previous year (2016). Several measures had a substantial improvement of greater than 10%. Those included: Asthma Medication Compliance, Follow up Care for Children on ADHD Medication Continuation Phase, Follow up After Hospitalization for Mental Illness, and Well-Child Visits. The measure of five Well Child Visits in the First 15 Months of Life did have a substantial decrease, but the six-plus Well Child Visits increased substantially. *Table 3: CHIP HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with substantial decreases in rate from 2016 to 2018.

Table 3: CHIP HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Substantial Increase in Rate (>10% improvement)			
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	45.45%	64.84%	19.39%
5-11 Years: Medication Compliance 75%	15.91%	32.81%	16.90%
12-18 Years: Medication Compliance 75%*	16.67%	27.03%	10.36%
Total Medication Compliance 50%	44.12%	58.51%	14.39%
Total Medication Compliance 75%	16.18%	29.88%	13.70%
Follow-up care for children prescribed ADHD Medication (add)			
Continuation and Maintenance (C&M) Phase	60.98%	71.70%	10.72%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total-30-day follow-up	55.29%	66.10%	10.81%
Total-7-day follow-up	27.06%	44.92%	17.86%
Well-Child Visits in the First 15 Months of Life (w15)			
6+ Visits	50.21%	70.02%	19.81%
Substantial Decrease in Rate (>10% decrease)			
Well-Child Visits in the First 15 Months of Life (w15)			
5 Visits	29.63%	13.79%	-15.84%

As of July 1, 2019, there are four new topics required for the CAN PIPs. The required topics are: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Magnolia submitted four PIPs and uploaded quarterly reports before the onsite visit. A PIP regarding Adult COPD was not submitted. *Table 4: CAN Performance Improvement Project Validation Scores* provides an overview of the PIPs submitted and the current validation scores for the CAN PIPs. The Asthma PIP was the only PIP that was validated for the current and previous review year since it has been active since 2016.

Table 4: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Asthma	99% High Confidence in Report Results	91/91= 100% High Confidence in Report Results
Behavioral Health Readmissions	N/A	67/72=93% High Confidence in Report Results
Improved Pregnancy Outcomes with Makena	N/A	62/62=100% High Confidence in Report Results
Sickle Cell Disease Outcomes	N/A	67/72=93% High Confidence in Report Results

As shown, four of the projects (4/4=100%) received a score of "High Confidence in Reported Results." CCME identified no corrective actions for the PIPs. There are two recommendations based on PIP validation. For the BH Readmissions PIP, the baseline results for 2018 should be added to the report. The Sickle Cell Disease report contains two typos that need to be corrected on pages A-1 (title) and A-2 (percentage).

CCME recommends that Magnolia initiate a PIP focused on Respiratory Illness Management specific to the Adult COPD population, as per DOM PIP requirements to focus on both Child-Asthma and Adult-COPD.

For CHIP, Magnolia submitted four projects for review. As per the contract, the topic of obesity should be selected annually for study, providing continuous evaluation. The Table below displays all four projects that were submitted, and their current and previous validation scores.

Table 5: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
EPSDT	95% High Confidence in Report Results	91/91=100% High Confidence in Report Results
Obesity for Children	84% Confidence in Reported Results	102/105= 97% High Confidence in Report Results
ADHD	95% High Confidence in Report Results	90/91=99% High Confidence in Report Results
Use of Appropriate Medications for People with Asthma	95% High Confidence in Report Results	91/91=100% High Confidence in Report Results

As shown, all four of the projects (4/4=100%) received a score of "High Confidence in Reported Results."

Utilization Management

CCME's assessment of utilization management (UM) includes reviews of CAN and CHIP program descriptions and evaluations, policies, *Member Handbooks, Provider Manuals*, approval, denial, appeal, and case management files, and Magnolia's website. Policies and procedures define how UM services are operationalized and provided to members.

The *UM Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Review of approval and denial files met criteria and timeframe requirements.

The CAN and CHIP *Care Management (CM) Program Description* and policies appropriately document care management processes and services provided. CAN *Policy MS.UM.05* and CHIP *Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications* omit the requirement that Magnolia must request approval from DOM to extend expedited requests beyond 24 hours. CM files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Magnolia has established policies defining processes for handling both CAN and CHIP appeals of adverse benefit determinations. Review of documentation in policies, member handbooks, provider manuals, etc. revealed numerous issues of incomplete, incorrect, and missing information about appeals processes and requirements. Several of the identified issues were identified during the 2018 EQR and appeared to be uncorrected. CCME's review of appeal files revealed only isolated issues and it appears that overall appeals are handled properly. Magnolia uses appeal data to identify opportunities to improve quality of care and service.

Delegation

Magnolia ensures all delegated organizations have written, signed agreements designating the delegated activities, reporting requirements, and compliance and oversight requirements. EPC-Cenpatico is no longer considered a delegated vendor for behavioral health because it was integrated into Centene.

Policies address processes, including pre-service audits, annual audits, quarterly oversight by committees, monthly review of delegated vendor reports, and initiation of corrective action plans when necessary, for vendor oversight and oversight of delegated credentialing entities. Proof of annual oversight was received for all national vendors and pre-service review or annual oversight was received for all entities to whom credentialing and recredentialing have been delegated. Tools were appropriate and comprehensive.

METHODOLOGY

On July 9, 2019, 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 providing Magnolia an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials CCME requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on August 8, 2019, for review at the CCME offices (see *Attachment 1*).

The second segment was a two-day onsite review conducted October 9-10, 2019, 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 and a Telephonic Provider Access Study.

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 CHIP programs are included in *Attachment 4*.

A. Administration

CCME's review of the Administration section for Magnolia focused on policies, procedures, staffing, information systems, compliance, and confidentiality for the CAN and CHIP lines of business.

Aaron Sisk is Magnolia's President and Chief Executive Officer (CEO). Sesha Mudunuri is Chief Operating Officer (COO). Magnolia's *Organizational Chart* does not reflect the reporting relationship for Member Connections staff. Magnolia provided clarification during the onsite visit and CCME recommended that Magnolia revise the *Organizational Chart* to show the reporting relationship.

Policies are organized by department or functional area within the organization, and staff can access policies through RSA Archer®, a policy maintenance and storage platform. Policies are reviewed at least annually and more frequently, if needed. CCME reminded Magnolia staff that, according to a directive from DOM, all policies and procedures should clearly indicate the line(s) of business to which they apply.

Magnolia's *Information Systems Capabilities Assessment* (ISCA) documentation indicates claims processing is closely monitored and reported monthly. Claims Operations management staff monitor claims processing to ensure compliance with contractual requirements. Although exact claims statistics were not provided, the documentation indicates internal claims audits ensure that 100% of clean claims are finalized within 30 calendar days, 99% of non-clean claims are paid or denied within 60 calendar days, and 100% of all claims, including adjustments, are processed and paid within 90 calendar days of receipt.

Magnolia's multi-tiered information technology (IT) infrastructure is maintained regularly, audited frequently, and can be recovered from a disaster. In addition to the internal efforts to validate its infrastructure, Magnolia's infrastructure controls were assessed by an independent third party, Klynveld Peat Marwick Goerdeler (KPMG), who found the infrastructure controls effective at controlling data access. The few exceptions KPMG found were reviewed and either corrected or deemed low risk and mitigated by other controls. Documentation of recent disaster recovery test results indicates the recovery efforts were completed successfully, validated by internal business units, and met the company's recovery time objectives.

Magnolia's *Compliance and Ethics Program Description* and a separate *Fraud, Waste and Abuse Plan* detail processes to guard against fraud, waste, and abuse (FWA). The corporate *Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace* defines expectations for ethical behavior for all employees of Centene Corporation and its subsidiaries. Appropriate processes are in place for training and educating staff, providers, etc. about compliance and FWA requirements, laws, and regulations. Employees and external committee members are required to sign a confidentiality

agreement annually. Magnolia encourages open communication and provides appropriate avenues for reporting potential compliance, FWA, and ethics concerns or violations. Anonymous reporting and a no-retaliation policy are in practice. Documented processes for monitoring the exclusion status of subcontractors and persons with an ownership or control interest or who are agents or managing employees of the health plan do not address the requirement to conduct routine checks of the Social Security Administration's Death Master File (SSDMF) and the National Plan and Provider Enumeration System (NPPES).

In the Administration section of the review, Magnolia received "Met" scores for 96.8% of the standards reviewed for both CAN and CHIP.

Figure 2: Administration Findings

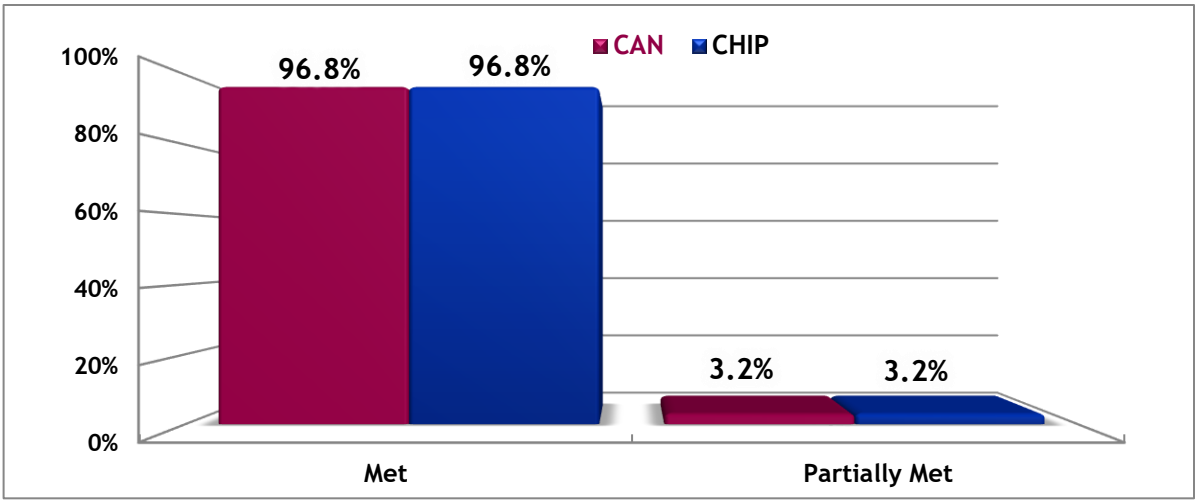


Table 6: Administration

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Compliance / Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including: Exclusion status monitoring	Partially Met	Partially Met

Strengths

- Magnolia obtains third-party Information Systems assessments, reviews the assessments, and takes action to address identified issues.

- Magnolia performs data recovery exercises that involve restoring data to a test recovery environment. Disaster recovery tests performed in this manner are preferred over tests that involve a "desktop simulation" of recovery steps.

Weaknesses

- Magnolia's *Organizational Chart* does not indicate the reporting relationship of the Member Connections staff.
- *Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening* describes processes for conducting exclusion status monitoring for employees, vendors, and Board Members. The policy does not indicate queries are conducted of the SSDMF and the NPPES. Centene contracted with an exclusion screening vendor, OIG Compliance Now, to provide this service. Review of the *OIGCN Database Sources* document, a list of exclusion data sources queried by OIG Compliance Now, does not include the SSDMF and NPPES.
- CCME noted discrepancies in documentation of Compliance Committee membership when reviewing the *Compliance and Ethics Program Description* (page 8), the *Compliance Committee Charter* revised February 2019, and the June 4, 2019 Compliance Committee meeting minutes.

Corrective Actions

- Revise *Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening* (or other applicable document) to include requirements to monitor the SSDMF and NPPES for any subcontractors and persons with an ownership or control interest or who are agents or managing employees of the CCO. Refer to *42 CFR §438.610*, the *CAN Contract, Section 1 (I)*, and *CHIP Contract, Section 1 (I)*.

Recommendations

- Revise the *Organizational Chart* to indicate the reporting relationship for Member Connections staff.
- Revise the applicable *Compliance and Ethics Program Description*, *Compliance Committee Charter*, and Compliance Committee minutes to consistently document the membership of the Compliance Committee.

B. Provider Services

CCME conducted a review of Magnolia's policies and procedures, provider training and educational materials, provider network information, credentialing and recredentialing files, practice guidelines, and the provider satisfaction survey for Provider Services.

The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. The voting committee members include the Vice President of Medical Affairs, two Magnolia

Medical Directors, one participating nurse practitioner, and five participating providers with specialties in pediatrics, family medicine, and psychiatry. The committee meets monthly and a quorum of 50% of voting members in attendance was established at each meeting.

Policies define the process for conducting the functions of practitioner selection and retention for network participation, and attachments address state-specific, unique credentialing requirements. Two policies that address provider office site review had incorrect or insufficient information regarding site reviews at initial credentialing. CCME's review of credentialing and recredentialing files showed issues such as missing proof of query of DOM's *Sanctioned Provider List*, missing proof that provider profiling was considered at recredentialing for behavioral health files, missing Clinical Laboratory Improvement Amendments (CLIA) certificate for an organizational file, and incomplete or outdated Ownership Disclosure forms.

Geo Access reports are run quarterly to assess network availability, and policies define availability and accessibility standards that comply with contract guidelines. However, *Policy MS.QI.04, Evaluation of Practitioner Availability* defines Magnolia's established measurement goals as 100% of members meeting the defined standards when reports show measurement goals are 95% compliant for Primary Care Physicians (PCPs) and 90% compliant for specialists.

New provider orientation is scheduled within 30 days of the execution of a new provider contract. The face-to-face orientation is offered to all provider office staff and attendance is documented. While both the CAN and CHIP *Provider Manuals* are detailed, a few issues that need to be corrected are discussed in the Weaknesses section of this report.

A review of the clinical practice guidelines received in the desk materials and located on the website showed some broken weblinks.

Provider Access and Availability Study

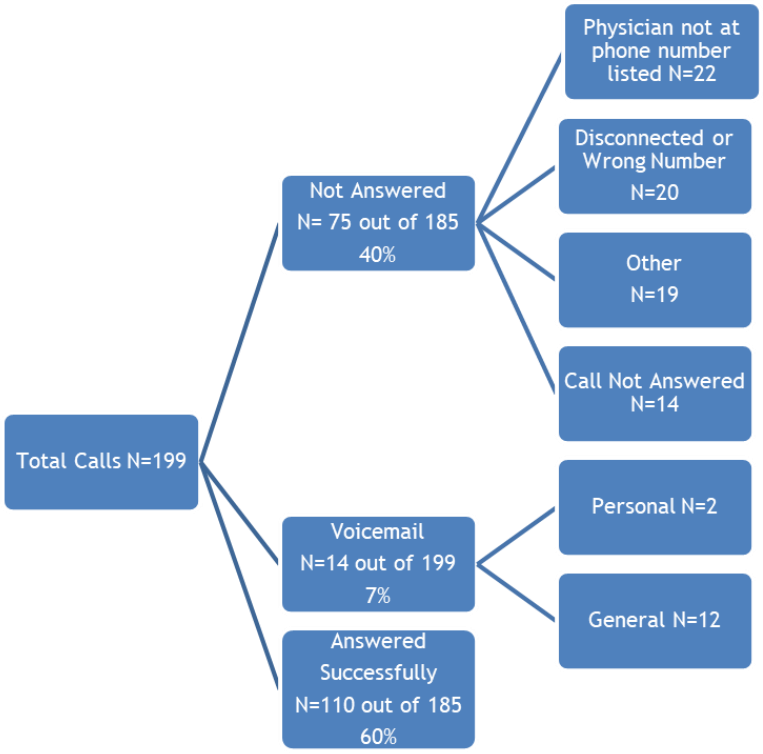
As part of the annual EQR process for Magnolia, CCME performed a Telephonic Provider Access Study for CAN and CHIP focusing on primary care providers (PCPs). CCME selected a random sample PCPs from a list of current PCPs provided by Magnolia. Attempts were made to contact these providers to ask a series of questions regarding access that members have with Magnolia's contracted providers. The results of each *Provider Access Study* are as follows

CAN Telephonic Provider Access Study Results

The Telephonic Provider Access Study for the CAN population shows improvement from the previous study's results. A modified review was conducted last year, so the most

recent access study was conducted in 2016 and had a success rate of 38% (99 of 258 calls). CCME has since adjusted the definition of successful calls. The success rate is now based on an adjusted denominator. Instead of using the total number of calls, the denominator is now the total calls made minus those answered with voicemail messages, as this is now standard for many provider offices. Given the new formula, the success rate for the 2019 Provider Access Study was 60% (110 of 185 total calls). *Figure 3: CAN Telephonic Provider Access Study Results* provides an overview of the results of the CAN Telephonic Provider Access Study.

Figure 3: CAN Telephonic Provider Access Study Results



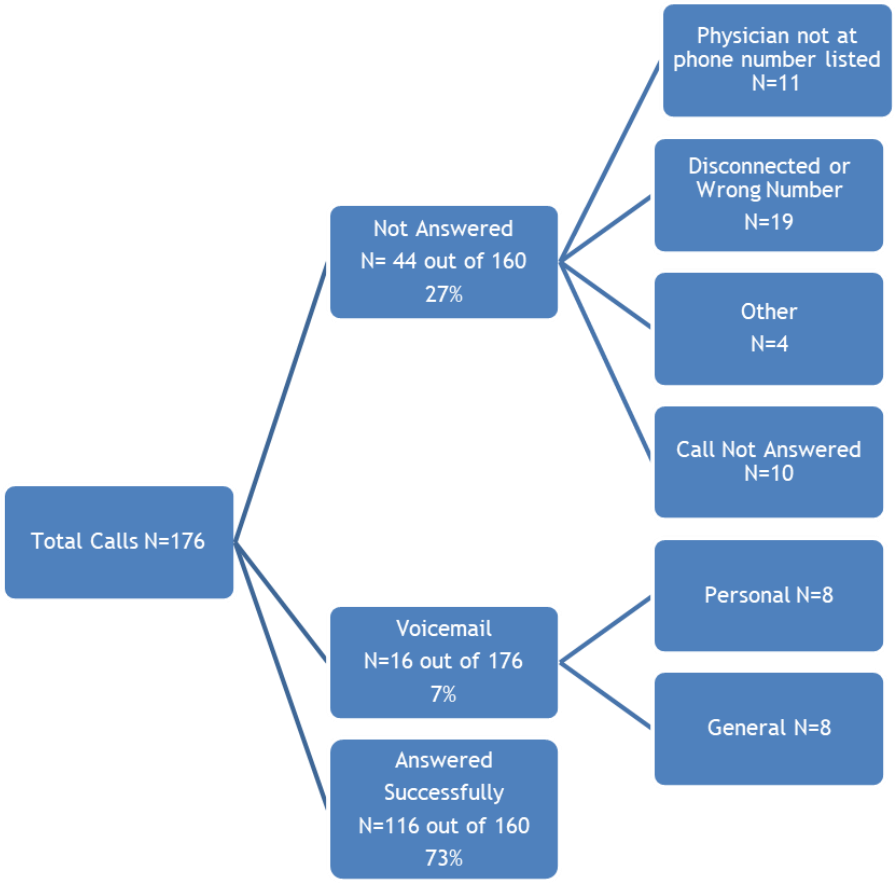
There were 199 total calls made, with 14 answered by voicemail. Of the 75 unsuccessful calls, the primary reason was that the physician was no longer at the number listed (n=22, 29%). Of the 110 providers that answered the question about whether they accept Magnolia, 48 (80%) said they accepted Magnolia. There were 49 providers that answered the question about accepting new patients, and of those 49 that answered, 47 (96%) said they do accept new Medicaid patients.

Thirty-four providers answered the question regarding prescreening requirements for new patients, and three of the 34 (9%) said they do require a prescreen. Of the three that required a prescreen for new patients, all (100%) require new patients forms, ID, and insurance cards but none of them require medical record review or an application.

CHIP Telephonic Provider Access Study Results

The CHIP Telephonic Provider Access Study shows improvement from the previous study's results. A modified review was conducted last year, so the most recent access study was conducted in 2016 and had a success rate of 39% (104 of 265 calls). CCME has since adjusted the definition of successful calls. The success rate is now based on an adjusted denominator. Instead of using the total number of calls, the denominator is now the total calls made minus those answered with voicemail messages, as this is now standard for many provider offices. Given the new formula, the success rate for the 2019 provider access study was 73% (116 of 160 total calls). The following figure provides an overview of the CHIP Provider Telephonic Access Study.

Figure 4: CHIP Telephonic Provider Survey Access Results



There were 176 total calls made, with 16 answered by voicemail. Of the 44 unsuccessful calls, the primary reason was that the number was disconnected, or it was the wrong number (n=19, 43%). Of the 101 providers that answered the question about whether they accept Magnolia CHIP, 76 (75%) said they accepted the health plan. There were 76 providers that answered the question about accepting new patients, and of those 76, 67 (88%) said they do accept new Medicaid patients.

Fifty-four providers answered the question regarding prescreening requirements for new patients, and nine of the 54 (17%) said they do require a prescreen. Of those nine that required a prescreen for new patients, one (11%) required a medical record review, five (56%) required an application, two (22%) required both, and one (11%) did not specify what was needed for the prescreen.

Provider Satisfaction Survey

As a part of this EQR, CCME validated the *Provider Satisfaction Survey* using the *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. Survey response rate was identified as an area needing improvement. *Table 7: Provider Satisfaction Survey Validation Results* reflects the section of the worksheet that needs improvement, the reason, and the recommendation. The complete worksheet is available as an attachment in this report.

Table 7: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	Initial sample using mail/internet data had a low response rate (6.2%) and the latter phone data sample had a response rate of 20.8%. This is below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.	Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.

In the Provider Services section of the review, Magnolia received "Met" scores for 92% of the standards reviewed for CAN and 89.4% of the standards for CHIP.

Figure 5: Provider Services Findings

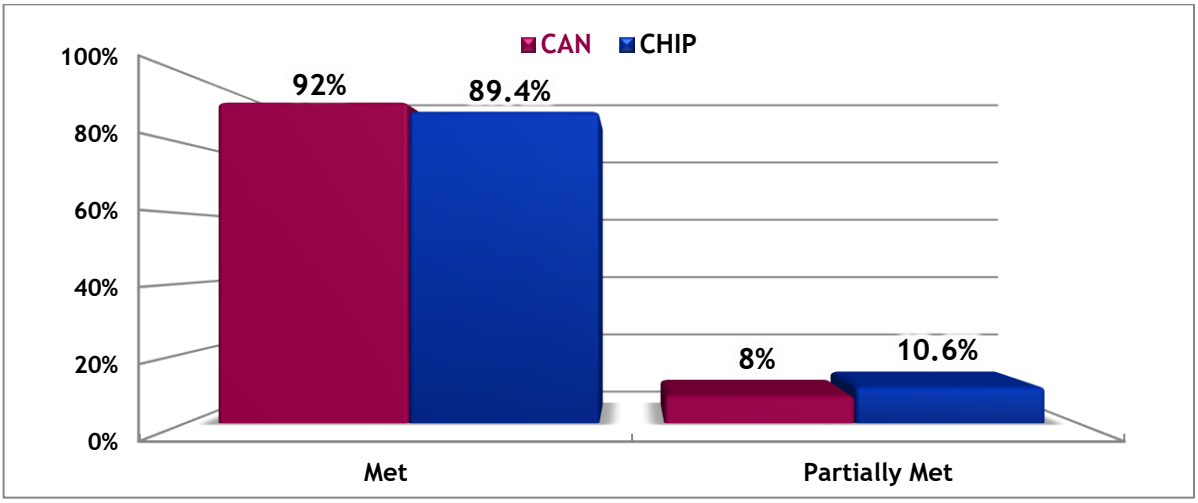


Table 8: Provider Services

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Credentialing and Recredentialing	Verification of information on the applicant, including: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	Partially Met	Partially Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	Partially Met	Partially Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	Partially Met	Partially Met
Adequacy of the Provider Network	Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	Partially Met	Partially Met
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member	Partially Met	Partially Met

Section	Standard	CAN 2019 Review	CHIP 2019 Review
	may utilize an out-of-network specialist with no benefit penalty.		
Provider Education	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	Partially Met	Partially Met
	Information regarding available translation services and how to access those services;	Met	Partially Met
Primary and Secondary Preventive Health Guidelines	The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	Met	Partially Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers and the expectation that they will be followed for CCO members.	Partially Met	Partially Met

Strengths

- The *Telephonic Provider Access Study* showed improvement from the previous rate of successfully answered calls.
- The Magnolia website is user-friendly and contains a wealth of provider resource information such as the *Provider Manuals*, practice guidelines, provider news, reference guides, training, and education.

Weaknesses

- The following weaknesses relate to the CAN and CHIP provider credentialing and recredentialing file review:
  - Nine credentialing files did not contain proof of query of the *MS DOM Sanctioned Provider List*.
  - One credentialing file did not contain a copy of the Ownership Disclosure form.
  - One organizational credentialing file for a hospice center only had a copy of an asset purchase page showing the owners, but not a copy of the Ownership Disclosure form.
  - Two recredentialing files did not contain proof of query of the *MS DOM Sanctioned Provider List*.

  - Two behavioral health files did not contain proof provider profiling was taken into consideration at recredentialing.
  - One organizational recredentialing file for a medical center did not contain proof of CLIA. Magnolia indicated that because that section was left blank on the application it assumed there was no CLIA; however, the website indicated there was a laboratory.
  - One organizational recredentialing file for a skilled nursing facility had an outdated Ownership Disclosure form that was over three years old.
  - One organizational recredentialing file for a durable medical equipment (DME) company did not have the complete Ownership Disclosure form. Only one page was obtained.
- *Policy CC.CRED.05, Practitioner Office Site Review* and *Policy MS.CONT.03, Site Assessments for New Provider Contracts* contain insufficient or incorrect information regarding provider office site visits at initial credentialing.
- *Policy MS.QI.04, Evaluation of Practitioner Availability* defines Magnolia's established standards for the geographic distribution of PCPs as 100% of members meeting the defined standards; however, reports show Magnolia measures the PCP compliance goal at 95%.
- *Policy MS.QI.04, Evaluation of Practitioner Availability* defines Magnolia's established standards for the geographic distribution of specialists as 100% of members meeting the defined standards; however, reports show Magnolia measures the specialist compliance goal at 90%.
- The telephonic appointment availability surveys for PCPs and behavioral health providers to assess urgent care, routine sick visits, and well care visits for 2018 was not reported in the *Annual Quality Improvement Program Evaluation MississippiCAN 2018 or the Annual Quality Improvement Program Evaluation Mississippi Children's Health Insurance Program 2018*.
- The following are issues or inconsistencies when comparing the benefits listed in the CAN *Provider Manual* to the CAN *Member Handbook*:
  - DME and medical supplies—the CAN *Member Handbook* states, "Covered in the member's place of residence and may require prior authorization. All medically necessary DME and medical supplies are covered for EPSDT-eligible members with prior authorization." There are no limitations listed in the CAN *Provider Manual*.
  - Enteral and Parenteral Nutrition for home use—the CAN *Member Handbook* states, "Available through pharmacy and medical benefit," and the CAN *Provider Manual* only mentions the pharmacy benefit.

- Flu and Pneumonia vaccines—the CAN *Member Handbook* states the following limitation that is not addressed in the CAN *Provider Manual*, "Limited to one each per 12 months."
- Home Healthcare Services—the CAN *Member Handbook* states, "Limited to 36 visits per benefit year. All medically necessary services are covered for EPSDT-eligible members regardless of benefit limit with prior authorization," but the CAN *Provider Manual* states, "Limited to 25 visits per benefit year."
- Neuro-Psychiatric services—the CAN *Member Handbook* states, "May require prior authorization," but there are no limitations listed in the CAN *Provider Manual*.
- Outpatient Therapy (Occupational Therapy, Physical Therapy, and Speech Therapy)—the CAN *Member Handbook* states, "Therapy in the home setting is only a covered benefit for EPSDT-eligible members," but this limit is not listed in the CAN *Provider Manual*.
- Podiatrist services—the CAN *Member Handbook* states, "Benefit limited to once every 60 days as a result of or associated with systemic condition." This conflicts with the CAN *Provider Manual* which states, "1 per year; unlimited for systemic condition."
- Prescription drugs—the CAN *Member Handbook* states, "Limit of 6 per month. EPSDT-eligible members are eligible for more prescriptions if determined to be medically necessary. Diabetic supplies and HIV medications do not count toward benefit limit;" however, the CAN *Provider Manual* states, "6 per month with no more than 2 of the 6 being brand name drugs. EPSDT-eligible members are eligible for more prescriptions if determined to be medically necessary."
- Preventive care—the CAN *Member Handbook* states, "dental exams for ages up to 21 (members should be referred to a plan participating dental provider at the eruption of the first tooth, but no later than 12 months of age)" which conflicts with the CAN *Provider Manual* statement, "dental exams for ages 2-21."
- Sleep study—the CAN *Member Handbook* lists "Outpatient only" when the CAN *Provider Manual* lists "Outpatient or home setting only."
- Stereotactic Radiosurgery—the CAN *Member Handbook* states, "Prior authorization is required," but this limit is not listed in the CAN *Provider Manual*.
- Swing bed services—the CAN *Member Handbook* states, "Covered and authorized by the DOM," but this statement in not listed in the CAN *Provider Manual*.

- The following are issues or inconsistencies when comparing the benefits listed in the CHIP *Provider Manual* to the CHIP *Member Handbook*:
  - Inpatient Services—the CHIP *Member Handbook* includes Imaging (CT, PET Scans, MRIs) and Routine Foot Care not listed in the CHIP *Provider Manual*.

- DME—the CHIP *Member Handbook* states, "May Require Prior Authorization" which is not addressed in the CHIP *Provider Manual*.
- Air Ambulance – Fixed Wing—this is a stated benefit in the CHIP *Member Handbook* but not addressed in the CHIP *Provider Manual*.
- Ambulatory Surgical Facilities—the CHIP *Member Handbook* states, "Does Not Require Prior Authorization;" however, the CHIP *Provider Manual* states on page 27, "some surgeries must be pre-authorized for medical necessity."
- Chiropractic Care—this is listed as benefit in the CHIP *Member Handbook* but not addressed in the CHIP *Provider Manual*.
- Dental Care—the CHIP *Provider Manual*, page 31 states the following that is not listed in the CHIP *Member Handbook*, "Sealants - covered up to age fourteen (14) years, every thirty six (36) months."
- Hearing Services—the CHIP *Member Handbook* states, "one hearing aid per ear is covered every three years;" however, the CHIP *Provider Manual* states, "hearing aids (limited to one [1] every three [3] years) are covered services."

- The CHIP *Provider Manual* does not provide instructions for providers about how to access translation services for members.
- The CHIP *Provider Manual* does not mention any information regarding the adoption of preventive and clinical practice guidelines, that providers should utilize the information, and where the information can be found on the website. It has, "*Appendix VI: Adopted Preventive Health Guidelines;*" however, the information is outdated, and the appendix is not listed in the Table of Contents.
- A review of the clinical practice guidelines received in the desk materials and located on the website revealed broken links to the following guidelines:
  - *2017 GINA Report, Global Strategy For Asthma Management and Prevention*. Updated 2017
  - *Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel (2013)*
  - *The Management of Sickle Cell Disease, Fourth Edition (2004)*
  - *Smoking Cessation During Pregnancy (Obstet Gynecol 2010; 116: 1241-4)*
- *Policy MS.QI.13, Medical Record Review* states an aggregate summary of medical record reviews completed are presented quarterly to Magnolia's Quality Committee; however, CCME could not find evidence the medical record review had ever been reported to the Quality Improvement Committee. Onsite discussion confirmed that only eight providers were included in the annual medical record review.
- The *Provider Satisfaction Survey* had a low initial sample response rate (6.2%) and the latter phone data sample had a response rate of 20.8 %. This is well below the

National Committee for Quality Assurance (NCQA) target response rate of 40% for surveys. The low response rate may impact the generalizability of the survey.

Corrective Actions

- Ensure credentialing files contain proof of query of the *MS DOM Sanctioned Provider List*.
- Ensure CLIAs are obtained for all organizational providers that provide laboratory services and ensure complete updated Ownership Disclosure forms are obtained.
- Update *Policy CC.CRED.05, Practitioner Office Site Review* and *Policy MS.CONT.03, Site Assessments for New Provider Contracts* to remove incorrect language and clearly address Magnolia's process for conducting provider office site visits at initial credentialing.
- Update *Policy MS.QI.04, Evaluation of Practitioner Availability* to reflect the correct geographic measurement goals for PCPs and for specialists that Magnolia uses to measure compliance.
- Update the CAN *Provider Manual* or CAN *Member Handbook* to address the benefit issues or inconsistencies.
- Update the CHIP *Provider Manual* or CHIP *Member Handbook* to address the benefit issues or inconsistencies.
- Update the CHIP *Provider Manual* to include information regarding what translation services are available and what a provider should do if a member needs translation service.
- Update the CHIP *Provider Manual* to contain information about the adoption and use of preventive health guidelines and correct or remove *Appendix VI: Adopted Preventive Health Guidelines*.
- Update the CHIP *Provider Manual* to include information about the adoption and use of clinical practice guidelines and correct or remove *Appendix VII: Clinical Practice Guidelines*.
- Correct the broken weblinks for the clinical practice guidelines listed on Magnolia's website.

Recommendations

- Ensure credentialing files contain a copy of the Ownership Disclosure form.
- Ensure proof of query of the *MS DOM Sanctioned Provider List* is included for all recredentialing files.
- Ensure behavioral health recredentialing files contain proof that provider profiling was taken into consideration at recredentialing.

- Ensure the results of the telephonic appointment availability surveys for PCPs and behavioral health providers are reported in the annual Quality Improvement program evaluations.
- Ensure results of the provider medical record review are reported to the QIC as defined in *Policy MS.QI.13, Medical Record Review*. In addition, CCME recommends conducting medical record reviews on a larger sample of providers to ensure the sample is representative of the network and providers are adhering to Magnolia's medical record standards.
- Focus on strategies that would help increase response rates for the *Provider Satisfaction Survey*. Solicit the help of the survey vendor.

C. Member Services

The review of Member Services included policies and procedures, member rights, member informational materials, grievances, grievance files, and the *Member Satisfaction Survey* for the CAN and CHIP lines of business. The member handbooks are thorough, easily understood, and meet the sixth-grade reading comprehension level required by DOM.

Magnolia's CAN and CHIP websites have quick links and resources for members to access information. CCME identified the *Member Handbook* link on the CHIP member website takes the user to a *Member Handbook* dated 2015.

The *Member Handbook* informs members about rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions for how to access benefits. CCME identified CAN and CHIP documentation issues with member rights and responsibilities and offered recommendations to address them. Additionally, the *Member Handbook* provides information on Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The *Member Handbook* is available in Spanish and alternate formats including large font, audio, and Braille.

Member Services staff are available per contract requirements via a toll-free number. Text telephone (also known as TTY 711) services are available for members with hearing impairments. Members are informed that translation services are available for calls and during appointments with providers. The toll-free Member Services telephone number routes calls to reach appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. CST., Monday through Friday. Callers also have the option to transfer to the 24-hour Nurse Advice Line. Call center functions are conducted as required by the CAN and CHIP Contracts.

Magnolia has established CAN and CHIP policies that describe Magnolia's processes for receiving, processing, and responding to member requests for informal and formal complaints and grievances. Review of the policies and related information about

complaints and grievances in member handbooks, provider manuals, and on Magnolia's CAN and CHIP websites revealed issues such as incomplete definitions of grievance terminology and use of outdated terminology (CHIP); incomplete and incorrect information about requirements for grievance acknowledgement (CAN and CHIP); and incorrect documentation of grievance resolution timeframes (CHIP).

CCME's review of CAN and CHIP grievance files revealed issues that included incorrectly stating the grievance in the resolution letter (CAN) and grievance resolution letters that contained references to an outdated three-step grievance process; typographical errors that change the meaning of the information supplied; incorrect dates; and incomplete sentences. These identified issues could result in confusion for the reader. CCME suggested implementing a quality review process for member letters to address these issues.

Member Satisfaction Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey continues to be conducted annually via a third-party vendor. Members Satisfaction validation for CAN and CHIP combined was performed based on the *CMS Survey Validation Protocol*. Generalizability of the survey results is difficult to discern due to low response rates. CCME provided recommendations to address the issues.

As noted in *Figure 6: Member Services Findings*, Magnolia CAN achieved "Met" scores for 93.9% of the standards reviewed, and 6.1% of the standards were "Partially Met." Magnolia CHIP achieved "Met" scores for 87.5% of the standards reviewed, and 12.5% were scored as "Partially Met."

Figure 6: Member Services Findings

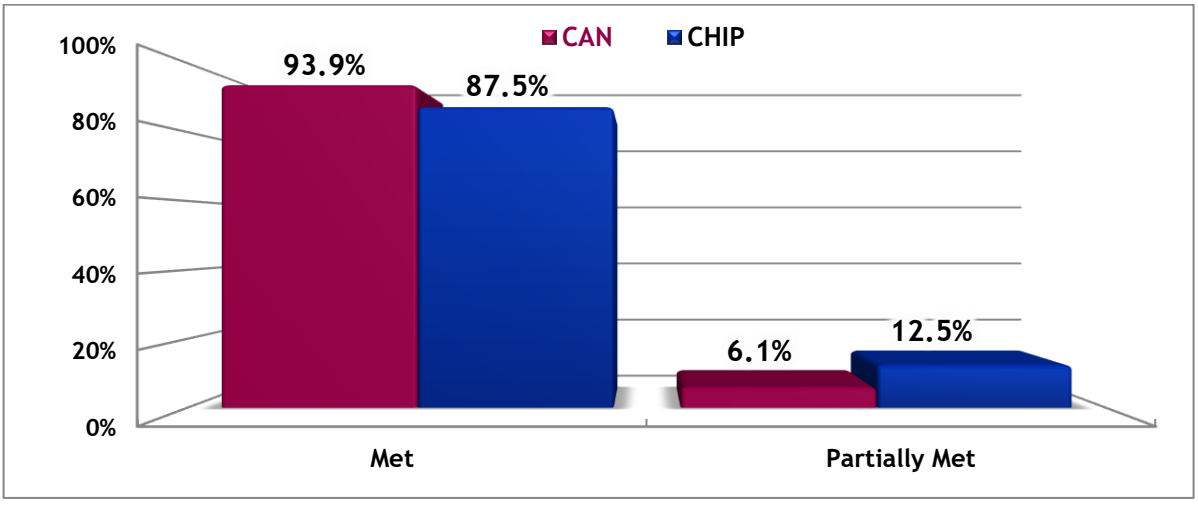


Table 9: Member Services

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Member Rights and Responsibilities	Member responsibilities include the responsibility: To show courtesy and respect to providers and staff To inform the CCO of changes in family size, address changes, or other health care coverage	Partially Met	Partially Met
Grievances	Definition of a grievance and who may file a grievance	Met	Partially Met
	The procedure for filing and handling a grievance	Partially Met	Partially Met

Strengths

- Magnolia hosts community events, such as baby showers, diaper days, member workshops, and community health fairs, for members.

Weaknesses

- The CAN and CHIP *Member Handbooks* state the member has a right to, "Be free to exercise these rights without retaliation," but fail to specify that the member will not receive adverse treatment from the health plan or providers.
- The CHIP website and page 61 of the *Member Handbook* make references to the Code of Federal Regulations (CFR) but do not provide the corresponding citation for member rights.
- Identified issues with CAN and CHIP member responsibilities:
  - Page 73 of the CAN *Member Handbook* and the CAN website do not include the responsibility to show courtesy and respect to providers and staff.
  - *Policy MS.MBRS.25, Member Rights and Responsibilities* and the CAN website do not include the member's responsibility to notify Magnolia about changes in family size, address changes, or other health care coverage.
  - The CHIP *Member Handbook* and CHIP website do not include the member's responsibility to show courtesy and respect to providers and staff. The CHIP *Provider Manual* omitted the word "staff" from this requirement.

  - Policy MS.MBRS.25, Member Rights and Responsibilities does not state that members are responsible for informing the plan of changes in family size, address, or health coverage.
- Identified issues with grievance terminology include:
  - The definition of a grievance on page 54 of the CHIP *Member Handbook* is incomplete; it does not include "other than an adverse benefit determination."
  - The definition of a grievance on page 62 of the CHIP *Provider Manual* uses the term "action" rather than the correct term of "adverse benefit determination."
- CAN *Policy MS.MBRS.07, Member Grievance and Complaints Process* states oral and written grievances must be acknowledged in writing within five calendar days of the receipt of the grievance. Written acknowledgement for oral grievances is not addressed in the CAN *Member Handbook*, CAN *Provider Manual*, and Magnolia Medicaid website.
- CHIP *Policy MS.MBRS.07.01, Member Grievance and Complaints Process* indicates written acknowledgement is required within five calendar days for both oral and written grievances; however, page 55 of the CHIP *Member Handbook* and the Magnolia website (CHIP) state telephonic/in-person grievances do not require written acknowledgement.
- The Magnolia CHIP website contains the statement, "Magnolia may need to obtain additional information to review the grievance. If a signed authorization to release information form is not included with the grievance, a form will be sent for signature. If the signed form isn't returned within 30 business days of the request, Magnolia may issue a decision on the grievance without review of some or all of the information." Onsite discussion confirmed this information is incorrect and should be removed from the website.
- Page 62 of the CHIP *Provider Manual* incorrectly states the grievance resolution timeframe is "not exceeding fifteen (15) calendar days from the date of the initial receipt of the grievance."
- The CHIP *Provider Manual* does not address extensions of the grievance resolution timeframe.
- One CAN grievance resolution letter incorrectly stated the member's grievance was related to being discharged from hospice when the grievance was regarding treatment at an outpatient surgery center.
- Issues identified in the CHIP grievance resolution letters may cause confusion for the reader and include references to an outdated three-step grievance process, typographical errors that change the meaning of the information supplied, incorrect dates, and incomplete sentences.

- Information on the Care Management program was not identified on the CAN and CHIP websites.
- For both CAN and CHIP, documentation that member materials require 12-point font size, and 18-point size for large print, was not identified.
- The CAN and CHIP *Provider Manuals* incorrectly state the toll-free Provider Relations call center is maintained Monday - Friday from 8:00 am to 5:00 pm.
- For both CAN and CHIP, generalizability of the *CAHPS* survey results is difficult to discern due to low response rates.
- For CAN and CHIP, the process used to follow-up on PCP change requests related to member dissatisfaction is not documented.
- The link to the *Member Handbook* on the CHIP member website accesses a 2015 *Member Handbook*.
- For CHIP, *Policy MS.ELIG.05, Disenrollment* does not specify the timeframe to notify DOM of members identified with a pregnancy diagnosis.

Corrective Actions

- Correct the definition of a grievance on page 54 of the CHIP *Member Handbook*.
- Revise the definition of a grievance on page 62 of the CHIP *Provider Manual* to use current terminology.
- Include in the CAN *Member Handbook*, CAN *Provider Manual*, and Magnolia's website that oral grievances require written acknowledgement and the timeframe for the written acknowledgement.
- Update page 55 of the CHIP *Member Handbook* and Magnolia's CHIP website to indicate written acknowledgement is required for telephonic/in-person grievances, as required by *Policy MS.MBRS.07.01*.
- Remove the following statement from the CHIP website: "Magnolia may need to obtain additional information to review the grievance. If a signed authorization to release information form is not included with the grievance, a form will be sent for signature. If the signed form isn't returned within 30 business days of the request, Magnolia may issue a decision on the grievance without review of some or all of the information."
- Correct the grievance resolution timeframe in the CHIP *Provider Manual* and include information about extensions of the grievance resolution timeframe.
- Edit page 73 of the CAN *Member Handbook* and the CAN website to include the member's responsibility to show courtesy and respect to providers and staff. Edit Policy MS.MBRS.25, Member Rights and Responsibilities to specify that members have

the responsibility to notify the plan about changes in family size, address changes, or other health care coverage. Refer to the *CAN Contract, Section 6 (J) (1)*.

- Edit page 62 in the CHIP *Member Handbook* and the CHIP website to include the member's responsibility to show courtesy and respect to providers and staff. Edit page 58 of the CHIP *Provider Manual* to include the word "staff" in this requirement. Refer to the *CHIP Contract, Section 6 (I) (1)*.

Recommendations

- Edit the CAN and CHIP *Member Handbooks* to indicate members have the right not to receive adverse treatment from the health plan or providers. Refer to *CAN Contract Section 6 (J) (g)*.
- On the CHIP website and in the CHIP *Member Handbook*, include the Code of Federal Regulations (CFR) citation when referencing the applicable federal regulations for member's rights or provide complete verbiage from the CFR.
- Ensure CAN grievance resolution letters contain correct information regarding the grievance and its resolution.
- Ensure CHIP grievance resolution letters contain correct, current dates and information, and do not contain typographical errors that change the meaning of the information. Consider implementing a quality review process for member letters.
- Include Care Management program information on the CAN and CHIP website. Refer to pages 58 and 59 in the CAN *Member Handbook* and page 48 in the CHIP *Member Handbook*.
- For both CAN and CHIP, ensure the requirements to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font size are documented. Refer to the *CAN Contract, Section 6 (F)*.
- In the CAN and CHIP *Provider Manuals*, correct the Provider Services hours to state 7:30 am to 5:30 pm CST.
- For both CAN and CHIP, continue working on interventions such as website banners and reminders on call center scripts to increase CAHPS Survey response rates.
- FOR CAN and CHIP, document the process used to follow up on PCP change requests related to member dissatisfaction in a policy or other document.
- Update the CHIP member website with the most current version of the *Member Handbook*.
- Edit *Policy MS.ELIG.05, Disenrollment* to reflect that Magnolia will notify DOM of members identified with a diagnosis related to pregnancy within seven calendar days of identification, as required in the *CHIP Contract, Section 4 (F)*.

D. Quality Improvement

The *2019 MississippiCAN Quality Program Description* and *2019 MississippiCAN Quality Behavioral Health Program Description* describe Magnolia's program to monitor and improve the clinical care and quality of services provided to members. The program descriptions are reviewed, updated as needed, and presented to the Quality Improvement Committee (QIC) and to the Board of Directors (BOD) for approval at least annually. For CHIP, Magnolia provided the *2019 Mississippi Children's Health Insurance Program Quality Program Description*. This program description describes the Quality Improvement (QI) framework Magnolia established to improve the services and health care provided to CHIP members. This program description is reviewed, updated as needed, and presented to the QIC and to the BOD for approval at least annually.

Magnolia provided the 2018 and 2019 CAN, CHIP, and Behavioral Health (BH) workplans for review. The workplans were divided into four tabs, "Committees, P&P Doc Reports, Performance Measures, and QIPI Activities." Each tab contained the goals/objectives, planned activities, responsible party, frequency, and completion date. The activities or scope of work in the BH workplans were identical to the CAN and CHIP and not specific to BH. For example, the Performance Improvement Projects (PIPs) state at least one project is related to obesity.

Magnolia's BOD has the authority, responsibility, and oversight for the Quality Program. The BOD delegates the operating authority of the QI Program to the QIC. This committee is responsible for implementing, monitoring, and directing QI activities. Other committees involved in the quality improvement activities include the Performance Improvement Team and the Quality Task Force.

The QIC is chaired by the Chief Medical Director. Members include senior leadership and participating network providers. The committee's participant roster indicates five participating providers with specialties of pediatrics, family medicine, and psychiatry, and a nurse practitioner. A minimum of five members, including three plan staff and two external physicians, must be present for a quorum.

Annually, Magnolia evaluates the effectiveness of the QI program. The *Annual Quality Improvement Program Evaluation MississippiCAN 2018* and the *Annual Quality Improvement Behavioral Health Program Evaluation 2018* was provided for review. Both program evaluations included the QI activities conducted in 2018, results of those activities, any barriers identified, interventions, and recommendations for 2019. Several issues were identified in the program evaluations regarding the analysis of the coordination between providers, the access and availability audit tables, the appointment and afterhours accessibility monitoring, and the monitoring of practitioner compliance with the adopted BH guidelines.

Policy *MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service* describes the process for monitoring and implementing interventions related to Well-Baby and Well-Child services. The product type listed on page one indicates the policy is applicable to CAN and CHIP; however, the policy does not specifically list Well-Baby and Well-Child. The policy only used the term "EPSDT." Onsite discussion indicated the process used in this policy is the same for the Well-Baby and Well-Child program.

Performance Measure Validation

As part of the EQR for Magnolia, CCME conducted a validation review of the HEDIS® performance measures following the protocols developed by CMS. This process assesses the production of these measures by the health plan to confirm reported information is valid. Magnolia was found to be fully compliant and met all the requirements for the HEDIS® measures as per the Attest Health Care Advisors report.

All relevant HEDIS performance measures for Magnolia CAN for the current review year (MY 2018), as well as the previous year (MY 2016), and the change from 2016 to 2018 are reported in *Table 10: CAN HEDIS Performance Measure Results*. The changes in rates shown in green indicate a substantial (>10%) improvement, and the rates shown in red indicate a substantial (>10%) decline.

Table 10: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	84.08%	86.86%	2.78%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	45.91%	57.42%	11.51%
Counseling for Nutrition	46.39%	51.58%	5.19%
Counseling for Physical Activity	34.38%	47.45%	13.07%
Childhood Immunization Status (cis)			
DTaP	79.33%	79.32%	-0.01%
IPV	92.07%	93.92%	1.85%
MMR	90.38%	94.16%	3.78%
HiB	88.46%	89.05%	0.59%
Hepatitis B	91.11%	93.19%	2.08%
VZV	89.90%	94.65%	4.75%
Pneumococcal Conjugate	81.25%	82.73%	1.48%
Hepatitis A	75.24%	76.40%	1.16%
Rotavirus	75.72%	80.54%	4.82%
Influenza	27.88%	32.36%	4.48%
Combination #2	75.72%	77.37%	1.65%
Combination #3	73.56%	75.18%	1.62%

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
Combination #4	61.30%	62.53%	1.23%
Combination #5	64.66%	65.94%	1.28%
Combination #6	24.52%	27.98%	3.46%
Combination #7	54.33%	55.47%	1.14%
Combination #8	22.60%	25.30%	2.70%
Combination #9	22.12%	24.82%	2.70%
Combination #10	20.43%	22.87%	2.44%
Immunizations for Adolescents (ima)			
Meningococcal	44.47%	53.77%	9.30%
Tdap/Td	73.56%	74.70%	1.14%
Combination #1	42.79%	52.07%	9.28%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	5.29%	20.19%	14.90%
Lead Screening in Children (lsc)	68.57%	71.88%	3.31%
Breast Cancer Screening (bcs)	57.57%	56.57%	-1.00%
Cervical Cancer Screening (ccs)	60.34%	56.20%	-4.14%
Chlamydia Screening in Women (chl)			
16-20 Years	48.00%	45.90%	-2.10%
21-24 Years	62.02%	61.14%	-0.88%
Total	50.86%	48.52%	-2.34%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis	59.68%	68.19%	8.51%
Appropriate Treatment for Children with URI (uri)	NR	NR	NR
Avoidance of Antibiotic Treatment in Adults with	NR	NR	NR
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.87%	30.91%	3.04%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	38.15%	41.53%	3.38%
Bronchodilator	74.01%	77.06%	3.05%
Medication Management for People with Asthma (mma)			
5-11 Years - Medication Compliance 50%	50.00%	49.43%	-0.57%
5-11 Years - Medication Compliance 75%	19.26%	23.65%	4.39%
12-18 Years - Medication Compliance 50%	46.30%	49.71%	3.41%
12-18 Years - Medication Compliance 75%	19.44%	24.04%	4.60%
19-50 Years - Medication Compliance 50%	48.15%	52.22%	4.07%
19-50 Years - Medication Compliance 75%	22.96%	25.60%	2.64%
51-64 Years - Medication Compliance 50%	61.86%	60.78%	-1.08%
51-64 Years - Medication Compliance 75%	38.14%	30.39%	-7.75%
Total - Medication Compliance 50%	49.82%	50.25%	0.43%
Total - Medication Compliance 75%	22.73%	24.25%	1.52%
Asthma Medication Ratio (amr)			

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
5-11 Years	76.28%	77.38%	1.10%
12-18 Years	53.94%	66.32%	12.38%
19-50 Years	39.06%	47.29%	8.23%
51-64 Years	40.99%	40.11%	-0.88%
Total	51.90%	67.23%	15.33%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	42.24%	45.26%	3.02%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	55.81%	58.00%	2.19%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	69.92%	73.69%	3.77%
Statin Adherence 80% - 21-75 years (Male)	43.85%	46.68%	2.83%
Received Statin Therapy - 40-75 years (Female)	60.00%	70.19%	10.19%
Statin Adherence 80% - 40-75 years (Female)	34.17%	41.99%	7.82%
Received Statin Therapy - Total	64.59%	71.95%	7.36%
Statin Adherence 80% - Total	39.02%	44.41%	5.39%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	86.16%	88.08%	1.92%
HbA1c Poor Control (>9.0%)	57.04%	47.93%	-9.11%
HbA1c Control (<8.0%)	36.99%	45.01%	8.02%
HbA1c Control (<7.0%)	NQ	NR	NA
Eye Exam (Retinal) Performed	69.45%	68.37%	-1.08%
Medical Attention for Nephropathy	91.65%	90.51%	-1.14%
Blood Pressure Control (<140/90 mm Hg)	NQ	47.45%	NA
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	NR	57.19%	NA
Statin Adherence 80%	NR	39.86%	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	NQ	NR	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	38.15%	38.76%	0.61%
Effective Continuation Phase Treatment	22.94%	23.88%	0.94%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	56.71%	57.06%	0.35%
Continuation and Maintenance (C&M) Phase	66.37%	70.50%	4.13%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	66.53%	NA
6-17 years - 7-Day Follow-Up	NR	40.24%	NA

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
18-64 years - 30-Day Follow-Up	NR	56.16%	NA
18-64 years - 7-Day Follow-Up	NR	28.15%	NA
65+ years - 30-Day Follow-Up	NR	0.00%	NA
65+ years - 7-Day Follow-Up	NR	0.00%	NA
30-Day Follow-Up	58.68%	61.92%	3.24%
7-Day Follow-Up	32.20%	34.89%	2.69%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NR	0.00%	NA
7-Day Follow-Up: 13-17 Years	NR	0.00%	NA
30-Day Follow-Up: 18+ Years	NR	5.16%	NA
7-Day Follow-Up: 18+ Years	NR	3.80%	NA
30-Day Follow-Up: Total	NR	4.74%	NA
7-Day Follow-Up: Total	NR	3.49%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	72.36%	72.45%	0.09%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	70.11%	69.47%	-0.64%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	79.59%	64.15%	-15.44%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	56.45%	57.21%	0.76%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	22.86%	24.32%	1.46%
6-11 Years	21.79%	19.25%	-2.54%
12-17 Years	25.21%	28.04%	2.83%
Total	23.70%	24.23%	0.53%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.81%	89.56%	0.75%
Digoxin	51.67%	NR	NA
Diuretics	88.57%	89.68%	1.11%
Total	88.29%	89.61%	1.32%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NQ	NR	NA
Appropriate Treatment for Children with URI (uri)	60.99%	65.20%	4.21%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.35%	32.96%	0.61%
Use of Imaging Studies for Low Back Pain (lbp)	69.11%	68.79%	-0.32%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	0.00%	NA

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
6-11 Years	0.43%	0.28%	-0.15%
12-17 Years	0.85%	0.35%	-0.50%
Total	0.65%	0.31%	-0.34%
Use of Opioids at High Dosage (uod)	NR	1.25%	NA
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	NR	17.14%	NA
Multiple Pharmacies	NR	10.85%	NA
Multiple Prescribers and Multiple Pharmacies	NR	4.68%	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	9.93%	NA
18-64 years - >=31 Days covered	NR	3.83%	NA
65+ years - >=15 Days covered	NR	50.00%*	NA
65+ years - >=31 Days covered	NR	0.00%*	NA
Total - >=15 Days covered	NR	9.94%	NA
Total - >=31 Days covered	NR	3.83%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.39%	88.17%	1.78%
45-64 Years	92.21%	92.25%	0.04%
65+ Years	84.38%	84.04%	-0.34%
Total	88.65%	89.95%	1.30%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.05%	97.82%	0.77%
25 Months - 6 Years	87.28%	91.70%	4.42%
7-11 Years	90.73%	92.74%	2.01%
12-19 Years	96.68%	90.95%	-5.73%
Annual Dental Visit (adv)			
2-3 Years	48.91%	54.89%	5.98%
4-6 Years	70.68%	76.66%	5.98%
7-10 Years	70.59%	76.52%	5.93%
11-14 Years	65.97%	72.61%	6.64%
15-18 Years	57.44%	63.52%	6.08%
19-20 Years	40.35%	45.02%	4.67%
Total	64.04%	70.10%	6.06%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NR	76.09%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NR	2.17%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NR	37.50%*	NA

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NR	0.00*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	NR	69.72%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NR	7.57%	NA
Total: Initiation of AOD Treatment: 13-17 Years	64.79%	67.26%	2.47%
Total: Engagement of AOD Treatment: 13-17 Years	4.69%	7.12%	2.43%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	NR	45.13%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	NR	4.09%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	NR	22.41%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	NR	7.73%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	NR	38.37%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NR	5.73%	NA
Total: Initiation of AOD Treatment: 18+ Years	29.26%	34.00%	4.74%
Total: Engagement of AOD Treatment: 18+ Years	4.47%	6.02%	1.55%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	NR	46.46%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	NR	4.01%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total	NR	22.54%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total	NR	7.66%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	NR	42.09%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total	NR	5.95%	NA
Total: Initiation of AOD Treatment: Total	32.57%	36.48%	3.91%
Total: Engagement of AOD Treatment: Total	4.49%	6.10%	1.61%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	91.69%	90.27%	-1.42%
Postpartum Care	62.95%	57.91%	-5.04%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 years	65.71%	66.67%	0.96%
6-11 years	72.15%	71.56%	-0.59%
12-17 years	66.62%	67.70%	1.08%
Total	68.93%	69.34%	0.41%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	5.21%	2.58%	-2.63%

Measure/Data Element	HEDIS 2017 (MY 2016) CAN Rates	HEDIS 2019 (MY 2018) CAN Rates	Change
1 Visit	5.24%	3.12%	-2.12%
2 Visits	6.01%	4.39%	-1.62%
3 Visits	7.96%	6.25%	-1.71%
4 Visits	13.75%	11.34%	-2.41%
5 Visits	24.39%	19.87%	-4.52%
6+ Visits	37.43%	52.45%	15.02%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	51.21%	60.43%	9.22%
Adolescent Well-Care Visits (awc)	34.03%	39.67%	5.64%

NA: Indicates denominator was too small or data were not available; NR: Not reported. *Indicates rate was calculated with small denominator

Magnolia had several measures with improvement greater than 10%: BMI Percentile for Children/Adolescent, Counseling for Physical Activity, HPV Vaccines, Well Child Visits in the First 15 Months of Life, and several others. The only measure with a substantial decrease in rate was the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

All relevant CHIP HEDIS performance measures for Magnolia CHIP for the current review year (MY 2018), the previous year (2016), and the change from 2016 to 2018 are reported in the Table below.

Table 11: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	49.64%	58.39%	8.75%
Counseling for Nutrition	45.78%	50.85%	5.07%
Counseling for Physical Activity	38.07%	47.69%	9.62%
Childhood Immunization Status (cis)			
DTaP	87.26%	87.59%	0.33%
IPV	93.03%	95.86%	2.83%
MMR	93.75%	93.19%	-0.56%
HiB	91.35%	93.92%	2.57%
Hepatitis B	92.31%	95.38%	3.07%
VZV	93.27%	93.19%	-0.08%
Pneumococcal Conjugate	85.58%	88.56%	2.98%
Hepatitis A	78.37%	80.05%	1.68%
Rotavirus	83.17%	86.62%	3.45%
Influenza	33.41%	38.20%	4.79%

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Combination #2	85.58%	86.62%	1.04%
Combination #3	82.69%	84.91%	2.22%
Combination #4	69.23%	74.70%	5.47%
Combination #5	75.72%	80.29%	4.57%
Combination #6	31.25%	35.28%	4.03%
Combination #7	63.46%	71.05%	7.59%
Combination #8	28.13%	32.12%	3.99%
Combination #9	29.57%	34.06%	4.49%
Combination #10	26.68%	30.90%	4.22%
Immunizations for Adolescents (ima)			
Meningococcal	49.52%	52.88%	3.36%
Tdap/Td	78.61%	81.20%	2.59%
HPV	9.62%	17.92%	8.30%
Combination #1	48.32%	52.13%	3.81%
Combination #2	8.65%	16.42%	7.77%
Lead Screening in Children (lsc)	62.42%	62.05%	-0.37%
Chlamydia Screening in Women (chl)			
16-20 Years	43.25%	34.75%	-8.50%
*21-24 Years**	NA	NA*	NA
Total	43.25%	34.75%	-8.50%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	66.70%	73.63%	6.93%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	45.45%	64.84%	19.39%
5-11 Years: Medication Compliance 75%	15.91%	32.81%	16.90%
12-18 Years: Medication Compliance 50%*	41.67%	50.45%	8.78%
12-18 Years: Medication Compliance 75%*	16.67%	27.03%	10.36%
Total Medication Compliance 50%	44.12%	58.51%	14.39%
Total Medication Compliance 75%	16.18%	29.88%	13.70%
Effectiveness of Care: Behavioral			
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	41.18%	50.86%	9.68%
Continuation and Maintenance (C&M) Phase	60.98%	71.70%	10.72%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	65.79%	NA
6-17 years - 7-Day Follow-Up	NR	45.61%	NA
18-64 years - 30-Day Follow-Up	NR	75.00%*	NA
18-64 years - 7-Day Follow-Up	NR	25.00%*	NA
Total-30-day follow-up	55.29%	66.10%	10.81%
Total-7-day follow-up	27.06%	44.92%	17.86%
Effectiveness of Care: Respiratory Conditions			
Appropriate Treatment or Children with URI (uri)	57.47%	61.88%	4.41%

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	98.83%	98.76%	-0.07%
25 Months-6 Years	90.49%	94.21%	3.72%
7-11 Years	90.44%	94.06%	3.62%
12- 19 Year	96.24%	91.96%	-4.28%
Annual Dental Visit (adv)			
2-3 Years	47.40%	56.37%	8.97%
4-6 Years	70.45%	78.72%	8.27%
7-10 Years	74.65%	80.81%	6.16%
11-14 Years	69.13%	75.73%	6.60%
15-18 Years	58.67%	65.17%	6.50%
19-20 Years	59.65%	57.58%	-2.07%
Total	66.05%	73.04%	6.99%
Prenatal and Postpartum Care (ppc)			
*Timeliness of Prenatal Care**	57.14%	50.00%*	NA
*Postpartum Care**	42.86%	0.00%*	NA
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.88%	1.75%	-1.13%
1 Visit	2.47%	0.66%	-1.81%
2 Visits	1.23%	1.53%	0.30%
3 Visits	3.70%	4.16%	0.46%
4 Visits	9.88%	8.10%	-1.78%
5 Visits	29.63%	13.79%	-15.84%
6+ Visits	50.21%	70.02%	19.81%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	51.11%	60.27%	9.16
Adolescent Well-Care Visits (awc)	34.01%	40.22%	6.21

NA: Indicates denominator was too small or data not available; NR: Not reported. *Indicates rate was calculated with small denominator

Magnolia had several measures that improved by greater than 10%. Those included: Asthma Medication Compliance, Follow up Care for Children on ADHD Medication Continuation Phase, Follow up After Hospitalization for Mental Illness, and Well-Child Visits. The measure of 5 Well Child Visits in the First 15 Months of Life did have a substantial decrease, but the 6+ Well Child Visits increased substantially.

Non-HEDIS Performance Measures Overview

Non-HEDIS performance measures include EPSDT Screening (<1 Year), EPSDT Screening (>1, <21 Years), Well-Child Visits in the First 15 months of Life, Nephropathy Screening, and Screening for Clinical Depression. CCME did not perform validation of the CAN non-HEDIS measures but reviewed the reported rates in comparison with target rates. *Table 12: CAN Non-HEDIS Performance Measure Rates* displays the CY 2018 rate for Magnolia CAN and the target rate.

Table 12: CAN Non-HEDIS Performance Measure Rates

Measure	Source	MS CAN Target Rate	MS CAN 2018 Rate
EPSDT Screening (<1 Year)	CMS 416-Report	85%	313.60%
EPSDT Screening (>1, <21 Years)	CMS 416-Report	75%	59.78%
Well-Child Visits in the First 15 Months of Life	HEDIS Modifier	59.76%	52.45%
Nephropathy Screening	CDC	90.33%	90.51%
Screening for Clinical Depression	CMS Adult Core Measure	25%	21.49%

The non-HEDIS performance measures, as per the *CHIP Contract*, includes: EPSDT Screening (<1 Year), EPSDT Screening (>1, <21 Years), and Well Child Visits in the First 15 Months of Life. CCME did not perform validation of the CHIP non-HEDIS measures but reviewed the reported rates in comparison to target rates. *Table 13: CHIP Non-HEDIS Performance Measure Rates* displays the CY 2018 rate for Magnolia CHIP and the target rate.

Table 13: CHIP Non-HEDIS Performance Measure Rates

Measure	Source	MS CHIP Target Rate	MS CHIP 2018 Rate
EPSDT Screening (<1 Year)	CMS 416-Report	85%	366.67%
EPSDT Screening (>1, <21 Years)	CMS 416-Report	75%	38.92%
Well-Child Visits in the First 15 months of Life	HEDIS Modifier	59.76%	70.02%

Performance Improvement Project Validation

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

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

As of July 1, 2019, four new topics are required for the CAN PIPs. The required topics are: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Magnolia submitted four PIPs and uploaded quarterly reports before the onsite visit. A PIP regarding COPD specific to the Adult population was not submitted. *Table 14: CAN Performance Improvement Project Validation Scores* provides an overview of the PIPs submitted and their current validation scores for the CAN PIPs. The Asthma PIP was the only PIP that was validated for the current and previous review years as it has been active since 2016.

Table 14: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Congestive Heart Failure (CHF) Readmissions	92% High Confidence in Report Results	CLOSED
Obesity	86% Confidence in Reported Results	CLOSED
Diabetes	98% High Confidence in Report Results	CLOSED
Asthma	99% High Confidence in Report Results	91/91=100% High Confidence in Reported Results
Behavioral Health Readmissions	N/A	67/72=93% High Confidence in Report Results
Improved Pregnancy Outcomes with Makena	N/A	62/62=100% High Confidence in Report Results

Project	Previous Validation Score	Current Validation Score
Sickle Cell Disease Outcomes	N/A	67/72=93% High Confidence in Report Results

As shown, four of the projects (4/4=100%) received a score of "High Confidence in Reported Results." CCME identified no corrective actions for the PIPs. As shown in the Table that follows, CCME provided two recommendations based on PIP validation. For the BH Readmissions PIP, the baseline results for 2018 should be added to report. The Sickle Cell Disease report contained two typos that need to be corrected on pages A-1 (title) and A-2 (percentage).

Also, Magnolia should initiate a PIP focused on Respiratory Illness Management specific to the Adult COPD population, as per DOM's PIP requirements, to focus on both Child-Asthma and Adult-COPD.

Table 15: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results should be updated to include baseline rate. It is documented in the narrative but is not included in the results Table.	Baseline results for 2018 can be added to report on page A-16 and A-6. Benchmark rates should also be added to report on A-6.
Sickle Cell Disease Outcomes	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The reported rate for the rationale is 27% and it should be 37.6% on page A-2.	Fix typo on page A-2 from 27% to 37.6%. Also fix typo on page A-1 under Name of Project.

For CHIP, Magnolia submitted four projects for desk review. As per the contract, the topic of obesity should be selected annually for study, providing continuous evaluation. The Table below displays the four projects Magnolia submitted along with their current and previous validation scores.

Table 16: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
EPSDT	95% High Confidence in Report Results	91/91=100% High Confidence in Report Results
Obesity for Children	84% Confidence in Reported Results	102/105= 97% High Confidence in Report Results

Project	Previous Validation Score	Current Validation Score
ADHD	95% High Confidence in Report Results	90/91=99% High Confidence in Report Results
Use of Appropriate Medications for People with Asthma	95% High Confidence in Report Results	91/91=100% High Confidence in Report Results

As shown, each of the four (4/4=100%) received a score of "High Confidence in Reported Results." CCME identified no corrective actions for the submitted PIPs. The Table that follows lists the specific errors by PIP and recommendations to correct the errors.

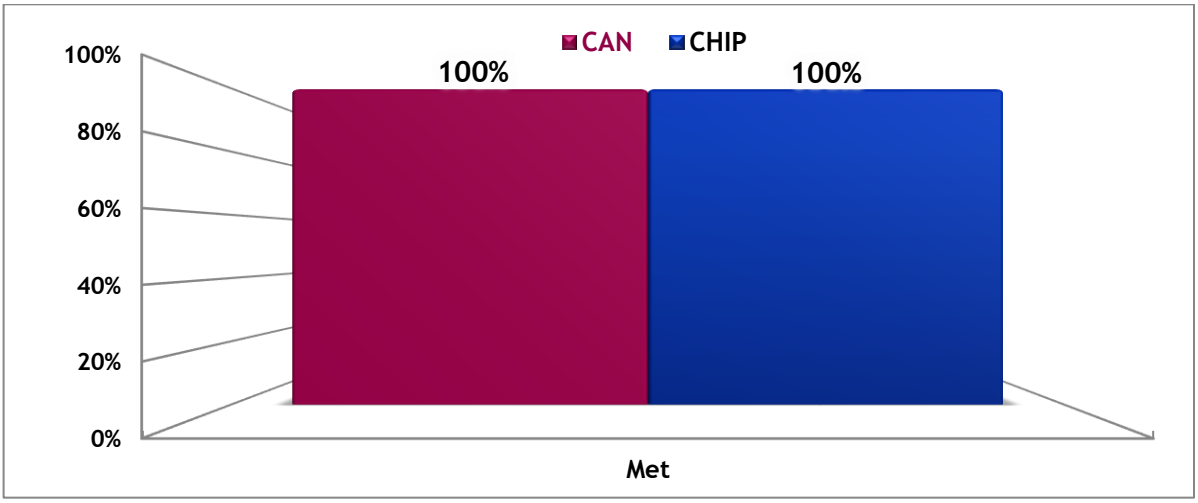
Table 17: CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Obesity for Children	Did the sample contain a sufficient number of enrollees?	The sample is extremely small for baseline and remeasurements 1 and 2. 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 who are eligible but unable to be reached.
	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate decreased instead of increasing.	Continue interventions to improve rates until project completion.
ADHD	Was there any documented, quantitative improvement in processes or outcomes of care?	Improvement did not occur in most recent remeasurement.	Continue interventions to improve rates until project completion.

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

All standards for CHIP and CAN received "Met" scores in the QI section, as shown in *Figure 7: Quality Improvement Findings*.

Figure 7: Quality Improvement Findings



Strengths

- The CAN and CHIP HEDIS performance measures were fully compliant.
- The validation scores for all PIPs were in the "High Confidence Range."
- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and the rationale for each topic was documented.

Weaknesses

- The activities or scope of work on the BH workplans were identical to CAN and CHIP, and not specific to behavioral health.
- There were several issues identified in the program evaluations regarding analysis of the coordination between providers, access and availability audit tables, appointment and afterhours accessibility monitoring, and monitoring of practitioner compliance with adopted BH guidelines.
- *Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service* does not specifically list Well-Baby and Well-Child. The policy only used the term "EPSDT."
- The CHIP Obesity and ADHD PIP reports showed a lack of improvement in rates.
- A specific PIP to address Adult COPD was not initiated.

Recommendations

- Include only the activities related to the BH population on the Behavioral Health QI workplans.

- Correct the issues identified in the *Annual Quality Improvement Program Evaluation MississippiCAN 2018* and in the *Annual Quality Improvement Behavioral Health Program Evaluation 2018*.
- Include the term "Well-Baby and Well-Child" *in Policy MS.QI.20, Early and Periodic Screening Diagnostic & Treatment (EPSDT) Service*.
- Continue interventions to improve rates in the PIPs until project completion.
- Initiate a PIP focused on Respiratory Illness Management specific to the Adult COPD population, as per DOM's PIP requirements to focus on both Child-Asthma and Adult-COPD.

E. Utilization Management

CCME's assessment for Magnolia's CAN and CHIP Utilization Management (UM) Programs includes reviews of program descriptions and evaluations, policies, *Member Handbooks*, *Provider Manuals*, approval, denial, appeal, and case management files, and the website. The *Utilization Management (UM) Program Description* and policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services.

Processes for review of service authorization requests for CAN and CHIP members are conducted utilizing InterQual guidelines or other established criteria. Magnolia assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing of both physician and non-physician reviewers. Review of approval and denial files reflect timely and consistent decision-making.

The *2018 UM Program Evaluation* revealed Magnolia experienced staffing issues related to high turnover and a lack of diversity of medical director specialties. Interventions were implemented to address these barriers.

Envolve Pharmacy Solutions (EPS) is delegated to provide pharmacy services and uses the most current version of the *Mississippi Medicaid Program Preferred Drug List* (PDL) on the State's website to fulfill pharmacy requirements. The *Care Management Program Description* outlines the framework for program's goals, scope, and lines of responsibility; however, CCME identified that CAN *Policy MS.UM.05* and CHIP *Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications* do not include the requirement that Magnolia must request approval from DOM to extend expedited requests beyond 24 hours.

Magnolia uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels and follows a standard outreach process as it applies to continual care, transitional care, and discharge planning.

Magnolia has established policies defining processes for handling both CAN and CHIP appeals of adverse benefit determinations. Review of documentation revealed issues such as incomplete and missing definitions of appeal terminology, use of terminology that is not consistent with definitions in the *CAN* and *CHIP Contracts* and Federal Regulations, lack of information about who can file an appeal, incorrect and incomplete information about the appeal filing timeframe and filing requirements, incorrect information about appeal resolution timeframes, and incomplete information about continuation of benefits pending the resolution of an initial member appeal, State Fair Hearing, or Independent External Review. Several of the identified issues had been previously identified during the 2018 EQR and appeared uncorrected.

CCME's review of appeal files confirmed that, overall, appeals are handled properly. One expedited CAN appeal had an untimely notification of resolution due to an error by the delegated vendor who processed the appeal. For one CHIP appeal, an incorrect resolution letter template was used and informed the appellant that the next level of review is a State Fair Hearing. CHIP members do not have the option of a State Fair Hearing.

Summaries of appeal actions, trends, and root causes are reported to the QIC and used to identify opportunities to improve quality of care and service. The QIC reports findings to the BOD.

As noted in *Figure 8: Utilization Management Findings*, Magnolia CAN received scores of "Met" for 90.6% of the standards, 5.7% were scored as "Partially Met," and 3.8% were scored as "Not Met." Magnolia CHIP received scores of "Met" for 90.6% of the standards, 7.5% were scored as "Partially Met," and 1.9% were scored as "Not Met."

Figure 8: Utilization Management Findings

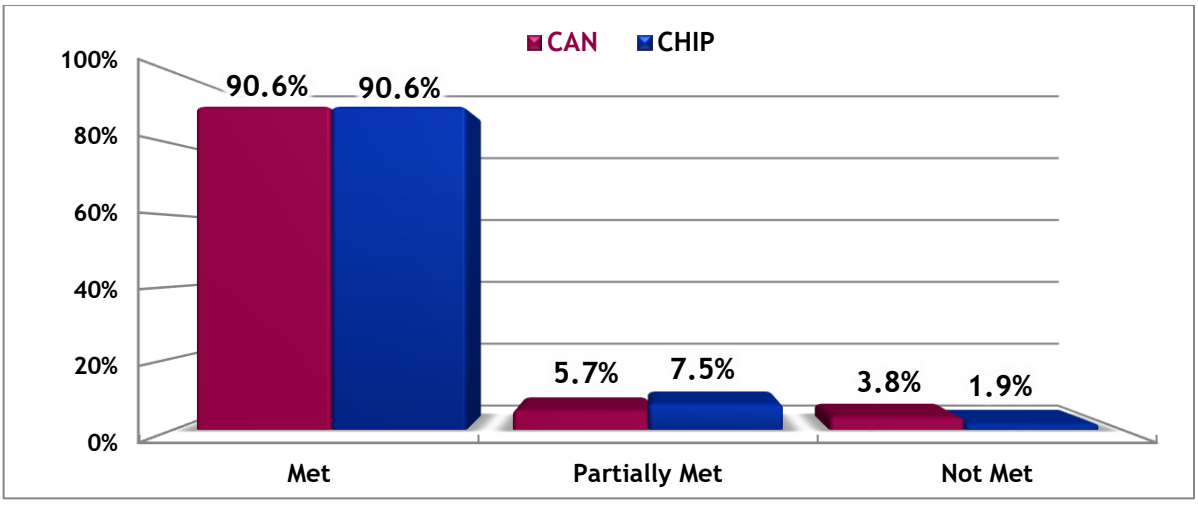


Table 18: Utilization Management

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Not Met	Not Met
	The procedure for filing an appeal	Partially Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Not Met	Partially Met
	Other requirements as specified in the contract	Partially Met	Partially Met
Transitional Care Management	The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Partially Met	Partially Met

Strengths

- Care managers consistently conduct Health Insurance Portability and Accountability Act (HIPAA) verification and assess for gaps in care during member contact.

Weaknesses

- CAN *Policy MS.UM.05* and CHIP *Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications* do not include the requirement that Magnolia must request approval from DOM to extend expedited requests beyond 24 hours.
- For CAN and CHIP, the following requirements are omitted from *Policy MS.CM.99, Transitional Care Management Process*:
  - Collaborating with hospital discharge planners, primary care, and BH staff
  - The 14-day timeframe to notify a provider of member's discharge
  - Ensuring that members receive the necessary supportive equipment and supplies
  - Promoting the ability, confidence, and change in self-management of chronic conditions
  - Providing Care Management until all goals are met or members elect not to receive services

- Issues noted with definitions of appeal terminology include:
  - *Policy MS.UM.08, Appeal of UM Decisions* and the CAN *Member Handbook* incompletely define the term "adverse benefit determination." Both documents are missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities."
  - The CAN *Provider Manual* defines an appeal as, "a request for Magnolia to review an action." The term "action" is outdated; the current term is "adverse benefit determination."
  - The CAN *Provider Manual* is missing the following parts of the definition of an adverse benefit determination: (1) For residents in a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under *42 C.F.R. §438.52(b)(2)(ii),* and (2) the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. Note: This was a corrective action item from the previous EQR.
  - Magnolia's CAN website incompletely defines an adverse benefit determination. It does not include "The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities."
  - CHIP *Policy MS.UM.08.01, Appeal of UM Decisions* and the CHIP *Member Handbook* incompletely define the term "adverse benefit determination." Both documents are missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities."
  - The CHIP *Member Handbook* states, "an appeal is a request for Magnolia to review a Magnolia Notice of Adverse Action." The term "action" is outdated; the current term is "adverse benefit determination."
  - The CHIP *Provider Manual* does not define the term "appeal" or "adverse benefit determination" and uses the term "action" throughout. Note: This was a corrective action item from the previous EQR.
  - Magnolia's CHIP website uses the term action instead of "adverse benefit determination" and incompletely defines the term. It is missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities."
- The CHIP *Provider Manual* does not define who may file an appeal.
- The following issues were identified regarding procedures for filing an appeal:

- The CAN *Notification of Adverse Determination for Requested Services* letter template incorrectly states appeals may be filed "within 60 calendar days from the date you receive this letter."
- The following state appeals may be filed orally or in writing, and oral appeals must be followed with a written request, but they do not include the timeframe to submit the written request: CAN *Member Handbook*, page 68, CAN *Provider Manual*, page 53, and CAN *Notification of Adverse Determination for Requested Services* letter template.
- The CHIP *Member Handbook*, page 57, and Magnolia's CHIP website incorrectly indicate the timeframe to file an appeal is "within 45 days of the receipt of the Notice of Action."
- The CHIP *Member Handbook* and the CHIP website do not indicate the timeframe to submit a written appeal request following an oral appeal.
- The CHIP *Notification of Adverse Determination for Requested Services* letter template incorrectly states appeals may be filed "within 60 calendar days from the date you receive this letter" and does not include the timeframe for a written appeal request to follow an oral request.
- The CHIP *Provider Manual* does not address the timeframe to file an appeal, appeal filing methods, that oral appeals require a written appeal to follow (or the timeframe for this), and that oral expedited appeals do not require a written appeal to follow.
- The CHIP website does not indicate a written appeal request is not required for expedited appeals.

- CAN *Policy MS.UM.08* does not include the timeframe (two calendar days) for Magnolia to notify the member in writing of a plan-initiated extension of the resolution timeframe. Note: This was an issue identified during the previous EQR.
- CHIP *Policy MS.UM.08.01* documents incorrect information regarding the timeframe for resolution of expedited appeals. Page 6 states expedited appeal determinations must be made "no later than 72 hours from receipt of necessary information;" however, *42 CFR §438.408 (b) (3)* requires resolution within 72 hours of receiving the appeal—not within 72 hours of receiving necessary information.
- Page 57 of the CHIP *Member Handbook* incorrectly states standard appeal resolution is required within 15 days from the date of the request.
- Page 63 of the CHIP *Provider Manual* references an outdated three-step appeal process and incorrectly states the entire appeal process is required to be completed within 90 days.
- Issues identified related to continuation of benefits include:

- The CAN *Member Handbook* includes only minimal information regarding continuation of benefits pending resolution of an initial appeal and a State Fair Hearing. Page 68, regarding initial appeals, does not include the timeframe to request continuation of benefits or conditions that must be met for continuation of benefits. Page 69, regarding State Fair Hearings, does not provide the conditions that must be met for continuation of benefits.
- The CAN *Provider Manual* provides incomplete information regarding continuation of benefits for both initial appeals and State Fair Hearings. For both, it fails to include the conditions that must be met for continuation of benefits.
- The CAN website includes only minimal information regarding continuation of benefits pending resolution of an initial appeal and a State Fair Hearing. For the initial appeal, the website does not include the timeframe to request continuation of benefits or conditions that must be met for continuation of benefits. For State Fair Hearings, the website does not provide the conditions that must be met for continuation of benefits.
- Requirements for continuation of benefits pending resolution of an initial appeal and Independent External Review are detailed in Policy MS.UM.08.01. However, continuation of benefits is not applicable for CHIP members when an appeal or Independent External Review is pending.

- One expedited CAN appeal file reflected untimely notification of resolution. The resolution notice was sent seven days after the receipt of the appeal. Onsite discussion confirmed this was an error on the part of the delegated vendor who reviewed the appeal.
- One CHIP appeal file reflected an incorrect resolution letter template was used and informed the appellant that the next level of review is a State Fair Hearing; however, CHIP members do not have the option of a State Fair Hearing. The letter should have indicated the next level of review is an Independent External Review.

Corrective Actions

- For CAN and CHIP, revise *Policy MS.CM.99, Transitional Care Management Process* to include all general transitional care requirements specified in the *CAN Contract, Section 8 (B) (1)* and the *CHIP Contract, Section (B).*
- Update *Policy MS.UM.08, Policy MS.UM.08.01,* the CAN *Member Handbook,* and the CHIP *Member Handbook* to include the full definition of an adverse benefit determination.
- Revise the definition of an appeal in the CAN *Provider Manual* to use current terminology.
- Revise the CAN *Provider Manual* and CAN website to include the complete definition of an adverse benefit determination.

- Revise the CHIP *Member Handbook* to use the current term "adverse benefit determination" instead of the outdated term "action."
- Update the CHIP *Provider Manual* to include definitions of an appeal and adverse benefit determination and to include information about who can file an appeal. Correct the use of the term "action."
- Update the CHIP website to use the current term of "adverse benefit determination" instead of "action." Ensure the website definition of an adverse benefit determination is complete.
- Revise the CAN *Notification of Adverse Determination for Requested Services* letter template to state appeals may be filed within 60 calendar days of the date on the notice of adverse benefit determination letter.
- Update the CAN *Member Handbook*, CAN *Provider Manual*, and CAN *Notification of Adverse Determination for Requested Services* letter template to include the timeframe to submit a written appeal request following an oral request.
- Correct the timeframe to file an appeal in the CHIP *Member Handbook*, page 57, and on the CHIP website.
- Update the CHIP *Member Handbook* and the CHIP website to include the timeframe to submit a written appeal request following an oral appeal.
- Revise the CHIP *Notification of Adverse Determination for Requested Services* letter template with the correct timeframe to file an appeal and to include the timeframe for a written appeal request to follow an oral request.
- Update the CHIP *Provider Manual* to include the timeframe to file an appeal, appeal filing methods, that oral appeals require a written appeal to follow and the timeframe for this, and that oral expedited appeals do not require a written appeal to follow.
- Update the CHIP website to indicate a written appeal request is not required for expedited appeals.
- Revise CAN *Policy MS.UM.08* to include the timeframe (two calendar days) for Magnolia to notify the member in writing of a plan-initiated extension of the appeal resolution timeframe.
- Correct the timeframe for resolution of expedited appeal on page six of CHIP *Policy MS.UM.08.01*.
- Revise page 57 of the CHIP *Member Handbook* with the correct timeframe for standard appeal resolution.
- Update the CHIP *Provider Manual* with the resolution timeframes for current appeal processes.

- Revise the CAN *Member Handbook*, CAN *Provider Manual*, and CAN website to include complete information regarding continuation of benefits pending the outcome of appeals and State Fair Hearings (CAN). Refer to *42 CFR §438.420*.
- Revise *Policy MS.UM.08.01* to remove information regarding continuation of benefits pending the outcome of appeals and Independent External Reviews for CHIP members. Refer to *42 CFR § 457.1260*.

Recommendations

- Edit CAN *Policy MS.UM.05, Timeliness of UM Decisions and Notifications* and CHIP *Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications* to indicate Magnolia will request approval from DOM to extend expedited service requests beyond 24 hours.
- Ensure delegates who process appeals have a clear understanding of processes and timeframes required and send resolution letters within the required timeframes.
- Ensure correct letter templates are used to inform CHIP appellants of the outcome of an appeal.

F. Delegation

Magnolia ensures all delegated organizations have written, signed agreements designating the activities that are delegated, requirements for reporting, and compliance and oversight requirements. Magnolia has delegation agreements with the entities identified in *Table 19: Delegated Entities and Services*.

Table 19: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve Dental	Dental claims, network, utilization management, credentialing, and quality management
Medical Transportation Management, Inc. (MTM) (CAN Only)	Non-emergency transportation claims, network, utilization management, and quality management
National Imaging Associates, Inc. (NIA)	Radiology utilization management
EPC-NurseWise	Nurse call center
EPC-Nurtur	Disease management
Envolve Vision	Vision services claims, network, utilization management, credentialing, and quality management
Envolve Pharmacy Solutions	Pharmacy claims, network, utilization management, credentialing

Delegated Entities	Delegated Services
Hattiesburg Clinic, PA; LSU Healthcare Network (New Orleans); North Mississippi Medical Clinic/North MS Healthlink; Rush Health Systems; Ochsner Clinic Foundation; St. Judes Research Hospital; Baptist Memorial Health Care-Baptist Health Services Group; Magnolia Regional Medical Center; Mississippi Physicians Care Network; Mississippi Health Partners; University of Mississippi Medical Center; Memorial Hospital at Gulfport	Credentialing Delegation

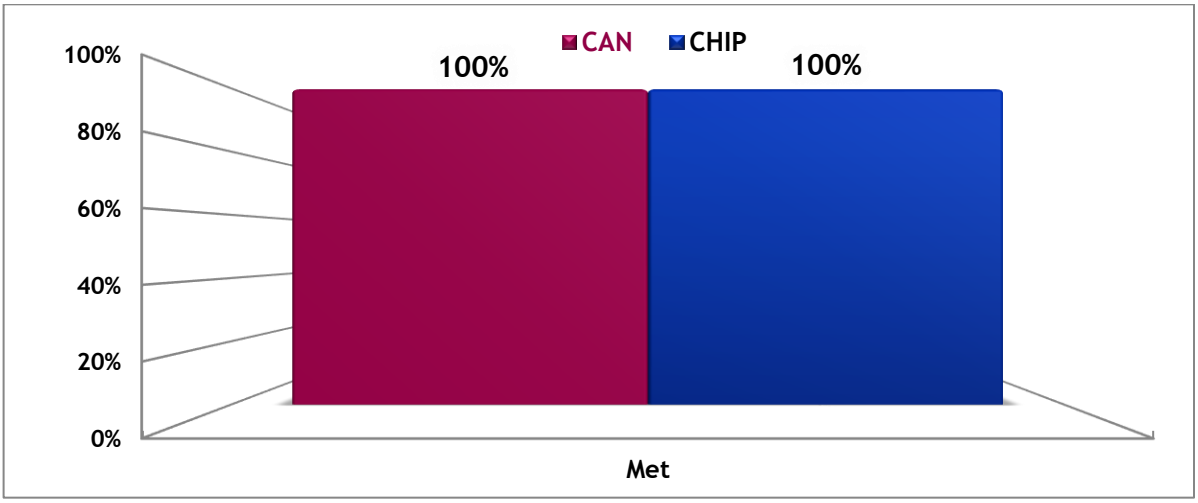
Policy CC.COMP.21.04, Third Party Audit Program defines overall processes for national third-party vendor oversight, including pre-service audits, annual audits, and validation audits to confirm the vendor has mitigated issues outlined in a quality improvement plan or corrective action plan. Proof of annual oversight was received for all national vendors.

Policy CC.CRED.12, Oversight of Delegated Credentialing defines procedures for evaluating a potential delegated entity's capacity to perform delegated activities prior to executing a delegation agreement. The pre-delegation review may be accomplished through an exchange of documents, pre-delegation meetings, or an on-site review and includes an assessment of the credentialing program, polices, and file review to ensure compliance to plan, NCQA, HIPAA, or other regulatory standards, such as State requirements. Magnolia retains accountability for delegated services and monitors the delegate's performance through review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings, and annual evaluation. Corrective action plans are developed when deficiencies are identified. Reports regarding ongoing corrective action plans are presented to the QIC at least quarterly.

CCME received evidence of pre-service review or annual oversight for all entities to whom credentialing and recredentialing have been delegated. Tools were appropriate and comprehensive.

As indicated in *Figure 9: Delegation Findings*, 100% of the standards in the Delegation section were scored as "Met."

Figure 9: Delegation Findings



Strengths

- The delegation oversight process includes pre-service audits, annual audits, quarterly committee oversight, monthly review of delegated vendor reports, and initiation of corrective action plans when necessary.

ATTACHMENTS

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

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

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

July 9, 2019

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 2019 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) and an 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 **October 9, 2019** through **October 10, 2019** for the MississippiCAN Program and the Mississippi CHIP Program.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **August 8, 2019**.

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. 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 803-212-7586 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

External Quality Review 2019 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

5. Submit a complete list of network providers for the MSCAN members. The lists should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for MississippiCAN Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

   Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information.

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

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

8. A copy of the current Fraud, Waste & Abuse/Compliance plan for the MSCAN and CHIP programs and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

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

10. The Quality Improvement work plans for MSCAN for 2018 and 2019.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 sample records from those abstracted charts.
    c. For projects with measures derived from administrative electronic systems:
        - full source code documentation of how the measure was processed and calculated for the PIP, and
        - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

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

14. Membership lists and a committee matrix for all (MSCAN 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.

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

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

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

18. Provide reports for measuring provider adherence to medical record standards for 2018 and 2019.

19. A complete list of all MSCAN members enrolled in the Care Management program from June 2018 through June 2019. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

22. 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.

23. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on MSCAN and CHIP programs.

24. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on MSCAN and CHIP programs.

25. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of June 2018 through June 2019.

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

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

28. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed. Please identify which preventative guidelines apply to CHIP and which ones apply to MSCAN.

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

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

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

32. A sample provider contract for the MSCAN program.

33. 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.

34. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO. Please indicate if the delegates apply to MSCAN or CHIP or both.

35. Contracts for all delegated entities.

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

37. 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.

38. 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 network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the MSCAN program made in the months of June 2018 through June 2019. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
    d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of June 2018 through June 2019, including any medical information and approval criteria used in the decision.
    Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

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

External Quality Review 2019 for Mississippi CHIP

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

5. Submit a complete list of network providers for the CHIP members. The lists should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for Mississippi CHIP Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

   Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information.

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

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

8. A copy of the current Fraud, Waste & Abuse/Compliance plan for the MSCAN and CHIP programs and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

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

10. The Quality Improvement work plans for CHIP for 2018 and 2019.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 sample records from those abstracted charts.
    c. For projects with measures derived from administrative electronic systems:
        - full source code documentation of how the measure was processed and calculated for the PIP, and
        - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

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

14. Membership lists and a committee matrix for all (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.

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

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

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

18. Provide reports for measuring provider adherence to medical record standards for 2018 and 2019.

19. A complete list of all CHIP members enrolled in the Care Management program from June 2018 through June 2019. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

22. 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.

23. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on MSCAN and CHIP programs.

24. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on MSCAN and CHIP programs.

25. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of June 2018 through June 2019.

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

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

28. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed. Please identify which preventative guidelines apply to CHIP and which ones apply to MSCAN.

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

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

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

32. A sample provider contract for the CHIP program.

33. 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.

34. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO. Please indicate if the delegates apply to MSCAN or CHIP or both.

35. Contracts for all delegated entities.

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

37. 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.

38. 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 network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the CHIP program made in the months of June 2018 through June 2019. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
    d. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP program made in the months of June 2018 through June 2019, including any medical information and approval criteria used in the decision.
    Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied

2. OIG Compliance Now Database Source List (referenced in Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening)

3. Examples of the Practitioner/Provider Profiling reports provided to network providers (MSCAN and BH providers)

4. Copy of the Cultural Competency Plan mentioned in Policy MS.QI.22, Cultural Competency

5. Copy of the most recent report mentioned in Policy MS.QI.05 showing results of the site specific surveys/audits regarding hours of operation, appointment access and after-hours access for PCP offices . We already have appointment results from the CAHPS member satisfaction survey.

6. Copy of Policy CC.COMP.21.04, Vendor Audit Program

7. Copy of Quarterly Reports for newly initiated PIPs for BH Readmissions, Pregnancy Outcomes with Makena, Sickle Cell and Hydroxyurea, and Adult COPD

8. Copy of Policy MS.MBRS.06, Member Materials and Readability and Translation or similar policy addressing how member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation

9. Standard Operating Procedure documents for the Member Services Call Center and the Provider Services Call Center (staffing, hours of operations, trainings, call scripts, etc.)

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

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied
2. Copies of all letter templates used for appeals
3. Copies of 2018 CHIP Child and Child with CCC CAHPS Survey Results
4. Examples of the Practitioner/Provider Profiling reports provided to network providers
5. Copy of Policy MS.MBRS.06, Member Materials and Readability and Translation or similar policy addressing how member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation
6. Standard Operating Procedure documents for the Member Services Call Center and the Provider Services Call Center (staffing, hours of operations, trainings, call scripts, etc.)

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

C. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN and CHIP
- Member Satisfaction Survey Validation CAN
- Member Satisfaction Survey Validation CHIP
- HEDIS PM Validation CAN
- HEDIS PM Validation CHIP
- PIP Validation CAN
  - ASTHMA
  - BEHAVIORAL HEALTH READMISSIONS
  - IMPROVING PREGNANCY OUTCOMES
  - SICKLE CELL DISEASE OUTCOMES
- PIP Validation CHIP
  - ADHD
  - ASTHMA- CLINICAL
  - EPSDT SERVICES FOR CHILDREN UP TO 19 YEARS OF AGE- CLINICAL
  - OBESITY FOR CHILDREN

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA HEALTH**
Survey Validated	**PROVIDER SATISFACTION (CAN AND CHIP)**
Validation Period	2018
Review Performed	2019

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**	-Purpose is documented in SPH report. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Objectives are clear and measurable. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Audience is identified in report. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**Met**	-Survey is reliable *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**Met**	-Survey is valid *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018

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:* - SPH Analytics Provider Satisfaction Report- 2018
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were clearly defined. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
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:* - SPH Analytics Provider Satisfaction Report- 2018
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:* - SPH Analytics Provider Satisfaction Report- 2018

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:* - SPH Analytics Provider Satisfaction Report- 2018
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:* - SPH Analytics Provider Satisfaction Report- 2018

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**	-Quality assurance plan was reflected in documentation. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
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:* - SPH Analytics Provider Satisfaction Report- 2018
5.3	Were confidentiality procedures followed?	**Met**	-Confidentiality was considered and procedures were appropriate. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018

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 and responses were analyzed. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	Statistical tests were applied correctly to responses. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018

Survey Element		Element Met / Not Met	Comments and Documentation
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018

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.	-SPH Analytics provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
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?	Survey had a low response rate (6.2% for mail surveys and 20.8% for phone surveys) This is well below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey. *Recommendation: Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.* *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018
7.4	What conclusions are drawn from the survey data?	Overall Satisfaction with Magnolia Health was 71.6%. This was an increase from 65.1% the previous year. The composite Finance Issues was 1 percentage point higher than 2017. Utilization and Quality Management (27.4%) increased in 2018 by 2.6 percentage points. Network/Coordination of Care increased in 2018 from 19.6% to 20.8%. Pharmacy (22.0%) increased by 1.4 percentage points over the 2017 rate. Health Plan Call Center Staff rate was 33.3% compared to 32.4% in 2017. The composites of Provider Relations and Recommended to Other Physicians' Practices are new composites for 2018, so there is no comparison data from previous years. *Documentation:* - SPH Analytics Provider Satisfaction Report- 2018 - 2018 MS CHIP QI Program Evaluation Final
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:* - SPH Analytics Provider Satisfaction Report- 2018
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA HEALTH (CAN)**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID ADULT)**
Validation Period	2018
Review Performed	2019

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**Met**	-Uses CAHPS and its standardized purpose *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
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:* -July 2018 Morpace Final Report Adult Medicaid

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 defined clearly *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were defined clearly *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
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:* -July 2018 Morpace Final Report Adult Medicaid
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:* -July 2018 Morpace Final Report Adult Medicaid

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:* -July 2018 Morpace Final Report Adult Medicaid
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 and according to completed questionnaire criteria *Documentation:* -July 2018 Morpace Final Report Adult Medicaid

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**Met**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS® 5.0H guidelines and HEDIS® Volume Three Technical Update Specifications *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
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:* -July 2018 Morpace Final Report Adult Medicaid
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures *Documentation:* -July 2018 Morpace Final Report Adult Medicaid

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:* -July 2018 Morpace Final Report Adult Medicaid
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* -July 2018 Morpace Final Report Adult Medicaid
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* -July 2018 Morpace Final Report Adult Medicaid

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - Morpace, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report
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 (24%). The 2017 NCQA Average response rate was 23%. *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts)* *Documentation:* -July 2018 Morpace Final Report Adult Medicaid

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	Year-over-year comparison data shows that the Getting Care Quickly composite has increased year over year and was 1.97 percentage points above 2017. How Well Doctors Communicate was .96 % percentage points above 2017, and Getting Needed Care had a significant increase of 3.17% percentage points above 2017. Rating of Health Plan was .06 percentage points above 2017, Rating of Specialist was 0.65 percentage points above 2017, Rating of Personal Doctor decreased by 1.13 percentage points, and Rating of Health Care fell below the 2017 rate by 1.86 percentage points but still met the goal. Customer Service had the largest increase from 2017, with an increase of 4.46 percentage points over 2017. All other key question and composite rates were above prior year. *Documentation:* -2018 QI Evaluation
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:* -July 2018 Morpace Final Report Adult Medicaid
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA HEALTH (CAN)**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD)**
Validation Period	2018
Review Performed	2019

Review Instructions

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

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

	Survey Element	Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**Met**	-Uses CAHPS and its standardized purpose *Documentation:* -July 2018 Morpace Final Report Child Medicaid
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives *Documentation:* -July 2018 Morpace Final Report Child Medicaid
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:* -July 2018 Morpace Final Report Child Medicaid

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:* -July 2018 Morpace Final Report Child Medicaid
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were clearly defined *Documentation:* -July 2018 Morpace Final Report Child Medicaid
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate *Documentation:* -July 2018 Morpace Final Report Child Medicaid
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:* -July 2018 Morpace Final Report Child Medicaid
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:* -July 2018 Morpace Final Report Child Medicaid

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:* -July 2018 Morpace Final Report Child Medicaid
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 and according to completed questionnaire criteria *Documentation:* -July 2018 Morpace Final Report Child Medicaid

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**Met**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS® 5.0H guidelines and HEDIS® Volume Three Technical Update Specifications *Documentation:* -July 2018 Morpace Final Report Child Medicaid
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:* -July 2018 Morpace Final Report Child Medicaid
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures *Documentation:* -July 2018 Morpace Final Report Child Medicaid

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:* -July 2018 Morpace Final Report Child Medicaid
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* -July 2018 Morpace Final Report Child Medicaid
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* -July 2018 Morpace Final Report Child Medicaid

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys - Morpace, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report
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%). The 2017 NCQA Average response rate was 22%. *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts)* *Documentation:* -July 2018 Morpace Final Report Child Medicaid

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	All composites and key questions met the 2018 goal. Year-over-year comparison data shows that the rates have varied but remained close in percentage points from the previous year. Getting Needed Care was 0.31 percentage points higher than 2017, while Getting Care Quickly was 0.94 percentage points higher. How Well Doctors Communicate fell below 2017 by 0.29 percentage points. Customer Service fell below 2017 rates by 0.56 percentage points. Rating of Health Care dropped 1.87 percentage points below 2017, and Rating of Specialist fell below 2017 by 1.34 percentage points. Rating of Personal Doctor fell slightly, by 0.17 percentage points, but Rating of Health Plan increased by 0.64 percentage points. *Documentation:* -2018 QI Evaluation
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:* -July 2018 Morpace Final Report Child Medicaid
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA HEALTH (CAN)**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD WITH CCC)**
Validation Period	2018
Review Performed	2019

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**Met**	-Uses CAHPS and its standardized purpose *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
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:* -July 2018 Morpace Final Report Child w CCC Medicaid

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:* -July 2018 Morpace Final Report Child w CCC Medicaid
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were defined clearly *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
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:* -July 2018 Morpace Final Report Child w CCC Medicaid
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:* -July 2018 Morpace Final Report Child w CCC Medicaid

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:* -July 2018 Morpace Final Report Child w CCC Medicaid
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 and according to completed questionnaire criteria *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**Met**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS® 5.0H guidelines and HEDIS® Volume Three Technical Update Specifications *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
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:* -July 2018 Morpace Final Report Child w CCC Medicaid
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid

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:* -July 2018 Morpace Final Report Child w CCC Medicaid
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys - Morpace, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report
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%) for total sample and 17% for general population. The 2017 NCQA Average response rate for the total sample was 22%. *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts)* *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	Year-over-year comparison data shows that all questions rated higher than 2017, except Rating of Health Care, which fell .83% percentage points below 2017. Getting Care Quickly was up 2.93 percentage points over 2017, How Well Doctors Communicate rose 2.18 percentage points, Getting Needed Care was up 3.03 percentage points, Customer Service was 1.70 percentage points above 2017, Rating of Personal Doctor increased by 0.31 percentage points, and Rating of Health Plan increased 1.18 percentage point above 2017. All key questions met the 2018 goal. *Documentation:* -2018 QI Evaluation
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 timeliness of healthcare furnished to beneficiaries by the MCO is provided in the report. *Documentation:* -July 2018 Morpace Final Report Child w CCC Medicaid
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA HEATH (CHIP)**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD)**
Validation Period	2018
Review Performed	2019

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**Met**	-Uses CAHPS and its standardized purpose *Documentation:* -July 2018 Morpace Final Report Child CHIP
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives *Documentation:* - July 2018 Morpace Final Report Child CHIP
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Uses standard CAHPS for measurement and use *Documentation:* - July 2018 Morpace Final Report Child CHIP

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**Met**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: 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 defined clearly *Documentation:* - July 2018 Morpace Final Report Child CHIP
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were defined clearly *Documentation:* - July 2018 Morpace Final Report Child CHIP
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate *Documentation:* - July 2018 Morpace Final Report Child CHIP
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**Met**	- Sample size was sufficient for intended use of the survey *Documentation:* - July 2018 Morpace Final Report Child CHIP
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**Met**	- Procedures to select the sample were appropriate *Documentation:* - July 2018 Morpace Final Report Child CHIP

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**Met**	- Specifications for calculating raw and adjusted response rates are documented *Documentation:* - July 2018 Morpace Final Report Child CHIP
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 and according to completed questionnaire criteria *Documentation:* - July 2018 Morpace Final Report Child CHIP

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**Met**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS® 5.0H guidelines and HEDIS® Volume Three Technical Update Specifications *Documentation:* - July 2018 Morpace Final Report Child CHIP
5.2	Did the implementation of the survey follow the planned approach?	**Met**	-Based on the timelines provided, the survey followed the planned approach *Documentation:* - July 2018 Morpace Final Report Child CHIP
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures *Documentation:* - July 2018 Morpace Final Report Child CHIP

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* - July 2018 Morpace Final Report Child CHIP
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* - July 2018 Morpace Final Report Child CHIP
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* - July 2018 Morpace Final Report Child CHIP

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys -Morpace, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report
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%). *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts)* *Documentation:* - July 2018 Morpace Final Report Child CHIP
7.4	What conclusions are drawn from the survey data?	All composites and key questions met the 2018 goal. *Documentation:* -2018 QI Evaluation

	Results Elements	Validation Comments And Conclusions
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 timeliness of healthcare furnished to beneficiaries by the MCO is provided in the report. *Documentation:* - July 2018 Morpace Final Report Child CHIP
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

CCME EQR Survey Validation Worksheet

Plan Name	**MAGNOLIA HEALTH (CHIP)**
Survey Validated	**CONSUMER SATISFACTION (CHILD CCC)**
Validation Period	2018
Review Performed	2019

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**Met**	-Uses CAHPS and its standardized purpose *Documentation:* -July 2018 Morpace Final Report Child CCC CHIP
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Uses standard CAHPS for measurement and use *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**Met**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: 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 defined clearly *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were defined clearly *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**Met**	- Sample size was sufficient for intended use of the survey *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**Met**	- Procedures to select the sample were appropriate *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**Met**	- Specifications for calculating raw and adjusted response rates are documented *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
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 and according to completed questionnaire criteria *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**Met**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS® 5.0H guidelines and HEDIS® Volume Three Technical Update Specifications *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
5.2	Did the implementation of the survey follow the planned approach?	**Met**	-Based on the timelines provided, the survey followed the planned approach *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys -Morpace, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report
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% for total sample and also 20% for general population). *Recommendation: Continue to work on interventions to increase response rates.* *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
7.4	What conclusions are drawn from the survey data?	All composites and key questions met the 2018 goal for Child with Chronic Conditions survey. *Documentation:* -2018 QI Evaluation

	Results Elements	Validation Comments And Conclusions
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 timeliness of healthcare furnished to beneficiaries by the MCO is provided in the report. *Documentation:* - July 2018 Morpace Final Report Child CCC CHIP
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

CCME EQR PM Validation Worksheet

Plan Name:	**MAGNOLIA HEALTH (CAN)**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2018**
Review Performed:	**2019**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**Met**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator data sources were met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator calculation were met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Plan uses Change Health 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 Change Health 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 Change Health for medical record abstraction.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**Met**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to technical specifications?	**Met**	Plan uses NCQA certified software, Inovalon. Review requirements for reporting were 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 HEALTH (CHIP)**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2018**
Review Performed:	**2019**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**Met**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator data sources were met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Plan uses NCQA certified software, Inovalon. Review requirements for numerator calculation were met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Plan uses Change Health 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 Change Health 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 Change Health for medical record abstraction.

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

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

Plan Name:	**MAGNOLIA HEALTH (CAN)**
Name of PIP:	**ASTHMA**
Reporting Year:	**2018**
Review Performed:	**2019**

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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined clearly.
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 utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
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.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
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.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to 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.
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 remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	There was improvement in 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)**	**MET**	Improvement appears to be related to interventions implemented.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistically significant improvement from baseline to remeasurement two (2)

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

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	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	**NA**	**NA**

Project Score	**91**
Project Possible Score	**91**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA HEALTH (CAN)**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS**
Reporting Year:	**2018**
Review Performed:	**2019**

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**	Hinds County has a high rate of readmissions.
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined clearly.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care and 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 utilized
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
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.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
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 in quarterly report that was uploaded before the onsite meeting.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No rates are reported.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	Results should be updated to include baseline rate. It is documented in the narrative but is not included in the results Table. ***Recommendation: Baseline results for 2018 can be added to report on page A-16 and A-6. Benchmark rates should also be added to report on A-6.***
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	No rates are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	No rates are reported.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	No rates are reported.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	No rates are reported.

Component / Standard (Total Points)	Score	Comments
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 rates are reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No rates are reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable 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	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

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

Project Score	67
Project Possible Score	72
Validation Findings	93%

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 (CAN)**
Name of PIP:	**IMPROVING PREGNANCY OUTCOMES**
Reporting Year:	**2018**
Review Performed:	**2019**

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**	In 2018, there were 101 preterm births (births prior to 37 weeks gestation). Of those, 34 were eligible for Makena but not prescribed the medication.
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined clearly.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care and 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 utilized
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
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.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
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 in quarterly report that was uploaded before the onsite meeting.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No rates are reported.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	No rates are reported.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	No rates are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	No rates are reported.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	No rates are reported.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	No rates are reported.
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 rates are reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No rates are reported.

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 determine

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	62
Project Possible Score	62
Validation Findings	100%

AUDIT DESIGNATION
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 (CAN)**
Name of PIP:	**SICKLE CELL DISEASE OUTCOMES**
Reporting Year:	**2018**
Review Performed:	**2019**

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**	**In 2018, a low percentage of members were compliant with taking their Hydroxyurea.**
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.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined clearly.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care and 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 utilized
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
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.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
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 in quarterly report that was uploaded before the onsite meeting.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No rates are reported.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	The reported rate for the rationale is 27% and it should be 37.6% on page A-2. *Recommendation: Fix typo on page A-2 from 27% to 37.6%. Also fix typo on page A-1 under Name of Project.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	No rates are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	No rates are reported.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	No rates are reported.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	No rates are reported.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to	**NA**	No rates are reported.

Component / Standard (Total Points)	Score	Comments
be the result of the planned quality improvement intervention)? **(5)**		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No rates are reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	67
Project Possible Score	72
Validation Findings	93%

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:	**ADHD**
Reporting Year:	2018
Review Performed:	2019

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**	ADHD incidence is more than double the national rate.
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)**	**Met**	Measures are defined under the measurable goal 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 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.
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**	

Component / Standard (Total Points)	Score	Comments
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 specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were specified clearly 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 not utilized for this 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 undertaken to address barriers are 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 plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly in narrative and table formats.
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 improve 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 was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Improvement did not occur in most recent remeasurement. *Recommendation: Continue interventions to improve rate until project completion.*
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**	Unable to determine

Component / Standard (Total Points)	Score	Comments
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was conducted, although improvement did not occur.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to determine

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	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	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	90
Project Possible Score	91
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 HEALTH (CHIP)**
Name of PIP:	**ASTHMA- CLINICAL**
Reporting Year:	2018
Review Performed:	2019

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 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)**	**Met**	Measures are defined under the measurable goal 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.
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**	Entire eligible population was 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**	Entire eligible population was used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Entire eligible population was 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 were specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were specified clearly 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 one (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 formats.
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.
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 one (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 determine

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	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	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	91
Project Possible Score	91
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA HEALTH (CHIP)**
Name of PIP:	**EPSDT SERVICES FOR CHILDREN UP TO 19 YEARS OF AGE- CLINICAL**
Reporting Year:	2018
Review Performed:	2019

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 was 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 addressed 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)**	**Met**	Measures are defined in the measurable goal section. Results do not need to be presented in indicator definition table.
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 defined clearly.
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**	

Component / Standard (Total Points)	Score	Comments
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 specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were specified clearly 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 not utilized for this 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 presented clearly in narrative and table formats.
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**	Conclusions were offered and revisions were made to continue recent 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 was 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 be impacting 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.

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**	Sustainment unable to be determined

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	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	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**91**
Project Possible Score	**91**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA HEALTH (CHIP)**
Name of PIP:	**OBESITY FOR CHILDREN**
Reporting Year:	2018
Review Performed:	2019

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)**	**Met**	Measure is defined under the measurable goal 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 defined clearly.
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)**	**Met**	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**	Hybrid sampling was utilized.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Partially Met**	The sample is extremely small for baseline and remeasurements one (1) and two (2). With such small samples, this PIP does not appear to have an impact on the health status of a broad spectrum of members. *Recommendation: Interventions should be implemented 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**	Data to be collected were specified clearly.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were specified clearly 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**	Personnel that were used to collect data were documented in the PIP 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**	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 for the baseline year.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly in 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 repeat measurements are identified.
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 to 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)**	**Not Met**	The rate decreased instead of increasing. *Recommendation: Continue interventions to improve rates until project completion.*
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 reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

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	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	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	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	NA	NA

Project Score	102
Project Possible Score	105
Validation Findings	97%

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.*

D. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**Magnolia Health CAN**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					*Policy CC.COMP.22, Policy and Procedure Documentation* details processes and requirements for policy management including policy development, review, approval, issue, and control. Onsite discussion confirmed this is a corporate policy that applies to all lines of business. RSA Archer® software is used to maintain and route policies for review and approval. Policies are reviewed at least annually and more frequently, if needed. CCME reminded Magnolia staff that according to a directive from DOM, all policies and procedures should clearly indicate the line(s) of business to which they apply.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Aaron Sisk is Plan President & Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Sesha Mudunuri is Chief Operating Officer.
1.3 Chief Financial Officer;	X					Trip Peeples is Chief Financial Officer and Michael Ruffin is Vice President, Finance.
1.4 Chief Information Officer;	X					Mark Brooks is the Centene Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					Cynthia Douglas is Vice President, Network Development & Contracting. Diandra Lee serves as Provider Services Manager.
1.6.1 *Provider credentialing and education;	X					Per onsite discussion, the Provider Services Team consists of 10 representatives and conducts provider education. Provider credentialing is conducted by corporate staff, but some intake activities occur at the plan level.
1.7 *Member Services Manager;	X					Kaneesha Higgins is the Senior Manager, Customer Service. She is supported by 2 Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services supervisors and 2 Member Services supervisors.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					
1.9 Utilization Management Coordinator;	X					Cherie Polk is the Interim VP, Medical Management. Onsite discussion confirmed recruiting activities are in place to fill this position, and Magnolia expects to fill the role within 12 months.
1.9.1 *Medical/Care Management Staff;	X					Utilization Management and Care Management staff are located in Mississippi. Magnolia staff reported a staff of 36 Utilization Management nurses and approximately 30 Case Managers for medical and behavioral health.
1.10 Quality Management Director;	X					Carrie Mitchell is VP, Quality Improvement.
1.11 *Marketing, member communication, and/or public relations staff;	X					Mary Anna McDonnieal is Director, Marketing & Communications. She is supported by 4 staff members. All staff are located in Mississippi.
1.12 *Medical Director;	X					Rebecca Waterer, M.D. is VP, Medical Affairs. Jeremy Erwin, M.D. is the Chief Medical Director (CMD). Leigh Campbell, M.D. and Bri May, M.D. are Medical Directors. The Medical Director for behavioral health is Faiza Qureshi, M.D.
1.13 *Compliance Officer.	X					Will Simpson is VP, Compliance and serves as the Compliance Officer for Magnolia. Nicole Litton is Director of Compliance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Operational relationships of CCO staff are clearly delineated.	X					Magnolia's *Organizational Chart* does not indicate the reporting relationship for Member Connections staff. *Recommendation: Revise the Organizational Chart to indicate the reporting relationship for Member Connections staff.*
3. A professionally staffed all service/help line/nurse line which operates 24 hours per day, 7 days per week.	X					Magnolia's 24-Hour Nurse Advice Line is staffed with Registered Nurses who provide health information, answers to health questions, medical advice, and can assist with scheduling primary care appointments.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia's *Information Systems Capabilities Assessment* (ISCA) documentation indicates claims processing is closely monitored and reported monthly. Claims Operations management staff monitors claims processing to ensure compliance with contractual requirements. Exact claims statistics were not provided. Magnolia conducts internal audits of Medicaid claims to ensure 100% of clean claims are finalized/paid/denied within 30 calendar days, 99% of non-clean claims are paid or denied within 60 calendar days from receipt, and 100% of all claims, including adjustments, are processed and paid within 90 calendar days of receipt.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Magnolia's expected turn-around time is 99% of clean claims processed within 30 days with 100% of all claims processed within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia collects all claim and encounter data using standard forms to ensure consistency and accuracy. Documents and forms with incorrect data or incomplete fields are rejected and returned to the provider or institution. All collected Medicaid data is tracked using member identification numbers that are generated from 834 file Medicaid IDs. Newborn enrollment is tracked using a report from Magnolia's inpatient authorization system. Finally, member characteristic data is stored using systems running National Committee for Quality Assurance (NCQA) HEDIS-certified software. Magnolia audits these systems annually.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Magnolia uses a multi-tiered IT infrastructure to collect and process performance, utilization, claims, member, and provider data. This data is consolidated into an enterprise data warehouse used for analytical, compliance, and operational reporting. HEDIS report data is sourced from these systems and validated by Magnolia's HEDIS Data Analyst monthly.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia provided a report of its August 20 – 24, 2018 disaster recovery (DR) test results. The DR tests included restoration of health plan systems and business-critical applications. The report indicates the recovery efforts were completed successfully, validated by internal business

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						units, and met the company's recovery time objectives.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					Magnolia's *Compliance and Ethics Program Description* (dated 2018) applies to both the CAN and CHIP lines of business. The program description describes internal controls for compliance with federal and state legislation and prevention of fraud and abuse throughout the organization. A separate *Fraud, Waste and Abuse Plan* provides greater detail about Magnolia's (and Centene's) mechanisms for timely detection, investigation, and prosecution of potential fraud.
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				Issues are addressed in the standards below.
2.1 Standards of conduct;						Centene Corporation's *Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace* (Code of Conduct) applies to all employees of Centene Corporation and its subsidiaries. As a condition of employment, all employees must complete and sign a questionnaire acknowledging receipt and understanding of the Code of Conduct and must complete a *Conflict of Interest Disclosure* annually. In addition to the Code of Conduct, Magnolia has a host of policies providing additional

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information about compliance and ethical behavior topics.
2.2 Identification of the Compliance Officer;						The *Compliance and Ethics Program Description* describes the roles and responsibilities of the plan Compliance Officer, including oversight of compliance activities for the health plan and reporting matters of compliance to both the CEO and the Board of Directors. The Compliance Officer's primary responsibility is "investigating allegations of non-compliance with the law, DOM contract requirements, and other applicable requirements." The Compliance Officer chairs the Compliance Committee. Magnolia's Vice President of Compliance serves as the local Compliance Officer and reports to Magnolia's President/CEO and Board of Directors. The Compliance Officer is accountable to Magnolia's senior management and is responsible for ensuring policies are followed to establish effective lines of communication between the Compliance Officer and staff and between the Compliance Officer and DOM.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						Compliance standards and procedures are conveyed to all employees, temporary employees, subcontractors, members of the Board of Directors, and others via mandatory training programs and written communication. Training topics include the Compliance Program,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identifying and reporting fraud and abuse, the Code of Conduct, and other Compliance-related policies, procedures, and standards.
2.5 Lines of communication;						Employees are required to report all suspected and confirmed incidents of fraud, abuse, illegal acts, inappropriate disclosures, and other incidents. Reporting mechanisms, including an Ethics and Compliance Hotline that permits anonymous reporting 24 hours a day, 7 days a week, are included in the *Compliance and Ethics Program Description*. Open lines of communication with staff are maintained using email, written memoranda, newsletters, and other communications. Magnolia maintains an open-door policy for all employees. Staff are encouraged to seek clarification and answers from the Compliance Officer for questions about company policies or procedures. Staff are encouraged to report problems or concerns to supervisors, managers, the local Compliance Officer, members of the Senior Leadership team, or the corporate Compliance Officer. Magnolia enforces a strict policy prohibiting intimidation or retaliation against any employee who reports suspected or actual violations, and policies about confidentiality and non-retaliation are widely publicized to all employees to encourage open communication and reporting.
2.6 Enforcement and accessibility;						Written policies describe disciplinary actions for noncompliance with company standards, policies, statutes, and regulations. Disciplinary

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						actions apply to all employees and independent contractors and can include "oral warnings to suspension, privilege revocation (subject to any applicable peer review procedures), termination or financial penalties, as appropriate." Employees are informed about disciplinary standards at employment and during Compliance and Ethics training sessions.
2.7 Internal monitoring and auditing;						Internal monitoring and auditing activities include but are not limited to: •regular reviews and monitoring of the compliance program by the Compliance Officer •periodic audits and monitoring of provider claims for compliance with established billing practices, regulations, and payor requirements •oversight and monitoring of vendors, including pre-contracting and annual audits
2.8 Response to offenses and corrective action;						The Compliance Officer assesses all alleged violations to determine if a compliance violation occurred and if the conduct was negligent, inadvertent, or willful and knowingly conducted. The *Compliance and Ethics Program Description* includes follow-up activities for negligent, inadvertent, and willful conduct and gross negligence. It also describes corrective actions taken.
2.9 Exclusion status monitoring.						*Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening* describes processes to conduct exclusion status monitoring for employees, vendors, and Board Members. Centene has contracted with an exclusion

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						screening vendor, OIG Compliance Now, to provide this service. The policy does not indicate queries of the Social Security Administration's Death Master File (SSDMF) and the National Plan and Provider Enumeration System (NPPES) are conducted. Review of the *OIGCN Database Sources*, a list of exclusion data sources queried by OIG Compliance Now, does not include the SSDMF and NPPES. *Corrective Action: Revise Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening (or other applicable documents) to include requirements for monitoring the SSDMF and NPPES for any subcontractors and persons with an ownership or control interest or who are agents or managing employees of the CCO. Refer to 42 CFR §438.610 and the CAN Contract, Section 1 (I).*
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					Magnolia's Compliance Committee is chaired by the Compliance Officer. The committee meets quarterly and as needed to review reports of suspected non-compliance and investigation findings, and to provide input on corrective and disciplinary actions recommended by the Compliance Officer. CCME noted discrepancies in documentation of Compliance Committee membership when reviewing the *Compliance and Ethics Program Description* (page 8), the *Compliance*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee Charter revised February 2019, and the June 4, 2019 committee meeting minutes. *Recommendation: Revise applicable documents to consistently document the membership of the Compliance Committee.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Information in the *Fraud, Waste and Abuse Plan* and ISCA tool confirms: •pre-payment claims edits are used to verify the validity of information such as diagnosis and procedure codes, modifiers, member and provider numbers, etc. • pre- and post-payment audits of the claim payment process and related systems are conducted •protocols to safeguard against unnecessary or inappropriate use of services are in place •processes to monitor for and detect over- and under-utilization are in place
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Allegations or suspicions of fraud, waste, and abuse (FWA) are investigated by the Special Investigations Unit (SIU) in collaboration with the Compliance Department and other applicable subsidiaries and departments. The SIU also works with applicable state and federal agencies and law enforcement to pursue and prosecute individuals or organizations involved in FWA activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The *Fraud, Waste and Abuse Plan* describes processes and requirements related to recoupments of overpayments upon completion of SIU investigations.
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

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 credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The process for conducting the functions of practitioner selection and retention for network participation is addressed in *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing.* Magnolia's state specific unique credentialing requirements are addressed in *Attachment B.* The policy is detailed and complies with contract requirements.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the	X					The Credentialing Committee is chaired by Dr. Jeremy Erwin, Chief Medical Director. The voting committee members include the Vice President of Medical Affairs, two Magnolia

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
applicant. Such decisions, if delegated, may be overridden by the CCO.						Medical Directors, one participating nurse practitioner, and five participating providers with specialties of pediatrics, family medicine, and psychiatry. The committee meets monthly and a quorum of 50% of voting members in attendance was established at every meeting. *Policy CC.CRED.03, Credentialing Committee*, outlines the structure, protocols, and peer-review process used to make recommendations regarding credentialing decisions. The QIC oversees the local Credentialing Committee and is the vehicle through which credentialing, monitoring, and reporting mechanisms are communicated to the Board of Directors.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;		X				Nine credentialing files did not contain proof of query of the *MS DOM Sanctioned Provider List*. *Corrective Action: Ensure credentialing files contain proof of query of the MS DOM Sanctioned Provider List.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
3.1.15 Ownership Disclosure form.	X					One credentialing file did not contain a copy of the *Ownership Disclosure* form. *Recommendation: Ensure credentialing files contain a copy of the Ownership Disclosure form.*
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* states the health plan may conduct an initial visit to the office of all potential primary care practitioners and all obstetricians / gynecologists prior to making the credentialing decision for that provider. *Attachment B* states Magnolia shall conduct site visits for all providers in accordance with the process outlined in *Policy MS.CONT.03 Site Assessments for New Provider Contracts*. However, *Policy MS.CONT.03* does not mention site visits for PCPs and OB/GYNs at initial credentialing and incorrectly addresses initial visits to all new hospitals, home health agencies, skilled nursing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						facilities, free-standing surgical centers, and behavioral health facilities providing mental health and substance abuse services in inpatient, residential, and ambulatory settings prior to making the final credentialing decision for that provider. Onsite discussion confirmed that Magnolia follows NCQA credentialing guidelines for organizational providers. *Corrective Action: Update Policy CC.CRED.05, Practitioner Office Site Review and Policy MS.CONT.03 Site Assessments for New Provider Contracts to remove incorrect language and clearly address Magnolia's process for conducting provider office site visits at initial credentialing.*
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
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 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					Two recredentialing files did not contain proof of query of the *MS DOM Sanctioned Provider List*. However, the majority of the other recredentialing files did contain proof. *Recommendation: Ensure proof of query of the MS DOM Sanctioned Provider List is included for all recredentialing files.*
4.2.9 Re-query 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 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);	X					
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					The recredentialing process includes consideration of provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization as defined in *Policy CC.CRED.01 Practitioner Credentialing & Recredentialing*. Applicable performance data from the QI Department is included in most of the recredentialing files. Two behavioral health files did not contain proof that provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						profiling was taken into consideration at recredentialing. *Recommendation: Ensure behavioral health recredentialing files contain proof that provider profiling was taken into consideration at recredentialing.*
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* defines the procedures for disciplinary action (including suspension, restriction, or termination) that may be taken against providers based on non-compliance with minimum administrative credentialing requirements or if imminent harm to patient health, fraud, or malfeasance is suspected. *Policy CC.CRED.08, Practitioner Appeal Hearing Process* addresses the opportunity for appeal when the Credentialing Committee recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to the competence or professional conduct of the practitioner. *Policy CC.QI.17, Potential Quality of Care Incidents* addresses the procedures for identifying, monitoring, investigating, and analyzing any potential or suspected quality of care incidents involving Centene Plan members in accordance with State and Federal regulations and accreditation requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				The process for conducting the functions of provider selection and retention of organizational providers is defined in *Policy CC.CRED.09, Organizational Assessment and Reassessment; Attachment E* addresses Mississippi specific criteria. A review of credentialing and recredentialing organizational files showed the following issues: •One recredentialing file for a medical center did not contain proof of CLIA. Magnolia indicated that because that section was left blank on the application, it assumed there was no CLIA; however, the website indicated there was a laboratory. •One recredentialing file for a skilled nursing facility had an outdated Ownership Disclosure form that was over three years old. •One recredentialing file for a DME company did not have the complete Ownership Disclosure form. Only one page was obtained. •One credentialing file for a hospice center only had a copy of an asset purchase page showing the owners, but not a copy of the Ownership Disclosure form. *Corrective Action: Ensure CLIA's are obtained for all organizational providers that provide laboratory services and ensure complete updated Ownership Disclosure forms are obtained.*
II B. Adequacy of the Provider Network						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					*Policy MS.PRVR.09, Verification of Member Eligibility* defines the procedures for ensuring PCPs are notified of members assigned them within five business days of receipt of the *Enrollee Listing Report* from DOM. All updates to the PCP Panel/Patient List are available for eligibility verification via the Secure Provider Portal. *Policy MS.PRVR.01, PCP Member Panel Reports* also states the plan will ensure all updates to the PCP Panel/Patient List will be available to all PCPs via the plan's secure provider web portal within five business days of receipt of enrollment data from DOM. If a provider does not have access to the secure provider web portal or would like an additional copy of the PCP Panel/Patient List, the provider may contact Provider Relations to request a copy.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					All providers may contact the toll-free telephone from the member's Plan ID card and use the plan's interactive voice response (IVR) system, available 24 hours a day, seven days a week to verify member eligibility. The IVR is updated daily as addressed in *Policy MS.PRVR.09, Verification of 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					CCME received evidence in the desk materials that Magnolia measures open and closed PCP panels via GEO Access reports. The CAN and CHIP *Provider Manuals* provide instructions for providers who want to make a change to the specific capacity of a PCP panel.
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.		X				*Policy MS.QI.04, Evaluation of Practitioner Availability* defines the procedures for monitoring the type, number, and geographic distribution of PCPs, high-volume specialists, and emergency room services to monitor the adequacy of the network and how effectively the network meets membership needs, preferences, and diversity. PCPs include general/family practitioners, pediatricians, and internists. The geographic distribution for PCPs is measured as 2 PCPs within 15 miles for urban and 2 PCPs within 30 miles for rural. GEO access reports received match defined parameters. *Policy MS.QI.04* defines Magnolia's established standards for the geographic distribution of PCPs as 100% of members meeting the defined standards. However, reports show Magnolia measures the PCP compliance goal as 95%. Results reported in the *Medicaid and CHIP Availability of Practitioners Analysis 2018* report showed PCPs met the 95% compliance goals for urban and rural geographic standards. *Corrective Action: Update Policy MS.QI.04, Evaluation of Practitioner Availability to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reflect the correct geographic measurement goals for PCPs that Magnolia uses to measure compliance.
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				The geographic access standards for hospitals, specialists, dental providers, behavioral health providers, pharmacy, urgent care, dialysis, and emergency service providers are defined in *Policy MS.QI.04, Evaluation of Practitioner Availability,* and comply with contract requirements. The policy defines Magnolia's established standards for the geographic distribution of specialists as 100% of members meeting the defined standards. However, reports show Magnolia measures the specialist compliance goal as 90%. The *Medicaid and CHIP Availability of Practitioners Analysis 2018* report shows monitoring results for high volume (OB/GYN) and high impact (oncology) specialists met the 90% compliance goals for urban and rural geographic standards. For behavioral health providers, standards in the rural areas for clinical psychology (61.5%), licensed social worker (51.8%), and marriage and family counselor (51.7%) were below the 90% goal. The behavioral health numerical analysis showed no standards for practitioner to member ratios were met. Onsite discussion confirmed that Magnolia has worked over the past year to strengthen the behavioral health network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update Policy MS.QI.04, Evaluation of Practitioner Availability to reflect the correct geographic measurement goals for specialists that Magnolia uses to measure compliance.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Practitioner type and availability is measured quarterly by the Magnolia Provider Relations and Network Development and Contracting Departments per *Policy MS.QI.04, Evaluation of Practitioner Availability.*
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Magnolia assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts practitioner availability within its network as defined in *Policy MS.QI.04, Evaluation of Practitioner Availability.*
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 ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					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 as defined in *Policy MS.QI.05, Evaluation of the Accessibility of Services.* Provider appointment access standards are addressed in the CAN *Provider Manual.* The *Annual Quality Improvement Program Evaluation MississippiCAN 2018* report showed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performance goals via Consumer Assessment of Healthcare Providers and Systems® (CAHPS) member satisfaction survey for primary care routine appointments, urgent appointments, and after-hours care were not met. Results from the after-hours access survey did not meet the goal of 95%. Of the 400 calls completed, 307 (77%) had an acceptable method of providing after-hours access for members. Quarterly reports were received for 2019 showing results of the telephonic appointment availability surveys for PCPs and behavioral health providers to assess urgent care, routine sick visits, and well care visits. However, 2018 information was not reported in the *Annual Quality Improvement Program Evaluation MississippiCAN 2018*. CCME recommended Magnolia report all efforts to assess provider appointment availability in the annual QI evaluation for CAN. Onsite discussion confirmed Magnolia educated providers about the after-hours access requirements. The plan trends appointment and after-hours access data and follows up with non-compliant providers. *Recommendation: Ensure the results of the telephonic appointment availability surveys for PCPs and behavioral health providers are reported in the annual QI program evaluations.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					Results of the telephonic *Provider Access Study* conducted by CCME shows improvement from the previous study results. A modified review was conducted last year, so the most recent access study was conducted in 2016 and had a success rate for 99 out of 258 calls (38%). Since that review, CCME adjusted the definition of successful calls. The success rate is now based on an adjusted denominator instead of the total calls made, the denominator is now the total calls made minus those answered with voicemail messages as this is now standard for many provider offices. Given the new formula, the success rate for the 2019 provider access study was 60% (110 out of 185 total calls).
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					*Policy CC.PRVR.13, Provider Orientations* defines the procedures for new provider orientation which is scheduled within 30 days of the execution of a new provider contract or the date the provider begins participating in the network, whichever comes first. The orientation is offered to all provider office staff and attendance is documented. A follow-up orientation will be scheduled tentatively with the provider for a later date to offer providers an opportunity to ask questions after accumulating more experience with the health plan. In addition, the CAN *Provider Manual* is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						detailed and a good reference document for new providers to navigate the plan.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;		X				The following are issues or inconsistencies when comparing the benefits listed in the CAN *Provider Manual* to the CAN *Member Handbook*: •Durable Medical Equipment (DME) and medical supplies—the CAN *Member Handbook* states, "Covered in the member's place of residence and may require prior authorization. All medically necessary DME and medical supplies are covered for EPSDT-eligible members with prior authorization." No limitations were listed in the CAN *Provider Manual*. •Enteral and Parenteral Nutrition for home use—The CAN *Member Handbook* states, "Available through pharmacy and medical benefit," and the CAN *Provider Manual* only mentions the pharmacy. •Flu and Pneumonia vaccines—The CAN *Member Handbook* states the following limitation that is not addressed in the CAN *Provider Manual*, "Limited to one each per 12 months." •Home Healthcare Services—The CAN *Member Handbook* states, "Limited to 36 visits per benefit year. All medically necessary services are covered for EPSDT-eligible members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						regardless of benefit limit with prior authorization;" but the CAN *Provider Manual* states, "Limited to 25 visits per benefit year." •Neuro-Psychiatric services—The CAN *Member Handbook* states, "May require prior authorization," but no limitations were listed in the CAN *Provider Manual*. •Outpatient Therapy (Occupational Therapy, Physical Therapy, and Speech Therapy)—The CAN *Member Handbook* states, "Therapy in the home setting is only a covered benefit for EPSDT-eligible members," but this limit is not listed in the CAN *Provider Manual*. •Podiatrist services—The CAN *Member Handbook* states, "Benefit limited to once every 60 days as a result of or associated with systemic condition." This conflicts with the CAN *Provider Manual* which states, "1 per year; unlimited for systemic condition." •Prescription drugs—The CAN *Member Handbook* states, "Limit of 6 per month. EPSDT-eligible members are eligible for more prescriptions if determined to be medically necessary. Diabetic supplies and HIV medications do not count toward benefit limit;" however, the CAN *Provider Manual* states, "6 per month with no more than 2 of the 6 being brand name drugs. EPSDT-eligible members are eligible for more prescriptions if determined to be medically necessary." •Preventive care—The CAN *Member Handbook* states, "dental exams for ages up to 21

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(members should be referred to a plan participating dental provider at the eruption of the first tooth, but no later than 12 months of age)" which conflicts with the CAN *Provider Manual* statement, "dental exams for ages 2-21." •Sleep study—The CAN *Member Handbook* lists "Outpatient only" when the CAN *Provider Manual* lists "Outpatient or home setting only." •Stereotactic Radiosurgery—The CAN *Member Handbook* states, "Prior authorization is required," but this limit is not listed in the CAN *Provider Manual*. •Swing bed services—The CAN *Member Handbook* states, "Covered and authorized by the DOM," but this statement in not listed in the CAN *Provider Manual*. *Corrective Action: Update the CAN Provider Manual or CAN Member Handbook to address the benefit issues or inconsistencies.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with contract requirements.	X					Magnolia maintains a user-friendly, searchable web-based provider directory as well as hard copy directories that are available upon request. Both directories sufficiently address provider information. *Policy MS.PRVR.19, Provider Directory* states the web-based directory is updated within five business days upon changes to the provider network by refreshing the web-based data nightly from the Enterprise Data Warehouse system. Provider directory data is sourced from the plan credentialing system in a live feed providing immediate updates. Hard copy provider directories are updated annually, or more often if the plan experiences significant network changes.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Provider Relations Representatives conduct regularly scheduled meetings with in-network providers to discuss plan initiatives as defined in *Policy MS.PRVR.14, Provider Visit Schedule*. Additional communication includes provider newsletters, informational postcards and letters, and the provider portal provides resource information such as training materials, manuals, forms, and news bulletins.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The process for adoption and distribution of preventive health guidelines is addressed in *Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines.* Guidelines are presented to the Quality Improvement Committee (QIC) for appropriate physician review and adoption. Guidelines are updated upon significant new scientific evidence, change in national standards, or at a minimum reviewed at least every two years.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					The preventive health guidelines are listed in the provider section of the Magnolia website and mentioned in the CAN *Provider Manual*. A link is referenced to show providers where they can access the guidelines on the website. The preventive health guidelines are distributed to new providers during onboarding. *Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines* states new or updated guidelines will be disseminated to providers via the Magnolia website within 60 days of adoption or revision.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					The process for adoption and distribution of clinical practice guidelines is addressed in *Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines.* The guidelines are distributed to new providers during onboarding. Guidelines are presented to the QIC for appropriate physician review and adoption. Guidelines will be updated upon significant new scientific evidence, change in national standards, or at a minimum reviewed at least every two years.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.		X				The clinical practice guidelines are listed in the provider section of Magnolia's website and mentioned in the CAN *Provider Manual*. A link is referenced to show providers where they can access the guidelines on the website. The preventive health guidelines are distributed to new providers during onboarding. *Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines* states new or updated guidelines will be disseminated to providers via

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Magnolia website within 60 days of adoption or revision. CCME's review of the clinical practice guidelines received in the desk materials and located on the website showed the following guidelines had broken links: •*2017 GINA Report, Global Strategy For Asthma Management and Prevention*. Updated 2017 •*Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel (2013)* •*The Management of Sickle Cell Disease, Fourth Edition (2004)* •*Smoking Cessation During Pregnancy (Obstet Gynecol 2010; 116: 1241-4)* *Corrective Action: Correct the broken weblinks for the clinical practice guidelines listed on the Magnolia website.*
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Magnolia defines minimum standards for practitioner medical record-keeping practices which include medical record content, medical record organization, ease of retrieving medical records, maintaining confidentiality of patient information, and appropriate documentation to support claims submitted as defined in *Policy MS.QI.13, Medical Record Review*. The CAN *Provider Manual* addresses requirements for medical record documentation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					Magnolia assesses network medical record-keeping practices annually against the established standards as defined in *Policy MS.QI.13, Medical Record Review*. Physicians sampled must meet 90% of the requirements for medical record keeping and 100% of claim validation or become subject to corrective action. A follow-up audit will be conducted within six months for any practitioner whose overall score is below 90% or the claims audit is below 100%. Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of recredentialing. The policy states an aggregate summary of medical record reviews completed are presented quarterly to Magnolia's Quality Committee; however, CCME could not find evidence the medical record review had been reported to the QIC. In addition, onsite discussion confirmed that only eight providers were included in the annual medical record review. *Recommendation: Ensure results of the provider medical record review are reported to the QIC as defined in Policy MS.QI.13, Medical Record Review. In addition, CCME recommends conducting medical record reviews on a larger sample of providers to ensure the sample is representative of the network and providers*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						are adhering to Magnolia's medical record standards.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					A *Provider Satisfaction Survey* was performed and met all requirements of the *CMS Survey Validation Protocol*. The *Provider Satisfaction Survey* initial sample using mail/internet data had a low response rate (6.2%), and the phone data sample had a response rate of 20.8 %. This is below the NCQA target response rate for surveys of 40%. The low response rate can 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 the Provider Satisfaction Survey. Solicit the help of the survey vendor.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The survey was analyzed by the plan.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QIC committee in December 2018 meeting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Magnolia guarantees member rights and responsibilities as outlined in *Policy MS.MBRS.25, Member Rights and Responsibilities* and described in the *CAN Member Handbook* and *Provider Manual*.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in *Policy MBR4a, Notification of Rights*, *Member Handbook*, *Provider Manual*, and the member website. See 2.1 to 2.9 for specific comments.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						Page 72 of the *Member Handbook* states the member has a right to "Be free to exercise these rights without retaliation." This statement fails to specify the member will not receive adverse treatment from the health plan or providers. *Recommendation: Edit page 72 of the CAN Member Handbook to indicate members have the right not to receive adverse treatment from the health plan or providers. Refer to CAN Contract, Section 6 (J) (g).*
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:		X				Member responsibilities are listed in *Policy MS.MBRS.25, Member Rights and Responsibilities*, *CAN Member Handbook*, *Provider Manual*, and the member website. See standards 3.1 through 3.5 for issues identified by CCME.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						Page 73 of the CAN *Member Handbook* and the website do not include the responsibility to show courtesy and respect to providers and staff. *Corrective Action: Edit page 73 of the Member Handbook and the website to include the member's responsibility to show courtesy and respect to providers and staff. Refer to the CHIP Contract, Section 6 (J) (1).*
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						*Policy MS.MBRS.25, Member Rights and Responsibilities* and the CAN website do not include the member's responsibility to notify Magnolia about changes in family size, address changes, or other health care coverage. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities to specify that members have the responsibility to notify the plan about changes in family size, address changes, or other health care coverage. Refer to the CAN Contract, Section 6 (J) (1).*
III B. Member CCO Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					*Policy MS.MBRS.01, New Member Packet/Member ID card*, *Policy MS.MBRS.02*, and the *Member Handbook* note new members will receive a New Member Packet that contains a CAN ID card, *Member Handbook*, and benefit booklet within 14 days after Magnolia receives enrollment information. Members may call Member Services or access the website for information on providers. See corresponding comments in sections 1.1 to 1.20.
1.1 Full disclosure of benefits and services included and excluded in coverage;						A grid of covered services with limits and exclusions is located on page 18 of the *Member Handbook*, and benefit information is noted throughout the handbook. The member website is user-friendly, allowing members to easily obtain information.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						The *Member Handbook, Provider Manual*, and website describe the limits of coverage and clearly states there are no co-payments for any service covered by Magnolia Health.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Information on accessing urgent and emergent care for medical dental and behavioral health services is provided in the CAN *Member Handbook* and member website. The *Urgent Care or Emergency Room* member brochure located on the website lists names and contact information for the respective facilities and provides examples of urgent and emergent situations. Prior authorization is not required for emergent or urgent care services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Magnolia notifies members of changes to the CAN program no later than 30 calendar days prior to implementation, as described in *Policy MS. MBRS.12, Member Notification of Plan Changes* and noted in the *Member Handbook*. Changes can include, but are not limited to, covered services, benefits, or the process that the member should use to access benefits. Once approved by DOM, notification can be distributed in multiple forms to ensure the member receives the notification such as mail, email, or website notification.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						The *Member Handbook* provides appropriate toll-free contact information and descriptions for Magnolia CAN Member Services, the 24-Hour Nurse Advice Line, and secure website access to the Member Secure Portal at www.MagnoliaHealthPlan.com.
1.13 A description of EPSDT services;						*Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service* describes EPSDT services and information is provided in the *Member Handbook* and website.
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						The *Member Handbook* informs members to contact Member Services or use the Provider Directory to select a PCP and obtain information about the PCP. A searchable *Provider Directory*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is available on the website and members can request a paper copy.
1.17 Instructions for reporting suspected cases of fraud and abuse;						The *Member Handbook* and website instruct members to call Magnolia's Waste, Abuse, and Fraud Hotline at 1-866-685-8664 if they suspect a member, provider, or anyone else is misusing Medicaid services. The website defines the terms fraud and abuse and provides examples of what it includes.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						Information on the Care Management Program is adequately provided in the *Member Handbook*. CCME did not identify information on the website. *Recommendation: Edit the CAN website to include information on the Care Management program. Refer to pages 58 and 59 in the Member Handbook.*
1.19 Information about advance directives;						Magnolia provides information about and recommends members to create a living will, designate a power of attorney, and provide their advance directive to their PCP. Examples of advanced directives and instructions to obtain the *Mississippi Advance Health Care Directive* form is included.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Magnolia notifies CAN members by mail 30 days before the effective date of any material changes and 14 days prior to implementing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						changes to covered benefits/services as described in *Policy MS.MBRS.12, Member Notification of Plan Changes and the Member Handbook*. *Policy MS.MBRS.27, Member Advisory of Provider Termination* and the *Member Handbook* state members who received primary care from, or were seen on a regular basis by, a terminated provider will be notified in writing within 15 days after Magnolia receives a provider termination notice. Additionally, the *Member Handbook* indicates members will be automatically assigned a new PCP or they can choose their own and they may continue visits, with the PCP or specialist for up to 60 days if approved. Pregnant women are encouraged to stay with the same provider after the postpartum period.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					*Policy MS.COMM.01, Marketing: General Guidelines for Marketing Activities* confirms member materials are written at no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. When 5% or more of the resident population of a county is non-English speaking and speaks a specific language, materials are made available in the respective language. Additionally, the *Member Handbook* informs members that written information in other formats such as 18-point font or larger print and audio or accessible electronic formats are available free of charge by contacting Member Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						During the onsite, Magnolia confirmed materials are printed in 12-point font size and provided *Policy MS.MBRS.06, Member Materials Readability and Translation*, which also provides guidelines for member written materials. CCME did not identify documentation for the requirement for 12-point font size and 18-point size for materials requiring large print. *Recommendation: Ensure the requirement to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font size are documented in Policy MBR 7 Member Materials/Sixth Grade Level of Reading Comprehension or other policy. Refer to CAN Contract, Section 6 (F).*
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Interpreter and translation services are provided to non-English speaking members, members who have limited English proficiency, and for members who are deaf or hearing impaired free of charge as described in the *Member Handbook*, *Policy MS.MBRS.03, Impaired/Language-Specific Interpreter Services*, and *Policy MS.MBRS.06, Member Materials Readability and Translation*.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					*Policy MS.MBRS.10, Member Service Calls/Hotline* describes the purpose and process for Magnolia's Member Services Call Center. The toll-free telephone number for Member Services and the Nurse Advice Line, 1-866-912-6285, is located on the member's ID card, in the *Member Handbook*, on the website, and in member education materials such as the *Spring 2019 HealthTalk*. The 24-Hour Nurse Advice Line has nurses available 24 hours a day, seven days a week, including holidays. The provider tab on the website indicates Provider Services business hours are from 7:30 am to 5:30 pm as required; however, page 9 of the *Provider Manual* states the toll-free Provider Relations call center is maintained Monday - Friday from 8:00 am to 5:00 pm. *Recommendation: Correct the hours of operation for the Provider Relations call center on page 9 of the Provider Manual. Consider editing the Provider Manual to include that the Member Services call center is available one evening per week from 5:00 p.m. to 8:00 p.m. CST and one weekend per month with the exception of Mississippi State holidays as stated in the CAN Contract, Section 6 (A).*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Evaluators monitor member and provider agent calls to score their performance against established quality guidelines reflecting their strength, deficiency, and training needs as described in *Policy MS.PRVR.24, Member & Provider Call Audit and Quality Criteria and Protocol*. The *2018 Quality Improvement Program Evaluation* indicates the Call Center's rating for overall satisfaction with Magnolia was 33.3% in 2018, citing additional training for the Provider Services Call Center as a barrier. Call Center statistics are monitored monthly by Centene Corporate and by the Performance Improvement Team, which reports to the Quality Improvement Committee. The call "abandoned rate" was 1.0%, which meets *CAN Contract, Section 6 (A) (5)* requirements.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					*Policy MS.CM.24, Health, Wellness, and Preventive Education Programs* describes Magnolia's process for promoting health education services to new and continuing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members. Additionally, members are informed of scheduled preventative health services, available case management programs, and how to obtain educational support for medical, behavioral health, and pharmaceutical services through the *Member Handbook* and member newsletters available on the website. Magnolia can send mailers, such as an EPSDT brochure or member newsletter, and make calls to eligible members reminding them of screenings and well visits.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					The *Member Handbook* informs members about the Start Smart for Your Baby® (Start Smart) program, through which pregnant members receive services, support, and education that can assist with achieving a healthy pregnancy. Pregnant members can be identified for Start Smart through enrollment, claims data, case management contacts, referrals. etc. The *Care Management Program Description* indicates Magnolia care managers will coordinate with Mississippi State Department of Health for high-risk pregnant women who may be eligible for Perinatal High-Risk Management/Infant Services System service. Pregnant members under 21 years of age are assigned into a Rising Risk category where engagement is tracked and monitored.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					*Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT)* appropriately describes how Magnolia identifies eligible members for EPSDT services and uses monthly reports to track gaps in care. Interventions such as reminder postcards and phone calls encourage members in need of EPSDT services. Additionally, EPSDT coordinators and Health Check Coordinators make outreach calls, identify barriers, and assist members with accessing EPSDT and immunization services. Magnolia implemented the CentAccount program that rewards members for healthy behaviors such as well child visits and immunizations.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the *CMS Survey Validation Protocol*. Magnolia contracts with Morpace, a certified *Consumer Assessment of Healthcare Providers System (CAHPS) Survey* vendor, to conduct the Adult and Child Surveys. The actual sample sizes were adequate and met the National Committee for Quality Assurance (NCQA) minimum sample size and number of valid surveys (at least 411), but the response rates were below the NCQA target of 40%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Generalizability of the survey results is difficult to discern due to low response rate for the following surveys: •For adults, the response rate is 24%. The 2017 NCQA Average response rate was 23%. •For the child survey, the response rate is 18%. The 2017 NCQA Average response rate was 22%. •For the child CCC survey, the response rate is 18% for total sample and 17% for general population. The 2017 NCQA Average response rate for the total sample was 22%. *Recommendation: In addition to the other interventions that are in progress, continue working with Morpace to increase response rates for Adult and Child surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the member satisfaction survey to identify quality problems. The Program Evaluation contained an analysis of the response rates for each of the three surveys, as well as comparative rates year over year.
3. The CCO reports results of the member satisfaction survey to providers.	X					The CCO reports the results of the member satisfaction survey to providers.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The CCO reports to the appropriate committee results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified. The August QIC minutes contained discussion of CAN and CHIP CAHPS results from 2018.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy MS.MBRS.07, Member Grievance and Complaints Process* describes Magnolia processes for receiving, processing, and responding to member requests for informal and formal complaints and grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The term "grievance" is appropriately defined in *Policy MS.MBRS.07*, the CAN *Member Handbook*, the CAN *Provider Manual*, and Magnolia's website (Medicaid). *Policy MS.MBRS.07*, the CAN *Member Handbook*, the CAN *Provider Manual*, and Magnolia's website (Medicaid) appropriately document who can file a grievance.
1.2 The procedure for filing and handling a grievance;		X				*Policy MS.MBRS.07* states oral and written grievances must be acknowledged in writing within five calendar days of receipt of the grievance; however, the following documentation does not address written acknowledgement for oral grievances: •CAN *Member Handbook* •CAN *Provider Manual* •Magnolia website (Medicaid) *Corrective Action: Include in the CAN Member Handbook, CAN Provider Manual, and Magnolia's website that oral grievances require written acknowledgement and the timeframe for the written acknowledgement.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Grievance logs document the member's Medicaid ID, receipt date, category, description of the grievance, summary of resolution, resolution date, and the number of days for resolution. *Policy MS.MBRS.07* confirms complaint and grievance records are retained for 10 years. If any litigation, claim negotiation, audit, or other action involving the records started before the expiration of the 10 year period, the records are retained until the completion of the action and resolution of issues which arise from it or until the end of the regular 10 year period, whichever is later.
2. The CCO applies the grievance policy and procedure as formulated.	X					Grievance files reviewed reflected timely acknowledgements, determinations, and notification of determinations. CCME's review revealed one grievance resolution letter incorrectly stated the member's grievance was related to being discharged from hospice when the grievance was regarding treatment at an outpatient surgery center.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure grievance resolution letters contain correct information regarding the grievance and its resolution.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					*Policy MS.MBRS.07* indicates complaint and grievance actions, trends, and root causes are reported to the QIC quarterly to identify opportunities to improve quality of service and care. The QIC's findings are reported to the Board of Directors. Review of QIC minutes confirms the review and discussion of grievance and complaint data, trends, root causes, and development of interventions to address identified issues and causes.
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					During the onsite Magnolia described the process used to follow-up on PCP change requests related to member dissatisfaction. *Recommendation: Document the process used to follow up on PCP change requests related to member dissatisfaction in a policy or other document.*
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					During the onsite Magnolia confirmed requests for PCP changes related to dissatisfaction are recorded as complaints and forwarded to Quality Management to follow-up and monitor.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The *2019 MississippiCAN Quality Program Description* and *2019 MississippiCAN Quality Behavioral Health Program Description* describes the program Magnolia has implemented to monitor and improve the clinical care and quality of services provided to members. The program description is reviewed, updated as needed, and presented to the QIC and to the Board of Directors (BOD) for approval at least annually.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The scope of the QI program includes identifying and addressing clinical areas of health disparities.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Magnolia conducts an annual assessment of utilization data to identify potential over- and under-utilization issues.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					The 2018 and 2019 CAN and Behavioral Health workplans were provided for review. Both workplans were divided into four tabs, "Committees, P&P Doc Reports, Performance Measures, and QIPI Activities." Each tab contained the goals/objectives, the planned activities, the responsible party, frequency, and completion date. The activities or scope of work on the BH workplan was identical to the CAN and not specific to behavioral health. For example,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Performance Improvement Projects (PIPs) state at least one project is related to obesity. *Recommendation: Include only the activities related to the Behavioral Health population on the Behavioral Health QI workplan.*
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia's BOD has authority, responsibility, and oversight of the Quality Program. The BOD delegates the operating authority of the QI program to the QIC. This committee is responsible for the implementation, monitoring and directing of the QI activities. Other committees involved in the quality improvement activities include the Performance Improvement Team and the Quality Task Force.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is chaired by the Chief Medical Director. Members include senior leadership and participating network providers. The committee's participant roster indicates there are five participating providers. Their specialties include pediatrics, family medicine, psychiatry, and a nurse practitioner. A minimum of five members, including three plan staff and two external physicians, must be present for a quorum.
3. The QI Committee meets at regular intervals.	X					The QIC meets at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded at each meeting and reflect the attendance and committee discussions for each item and any follow-up actions needed.
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Magnolia was found to be fully compliant and met all requirements for the HEDIS® measures as per the report by Attest Health Care Advisors. There were several measures that had substantial improvement of greater than 10%, including BMI Percentile for Children/Adolescent, Counseling for Physical Activity, HPV Vaccines, Well Child Visits in the First 15 Months of Life, and several others. The only measure with a substantial decrease in rate was the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. Details of the validation activities for the performance measures may be found in *Attachment 3, CCME EQR Validation Worksheets*.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					As of July 1, 2019, there are four new topics required for CCO PIPs. The required topics are: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Magnolia submitted fours PIPs and uploaded quarterly reports before the onsite visit. A PIP regarding COPD for the Adult population was not submitted. *Recommendation: Initiate a PIP focused on Respiratory Illness Management specific to the Adult COPD population, as per DOM PIP requirements to focus on both Child-Asthma and Adult-COPD.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					Four of the projects (4/4=100%) received a score of "High Confidence in Reported Results." Details of the validation activities for the PIPs, and specific outcomes are found in *Attachment 3, CCME EQR Validation Worksheets.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Per QI program descriptions, Magnolia profiles the quality of care delivered by high-volume PCPs or other network practitioners to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					The *2019 MississippiCAN Quality Program Description* and *2019 MississippiCAN Quality Behavioral Health Program Description* indicates that Magnolia will measure compliance with the preventive health and clinical practice guidelines. Per policy *MS.QI.08.01, Practitioner Adherence to Clinical Guidelines*, Magnolia measures practitioner compliance with at least two Clinical Practice Guidelines (CPGs) at least annually. At least one (1) of the CPGs selected for annual evaluation is related to a DOM performance measure. If the performance measurement rates fall below Magnolia or State goals, Magnolia shall implement interventions for improvement as applicable.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					Per policy *MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System*, Magnolia runs monthly reports to identify new members who have recently enrolled into Magnolia, members who appear to be behind on the immunization schedule, and EPSDT screenings are contacted by the EPSDT Coordinator or Health Check Coordinator to explain benefits and advice of needed services.
4.3 Diagnosis and/or treatment for children.	X					Policy *MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Services* describes the monitoring conducted by Magnolia for any diagnosis identified during and EPSDT screening and the following up care provided. According to the policy, Magnolia runs a monthly report to identify members needing follow-up care, and documents the treatment provided. The policy further indicates this data is tracked and trended at least quarterly and reported to the Performance Improvement Team.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Annually, Magnolia evaluates the effectiveness of the QI program. The *Annual Quality Improvement Program Evaluation MississippiCAN 2018* and the *Annual Quality Improvement Behavioral Health Program Evaluation 2018* was provided. Both

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						program evaluations included the QI activities conducted in 2018, the results of those activities, any barriers identified, interventions, and the recommendations for 2019. The following issues were noted in the *Annual Quality Improvement Program Evaluation MississippiCAN 2018:* •It was unclear what was being measured in the section titled Coordination between Providers, page 27. •The Access and Availability Audits table on pages 32 and 33 did not contain the analysis of the results being reported. The following issues were noted in the *Annual Quality Improvement Behavioral Health Program Evaluation 2018:* •It was unclear what was being measured in the section titled Coordination between Providers, page 22. •Pages 18 and 23 indicated Magnolia monitors appointment and afterhours accessibility; however, the results reported in the tables do not include appointment and afterhours accessibility monitoring. •The monitoring of practitioner compliance with the adopted Behavioral Health guidelines is addressed on page 54; however, the results of this monitoring are not provided. *Recommendation: Correct the issues identified in the Annual Quality Improvement Program Evaluation MississippiCAN 2018 and in the Annual*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Behavioral Health Program Evaluation 2018.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *Utilization Management Program Description* outlines the objectives, scope, and staff roles for Magnolia's Utilization Management (UM) Program for physical, behavioral health, and pharmaceutical services. Several policies, such as *MS.UM.02.01, Medical Necessity Review,* and *MS.UM.05.05, Timeliness of UM Decisions and Notifications* provide guidance on UM processes and requirements. Envolve People Care (EPC) is the delegated provider of BH utilization. Envolve Pharmacy Solutions (EPS) is delegated to provide pharmacy services. Both are NCQA accredited.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description* states the Chief Medical Director, Jeremy Erwin, MD, is licensed to practice in Mississippi and responsibilities include, but are not limited to, oversight of the UM Program, supervising medical necessity decisions, conducting reviews, and chairing the Utilization Management Committee (UMC). Daily management of UM activities are delegated to the Interim Vice-President of Medical Management (VPMM), Cherie Polk.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually to assess its strengths, effectiveness, and opportunities for process improvement. The evaluation and recommendations are presented to the QIC and BOD for approval. Additionally, UM criteria is reviewed and approved annually and updated as needed.
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					Magnolia uses Centene clinical policies, *InterQual Level of Care and Care Planning* criteria, applicable state and/or regulatory guidelines, as described in *Policy MS.UM.02, Clinical Decision Criteria and Application*. The *UM Program Description* states the plan generally uses InterQual guidelines to determine medical necessity and appropriateness of physical and behavioral health care.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files reflect consistent decision making using evidenced base criteria and relevant medical information, as described in the *UM Program Description*, *Policy MS.UM.02, Clinical Decision Criteria*, and *Policy MS.UM.02.01, Medical Necessity Review*.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					*Policy MS.UM.02, Clinical Decision Criteria and Application* states Magnolia applies InterQual criteria to level I and Level II reviews while considering other factors when applying criteria to a given individual situation such as, but not limited to, the member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. Approval files reflect examples of individual member circumstances were taken into consideration and staff consulted with the Medical Director about appropriate service requests.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					*Policy CC.UM.02.05, Interrater Reliability* and *Policy MS.UM.03.01, Interrater Reliability* state annual inter-rater reliability (IRR) testing is conducted for physician, non-physician, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						clinical staff reviewers to evaluate consistency of applying decision-making criteria. Staff scoring below the 90% benchmark will be retrained and retested within 30 days.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Envolve Pharmacy Solutions is the contracted pharmacy benefit manager (PBM) for the plan and is responsible for implementing the pharmacy program as required. A link to access the most current version of *Preferred Drug List (PDL*) is posted on Magnolia's website and directly transfers the user to DOM's website, where the PDL is posted in a searchable electronic format. The *Member Handbook* states over-the-counter medications are covered with a prescription from licensed provider, and the reader is instructed to call Member Services or click the embedded link for a complete list of covered medications.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					Envolve Pharmacy Solutions conducts the prior authorization process for covered outpatient drugs and is required to provide a 72-hour emergency supply of medication until authorization is complete when there is immediate need for the drug. The CAN *Member Handbook* and CAN *Provider Manual* include appropriate information regarding the PDL and emergency supply of medication.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and *Policy MS.UM.02.01, Medical Necessity Review* describe the role of licensed and unlicensed staff who are trained to perform prior authorizations. A Level I review is performed by a Mississippi licensed nurse or Referral Specialist, and a Mississippi-licensed physician or other appropriate healthcare practitioner performs Level II medical necessity review. A qualified BH practitioner is consulted on BH service requests and dental practitioners conduct Level II dental reviews. The Pharmacy Director is licensed in Mississippi and conducts Level II reviews in conjunction with the Medical Director.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with *Policy MS.UM.05, Timeliness of UM Decisions and Notifications*, the *UM Program Description*, and *CAN Contract* requirements; however, onsite discussions revealed 2018 timeframe goals for service authorizations were not met and interventions were put in place to address them. Regarding extensions of expedited requests, page 6 of *Policy MS.UM.05, Timeliness of UM Decisions and Notifications* states, "If the Plan requires additional clinical information in order to make a decision, a one-time extension of up

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to forty-eight (48) hours may be implemented." This statement is not consistent with requirements of the *CAN Contract, Section 6 (J)* that states, "This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, or the Provider, or if Contractor requests an extension from the Division." Onsite discussions confirmed that Magnolia is required to request approval from DOM to extend expedited requests beyond 24 hours. *Recommendation: Edit Policy MS.UM.05, Timeliness of UM Decisions and Notifications to indicate Magnolia will request approval from DOM to extend expedited service requests beyond 24 hours.*
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialist as outlined in *Policy UCSMM.06.16 Initial Review Timeframes*.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the	X					Review of denial files reveal denial decisions are made according to the processes described in *Policy UCSMM.06.16 Initial Review Timeframes*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
denial of service and the procedure for appeal.						Denial notifications are appropriately rendered via mail, fax, or telephone.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					Magnolia's processes for receiving, reviewing, and resolving member appeals are described in *Policy MS.UM.08, Appeal of UM Decisions.*
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;			X			*Policy MS.UM.08* and the CAN *Member Handbook* incompletely define the term "adverse benefit determination." Both documents are missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." The CAN *Provider Manual* defines an appeal as, "a request for Magnolia to review an action." The term "action" is outdated; the current term is "adverse benefit determination." The CAN *Provider Manual* is missing the following two parts of the definition of an adverse benefit determination: •For residents in a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under *42 C.F.R. §438.52(b)(2)(ii)* •The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						liabilities. Note: This was a corrective action item from the previous EQR. Magnolia's website (Medicaid) incompletely defines an adverse benefit determination. It does not include "The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." *Corrective Action: Update the definition of an adverse benefit determination in Policy MS.UM.08 and the CAN Member Handbook to include the full definition. Revise the definition of an appeal in the CAN Provider Manual to use the current terminology. Revise the CAN Provider Manual and Magnolia's Medicaid website to include the complete definition of an adverse benefit determination. Refer to the CAN Contract, Section 2 (A) and 42 CFR § 438.400 (b).*
1.2 The procedure for filing an appeal;		X				*Policy MS.UM.08*, the CAN *Member Handbook*, the CAN *Provider Manual*, and Magnolia's Medicaid website appropriately document the timeframe to file an appeal as within 60 calendar days from the date on the notice of adverse benefit determination. However, the CAN *Notification of Adverse Determination for Requested Services* letter template incorrectly states appeals may be filed "within 60 calendar days from the date you receive this letter."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The following inform that appeals may be filed orally or in writing, and that oral appeals must be followed with a written request, but they do not include the timeframe to submit the written request: •CAN *Member Handbook* (p 68) •CAN *Provider Manual* (p 53) •*Notification of Adverse Determination for Requested Services* letter template *Corrective Action: Revise the CAN Notification of Adverse Determination for Requested Services letter template to state appeals may be filed within 60 calendar days of the date on the notice of adverse benefit determination letter. Update the CAN Member Handbook, CAN Provider Manual, and CAN Notification of Adverse Determination for Requested Services letter template to include the timeframe to submit a written appeal request following an oral request. Refer to 42 CFR §438.402 (c) (ii) (2) (ii) and the CAN Contract, Section 6 (K) and Exhibit D.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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			*Policy MS.UM.08* appropriately documents resolution timeframes for standard and expedited appeals and includes information about extensions. The policy does not include the timeframe (two calendar days) for Magnolia to notify the member in writing of a plan-initiated extension of the resolution timeframe. Note: This was an issue identified during the previous EQR. *Corrective Action: Revise Policy MS.UM.08 to include the timeframe (2 calendar days) for Magnolia to notify the member in writing of a plan-initiated extension of the appeal resolution timeframe.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.		X				The CAN *Member Handbook* includes only minimal information regarding continuation of benefits pending resolution of an initial appeal and a State Fair Hearing: •Page 68, regarding initial appeals, does not include the timeframe to request continuation of benefits or conditions that must be met for continuation of benefits. •Page 69, regarding State Fair Hearings, does not provide the conditions that must be met for continuation of benefits.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CAN *Provider Manual* provides incomplete information regarding continuation of benefits for both initial appeals and State Fair Hearings. For both, it fails to include the conditions that must be met for continuation of benefits. The Magnolia CAN website includes only minimal information regarding continuation of benefits pending resolution of an initial appeal and a State Fair Hearing. •For the initial appeal, the website does not include the timeframe to request continuation of benefits or conditions that must be met for continuation of benefits. •For State Fair Hearings, the website does not provide the conditions that must be met for continuation of benefits. *Corrective Action: Revise the CAN Member Handbook, CAN Provider Manual, and website to include complete information regarding continuation of benefits pending the outcome of appeals and State Fair Hearings. Refer to 42 CFR §438.420.*
2. The CCO applies the appeal policies and procedures as formulated.	X					Appeal files reflect that, overall, appeals are handled appropriately. One expedited appeal was noted to have untimely notification of resolution. The resolution notice was sent seven days after the receipt of the appeal. Onsite discussion confirmed this was an error on the part of the delegated vendor who reviewed the appeal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure delegates who process appeals have a clear understanding of processes and timeframes required and send resolution letters within the required timeframes.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					*Policy MS.UM.08* indicates summaries of appeal actions, trends, and root causes are reported quarterly to the QIC. The information is used to identify opportunities to improve quality of care and service. The QIC reports findings to the Board of Directors. Review of QIC minutes confirmed appeal data is reported and discussed. Minutes indicate Magnolia identified trends and took action to determine root causes and address the findings.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management Program.	X					The *2019 Care Management Program Description* outlines the framework for the Care Management (CM) program goals, scope, and lines of responsibility. The program follows the Case Management Society of America's Standards of Practice for Case Management. The program goals include, but are not limited to, assisting members in achieving optimum health outcomes, functional capability, and quality of life through improved management of their disease or condition.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Methods used to identify eligible members into case management, include but are not limited

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to, review of clinical claims, medical records, and utilization management data. Additionally, Magnolia routinely uses a predictive modeling and care management analytics tool to identify and stratify members into low risk, medium risk, and high risk categories.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					*Policy MS.CM.01, Care Management Program and Program Description* adequately addresses that a health risk assessment will occur as quickly as required, but no later than 30 days of referral to the high, medium or low risk level. This can occur via telephone or in person.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					A Care Treatment Plan is developed by a Care Manager and can include a Behavioral Health Specialist, caregiver/family, and the PCP. Behavioral health care coordination is incorporated in the care treatment plan as needed. Care Managers are licensed nurses and may hold certifications in care management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Magnolia uses care management techniques 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. Guidelines for outreach are noted in policies such as, but not limited to, *MS.CM.01, Care Management Program and Program Description*, *MS.UM.24, Continuity and Coordination of Services*, and *MS.UM.24.04, Post Discharge Member Outreach*.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.6 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 Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 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;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring 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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
risk level and the specific services required by the contract.						
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					In addition to providing high risk members all services accessible to low and medium risk members, Rising Risk is a stratification for members with a new catastrophic or chronic condition such as premature infants and pregnant members under the age of 21.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					*Policy MS.UM.24, Continuity and Coordination of Services* describes Magnolia will transfer the member's care management history, six months of claims history, and other pertinent information when a member disenrolls. If a member with special needs transfers into the health plan, the CM will coordinate care with the former plan so that services are not interrupted.
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					The *UM Program Description* lists disease management programs that may include, but are not limited to: Asthma, Diabetes, Heart Failure, and Weight Loss & Obesity Program. Condition Specific Care Management Programs may include, but are not limited to, Emergency Department Diversion Program, Sickle Cell, HIV/AIDS, and High Risk Pregnancy.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					*Policy MS.CM.99, Transitional Care Management Process* outlines the various transition processes for new members, members transferring from another contractor, and when discharged from a clinic or inpatient setting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Integrated Care Team (ICT) will facilitate communication and coordination between the PCP and specialists, including behavioral health providers, as needed to ensure continuity of care and prevent duplication of services as described in *Policy MS.UM.24, Continuity and Coordination of Services*.
2. The CCO 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 Magnolia's process for transitioning members; however, it does not include the complete list of general transitional care management requirements as stated in the *CAN Contract, Section 9 (B)*. CCME could not identify the following requirements: •Collaborating with hospital discharge planners, primary care and BH staff •The 14-day timeframe to notify a provider of member's discharge •Ensuring that the member receives the necessary, supportive equipment and supplies •Promoting the ability, confidence and change in self-management of chronic conditions •Providing Care Management until all goals are met or members elect to not receive services *Corrective Action: Revise Policy MS.CM.99, Transitional Care Management Process to include all general transitional care requirements specified in the CAN Contract, Section 9 (B) (1).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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* describes the transition of care team includes, but is not limited to, RN Care managers, Social Service Specialists, and BH staff.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					Evaluation of the UM Program is conducted annually and provides an overall assessment of the effectiveness of the UM Program as well as analysis of program-specific outcomes. UM Program barriers are identified with interventions and recommendations to address them. At the onsite, discussions of the *2018 UM Program Evaluation* revealed Magnolia experienced staffing issues related to high turnover and a lack of diversity of medical director specialties. Interventions were implemented in Q4 2017 and Q1 2018 to address these barriers.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	x					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has written agreements with all contractors or agencies performing delegated	X					Magnolia ensures all delegated organizations have written, signed agreements designating the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
functions that outline responsibilities of the contractor or agency in performing those delegated functions.						delegated activities, reporting requirements, and compliance and oversight requirements. EPC-Cenpatico is no longer considered a delegated vendor for behavioral health because it was integrated into Centene. Magnolia has delegation agreements with the following entities: •Envolve Dental—Dental claims, network, utilization management, credentialing, and quality management •Medical Transportation Management, Inc. (MTM) (CAN Only)—Non-emergency transportation claims, network, utilization management, and quality management •National Imaging Associates, Inc. (NIA)—Radiology utilization management •EPC-NurseWise—Nurse call center •EPC-Nurtur—Disease management •Envolve Vision—Vision services claims, network, utilization management, credentialing, and quality management •Envolve Pharmacy Solutions—Pharmacy claims, network, utilization management, credentialing •Hattiesburg Clinic, PA—Credentialing •LSU Healthcare Network (New Orleans)—Credentialing •North Mississippi Medical Clinic/North MS Healthlink—Credentialing •Rush Health Systems—Credentialing •Ochsner Clinic Foundation—Credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•St. Judes Research Hospital—Credentialing •Baptist Memorial Health Care-Baptist Health Services Group—Credentialing •Magnolia Regional Medical Center—Credentialing •Mississippi Physicians Care Network—Credentialing •Mississippi Health Partners—Credentialing •University of Mississippi Medical Center—Credentialing •Memorial Hospital at Gulfport—Credentialing
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					*Policy CC. COMP.21.04, Third Party Audit Program* defines the overall process for national third-party vendor oversight which includes pre-service audits, annual audits, and validation audits to confirm the vendor has mitigated issues outlined in a quality improvement plan or corrective action plan. Proof of annual oversight was received for all national vendors. *Policy CC.CRED.12, Oversight of Delegated Credentialing* defines the procedures for evaluating a potential entity's capacity to perform delegated activities prior to a delegation agreement. The pre-delegation review may be accomplished through an exchange of documents, through pre-delegation meetings, or an on-site review and includes an assessment of the credentialing program, polices, and file review to ensure compliance to plan, NCQA, HIPAA, or other regulatory standards, such as State requirements. Magnolia retains accountability for delegated services and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitors the delegate's performance through review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings with each delegate, and annual evaluation. Corrective action plans are developed when deficiencies are identified. Reports regarding ongoing corrective action plans are presented to the QIC at least quarterly. Pre-service review or annual oversight was received for all entities where credentialing and recredentialing has been delegated. Tools were appropriate and comprehensive.

CCME CHIP Data Collection Tool

Plan Name:	**Magnolia Health CHIP**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					*Policy CC.COMP.22, Policy and Procedure Documentation* details processes and requirements for policy management including policy development, review, approval, issue, and control. Onsite discussion confirmed this is a corporate policy that applies to all lines of business. RSA Archer® software is used to maintain and route policies for review and approval. Policies are reviewed at least annually and more frequently if needed. CCME reminded Magnolia staff that, according to directive from DOM, all policies and procedures should clearly indicate the line(s) of business to which they apply.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Aaron Sisk is Plan President and Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Sesha Mudunuri is Chief Operating Officer.
1.3 Chief Financial Officer;	X					Trip Peeples is Chief Financial Officer, and Michael Ruffin is Vice President, Finance.
1.4 Chief Information Officer;	X					Mark Brooks is the Centene Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					Cynthia Douglas is VP, Network Development & Contracting. Diandra Lee serves as Provider Services Manager.
1.6.1 *Provider credentialing and education;	X					Per onsite discussion, the Provider Services Team, consisting of 10 representatives, conducts provider education. Provider credentialing is conducted by corporate staff, but some intake activities occur at the plan level.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Member Services Manager;	X					Kaneesha Higgins is the Senior Manager, Customer Service. She is supported by 2 Provider Services supervisors and 2 Member Services supervisors.
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					
1.9 Utilization Management Coordinator;	X					Cherie Polk is the interim VP, Medical Management. Onsite discussion confirmed recruiting activities are in place to fill this position. Magnolia reported it expects to have this position filled within 12 months.
1.9.1 *Medical/Care Management Staff;	X					Utilization Management and Care Management staff are located in Mississippi. Onsite discussion revealed there are 36 Utilization Management nurses and approximately 30 Case Managers for medical and behavioral health.
1.10 Quality Management Director;	X					Carrie Mitchell is VP, Quality Improvement.
1.11 *Marketing and/or Public Relations;	X					Mary Anna McDonnieal is Director, Marketing & Communications. She is supported by 4 staff members. All are located in Mississippi.
1.12 *Medical Director;	X					Rebecca Waterer, M.D. is VP, Medical Affairs. Jeremy Erwin, M.D. is the Chief Medical Director. Leigh Campbell, M.D. and Bri May, M.D. are Medical Directors. The Medical Director for behavioral health is Faiza Qureshi, M.D.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 *Fraud and Abuse/Compliance Officer.	X					Will Simpson is VP, Compliance and serves as the Compliance Officer for Magnolia. Nicole Litton is Director of Compliance.
2. Operational relationships of CCO staff are clearly delineated.	X					Magnolia's *Organizational Chart* does not indicate the reporting relationship for Member Connections staff. *Recommendation: Revise the Organizational Chart to indicate the reporting relationship for Member Connections staff.*
3. A professionally staffed all service/help line/nurse line which operates 24 hours per day, 7 days per week.	X					Magnolia's 24-Hour Nurse Advice Line is staffed with Registered Nurses who provide health information, answers to health questions, medical advice, and can assist with scheduling primary care appointments.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia's *Information Systems Capabilities Assessment* (ISCA) documentation indicates that claims processing is closely monitored and reported monthly. Magnolia's Claims Operations management staff monitors claims processing to ensure compliance with contractual requirements. Exact claims statistics were not provided. Magnolia conducts internal audits of Medicaid claims to ensure 100% of clean claims are finalized/paid/denied within 30 calendar days, 99% of non-clean claims are paid or denied within 60 calendar days from receipt, and 100% of all claims, including adjustments, are processed and paid within 90 calendar days of receipt.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia collects hospital, physician, pharmacy, nursing home, home health, mental health, and dental claims and encounter data using standard forms to ensure consistency and accuracy. Documents and forms with incorrect data or incomplete fields are rejected and sent back to the provider or institution. All Medicaid data collected is tracked using member identification numbers generated from 834 file Medicaid IDs. Newborn enrollment is tracked using a report from Magnolia's inpatient authorization system. Finally, member characteristic data is stored using systems running NCQA HEDIS-certified software. Magnolia audits these systems annually.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Magnolia uses a multi-tiered IT infrastructure to collect and process performance, utilization, claims, member, and provider data. This data is consolidated into an enterprise data warehouse that is used for analytical, compliance, and operational reporting. HEDIS report data is sourced from these systems and validated by Magnolia's HEDIS data analyst monthly.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia provided a report of its August 20 – 24, 2018 disaster recovery (DR) test results. The DR tests included restoration of health plan systems and business-critical applications. The report provided indicates the recovery efforts were completed successfully, validated by internal business units, and met the company's recovery time objectives.
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					Magnolia's *Compliance and Ethics Program Description* (dated 2018) applies to both the CAN and CHIP lines of business. The program description describes internal controls for compliance with federal and state legislation and to prevent fraud and abuse throughout the organization. A separate *Fraud, Waste and Abuse Plan* provides greater detail about Magnolia's (and Centene's) mechanisms for timely detection, investigation, and prosecution of potential fraud.
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				Issues are addressed in the standards below.
2.1 Standards of conduct;						Centene Corporation's *Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace* (Code of Conduct) applies to all employees of Centene Corporation and its subsidiaries. As a condition of employment, all employees must complete and sign a questionnaire acknowledging receipt and understanding of the Code of Conduct and must complete a *Conflict of Interest Disclosure* annually. In addition to the Code of Conduct, Magnolia has a host of policies providing additional information about compliance and ethical behavior topics.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The *Compliance and Ethics Program Description* describes the roles and responsibilities of the plan's Compliance Officer, including oversight of compliance activities for the health plan and reporting on matters of compliance to the CEO and the Board of Directors. The Compliance Officer's primary responsibility is "investigating allegations

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of non-compliance with the law, DOM contract requirements, and other applicable requirements." The Compliance Officer chairs the Compliance Committee. Magnolia's Vice President, Compliance serves as the local Compliance Officer and reports to Magnolia's President/CEO and Magnolia's Board of Directors, to whom regular updates are provided. The Compliance Officer is accountable to Magnolia's senior management and is responsible for ensuring policies are followed to establish effective lines of communication between the Compliance officer and Magnolia's staff and between the Compliance Officer and DOM staff.
2.3 Information about the Compliance Committee;						The *Compliance and Ethics Program Description* describes the Compliance Committee's membership, functions, and meeting frequency.
2.4 Compliance training and education;						Compliance standards and procedures are conveyed to all employees, including temporary employees, subcontractors, members of the Board of Directors, and others via mandatory training programs and written communications. Training topics include the Compliance Program, identifying and reporting fraud and abuse, the Code of Conduct, and other Compliance-related policies, procedures, and standards. Employees and external committee members are required to sign a confidentiality agreement annually.
2.5 Lines of communication;						Employees are required to report all suspected and confirmed incidents of fraud, abuse, illegal acts, inappropriate disclosures, and other incidents. Reporting mechanisms, including an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Ethics and Compliance Hotline available 24 hours a day, 7 days a week that permits anonymous reporting, are included in the *Compliance and Ethics Program Description*. Open lines of communication with staff are maintained with email, written memoranda, newsletters, and other communications. Magnolia maintains an open-door policy for all employees. Magnolia encourages staff to seek clarification and answers from the Compliance Officer. Staff are encouraged to report problems or concerns to supervisors, managers, the local Compliance Officer, members of the Senior Leadership team, or the corporate Compliance Officer. Magnolia enforces a strict policy prohibiting intimidation or retaliation against any employee who reports suspected or actual violations, and confidentiality and non-retaliation policies are widely publicized to all employees to encourage open communication and reporting.
2.6 Enforcement and accessibility;						Written policies describe disciplinary actions for noncompliance with company standards, policies, statutes, and regulations. Disciplinary actions apply to all employees and independent contractors and can include “oral warnings to suspension, privilege revocation (subject to any applicable peer review procedures), termination or financial penalties, as appropriate.” Employees are informed about disciplinary standards at employment and during Compliance and Ethics training sessions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Internal monitoring and auditing;						Internal monitoring and auditing activities include but are not limited to: •regular reviews and monitoring of the compliance program by the Compliance Officer •periodic audits and monitoring of provider claims for compliance with established billing practices, regulations, and payor requirements •oversight and monitoring of vendors, including pre-contracting and annual audits
2.8 Response to offenses and corrective action;						The Compliance Officer assesses all alleged violations to determine if a compliance violation occurred and if the conduct was negligent, inadvertent, or willful and knowingly conducted. The *Compliance and Ethics Program Description* includes follow-up activities for negligent/inadvertent conduct, willful/knowing conduct, and gross negligence. It also describes corrective actions taken.
2.9 Exclusion status monitoring.						*Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening* describes processes to conduct exclusion status monitoring for employees, vendors, and Board Members. Centene has contracted with an exclusion screening vendor, OIG Compliance Now, to provide this service. The policy does not indicate queries of the SSDMF and the NPPES are conducted. Review of the *OIGCN Database Sources*, a list of exclusion data sources queried by OIG Compliance Now, does not include the SSDMF and NPPES.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Revise Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening (or other applicable document) to include requirements to monitor the SSDMF and the NPPES for any subcontractors and persons with an ownership or control interest or who are agents or managing employees of the CCO. Refer to 42 CFR §438.610 and the CHIP Contract, Section 1 (I).
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					Magnolia's Compliance Committee is chaired by the Compliance Officer. The committee meets quarterly and as needed to review reports of suspected non-compliance and investigation findings and to provide input on corrective and disciplinary actions recommended by the Compliance Officer. CCME noted discrepancies in documentation of Compliance Committee membership when reviewing the *Compliance and Ethics Program Description* (page 8), the *Compliance Committee Charter* revised February 2019, and the June 4, 2019 committee meeting minutes. *Recommendation: Revise applicable documents to consistently document the membership of the Compliance Committee.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Information in the *Fraud, Waste and Abuse Plan* and ISCA tool confirms: •pre-payment claims edits are used to verify information such as diagnosis and procedure

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						codes, modifiers, member and provider numbers, etc. are valid •pre- and post-payment audits of the claim payment process and related systems are conducted • protocols to safeguard against unnecessary or inappropriate use of services are used •processes to monitor for and detect over- and under-utilization are in place
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Allegations or suspicions of fraud, waste, and abuse (FWA) are investigated by the Special Investigations Unit (SIU) in collaboration with the Compliance Department and other applicable subsidiaries and departments. The SIU also works with applicable state and federal agencies and law enforcement to pursue and prosecute individuals or organizations involved in FWA activities.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The *Fraud, Waste and Abuse Plan* describes processes and requirements related to recoupments of overpayments upon completion of SIU investigations.
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

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 a manner consistent with contractual requirements.	X					The process for conducting the functions of practitioner selection and retention for network participation is addressed in *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing*. Magnolia's state-specific unique credentialing requirements are addressed in *Attachment B*. The policy is detailed and complies with contract requirements.
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					Dr. Jeremy Erwin, Chief Medical Director chairs the Credentialing Committee. Voting committee members also include the Vice President of Medical Affairs, two Magnolia Medical Directors, one participating nurse practitioner, and five participating providers with specialties in pediatrics, family medicine, and psychiatry. The committee meets monthly, and a quorum of 50% of voting members in attendance is established at every meeting. *Policy CC.CRED.03, Credentialing Committee* outlines the structure, protocols, and peer-review process the Credentialing Department and the plan use to make recommendations regarding credentialing decisions. The QIC oversees the local Credentialing Committee and is the vehicle through which credentialing, monitoring, and reporting mechanisms are communicated to the Board of Directors.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the respective section of this report.
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) and the MS DOM Sanctioned Provider List;		X				Nine credentialing files did not contain proof of query of the *MS DOM Sanctioned Provider List*. *Corrective Action: Ensure credentialing files contain proof of query of the MS DOM Sanctioned Provider List.*
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					
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					One credentialing file did not contain a copy of the Ownership Disclosure form. *Recommendation: Ensure credentialing files contain a copy of the Ownership Disclosure form.*
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* states the plan may conduct an initial visit to the offices of all potential primary care practitioners and all obstetricians/gynecologists prior to making the credentialing decision for that provider. *Attachment B* states Magnolia shall conduct site visits for all providers in accordance with the process outlined in *Policy MS.CONT.03, Site Assessments for New Provider Contracts*; however, *Policy MS.CONT.03* does not mention site visits for PCPs and OB/GYNs at initial credentialing. The policy also incorrectly addresses initial visits to all new hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, and behavioral health facilities providing mental health and substance abuse services in inpatient, residential, and ambulatory settings prior to making the final credentialing decision. Onsite discussion confirmed that Magnolia follows NCQA credentialing guidelines for organizational providers. *Corrective Action: Update Policy CC.CRED.05, Practitioner Office Site Review and Policy MS.CONT.03 Site Assessments for New Provider Contracts to remove incorrect language and clearly*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						address Magnolia's process for conducting provider office site visits at initial credentialing.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					Two recredentialing files did not contain proof of query of the *MS DOM Sanctioned Provider List*; however, the majority of the other recredentialing files contained proof. *Recommendation: Ensure proof of query is included for all recredentialing files.*
4.2.9 Re-query 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 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration (NPPES);	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Provider office site reassessment for grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established grievance threshold has been met.	X					
4.4 Review of practitioner profiling activities.	X					The recredentialing process includes consideration of provider-specific performance data such as those collected through the quality improvement program, the utilization management and grievance/complaint systems, satisfaction surveys, and other activities, as defined in *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing*. Applicable performance data from the QI Department is included in most of the recredentialing files; however, two behavioral health files did not contain proof provider profiling was taken into consideration at recredentialing. *Recommendation: Ensure behavioral health recredentialing files contain proof that provider profiling was taken into consideration at recredentialing.*
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* defines the procedures for disciplinary action that may be taken against providers, including suspension, restriction, or termination, based on non-compliance with minimum administrative credentialing requirements

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or if imminent harm to patient health, fraud, or malfeasance is suspected. *Policy CC.CRED.08, Practitioner Appeal Hearing Process* addresses the opportunity for appeal when the Credentialing Committee recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to the competence or professional conduct of the practitioner. *Policy CC.QI.17, Potential Quality of Care Incidents* addresses the procedures for identifying, monitoring, investigating, and analyzing any potential or suspected quality of care incidents involving Centene Plan members in accordance with State and Federal regulations and accreditation requirements.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				The process for conducting the functions of provider selection and retention of organizational providers is defined in *Policy CC.CRED.09, Organizational Assessment and Reassessment; Attachment E* addresses Mississippi specific criteria. A review of credentialing and recredentialing organizational files showed the following issues: •One recredentialing file for a medical center did not contain proof of CLIA. Magnolia indicated that because that section was left blank on the application it assumed there was no CLIA; however, the website indicated there was a laboratory. •One recredentialing file for a skilled nursing facility had an outdated Ownership Disclosure form that was over three years old.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•One recredentialing file for a DME company did not have the complete Ownership Disclosure form. Only one page was obtained. •One credentialing file for a hospice center only had a copy of an asset purchase page showing the owners, but not a copy of the Ownership Disclosure form. *Corrective Action: Ensure CLIAs are obtained for all organizational providers that provide laboratory services and ensure complete updated Ownership Disclosure forms are obtained.*
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					*Policy MS.PRVR.09, Verification of Member Eligibility* defines the procedures for ensuring PCPs are notified of members assigned within five business days of receipt of the *Enrollee Listing Report* from DOM. All updates to the PCP Panel/Patient List are available for eligibility verification via the Secure Provider Portal. *Policy MS.PRVR.01, PCP Member Panel Reports* also states the plan will ensure all updates to the PCP Panel/Patient List are available to all PCPs via the plan's Secure Provider Portal within five business days of receipt of enrollment data from DOM. If a provider does not have access to the secure portal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or would like an additional copy of the PCP Panel/Patient List, the provider may contact Provider Relations to request a copy.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					All providers may contact the toll-free telephone from the member's Plan ID card and use the plan's interactive voice response (IVR) system (available 24 hours a day, seven days a week) to verify member eligibility. The IVR is updated daily as addressed in *Policy MS.PRVR.09, Verification of Member Eligibility*.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Magnolia measures open and closed PCP panels via GEO Access reports. The CAN and CHIP *Provider Manuals* provide instructions for providers that want to make a change to the specific capacity of their PCP panel.
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* defines the procedures for monitoring the type, number, and geographic distribution of PCPs, high-volume specialists, and emergency room services in order to monitor the adequacy of the network and how effectively the network meets membership needs, preferences, and diversity. PCPs include general/family practitioners, pediatricians, and internists. The geographic distribution for PCPs is measured as 2 PCPs within 15 miles (urban) and 2 PCPs within 30 miles (rural); GEO access reports received match defined parameters. *Policy MS.QI.04* defines Magnolia's established standards for the geographic distribution of PCPs as 100% of members meeting the defined standards;

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						however, reports show Magnolia measures the PCP compliance goal as 95%. Results reported in the *Medicaid and CHIP Availability of Practitioners Analysis 2018* report showed PCPs met the 95% compliance goals for urban and rural geographic standards. *Corrective Action: Update Policy MS.QI.04, Evaluation of Practitioner Availability to reflect the correct geographic measurement goals for PCPs used by Magnolia to measure compliance.*
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				The geographic access standards for dental, behavioral health, pharmacy, urgent care, dialysis, and emergency service providers, hospitals, and specialists are defined in *Policy MS.QI.04, Evaluation of Practitioner Availability* and comply with contract requirements. The policy defines Magnolia's established standards for the geographic distribution of specialists as 100% of members meeting the defined standards; however, reports show Magnolia measures the specialist compliance goal as 90%. The *Medicaid and CHIP Availability of Practitioners Analysis 2018* report shows monitoring results for high volume (OB/GYN) and high impact (oncology) specialists met the 90% compliance goals for urban and rural geographic standards. For behavioral health providers, standards in the rural areas for clinical psychology (61.5%), licensed social worker (51.8%), and marriage and family counselor (51.7%) were below the 90% goal. The behavioral health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						numerical analysis showed no standards for practitioner to member ratios were met. Onsite discussion confirmed that Magnolia has worked over the past year to strengthen the behavioral health network. *Corrective Action: Update Policy MS.QI.04, Evaluation of Practitioner Availability to reflect the correct geographic measurement goals for specialists that Magnolia uses to measure compliance.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Practitioner type and availability is measured quarterly by the Magnolia Provider Relations and Network Development and Contracting Departments per *Policy MS.QI.04, Evaluation of Practitioner Availability*.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Magnolia assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts practitioner availability within its network as defined in *Policy MS.QI.04, Evaluation of Practitioner Availability*.
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 ensures that practitioners act within written policies and procedures that define acceptable access	X					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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
to practitioners and that are consistent with contract requirements.						satisfaction survey process as defined in *Policy MS.QI.05, Evaluation of the Accessibility of Services*. Provider appointment access standards are addressed in the CHIP *Provider Manual*. The *Annual Quality Improvement Program Evaluation Mississippi Children's Health Insurance Program 2018* report showed performance goals via CAHPS member satisfaction survey for primary care routine appointments, urgent appointments, and member complaints access were met, while primary care after-hours care was not met. Results from the after-hours access survey did not meet the goal of 95%. Of the 400 calls completed, 307 (77%) had an acceptable method of providing after-hours access for members. Quarterly reports were received for 2019 showing results of the telephonic appointment availability surveys for PCPs and behavioral health providers to assess urgent care, routine sick visits, and well care visits. This information for 2018 was not reported in the *Annual Quality Improvement Program Evaluation Mississippi Children's Health Insurance Program 2018*. CCME recommended Magnolia report all efforts to assess provider appointment availability in the annual QI evaluation for CHIP. Onsite discussion confirmed Magnolia educated providers on the after-hours access requirements. Magnolia trended appointment and after-hours access data and followed up with non-compliant providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the results of the telephonic appointment availability surveys for PCPs and behavioral health providers are reported in the annual QI program evaluations.
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					Results of the telephonic Provider Access and Availability Study conducted by CCME shows improvement from the previous study's results. A modified review was conducted last year, so the most recent access study was conducted in the 2016 review and had a success rate of 39% (104 out of 265 calls). Since that review, CCME adjusted the definition of successful calls. The success rate is now based on an adjusted denominator. Instead of using total number of calls, the denominator is now the total calls made minus those answered with voicemail messages as this is now standard for many provider offices. Given the new formula, the success rate for the 2019 provider access study was 73% (116 out of 160 total calls).
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					*Policy CC.PRVR.13, Provider Orientations* defines procedures for new provider orientation which is scheduled within 30 days of the execution of a new provider contract or the date the provider becomes participating in the network, whichever comes first. The orientation is offered to all provider office staff and attendance is documented. A follow-up orientation is tentatively scheduled with the provider for a later date to offer providers an opportunity to ask questions after accumulating

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						more experience with the health plan. In addition, the CHIP *Provider Manual* is detailed and a good reference document for new providers to navigate the plan.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;		X				The following issues or inconsistencies were noted when comparing the benefits listed in the CHIP *Provider Manual* to the CHIP *Member Handbook*: •Inpatient Services—The CHIP *Member Handbook* includes Imaging (CT, PET Scans, MRIs) and Routine Foot Care that are not listed in the CHIP *Provider Manual*. •Durable Medical Equipment (DME)—The CHIP *Member Handbook* states, "May Require Prior Authorization" which is not addressed in the CHIP *Provider Manual*. •Air Ambulance–Fixed Wing—This is a stated benefit in the CHIP *Member Handbook* but not addressed in the CHIP *Provider Manual*. •Ambulatory Surgical Facilities—the CHIP *Member Handbook* states, "Does Not Require Prior Authorization;" however, the CHIP *Provider Manual* states on page 27, "some surgeries must be pre-authorized for medical necessity."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Chiropractic Care—This is listed as a benefit in the CHIP *Member Handbook* but not addressed in the CHIP *Provider Manual*. •Dental Care—The CHIP *Provider Manual*, page 31, states the following that is not listed in the CHIP *Member Handbook*, "Sealants - covered up to age fourteen (14) years, every thirty six (36) months." •Hearing Services—The CHIP *Member Handbook* states, "one hearing aid per ear is covered every three years;" however, the CHIP *Provider Manual* states, "hearing aids (limited to one [1] every three [3] years) are covered services." *Corrective Action: Update the CHIP Provider Manual or CHIP Member Handbook to address the benefit issues or inconsistencies.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;		X				The CHIP *Provider Manual* does not provide instructions for providers to access translation services for their members. *Corrective Action: Update the CHIP Provider Manual to include information regarding what translation services are available and what a*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider should do if a member needs translation service.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.	X					Magnolia maintains a searchable, user-friendly, web-based provider directory as well as hard copy directories that are available upon request. Both directories sufficiently address provider information. Policy *MS.PRVR.19, Provider Directory* states the web-based directory is updated within five business days of changes to the provider network by refreshing the web-based data nightly from the Enterprise Data Warehouse system. Provider directory data is sourced from the plan credentialing system in a live feed providing immediate updates. Hard copy provider directories are updated annually or more often if the plan has significant network changes.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Provider Relations Representatives conduct regularly scheduled meetings with network providers to discuss plan initiatives as defined in *Policy MS.PRVR.14, Provider Visit Schedule*. Additional communication includes provider newsletters, informational postcards, and letters.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The provider portal provides resource information such as training materials, manuals, forms, and news bulletins.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The process for adoption and distribution of preventive health guidelines is addressed in *Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines*. Guidelines are presented to the QIC for appropriate physician review and adoption. Guidelines will be updated upon significant new scientific evidence, changes in national standards, or at a minimum reviewed at least every two years.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.		X				The preventive health guidelines are listed in the provider section of the Magnolia website and they are distributed to new providers during onboarding. The CHIP *Provider Manual* does not mention any information regarding the adoption of preventive and clinical practice guidelines, that providers should utilize the information, and where the information can be found on the website. The plan has *Appendix VI: Adopted Preventive Health Guidelines*; however, the information is outdated, and the appendix is not listed in the Table of Contents. *Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines* states new or updated guidelines will be disseminated to providers via the Magnolia website within 60 days of adoption or revision.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the CHIP Provider Manual to include information about the adoption and use of preventive health guidelines, and correct or remove Appendix VI: Adopted Preventive Health Guidelines.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to member high-risk groups;	X					
3.5 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					The process for adoption and distribution of clinical practice guidelines is addressed in *Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines.* The guidelines are distributed to new providers during onboarding. Guidelines are presented to the QIC for appropriate physician review and adoption. Guidelines are updated upon significant new scientific evidence, changes in national standards, or at a minimum reviewed at least every two years.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO members.		X				The clinical practice guidelines are listed in the provider section of the Magnolia website. The guidelines are distributed to new providers during onboarding. The CHIP *Provider Manual* does not mention any information regarding the adoption of preventive and clinical practice guidelines, that providers should utilize the information, and where the information can be found on the website. The plan has *Appendix VII: Adopted Clinical Practice Guidelines*; however, the information is outdated, and the appendix is not listed in the Table of Contents. A review of the clinical practice guidelines received in the desk materials and located on the website showed the following guidelines had broken links: •*2017 GINA Report, Global Strategy For Asthma Management and Prevention*. Updated 2017 •*Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel (2013)* •*The Management of Sickle Cell Disease, Fourth Edition (2004)* •*Smoking Cessation During Pregnancy (Obstet Gynecol 2010; 116: 1241-4)* *Policy MS.QI.08 Preventive Health and Clinical Practice Guidelines* states new or updated guidelines will be disseminated to providers via Magnolia website within 60 days of adoption or revision.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the CHIP Provider Manual to include information about the adoption and use of clinical practice guidelines, and correct or remove Appendix VII: Clinical Practice Guidelines. In addition, correct any broken weblinks for the clinical practice guidelines listed on the Magnolia website.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Magnolia defines minimum standards for practitioner medical record-keeping practices that include medical record content and organization, ease of retrieving medical records, maintaining confidentiality of patient information, and appropriate documentation to support claims submitted as defined in *Policy MS.QI.13, Medical Record Review*. The CHIP *Provider Manual* addresses requirements for medical record documentation.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Magnolia assesses network medical record-keeping practices annually against the established standards as defined in *Policy MS.QI.13, Medical Record Review*. Physicians sampled must meet 90% of the requirements for medical record keeping and 100% of claim validation or become subject to corrective action. A follow-up audit will be conducted within 6 months for any practitioner whose overall score is below 90% or the claims audit is below 100%. Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of recredentialing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The policy states an aggregate summary of medical record reviews are presented quarterly to Magnolia's Quality Committee; however, CCME could not find evidence the medical record review had been reported to the QIC. In addition, onsite discussion confirmed that only eight providers were included in the medical record review. *Recommendation: Ensure results of the provider medical record review are reported to the QIC as defined in Policy MS.QI.13, Medical Record Review. In addition, CCME recommends conducting medical record reviews on a larger sample of providers to ensure the sample is representative of the network and providers are adhering to Magnolia's medical record standards.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey performed and meets all requirements of the CMS Survey Validation Protocol.	X					A *Provider Satisfaction Survey* was performed and met all requirements of the *CMS Survey Validation Protocol*. The *Provider Satisfaction Survey* initial sample using mail/internet data had a low response rate (6.2%), and the phone data sample had a response rate of 20.8 %. This is 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Focus on strategies that would help increase response rates for the Provider Satisfaction Survey. Solicit the help of the survey vendor.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The survey was analyzed by the plan.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QIC committee in December 2018 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Magnolia guarantees member rights and responsibilities as outlined in *Policy MS.MBRS.25, Member Rights and Responsibilities* and described in the CHIP *Member Handbook* and *Provider Manual*.
2. Member rights include, but are not limited to, the right:	X					The following areas reference the Code of Federal Regulations but do not provide the corresponding citation, which can prohibit the member from knowing their rights:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The CHIP website refers to the "federal regulations" and "federal code" (8th and 10th bullets) •The *Member Handbook* states, "in accordance with federal code" (11th bullet on page 61) *Recommendation: Include the CFR citation when referencing the applicable federal code or provide complete verbiage from the CFR.*
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						Page 61 of the *Member Handbook* does not include the right to "Free exercise of rights and the exercise of those rights does not adversely affect the way Contractor and its providers treat the Member." *Recommendation: Edit page 61 in the CHIP Member Handbook to include the member's right "Free exercise of rights and the exercise of those rights does not adversely affect the way Contractor and its providers treat the Member", as stated in the CHIP Contract, Section (I) (1 a-h).*
3. Member responsibilities include the responsibility:		X				Member responsibilities are listed in *Policy MS.MBRS.25, Member Rights and Responsibilities*, the CHIP *Member Handbook*, *Provider Manual*, and the member website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, CCME identified issues with documentation of member responsibilities noted in 3.1-3.9.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						The CHIP *Member Handbook* and website do not include the member's responsibility to show courtesy and respect to providers and staff. The CHIP *Provider Manual* omitted the word "staff" from this requirement. *Corrective Action: Edit page 62 in the CHIP Member Handbook and the CHIP website to include the member's responsibility to show courtesy and respect to providers and staff; and edit page 58 of the CHIP Provider Manual, to include the word "staff" in this requirement. Refer to the CHIP Contract, Section 6 (I) (1).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						*Policy MS.MBRS.25, Member Rights and Responsibilities* does not state that members are responsible for informing the plan of changes in family size, address, or health coverage. *Corrective Action: Revise Policy MS.MBRS.25, Member Rights and Responsibilities to include that members are responsible for informing the plan of changes in family size, address, or health coverage. Refer to the CHIP Contract Section (l) (1).*
III B. Member Program Education						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:	X					*Policy MS.MBRS.01, New Member Packet/Member ID Card* notes new members will receive a *New Member Packet* that contains a welcome letter, ID card, *Member Handbook*, and instructions to access or obtain a *Provider Directory*.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						A grid of covered services, with limits and exclusions, is located on page 17 of the *Member Handbook*, and benefit information is noted throughout the handbook. The member website is user-friendly, allowing members to easily obtain information. CCME identified the link on the CHIP member website accesses a 2015 *Member Handbook*. *Recommendation: Update the member website with the most current version of the Member Handbook.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						The *Member Handbook* and *Provider Manual* describe the limits of coverage, out-of-pocket maximums, and required copayments for each CHIP coverage plan. Additionally, the copayment amount is noted on the ID card.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Information about accessing urgent and emergent care for medical dental and behavioral health services is adequately provided in the CHIP *Member Handbook*, along with example lists of urgent and emergent situations. The website notes that Member Services can assist with emergency issues. Prior authorization is not required for emergent or urgent care services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Magnolia notifies members of changes to the CHIP program no later than 30 calendar days prior to implementation as described in *Policy MS.MBRS.12, Member Notification of Plan Changes* and noted in the *Member Handbook*. Changes can include, but are not limited to, covered services, benefits, or processes members should use to access benefits. Once approved by DOM, notification can be distributed in multiple forms to ensure the member receives the notification, such as mail, email, or website notifications.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						The *Member Handbook* provides appropriate toll-free contact information and descriptions for Magnolia CHIP Member Services and NurseWise, Magnolia's 24-hour health information line. Information about the website and how to access it is provided on page 7 of the *Member Handbook*.
1.13 A description of the Well-Baby and Well-Child services which include:						*Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service* describes EPSDT services and information is appropriately provided in the *Member Handbook* and website.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/education and referral for identified problems.						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						The *Member Handbook* informs members to contact Member Services or use the *Provider Directory* to select a PCP and obtain information about the PCP. A searchable *Provider Directory* is available on the website or members can request a paper copy.
1.17 Instructions on reporting suspected cases of fraud and abuse;						The *Member Handbook* and website instructs members to call Magnolia's Waste, Abuse, and Fraud Hotline if they suspect misuse of Medicaid services. The plan defines the terms fraud and abuse and provide examples.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						Information about the Care Management Program is adequately provided in the *Member Handbook*. CCME identified brief mention of the program on the website. *Recommendation: Edit the CHIP website to include adequate information on the Care Management program. Refer to page 48 in the Member Handbook.*
1.19 Information about advance directives;						Magnolia provides information for caregivers to create a living will or designate a power of attorney and provide their advance directive to their primary care physician. A link to obtain the *Mississippi Advance Health Care Directive* form is included on the website.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Magnolia notifies CHIP members by mail 30 days before the effective date of any material changes and 14 days prior to implementing changes to covered benefits/services as described in *Policy MS.MBRS.12, Member Notification of Plan Changes* and the *Member Handbook*. *Policy MS.MBRS.27, Member Advisory of Provider Termination* and the *Member Handbook* state members who received primary care from, or were seen on a regular basis by, a terminated provider will be notified in writing within 15 days after Magnolia receives a provider's termination notice.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, the *Member Handbook* indicates members will be automatically assigned a new PCP or they can choose their own, and they may continue visits with the PCP or specialist up to 60 days, if approved. Pregnant women are encouraged to stay with the same provider after the postpartum period.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages.	X					*Policy MS.COMM.01, Marketing: General Guidelines for Marketing Activities* confirms member materials are written at no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. When 5% or more of the resident population of a county is non-English speaking and speaks a specific language, materials are made available in the respective language. Additionally, the *Member Handbook* informs members that written information in other formats such as 18-point font or larger print, audio, or accessible electronic formats are available free of charge by contacting Member Services. During the onsite Magnolia confirmed materials are printed in 12-point font size and provided *Policy MS.MBRS.06, Member Materials Readability and Translation* which also provides guidelines for member written materials. CCME did not identify documentation for the requirement for 12-point font size and 18-point font for materials requiring large print. *Recommendation: Ensure the requirement to print written material using a minimum 12-point font and items requiring large print are created in 18-*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						point font are documented in Policy MBR 7, Member Materials/Sixth Grade Level of Reading Comprehension or other policy. Refer to the CHIP Contract, Section 6 (F).
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Interpreter and translation services are provided free of charge to non-English speaking members, people who have limited English proficiency, and members who are deaf or hearing impaired as described in the *Member Handbook*, *Policy MS.MBRS.03, Impaired/Language-Specific Interpreter Services*, and *Policy MS.MBRS.06, Member Materials Readability and Translation*.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					*Policy MS.MBRS.10, Member Service Calls/Hotline* describes the purpose and process for Magnolia's Member Services Call Center. The toll-free telephone number for Member Services and the Nurse Advice Line is located on the member's ID card, in the *Member Handbook*, the website, and in member education materials such as the *Spring 2019 HealthTalk*. The 24-Hour Nurse Advice Line has nurses available 24 hours a day, 7 days a week, including holidays. The provider tab on the website indicated Provider Services business hours are from 7:30 am to 5:30 pm as required. Page 7 of the *Provider Manual*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						states the toll-free Provider Relations call center is maintained Monday -Friday from 8 am to 5 pm. *Recommendation: Correct the hours of operations on page 7 of the Provider Manual to state operating hours are 7:30 am to 5:30 pm CST, as required by the CHIP Contract, Section 6 (A).*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Evaluators monitor member and provider agent calls to score their performance against established quality guidelines reflecting strengths, deficiencies, and training needs as described in *Policy MS.PRVR.24, Member & Provider Call Audit and Quality Criteria and Protocol*. The 2018 *Quality Improvement Program Evaluation* indicates the Call Center's rating for overall satisfaction with Magnolia was 33.3% in 2018, citing additional training for Provider Services Call Center as a barrier. Call Center statistics are monitored monthly by Centene Corporate and the Performance Improvement Team, which reports to the Quality Improvement Committee. The call "abandoned rate" was 1.0% which meets requirements of the *CHIP Contract, Section 6 (A) (5)*.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					*Policy MS.ELIG.05, Disenrollment* describes the member disenrollment process and states Magnolia will notify DOM of any member meeting the criteria for disenrollment within three days of receiving the enrollment file. The policy does not specify if this timeframe includes members identified with a pregnancy diagnosis. At the onsite, Magnolia confirmed the eligibility teams sends DOM a daily report of any member meeting the criteria for disenrollment. *Recommendation: Edit Policy MS.ELIG.05, Disenrollment to reflect Magnolia will notify DOM of Members identified with a diagnosis related to pregnancy within seven (7) calendar days of identification as required in CHIP Contract Section 4(F).*
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about available preventive health and chronic disease management services and encourages members to utilize these benefits.	X					*Policy MS.CM.24, Health, Wellness, and Preventive Education Programs* describes Magnolia's process for promoting health education services to new and continuing members. Additionally, members are informed of scheduled preventative health services, available case management programs, and how to obtain educational support for medical, BH, and pharmaceutical services through the *Member Handbook* and member newsletters available on the website. Magnolia can send mailers, such as an EPSDT brochure or member newsletter, and make calls to eligible members reminding them of screenings and well visits.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					The *Member Handbook* informs members about the Start Smart for Your Baby® (Start Smart) through which pregnant members receive services, support, and education that can assist in achieving a healthy pregnancy. Pregnant members can be identified for Start Smart through enrollment and claims data, case management contacts, or referrals. The *Care Management Program Description* indicates Magnolia Care Managers coordinate with the Mississippi State Department of Health for high-risk pregnant women who may be eligible for Perinatal High Risk Management/Infant Services System service. Additionally, the *Member Handbook* instructs parents and guardians to contact DOM to have the member's eligibility as a pregnant minor evaluated for coverage under Medicaid.
3. The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					*Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT)* appropriately describes the process Magnolia uses to identify eligible members for Well-Baby and Well-Child services and use monthly reports to track gaps in care. Interventions such as reminder postcards and phone calls encourage members in need of Well-Baby and Well-Child services. Additionally, EPSDT Coordinators and Health Check Coordinators make outreach calls, identify barriers, and assist members with accessing Well-Baby and Well-Child and immunization services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Magnolia implemented the CentAccount program that rewards members for healthy behaviors such as well child visits and immunizations.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the *CMS Survey Validation Protocol*. Magnolia contracts with Morpace, a certified *Consumer Assessment of Healthcare Providers System (CAHPS) Survey* vendor, to conduct the Adult and Child Surveys. The sample sizes were adequate and met the National Committee for Quality Assurance (NCQA) minimum sample size and number of valid surveys (at least 411), but the response rates were below the NCQA target of 40%. For the child survey, generalizability of the survey results is also difficult to discern due to low response rate (19%). *Recommendation: In addition to the other interventions that are in progress, continue working with Morpace to increase response rates for Adult and Child surveys.*

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					Magnolia analyzes data obtained from the survey to identify quality problems.
3. The CCO reports the results of the member satisfaction survey to providers.	X					Magnolia reports results of the survey to providers.
4. The CCO reports the results of the member satisfaction survey and the impact of measures taken to address quality problems that were identified to the appropriate committee.	X					Magnolia reports to the appropriate committee results of the member satisfaction survey and the impact of measures taken to address any quality problems identified. Discussion of CAHPS results are noted in the August 2018 Quality Improvement Committee minutes.
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy MS.MBRS.07.01, Member Grievance and Complaints Process* describes Magnolia's processes for receiving, processing, and responding to member requests for informal and formal complaints and grievances.
1.1 Definition of a grievance and who may file a grievance;		X				The term "grievance" is appropriately defined in *Policy MS.MBRS.07.01* and on Magnolia's website (CHIP). Identified issues with terminology include: •The definition of a grievance on page 54 of the CHIP *Member Handbook* is incomplete. It does not include "other than an adverse benefit determination." •The definition of a grievance on page 62 of the CHIP *Provider Manual* is uses the term "action" rather than the correct term of "adverse benefit determination."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MS.MBRS.07.01, the CHIP *Member Handbook*, the CHIP *Provider Manual*, and Magnolia's website (CHIP) document who can file a grievance. *Corrective Action: Correct the definition of a grievance on page 54 of the CHIP Member Handbook. Revise the definition of a grievance on page 62 of the CHIP Provider Manual to use current terminology.*
1.2 The procedure for filing and handling a grievance;		X				*Policy MS.MBRS.07.01* indicates written acknowledgement is required within five calendar days for both oral and written grievances; however, page 55 of the CHIP *Member Handbook* and the Magnolia website (CHIP) state telephonic/in-person grievances do not require written acknowledgement. The Magnolia CHIP website contains the statement, "Magnolia may need to obtain additional information to review the grievance. If a signed authorization to release information form is not included with the grievance, a form will be sent for signature. If the signed form isn't returned within 30 business days of the request, Magnolia may issue a decision on the grievance without review of some or all of the information." Onsite discussion confirmed this information is incorrect and should be removed from the website. *Corrective Action: Update page 55 of the CHIP Member Handbook and the Magnolia website (CHIP) to indicate written acknowledgement is required*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for telephonic/in-person grievances, as required by Policy MS.MBRS.07.01. Remove the statement indicated above from Magnolia's CHIP website.
1.3 Timeliness guidelines for resolution of the grievance;		X				Page 62 of the CHIP *Provider Manual* incorrectly states the grievance resolution timeframe is "not exceeding fifteen (15) calendar days from the date of the initial receipt of the grievance." The CHIP *Provider Manual* does not address extensions of the resolution timeframe. *Corrective Action: Correct the grievance resolution timeframe in the CHIP Provider Manual and include information about extensions of the grievance resolution timeframe.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;	X					Grievance logs document the member's Medicaid ID, receipt date, category, description of the grievance, summary of resolution, resolution date, and the number of days for resolution. *Policy MS.MBRS.07.01* confirms complaint and grievance records are retained for 10 years. If any litigation, claim negotiation, audit, or other action involving the records has been started before expiration of the 10 year period, the records are retained until the completion of the action and resolution of issues which arise from it or until the end of the regular 10 year period, whichever is later.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO applies the grievance policy and procedure as formulated.	X					Grievance files reflected timely acknowledgements, determinations, and notification of determinations. CCME's review revealed issues with the grievance resolution letters that could result in confusion for the reader, such as: •references to the outdated three-step grievance process •typographical errors that changed the meaning of the information supplied •Incorrect dates •incomplete sentences *Recommendation: Ensure grievance resolution letters contain correct, current information, do not contain typographical errors that change the meaning of the information, and contain correct dates. Consider implementing a quality review process for member letters.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					*Policy MS.MBRS.07.01* indicates a monthly report of grievances is provided to DOM and that Magnolia uses the reported information in Quality Improvement Program activities. Review of QIC minutes confirms the review and discussion of grievance and complaint data, trends, root causes, and development of interventions to address identified issues and causes.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					At the onsite Magnolia described the process used to follow-up on PCP change requests related to member dissatisfaction, but this process is not documented in a policy or elsewhere. *Recommendation: Document the process used to follow up on PCP change requests related to member dissatisfaction in a policy or other document.*
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					During the onsite Magnolia confirmed requests for PCP changes related to dissatisfaction are recorded as complaints and forwarded to Quality Management to follow-up and monitor.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The *2019 Mississippi Children's Health Insurance Program Quality Program Description* describes the Quality Improvement activities Magnolia has established to improve the services and health care provided to the Children's Health Insurance Program (CHIP) members. This program description is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviewed, updated as needed, and presented to the QIC and the BOD for approval at least annually.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					The 2018 and 2019 MSCHIP and MSCHIP BH workplans were provided. Both workplans were divided into four tabs, "Committees, P&P Doc Reports, Performance Measures, and QIPI Activities." Each tab contained the goals/objectives, planned activities, responsible party, frequency, and completion date. The activities or scope of work on the Behavioral Health workplan was identical to the CHIP workplan and not specific to behavioral health. For example, the PIPs state at least one project is related to obesity. *Recommendation: Include only the activities related to the Behavioral Health population on the Behavioral Health QI workplan.*
IV B. Quality Improvement Committee						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia's BOD has authority, responsibility, and oversight of the Quality Improvement (QI) program. The BOD delegates the operating authority of the QI program to the QIC. This committee is responsible for implementing, monitoring, and directing QI activities. Other committees involved in the quality improvement activities include the Performance Improvement Team and the Quality Task Force.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is chaired by the Chief Medical Director. Members include senior leadership and participating network providers. The committee's participant roster indicates there are five participating providers. Their specialties include pediatrics, family medicine, psychiatry, and a nurse practitioner. A minimum of five members, including three plan staff and two external physicians, must be present for a quorum.
3. The QI Committee meets at regular intervals.	X					The QIC meets at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded at each meeting and reflect the attendance and committee discussions for each item and any follow-up actions needed.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Magnolia was found to be fully compliant and met all the requirements for the HEDIS® measures as per the report by Attest Health Care Advisors. Several measures had substantial improvement greater than 10%: Asthma Medication Compliance, Follow up Care for Children on ADHD Medication Continuation Phase, Follow up After Hospitalization for Mental Illness, and Well-Child Visits. The measure of five

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Well Child Visits in the First 15 Months of Life had a substantial decrease, but the six-plus Well Child Visits increased substantially. Details of the validation activities for the performance measures may be found in *Attachment 3, CCME EQR Validation Worksheets*.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					For CHIP, Magnolia submitted four projects for desk review. As per the contract, the topic of obesity should be selected annually for continuous evaluation. Topics included: EPSDT, Obesity for Children, 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					All four of the projects (4/4=100%) received a score of "High Confidence in Reported Results." There are no corrective actions for the submitted PIPs. However, the Obesity and ADHD PIP reports showed a lack of improvement in rates. Details of the validation activities for the PIPs, and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets.* *Recommendation: Continue interventions to improve rates until project completion.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						Policy *MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service* describes the process for monitoring and implementing interventions related to Well-Baby and Well-Child services. The product type listed on page one of the policy indicates this policy is applicable for both CAN and CHIP; however, the policy does not specifically list Well-Baby and Well-Child. The policy only used the term "EPSDT." Onsite discussion indicated the process used in this policy is the same for the Well-Baby and Well-Child program. *Recommendation: Include the term "Well-Baby and Well-Child"* in policy *MS.QI.20, Early and Periodic Screening Diagnostic & treatment (EPSDT) Service.*
4.1 Initial visits for newborns;	X					
4.2 Well-Baby and Well-Child screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					According to the policy, Magnolia runs a monthly report to identify members needing follow-up care and documents the treatment provided. The policy further indicates this data is tracked and trended at least quarterly and reported to the Performance Improvement Team. Examples of this report were provided.
IV F. Annual Evaluation of the Quality Improvement Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					For the CHIP program, Magnolia conducts an evaluation of the effectiveness of their QI program. The *Annual Quality Improvement Program Evaluation Magnolia Health Mississippi Children's Health Insurance Program (MSCHIP) 2018* was provided, and the program evaluation contained the results of the QI activities conducted for CHIP.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to:	X					Magnolia's *UM Program Description* outlines the objectives, scope, and staff roles for physical, behavioral health, and pharmaceutical services. Several policies, such as *MS.UM.02.01, Medical Necessity Review* and *MS.UM.05.05, Timeliness of UM Decisions and Notifications*, provide guidance on UM processes and requirements. Envolve People Care (EPC) is the delegated provider of BH utilization. Envolve Pharmacy Solutions (EPS) is delegated to provide pharmacy services and both are NCQA accredited.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The Chief Medical Director, Jeremy Erwin, MD, is licensed to practice in Mississippi. His responsibilities include, but are not limited to, oversight of the UM Program, supervising medical necessity decisions, conducting reviews, and chairing the Utilization Management Committee. Daily management of UM activities are delegated to the interim Vice President of Medical Management, Cherie Polk.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM program is evaluated at least annually to assess its strengths, effectiveness, and opportunities for process improvement. The evaluation and recommendations are presented to the QIC and BOD for approval. Additionally, UM criteria are reviewed and approved annually and updated as needed.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Magnolia uses Centene clinical policies, InterQual, and applicable state and regulatory guidelines as described in *Policy MS.UM.02, Clinical Decision Criteria and Application*. The *UM Program Description* states the plan generally uses InterQual guidelines to determine medical necessity and appropriateness of physical and behavioral health care.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files reflect consistent decision-making using evidenced base criteria and relevant medical information, as described in the *UM Program Description*, *Policy MS.UM.02, Clinical Decision Criteria*, and *Policy MS.UM.02.01, Medical Necessity Review*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					*Policy MS.UM.02, Clinical Decision Criteria and Application* describes how Magnolia applies InterQual criteria to level I and Level II reviews while considering other factors when applying criteria to a given individual situation such as, but not limited to, the member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. Approval files reflect individual member circumstances are taken into consideration and staff consults with the Medical Director about appropriate service requests.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					*Policy CC.UM.02.05, Interrater Reliability* and *Policy MS.UM.03.01, Interrater Reliability* state annual inter-rater reliability (IRR) testing is conducted for physician, non-physician, and clinical staff reviewers to evaluate consistency of applying decision-making criteria. Staff scoring below the 90% benchmark will be retrained and retested within 30 days.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Envolve Pharmacy Solutions is the contracted pharmacy benefit manager (PBM) for the health plan and is responsible for implementing the pharmacy program as required. A link to access the most current version of *Preferred Drug List* (PDL) is posted on Magnolia's website and directly transfers the user to DOM's website where the PDL is posted in a searchable, electronic format. The *Member Handbook* states over-the-counter medications are covered with a prescription from a licensed provider and the reader is instructed to call

STANDARD	SCORE					COMMENTS
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						Member Services or click the embedded link for a complete list of covered medications.
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Envolve Pharmacy Solutions conducts the prior authorization process for covered outpatient drugs and is required to provide a 72-hour emergency supply of medication until authorization is complete when there is immediate need for the drug. The CHIP *Member Handbook* and CHIP *Provider Manual* include appropriate information regarding the PDL and emergency supply of medication.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and *Policy MS.UM.02.01, Medical Necessity Review* describe the role of licensed and unlicensed staff who are trained to perform prior authorizations. A Level I review is performed by a Mississippi licensed nurse or Referral Specialist, and a Mississippi-licensed physician or other appropriate healthcare practitioner performs Level II medical necessity review. A qualified BH practitioner is consulted on BH service requests and dental practitioners conduct Level II dental reviews. The Pharmacy Director is licensed in Mississippi and conducts Level II reviews in conjunction with the Medical Director.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with *Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications*, the *UM Program*

STANDARD	SCORE					COMMENTS
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						Description, and *CHIP Contract* requirements. Onsite discussions revealed 2018 timeframe goals for service authorizations were not met and interventions were implemented to address them. Regarding extensions of expedited requests, page 6 of *Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications* states, "If the Plan requires additional clinical information in order to make a decision, a one-time extension of up to forty-eight (48) hours may be implemented." This statement is not consistent with requirements in *CHIP Contract, Section 5 (H)*. Onsite discussions confirmed that Magnolia is required to request approval from DOM to extend expedited requests beyond 24 hours. *Recommendation: Edit CHIP Policy MS.UM.05.05, Timeliness of UM Decisions and Notifications to indicate Magnolia will request approval from DOM to extend expedited service requests beyond 24 hours.*
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists as outlined in *Policy UCSMM.06.16, Initial Review Timeframes*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files reveal denial decisions are made according to the processes described in *Policy UCSMM.06.16 Initial Review Timeframes*. Notifications are appropriately rendered via mail, fax, or telephone.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					Magnolia's processes for receiving, reviewing, and resolving member appeals are described in *Policy MS.UM.08.01, Appeal of UM Decisions*.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;			X			Issues noted with definitions of appeal terminology include: •*Policy MS.UM.08.01* and the CHIP *Member Handbook* incompletely define the term "adverse benefit determination." Both documents are missing "the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." •The CHIP *Member Handbook* states, "an appeal is a request for Magnolia to review a Magnolia Notice of Adverse Action." The term "action" is outdated; the current term is "adverse benefit determination." •The CHIP *Provider Manual* does not define the term "appeal" or "adverse benefit determination" and uses the term "action" throughout. Note: This was a corrective action item from the previous EQR. •Magnolia's website (CHIP) uses the term action instead of "adverse benefit determination" and incompletely defines the term. It is missing "the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." The CHIP *Provider Manual* does not define who may file an appeal. *Corrective Action: Revise Policy MS.UM.08.01 and the CHIP Member Handbook to include the complete definition of the term "adverse benefit determination." Revise the CHIP Member Handbook to use the current term of "adverse benefit determination" instead of the outdated term "action." Update the CHIP Provider Manual to include definitions of an appeal and adverse benefit determination, to include information about who can file an appeal, and correct the use of the term "action." Update the CHIP website to use the current term of "adverse benefit determination" instead of "action." Ensure the website definition of an adverse benefit determination is complete.*
1.2 The procedure for filing an appeal;		X				*Policy MS.UM.08.01* states appeals may be filed within 60 calendar days from the date on the adverse benefit determination notice, as required by *42 CFR §438.402 (c) (ii) (2) (ii)*. The policy also states oral appeals require a written request w/in 30 calendar days (unless expedited). The following issues regarding procedures for filing an appeal were identified: •The CHIP *Member Handbook*, page 57, and Magnolia's website incorrectly indicate the

STANDARD	SCORE					COMMENTS
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						timeframe to file an appeal is "within 45 days of the receipt of the Notice of Action." •The CHIP *Member Handbook* and the CHIP website do not indicate the timeframe to submit a written appeal request following an oral appeal. •The CHIP *Notification of Adverse Determination for Requested Services* letter template incorrectly states appeals may be filed "within 60 calendar days from the date you receive this letter" and does not include the timeframe for a written appeal request to follow an oral request. •The CHIP *Provider Manual* does not address the timeframe to file an appeal, appeal filing methods, that oral appeals require a written appeal to follow (or the timeframe for this), and that oral expedited appeals do not require a written appeal to follow. •The CHIP website does not indicate a written appeal request is not required for expedited appeals. *Corrective Action: Correct the timeframe to file an appeal in the CHIP Member Handbook, page 57, and on Magnolia's website. Update the CHIP Member Handbook and the CHIP website to include the timeframe to submit a written appeal request following an oral appeal. Revise the CHIP Notification of Adverse Determination for Requested Services letter template with the correct timeframe to include the correct timeframe to file an appeal and to include the timeframe for a written appeal request to follow an oral request. Update the CHIP Provider Manual to include the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						timeframe to file an appeal, appeal filing methods, that oral appeals require a written appeal to follow or the timeframe for this, and that oral expedited appeals do not require a written appeal to follow. Update the CHIP website to indicate a written appeal request is not required for expedited appeals.
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;		X				*Policy MS.UM.08.01* documents incorrect information regarding the timeframe for resolution of expedited appeals. Page 6 states expedited appeal determinations must be made "no later than 72 hours from receipt of necessary information;" however, *42 CFR §438.408 (b) (3)* requires resolution within 72 hours of receiving the appeal and not 72 hours of receiving necessary information. Page 57 of the CHIP *Member Handbook* incorrectly states standard appeal resolution is required within 15 days from the date of the request. Page 63 of the CHIP *Provider Manual* references the outdated three-step appeal process and incorrectly states the entire appeal process is required to be completed within 90 days.

STANDARD	SCORE					COMMENTS
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						Corrective Action: Correct the timeframe for resolution of expedited appeal on page 6 of Policy MS.UM.08.01. Revise page 57 of the CHIP Member Handbook with the correct timeframe for standard appeal resolution. Update the CHIP Provider Manual with the resolution timeframes for current appeal processes.
1.6 Written notice of the appeal resolution;	X					
1.7 Other requirements as specified in the contract.		X				Requirements for continuation of benefits pending resolution of an initial appeal and Independent External Review are detailed in *Policy MS.UM.08.01*. However, continuation of benefits is not applicable for CHIP members when an appeal or Independent External Review is pending. *Corrective Action: Revise Policy MS.UM.08.01 to remove information regarding continuation of benefits pending the outcome of appeals and Independent External Reviews. Refer to 42 CFR § 457.1260.*
2. The CCO applies the appeal policies and procedures as formulated.	X					Appeal files reflect that overall appeals are handled appropriately with timely acknowledgement and notice of resolution. For one CHIP appeal, an incorrect resolution letter template was used and informed the appellant that the next level of review is a State Fair Hearing; however, CHIP members do not have the option of a State Fair Hearing. The letter should have indicated the next level of review is an Independent External Review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure correct letter templates are used to inform CHIP appellants of the outcome of an appeal.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					*Policy MS.UM.08.01* indicates summaries of appeal actions, trends, and root causes are reported quarterly to the QIC. The information is used to identify opportunities to improve quality of care and service. The QIC reports findings to the Board of Directors. Review of QIC minutes confirmed appeal data is reported and discussed. Minutes indicate Magnolia identified trends and took action to determine root causes and address the findings.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management Program.	X					The *2019 Care Management Program Description* outlines the framework for the CM Management Program's goals, scope, and lines of responsibility. The program follows the Case Management Society of America's (CMSA) Standards of Practice for Case Management and adheres to HEDIS measures. The program goal includes but is not limited to assisting members in achieving optimum health outcomes, functional capability, and quality of life through improved management of their disease or condition.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Methods used to identify eligible members into case management include but are not limited to review of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						clinical claims, medical records, and utilization management data. Additionally, Magnolia routinely uses a predictive modeling and care management analytics tool to identify and stratify members into low risk, medium risk and high risk categories.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					*Policy MS.CM.01, Care Management Program and Program Description* adequately addressed that a health risk assessment occurs as quickly as required, but no later than 30 days of referral to the high, medium or low risk level. This can occur via telephone or in person.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					A Care Treatment Plan is developed by a CM and can include a BH specialist, caregiver/family, and the PCP. BH care coordination is incorporated in the care treatment plan as needed. Care Managers are licensed nurses and may hold certifications in care management.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Magnolia uses care management techniques 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. Guidelines for outreach are noted in policies such as, but not limited to, *MS.CM.01, Care Management Program and Program Description*, *MS.UM.24, Continuity and Coordination of Services*, and *MS.UM.24.04, Post Discharge Member Outreach*.
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 contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
7.7 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;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring 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 level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract.	X					In addition to providing high risk members all services accessible to low and medium risk members, Rising Risk is a stratification for members with a new catastrophic or chronic condition such as premature infants and pregnant members under the age of 21. Magnolia's Care Managers coordinate with Mississippi State Department of Health for high-risk pregnant

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						women who may be eligible for Perinatal High Risk Management/Infant Services System services.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					*Policy MS.UM.24, Continuity and Coordination of Services* states Magnolia will transfer the member's care management history, six months of claims history, and other pertinent information when a member disenrolls. If a member with special needs transfers into the health plan, the CM will coordinate care with the former plan so that services are not interrupted.
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					The *UM Program Description* lists disease management programs which may include but are not limited to: Asthma, Diabetes, Heart Failure, and Weight Loss & Obesity Program. Condition Specific Care Management Programs may include but are not limited to: Emergency Department Diversion Program, Sickle Cell, HIV/AIDS, and High Risk Pregnancy.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					*Policy MS.CM.99, Transitional Care Management Process* outlines the various transition processes for new members, members transferring from another contractor, and when discharged from a clinic or inpatient setting. The Integrated Care Team (ICT) facilitates communication and coordination between the PCP and specialists, including behavioral health providers, to ensure continuity of care and prevent duplication of services as described in *Policy MS.UM.24, Continuity and Coordination of Services*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.		X				*Policy MS.CM.99, Transitional Care Management Process* describes Magnolia's process for transitioning members; however, it does not include the complete list of general transitional care management requirements as stated in the *CHIP Contract, Section 8 (B)*. CCME could not identify the following requirements: •Collaborating with hospital discharge planners, primary care and BH staff •The 14-day timeframe to notify a provider of member's discharge •Ensuring that the member receives the necessary supportive equipment and supplies •Promoting ability, confidence, and change in self-management of chronic conditions •Providing Care Management until all goals are met or members elect to not receive services *Corrective Action: Revise Policy MS.CM.99, Transitional Care Management Process to include all general transitional care requirements specified in CHIP Contract Section 8(B)(1).*
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements the transition of care plan, and provides oversight to the transition process.	X					*Policy MS.CM.99, Transitional Care Management Process* states the transition of care team includes but is not limited to, RN Care Managers, Social Service Specialists, and BH staff.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					Evaluation of the CHIP UM Program is conducted annually and provides an overall assessment of the effectiveness of the UM program as well as analysis

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						on program-specific outcomes. UM Program barriers are identified with interventions and recommendations to address them. At the onsite, discussions of the 2018 UM Program evaluation revealed Magnolia experienced staffing issues related to high turnover and a lack of diversity of medical director specialties. Interventions were implemented in Q4 2017 and Q1 2018 to address these barriers.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Magnolia ensures all delegated organizations have written, signed agreements designating the delegated activities, reporting requirements, and compliance and oversight requirements. EPC-Cenpatico is no longer considered a delegated vendor for behavioral health because it was integrated into Centene. Magnolia has delegation agreements with the following entities: •Envolve Dental—Dental claims, network, utilization management, credentialing, and quality management •Medical Transportation Management, Inc. (MTM) (CAN Only)—Non-emergency transportation claims, network, utilization management, and quality management •National Imaging Associates, Inc. (NIA)—Radiology utilization management •EPC-NurseWise—Nurse call center •EPC-Nurtur—Disease management •Envolve Vision—Vision services claims, network, utilization management, credentialing, and quality management •Envolve Pharmacy Solutions—Pharmacy claims, network, utilization management, credentialing •Hattiesburg Clinic, PA—Credentialing •LSU Healthcare Network (New Orleans)—Credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•North Mississippi Medical Clinic/North MS Healthlink—Credentialing •Rush Health Systems—Credentialing •Ochsner Clinic Foundation—Credentialing •St. Judes Research Hospital—Credentialing •Baptist Memorial Health Care-Baptist Health Services Group—Credentialing •Magnolia Regional Medical Center—Credentialing •Mississippi Physicians Care Network—Credentialing •Mississippi Health Partners—Credentialing •University of Mississippi Medical Center—Credentialing •Memorial Hospital at Gulfport—Credentialing
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					*Policy CC. COMP.21.04, Third Party Audit Program* defines the overall process for national third-party vendor oversight which includes pre-service audits, annual audits, and validation audits to confirm the vendor has mitigated issues outlined in a quality improvement plan or corrective action plan. Proof of annual oversight was received for all national vendors. *Policy CC.CRED.12, Oversight of Delegated Credentialing* defines the procedures for evaluating a potential entity's capacity to perform delegated activities prior to a delegation agreement. The pre-delegation review may be accomplished through an exchange of documents, through pre-delegation meetings, or an on-site review and includes an assessment of the credentialing program, polices, and file review to ensure compliance to plan, NCQA, HIPAA, or other regulatory standards, such as State

STANDARD	SCORE					COMMENTS
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						requirements. Magnolia retains accountability for delegated services and monitors the delegate's performance through review of the delegate's program descriptions, policies, procedures, routine reporting, Joint Oversight Committee meetings with each delegate, and annual evaluation. Corrective action plans are developed when deficiencies are identified. Reports regarding ongoing corrective action plans are presented to the QIC at least quarterly. Pre-service review or annual oversight was received for all entities where credentialing and recredentialing has been delegated. Tools were appropriate and comprehensive.