CCME

Mississippi External Quality Review

ANNUAL COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR JUNE 2018 – MAY 2019

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Prepared on behalf of the
Mississippi Division of Medicaid

EXECUTIVE SUMMARY 3
A. Overall Findings 3
Information Systems Capabilities Assessment 3
Provider Services 3
Member Services 4
Quality Improvement 5
Performance Measures 5
Performance Improvement Projects 6
Utilization Management 6
B. Overall Scoring 7
BACKGROUND 8
METHODOLOGY 9
FINDINGS 9
A. Information Systems Capabilities Assessment 9
Strengths 11
Weaknesses 11
Recommendations 11
B. Provider Services 11
Provider Satisfaction Survey 12
Strengths 22
Weaknesses 22
Recommendations 22
C. Member Services 22
Member Satisfaction 23
Grievances 24
Strengths 27
Weaknesses 27
Recommendations 27
D. Quality Improvement 28
Performance Measure Validation 28
Non-HEDIS Performance Measures 40
Performance Improvement Project Validation 42
Strengths 49
Weaknesses 49
Recommendations 49
E. Utilization Management 49
Strengths 55
Weaknesses 55
Recommendations 56

EXECUTIVE SUMMARY

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

The purpose of the EQRs was to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. CCME accomplished this by conducting the following activities for the CAN and CHIP Programs: validation of performance improvement projects (PIPs), performance measures (PMs), and surveys; and determination of compliance with state and federal regulations. This report is a compilation of findings of annual reviews conducted in 2018 for each CCO's CAN and CHIP Programs.

A. Overall Findings

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

Information Systems Capabilities Assessment

Magnolia's claims payment benchmarks comply with contractual requirements and internal audits are conducted to ensure quality and accuracy. An internal team monitors claims to ensure compliance with established benchmarks. United's *Information Systems Capabilities Assessment* (ISCA) documentation indicates the plan can meet or exceed contractual claims payment requirements; however, United estimates only 85-90% of its claims are completed within the required timeframe. Both health plans have appropriate processes in place to identify and track members and to collect and store performance and effectiveness data. Appropriate backup and disaster recovery plans are in place and are tested, and the CCOs can track and remediate any issues encountered during disaster recovery testing.

Provider Services

United and Magnolia have comprehensive credentialing programs for CAN and CHIP which include approval oversight by local Credentialing Committees that are chaired by a local

Chief Medical Director (CMD) or Chief Medical Officer (CMO). A few issues were identified that related to lack of information in policies and credentialing/recredentialing files not containing appropriate documentation. United's credentialing/recredentialing files were missing information such as the Social Security Death Master File (SSDMF) and Clinical Laboratory Improvement Amendments (CLIA); some ownership disclosure forms had incorrect signatures; and a few organizational files were missing queries.

Magnolia's credentialing policies and file review did not include the MS Medicaid Sanctioned Provider List query, and a policy had incorrect information about credentialing delegation. CCME also identified an area of concern related to Magnolia's lack of ability to provide proof of provider office site visits for initial credentialing.

United and Magnolia use a National Committee for Quality Assurance (NCQA)-certified vendor to conduct the Provider Satisfaction Surveys. Survey validations for United and Magnolia found one element did not meet the CMS validation protocol related to low response rates, which were 5% for United and 10% for Magnolia's initial sample; and 35% for Magnolia's latter sample.

Member Services

United and Magnolia use vendors certified by NCQA to conduct *Consumer Assessment of Healthcare Providers and Systems* surveys for CAN and CHIP membership. Although response rates were low for all population groups surveyed, results were analyzed to identify quality problems and were reported to providers and appropriate organizational committees. CCME provided suggestions for improving response rates for future surveys.

Grievance policies are in place to guide United and Magnolia staff in grievance processes and requirements. Members and providers are educated about grievances through various forums such as member handbooks, provider manuals, and plan websites. CCME identified deficiencies in documentation of grievance information including but not limited to terminology, procedures for filing and handling grievances, and resolution timeframes. Grievance files revealed isolated issues for both United and Magnolia CAN and CHIP; however, findings in Magnolia's grievance files for CAN were of more concern as they reflected a pattern of failing to refer applicable grievances for review and investigation as potential quality of care concerns. Also, Magnolia sometimes took no action to resolve member grievances—instead, members were instructed to file the grievance elsewhere, such as with the provider, state agencies, or licensing boards. Both United and Magnolia have appropriate processes to analyze grievance data for patterns and potential quality improvement opportunities, and to report data and findings to appropriate committee(s).

Quality Improvement

For the 2018 review, CCME conducted a validation review of the HEDIS® and non-HEDIS performance measures and validated the performance improvement projects for the CAN and CHIP programs.

Performance Measures

To evaluate the accuracy of the performance measures (PMs) reported, CCME used the *Centers for Medicare & Medicaid Services (CMS) Protocol, Validation of Performance Measures*. This validation method balances the subjective and objective parts of the review, outlines a review process that is fair to the plans, and provides the State information about how each plan is operating. Both CCOs are using a HEDIS-certified vendor or software to collect and calculate the measures and were fully compliant.

When comparing the Measurement Year (MY) 2015 CAN HEDIS rates to the MY 2016 CAN HEDIS rates, United had a substantial improvement of greater than 10% in rates for Body Mass Index (BMI) Percentile documentation for children/adolescents and Persistence of Beta-Blocker Treatment After a Heart Attack among others. CCME noted a decline in rates for Asthma Medication compliance and Antidepressant Medication Management.

Adult Body Mass Index (BMI) Assessments, BMI Percentile for children/adolescents, Counseling for Nutrition, Counseling for Physical Activity, Rotavirus Immunizations, and several others were noted as having a substantial improvement (greater than 10%) for Magnolia. The Statin Adherence measure was the only measure with a substantial decrease in rate for Magnolia.

For the CHIP HEDIS rates, United had several measures that improved more than 10%, including BMI Percentile documentation, lead screening, and antidepressant medication management. Measures with a substantial decrease in rate include dental visits for 19-20 year-olds and Initiation and Engagement of AOD Dependence Treatment (iet) for the 18+ age group.

Magnolia also had several measures that had a substantial improvement of greater than 10%, including BMI percentile documentation, immunization rates, and dental visits. Measures with a substantial decrease in rate include prenatal and postpartum care, and ongoing prenatal care.

Non-HEDIS performance measures selected by DOM include Asthma Related ER visits, Asthma Related Readmissions, EPSDT Screening, CHF Readmissions, Pre/Post Natal Complications, and Pregnancy Outcome. Each CCO was provided a Microsoft® Excel (Excel) reporting template prepared by a DOM vendor for reporting CAN non-HEDIS rates. During the onsite visit, CCME determined that the Excel formulas in the reporting template were incorrect and did not provide the measure rates in accordance with the

DOM specifications. Based on this determination, CCME did not validate the CAN non-HEDIS measures for the 2018 review cycle. Both CCOs met the validation requirements for the non-HEDIS CHIP performance measure.

Performance Improvement Projects

CCME validated 16 Performance Improvement Projects (PIPs) for the CCOs. Fourteen received a score in the High Confidence Range and two projects were scored in the Confidence Range. No projects scored in the Low Confidence or Not Credible Range.

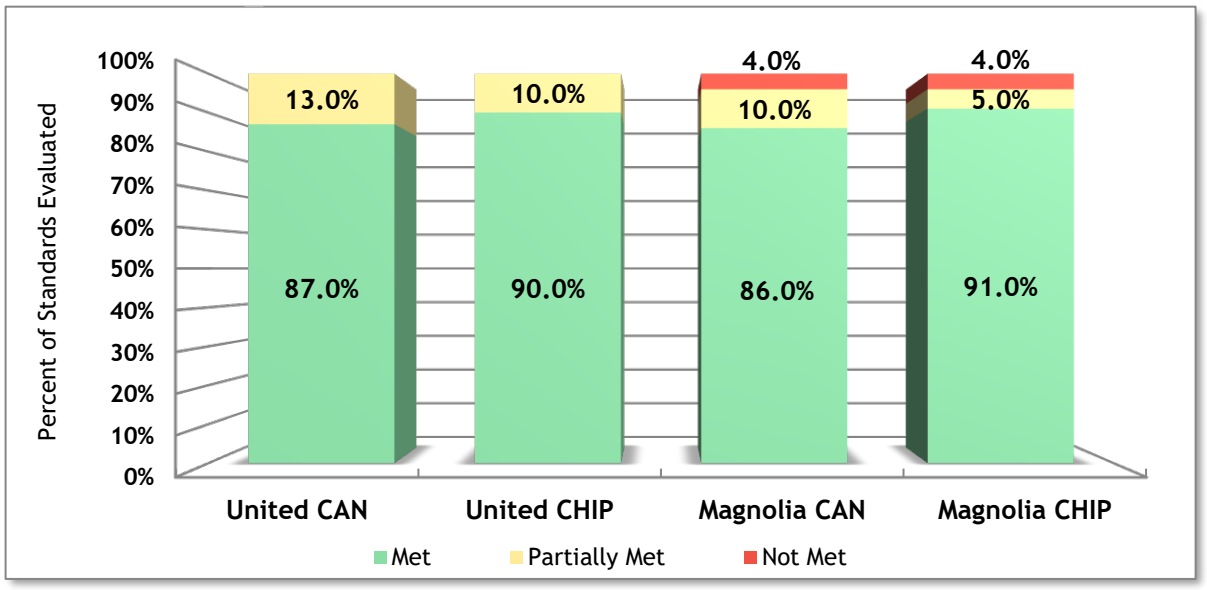
Utilization Management

The Utilization Management (UM) reviews for United and Magnolia include program descriptions, program evaluations, policies, committee minutes, provider manuals, member handbooks, and case management and appeal files. The *CAN* and *CHIP UM Program Descriptions* outline the purpose, goals, objectives, and staff roles. Policies define how appeals and case management services are operationalized to service members.

CCME found issues with appeals processes and requirements for CAN and CHIP and has provided recommendations to address the issues. Specifically, Magnolia's CAN and CHIP appeal files revealed the start time for processing appeals submitted on the member's behalf begins with receipt of the member or member's guardian signed *Authorized Representative Form* (ARF) instead of the date the appeal request is received. United had documentation of incorrect timeframes for requesting a State Fair Hearing.

CCME did not identify any uncorrected deficiencies from the previous EQRs. *Figure 1, Overall Results for 2018 EQR,* provides an overview of the percentage of "Met," "Partially Met," "Not Met," or "Not Applicable" scores by health plan and Medicaid Program.

Figure 1: Overall Results for 2018 EQR



B. Overall Scoring

To objectively compare the CCOs, CCME applied a numerical score (points) to each standard's rating within a section to derive the overall score (percentage) for each plan and each Medicaid Program. Using the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations*, the overall score was calculated based on the following method:

1. Points were assigned to each rating ("Met" = 2 points and "Partially Met" = 1 point), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.
2. The total number achieved was calculated by adding the earned points together.
3. The final section score was derived by dividing the section's total points (total number achieved) by the total possible points for that section.
4. The overall score (percentage) was then calculated by averaging the final section scores for the seven sections reviewed.

Results of the scoring matrix are included in *Table 1: Overall Scoring Matrix*.

Table 1: Overall Scoring Matrix

United		Magnolia	
CAN	CHIP	CAN	CHIP
94%	95%	91%	94%

BACKGROUND

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

As the EQRO, CCME conducts EQRs of the CAN and CHIP Medicaid Managed Care Programs for each CCO on behalf of DOM. Federal regulations require that EQRs include three mandatory activities: validation of PIPs, validation of PMs, and an evaluation of compliance with state and federal regulations for each health plan. In addition to the required mandatory activities, CCME validates consumer and provider surveys conducted by the CCOs for the CAN and CHIP Programs.

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

The *Annual Comprehensive Technical Report* for contract year June 2018 through May 2019 contains data regarding results from the EQRs conducted for the United and Magnolia CAN and CHIP Programs.

METHODOLOGY

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

FINDINGS

CCME conducted an annual review of United and Magnolia for the CAN and CHIP Programs during the reporting period. The CCOs were evaluated using the standards developed by CCME, and the tables in each following section reflect the scores for each standard evaluated in the review. Each standard was scored as fully meeting a standard (Met), acceptable but needing improvement (Partially Met), or failing a standard (Not Met). The arrows indicate a change in the score from the previous review. For example, an arrow pointing up indicates the score for that standard improved from the previous review, and a down arrow indicates the standard was scored lower than the previous review. Scores without arrows indicate no change in the score or the standard was not evaluated in the previous review. The CCOs are required to submit a corrective action plan to CCME to address any standards scored as Partially Met or Not Met.

A. Information Systems Capabilities Assessment

CCME conducted an evaluation of the health plans' *Information System Capabilities Assessment* (ISCA) documents and additional supporting documentation. The purpose of the ISCA review is to assess the plans' abilities to comply with state guidelines for the delivery of health care services, securely and accurately collect health care data, appropriately process claims within the required timeframes, and report required activities.

CCME's review of the ISCA for each of the plans determined Magnolia has documented benchmarks for claims payment timeframes that are compliant with contractual requirements. Magnolia conducts internal audits to ensure claim quality and accuracy, and an internal Claims Operations Management Team monitors claims daily and monthly to verify compliance with established benchmarks. United submitted ISCA documentation that indicates the plan is capable of meeting or exceeding the contractual requirements for claims payments. One of the requirements is that 99% of clean claim payments must be completed within 90 days; however, United estimates only 85-90% of its claims are completed within this timeframe.

Both health plans have appropriate processes in place to uniquely identify members, identify duplicate members, track members across product lines, and correlate newborns with existing members. Both plans also have appropriate processes to collect and store performance and effectiveness data. United uses software that is accredited by the National Committee for Quality Assurance (NCQA). Magnolia's processes were audited by Attest Health Care Advisors and found to comply with all required HEDIS standards.

United and Magnolia have established backup and disaster recovery plans and conduct disaster recovery testing exercises. Documentation confirmed processes are in place to track and remediate any issues encountered during disaster recovery testing.

An overview of the scores for each health plan's ISCA review are provided in *Table 2: CAN Information Systems Capabilities Assessment Comparative Data and Table 3: CHIP Information Systems Capabilities Assessment Comparative Data.*

Table 2: CAN Information Systems Capabilities Assessment Comparative Data

Section	Standard	United CAN	Magnolia CAN
Information Systems Capabilities Assessment	The CCO processes provider claims in an accurate and timely fashion	Partially Met ↓	Met
	The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met
	The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met
	The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	Met	Met

Table 3: CHIP Information Systems Capabilities Assessment Comparative Data

Section	Standard	United CHIP	Magnolia CHIP
Information Systems Capabilities Assessment	The CCO processes provider claims in an accurate and timely fashion	Partially Met ↓	Met
	The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met

Section	Standard	United CHIP	Magnolia CHIP
Information Systems Capabilities Assessment	The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met
	The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met

Strengths

- Both health plans have demonstrated the ability to successfully recover key production systems in the case of a disaster.

Weaknesses

- United estimates its claims payments meet contractual requirements only 85-90% of the time.

Recommendations

- Make sure claim payments are compliant with contractual requirements specified in the CAN and CHIP contracts.

B. Provider Services

CCME's review of the Provider Services section included a review of the health plans' materials related to credentialing and recredentialing processes and file review, provider network accessibility and availability, and the *Provider Satisfaction Survey*. Both United and Magnolia have established credentialing programs with Credentialing Committees chaired by a local Chief Medical Director (CMD) or Chief Medical Officer (CMO). The committees are comprised of local network providers with various specialties. Magnolia's Credentialing Committee meets monthly and United's committee, the Provider Advisory Committee, meets quarterly. United also has a National Credentialing Committee that reviews all credentialing/recredentialing decisions and the Mississippi CMO attends the meetings frequently.

Both plans have credentialing policies or credentialing plans that define the procedures for conducting practitioner/organizational selection and retention. A review of United CAN and CHIP files identified the following issues: missing proof of queries of the Social Security Death Master File (SSDMF); not collecting Clinical Laboratory Improvement Amendments (CLIA) for behavioral health files when the application indicates laboratory services are performed; accepting ownership disclosure forms signed by a credentialing

specialist when United's document states that provider entity signatures must be from an individual with the power to legally bind the entity; and missing queries in organizational files. United addressed these issues and made the necessary corrections in their corrective action plan except for querying the SSDMF at initial credentialing and at recredentialing. A teleconference was held with United and DOM staff to discuss the unresolved deficiency. As of the date of this report, United has not made the necessary corrections and remains out of compliance with the *DOM Contract, Section 17 (E)*.

Magnolia's credentialing process for CAN and CHIP did not include the requirement to query the MS Medicaid Sanctioned Provider List, and a policy contained outdated information regarding behavioral health delegation. An area of concern was related to Magnolia's lack of ability to provide proof of provider office site visits for initial credentialing. The CAN and CHIP files lacked proof of querying the MS Medicaid Sanctioned Provider List, and a few files lacked other required documentation.

Both United and Magnolia received "Met" scores for all the standards related to adequacy of the provider network. Policies define geographic access standards that comply with contract guidelines. GEO access reports are used to measure defined standards, and the plans assess network compliance at least quarterly, as required. Both plans have processes to measure provider appointment availability and after-hours access.

Provider Satisfaction Survey

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

United and Magnolia used a National Committee for Quality Assurance (NCQA)-certified vendor to conduct the *Provider Satisfaction Surveys*. Survey validations for United and Magnolia found one element did not meet the CMS protocol for validation related to low response rates, which were 5% for United and 10% for Magnolia's initial sample; and 35% for Magnolia's latter sample. *Table 4, Provider Satisfaction Survey Validation Results* provides an overview of the provider survey validation results.

Table 4: Provider Satisfaction Survey Validation Results

Reason	Recommendations
UNITED	
The survey had a low response rate (5%). 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 the survey vendor.

Reason	Recommendations
MAGNOLIA	
Initial sample had a low response rate (10%) and the latter sample had a response rate of 35%. This is just slightly below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.	Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.

An overview of the scores for the Provider Services section is illustrated in *Table 5: CAN Provider Services Comparative Data* and *Table 6: CHIP Provider Services Comparative Data*.

Table 5: CAN Provider Services Comparative Data

Section	Standard	United CAN	Magnolia CAN
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Met ↑	Partially Met ↓
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO	Met ↑	Partially Met ↓
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met
	Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members;	Met	Met
	Valid DEA certificate and/or CDS certificate;	Met	Met
	Professional education and training, or board certification if claimed by the applicant	Met	Met
	Work history	Met	Met
	Malpractice claims history	Met	Met

Section	Standard	United CAN	Magnolia CAN
Credentialing and Recredentialing	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Met
	Query of the National Practitioner Data Bank (NPDB)	Met	Met
	Query of the System for Award Management (SAM)	Met	Met
	Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Not Met ↓
	Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Partially Met	Met
	Ownership Disclosure Form	Partially Met ↓	Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Met	Not Met

Section	Standard	United CAN	Magnolia CAN
Credentialing and Recredentialing	Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met
	Recredentialing every three years	Met	Met
	Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met
	Valid DEA certificate and/or CDS certificate	Met	Met
	Board certification if claimed by the applicant	Met	Met
	Malpractice claims since the previous credentialing event	Met	Met
	Practitioner attestation statement	Met	Met
	Requery the National Practitioner Data Bank (NPDB)	Met	Met
	Requery the System for Award Management (SAM)	Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Met	Not Met ↓
	Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Query of the National Plan and Provider Enumeration (NPPES)	Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a	Met ↑	Met

Section	Standard	United CAN	Magnolia CAN
	certificate of registration along with a CLIA identification number		
Credentialing and Recredentialing	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met
	Ownership Disclosure form	Partially Met ↓	Met
	Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met	Met	Met
	Review of practitioner profiling activities	Met	Met
	The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO	Met	Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Not Met ↓
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met
	The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met
	The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Met	Met
	Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties	Met	Met ↑
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Met

Section	Standard	United CAN	Magnolia CAN
Adequacy of the Provider Network	The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met
	Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met
	The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met
	The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met ↑
Provider Satisfaction Survey	A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol	Met ↑	Met ↑
	The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met
	The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met

Table 6: CHIP Provider Services Comparative Data

Section	Standard	United CHIP	Magnolia CHIP
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Met ↑	Partially Met ↓
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including	Met ↑	Partially Met ↓

Section	Standard	United CHIP	Magnolia CHIP
	peers of the applicant. Such decisions, if delegated, may be overridden by the CCO		
Credentialing and Recredentialing	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met
	Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members;	Met	Met
	Valid DEA certificate and/or CDS certificate;	Met	Met
	Professional education and training, or board certification if claimed by the applicant	Met	Met
	Work history	Met	Met
	Malpractice claims history	Met	Met
	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Met
	Query of the National Practitioner Data Bank (NPDB)	Met	Met
	Query of the System for Award Management (SAM)	Met	Met
	Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Not Met
	Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met	Met

Section	Standard	United CHIP	Magnolia CHIP
Credentialing and Recredentialing	Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Partially Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Met	Met
	Ownership Disclosure Form	Met	Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Met	Not Met ↓
	Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met
	Recredentialing every three years	Met	Met
	Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met
	Valid DEA certificate and/or CDS certificate	Met	Met
	Board certification if claimed by the applicant	Met	Met
	Malpractice claims since the previous credentialing event	Met	Met
	Practitioner attestation statement	Met	Met
	Requery the National Practitioner Data Bank (NPDB)	Met	Met

Section	Standard	United CHIP	Magnolia CHIP
Credentialing and Recredentialing	Requery the System for Award Management (SAM)	Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Met	Not Met ↓
	Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Query of the National Plan and Provider Enumeration (NPPES)	Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met
	Ownership Disclosure form	Met	Met
	Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met	Met	Met
	Review of practitioner profiling activities	Met	Met
	The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO	Met	Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Met ↑	Not Met ↓

Section	Standard	United CHIP	Magnolia CHIP
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met
	The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met
	The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Met	Met
	Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties	Met	Met ↑
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Met
	The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met
	Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met
Adequacy of the Provider Network	The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met
	The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met ↑	Met ↑
Provider Satisfaction Survey	A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol	Met ↑	Met ↑
	The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met

Section	Standard	United CHIP	Magnolia CHIP
Provider Satisfaction Survey	The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met

Strengths

- United and Magnolia use NCQA-certified vendors to conduct *Provider Satisfaction Surveys*.

Weaknesses

- Magnolia's credentialing policies did not address all required queries and contained outdated information about credentialing delegation.
- Credentialing and recredentialing files for both United and Magnolia were missing some required information.
- Magnolia was unable to show proof of provider office site assessments for all initial credentialing files.
- United was not compliant with its policy regarding appropriate signatures on ownership disclosure forms.
- The *Provider Satisfaction Survey* for both plans had low response rates which may impact the generalizability of the survey.

Recommendations

- Ensure credentialing policies and plans are current and address all required queries.
- Ensure credentialing and recredentialing files include all required information, including appropriate ownership disclosure form signatures.
- Ensure evidence of the provider office site assessment is included in the initial credentialing files.
- Focus on strategies that help increase the *Provider Satisfaction Survey* response rates. Solicit the help of survey vendors.

C. Member Services

The Member Services review of the CAN and CHIP lines of business for Magnolia and United included member satisfaction and processes for handling grievances.

Member Satisfaction

Per the contract requirement, both health plans assessed member satisfaction by conducting the *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) surveys for CAN and CHIP using vendors certified by the National Committee for Quality Assurance (NCQA).

As part of the annual EQR of the health plans, CCME conducted a validation review of the surveys using the Center for Medicare and Medicaid Services (CMS) protocol titled, *EQR Protocol 5: Validation and Implementation of Surveys – A Voluntary Protocol for External Quality Review*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol includes seven activities:

1. Review survey purpose(s), objective(s) and intended use
2. Assess the reliability and validity of the survey instrument
3. Review the sampling plan
4. Assess the adequacy of the response rate
5. Review survey implementation
6. Review survey data analysis and findings/conclusions
7. Document evaluation of the survey

One element of Activity 7 was not met for both plans: *Activity 7.3. Do the survey findings have any limitations or problems with generalization of the results?* The reason this element was not met is presented in *Table 7: Results of the Validation of CCO Satisfaction Surveys*. All other activities were met by both plans.

Table 7: Results of the Validation of CCO Satisfaction Surveys

Enrollee Satisfaction Survey Validation			
United CAN	**United CHIP**	**Magnolia CAN**	**Magnolia CHIP**
The generalizability of the survey results is difficult to discern due to low response rate (23% for the Adult survey and 21% for the Child/Child with CCC survey).	The generalizability of the survey results is difficult to discern due to low response rate (29% total; 27% for the general population).	The generalizability of the survey results is difficult to discern due to low response rate (25% for the Adult survey, 18% for the Child survey and 19% for the Child with CCC survey).	The generalizability of the survey results is difficult to discern due to low response rate (20% for the Child survey and 22% for the Child with CCC survey).

Grievances

United and Magnolia have grievance policies to inform staff of requirements and processes for conducting grievance review and resolution activities. Members and providers are educated about grievance processes through various avenues, including member handbooks, provider manuals, and plan websites. CCME conducted a review of these information sources to determine each plan's compliance with state and federal grievance requirements. United's review revealed deficiencies in documentation of grievance and complaint terminology. Both United and Magnolia had deficiencies in documentation of procedures for filing and handling grievances and complaints as well as resolution timeframes.

To determine each health plan's compliance with grievance requirements, CCME reviewed a random selection of grievance files for the CAN and CHIP lines of business of each health plan. Findings were generally isolated and included instances such as use of language in resolution letters that members may not understand, grievance outcomes documented in resolution letters not matching the members' grievances, and insufficient documentation of the grievance in the file. Findings of concern noted in Magnolia's CAN grievance files were related to failure to refer grievances for review and investigation as potential quality of care concerns. Additionally, documentation revealed Magnolia did not act to resolve many member grievances and simply instructed members to file the grievance elsewhere, such as with the provider, state agencies, or licensing boards.

Both United and Magnolia had appropriate processes to analyze grievance data for patterns and potential quality improvement opportunities, and to report data and findings to the appropriate committee(s).

An overview of the scores for the Member Services section is illustrated in *Table 8: CAN Member Services Comparative Data* and *Table 9: CHIP Member Services Comparative Data*.

Table 8: CAN Member Services Comparative Data

Section	Standard	United CAN	Magnolia CAN
Member Satisfaction Survey	The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Met
	The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met

Section	Standard	United CAN	Magnolia CAN
Member Satisfaction Survey	The CCO reports the results of the member satisfaction survey to providers	Met	Met
	The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements	Met	Met
	Definition of a complaint/grievance and who may file a complaint/grievance	Partially Met ↓	Met ↑
	The procedure for filing and handling a complaint/grievance	Partially Met	Partially Met ↓
	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Met	Partially Met
	Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met ↑	Met
	Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract	Partially Met ↓	Met ↑
	The CCO applies the complaint/grievance policy and procedure as formulated	Met	Partially Met ↓
	Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met
	Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures	Met	Met

Table 9: CHIP Member Services Comparative Data

Section	Standard	United CHIP	Magnolia CHIP
Member Satisfaction Survey	The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Met
	The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met
	The CCO reports the results of the member satisfaction survey to providers	Met	Met
	The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements	Met	Met
	Definition of a complaint/grievance and who may file a complaint/grievance	Partially Met ↓	Met ↑
	The procedure for filing and handling a complaint/grievance	Partially Met	Partially Met ↓
	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Partially Met ↓	Met ↑
	Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met ↑	Met
	Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Met ↑
	The CCO applies the complaint/grievance policy and procedure as formulated	Met	Met
	Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities,	Met	Met

Section	Standard	United CHIP	Magnolia CHIP
	and reported to the Quality Improvement Committee		
Complaints/ Grievances	Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures	Met	Met

Strengths

- United and Magnolia use NCQA-certified vendors to conduct the CAN and CHIP CAHPS surveys.
- Grievance data is categorized, analyzed, used to identify quality improvement opportunities, and routinely reported to appropriate quality committee(s).

Weaknesses

- Low response rates to member satisfaction surveys affect the generalizability of survey results. For the CAN and CHIP lines of business, survey response rates ranged from a low of 18% to a high of 29% for the various populations (Adult, Child, Children with Chronic Conditions).
- Deficiencies in documentation of grievance and complaint terminology, procedures for filing and handling grievances and complaints, and resolution timeframes might negatively affect staff, member, and provider understanding of grievance processes and requirements.
- Isolated deficiencies were noted in grievance processing for both United and Magnolia; however, Magnolia's grievance files for CAN members revealed issues of greater concern, including failure to refer grievances for review and investigation as potential quality of care concerns. In addition, documentation indicates no action was taken to resolve many grievances and members were instructed to file the grievance elsewhere.

Recommendations

- Focus on strategies that help increase CAHPS survey response rates. Set an internal response rate goal as opposed to the target rate set by NCQA (e.g., receiving a 2% increase over the previous year's response rate).
- Ensure documentation of grievance processes is correct and consistent with requirements and terminology in the applicable *DOM Contract* and *Federal Regulations*.

- Ensure Magnolia staff refer grievances that contain potential quality of care concerns for review and that staff take appropriate steps to review and resolve member grievances rather than instructing members to file grievances elsewhere.

D. Quality Improvement

For the 2018 review, CCME conducted a validation review of the HEDIS® and non-HEDIS performance measures and validated the performance improvement projects (PIPs) for the CAN and CHIP programs following CMS protocols. This section is an overview of that validation process, starting with performance measure (PM) validation.

Performance Measure Validation

Health plans are required to have an ongoing program of PIPs and to report plan performance using HEDIS measures applicable to the Medicaid population. To evaluate the accuracy of the PM reported, CCME uses the CMS protocol, *EQR Protocol 2: Validation of Performance Measures Managed Care Organization Version 2.0 (September 2012)*. This validation protocol balances the subjective and objective parts of the review, supports a review that is fair to the plans, and provides the State information about how each plan is operating.

Both CCOs use a HEDIS-certified vendor or software to collect and calculate the measures and were fully compliant. Plan rates for the most recent review year are reported in *Table 10: HEDIS® Performance Measure Data for CAN Programs*. The statewide average is calculated as the average of the plan rates and shown in the last column of the following table.

Table 10: HEDIS® Performance Measure Data for CAN Programs

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	80.79%	84.08%	82.44%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	45.99%	45.91%	45.95%
Counseling for Nutrition	48.91%	46.39%	47.65%
Counseling for Physical Activity	40.63%	34.38%	37.51%
Childhood Immunization Status (cis)			

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
DTaP	77.86%	79.33%	78.60%
IPV	92.70%	92.07%	92.39%
MMR	90.75%	90.38%	90.57%
HiB	87.10%	88.46%	87.78%
Hepatitis B	89.78%	91.11%	90.45%
VZV	90.27%	89.90%	90.09%
Pneumococcal Conjugate	77.13%	81.25%	79.19%
Hepatitis A	76.89%	75.24%	76.07%
Rotavirus	75.18%	75.72%	75.45%
Influenza	26.03%	27.88%	26.96%
Combination #2	73.48%	75.72%	74.60%
Combination #3	69.83%	73.56%	71.70%
Combination #4	59.61%	61.30%	60.46%
Combination #5	61.31%	64.66%	62.99%
Combination #6	21.90%	24.52%	23.21%
Combination #7	52.31%	54.33%	53.32%
Combination #8	20.19%	22.60%	21.40%
Combination #9	19.71%	22.12%	20.92%
Combination #10	18.00%	20.43%	19.22%
Immunizations for Adolescents (ima)			
Meningococcal	51.58%	44.47%	48.03%
Tdap	79.81%	73.56%	76.69%
HPV	6.81%	5.29%	6.05%
Combination #1	51.58%	42.79%	47.19%
Combination #2	6.08%	5.29%	5.69%
Lead Screening in Children (lsc)	66.52%	68.57%	67.55%

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
Breast Cancer Screening (bcs)	50.21%	57.57%	53.89%
Cervical Cancer Screening (ccs)	56.82%	60.34%	58.58%
Chlamydia Screening in Women (chl)			
16-20 Years	48.43%	48.00%	48.22%
21-24 Years	62.73%	62.02%	62.38%
Total	51.15%	50.86%	51.01%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	62.76%	59.68%	61.22%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	29.49%	27.87%	28.68%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	32.40%	38.15%	35.28%
Bronchodilator	67.17%	74.01%	70.59%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	52.55%	50.00%	51.28%
5-11 Years: Medication Compliance 75%	21.94%	19.26%	20.60%
12-18 Years: Medication Compliance 50%	49.25%	46.30%	47.78%
12-18 Years: Medication Compliance 75%	21.89%	19.44%	20.67%
19-50 Years: Medication Compliance 50%	50.97%	48.15%	49.56%
19-50 Years: Medication Compliance 75%	23.30%	22.96%	23.13%
51-64 Years: Medication Compliance 50%	57.45%	61.86%	59.66%
51-64 Years: Medication Compliance 75%	40.43%	38.14%	39.29%
Total: Medication Compliance 50%	51.38%	49.82%	50.60%
Total: Medication Compliance 75%	23.69%	22.73%	23.21%
Asthma Medication Ratio (amr)			
5-11 Years	82.52%	76.28%	79.40%

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
12-18 Years	67.70%	53.94%	60.82%
19-50 Years	47.69%	39.06%	43.38%
51-64 Years	46.67%	40.99%	43.83%
Total	62.44%	51.90%	57.17%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	47.69%	42.24%	44.97%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	64.29%	55.81%	60.05%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy: 21-75 Years (Male)	69.29%	69.92%	69.61%
Statin Adherence 80%: 21-75 Years (Male)	37.25%	43.85%	40.55%
Received Statin Therapy: 40-75 Years (Female)	61.17%	60.00%	60.59%
Statin Adherence 80%: 40-75 Years (Female)	35.65%	34.17%	34.91%
Received Statin Therapy: Total	65.19%	64.59%	64.89%
Statin Adherence 80%: Total	36.49%	39.02%	37.76%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	87.10%	86.16%	86.63%
HbA1c Poor Control (>9.0%)	56.93%	57.04%	56.99%
HbA1c Control (<8.0%)	35.04%	36.99%	36.02%
HbA1c Control (<7.0%)	NR	NR	NA
Eye Exam (Retinal) Performed	63.50%	69.45%	66.48%
Medical Attention for Nephropathy	93.67%	91.65%	92.66%
Blood Pressure Control (<140/90 mm Hg)	49.39%	NR	NA
Statin Therapy for Patients With Diabetes (spd)			

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
Received Statin Therapy	NR	NR	NA
Statin Adherence 80%	NR	NR	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	NR	NR	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	42.17%	38.15%	40.16%
Effective Continuation Phase Treatment	24.65%	22.94%	23.80%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	58.10%	56.71%	57.41%
Continuation and Maintenance (C&M) Phase	70.30%	66.37%	68.34%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	73.43%	58.68%	66.06%
7-Day Follow-Up	53.97%	32.20%	43.09%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	70.59%	72.36%	71.48%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	67.25%	70.11%	68.68%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NR	79.59%	79.59%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	56.87%	56.45%	56.66%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	35.42%	22.86%	29.14%
6-11 Years	23.23%	21.79%	22.51%
12-17 Years	21.21%	25.21%	23.21%
Total	22.39%	23.70%	23.05%

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.09%	88.81%	88.45%
Diuretics	87.08%	51.67%	69.38%
Total	87.33%	88.57%	87.95%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.88%	NR	NA
Appropriate Treatment for Children With URI (uri)	60.15%	60.99%	60.57%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.18%	32.35%	32.27%
Use of Imaging Studies for Low Back Pain (lbp)	65.59%	69.11%	67.35%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NA	NA
6-11 Years	NR	0.43%	NA
12-17 Years	NR	0.85%	NA
Total	NR	0.65%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.31%	86.39%	86.35%
45-64 Years	91.83%	92.21%	92.02%
65+ Years	93.62%	84.38%	89.00%
Total	88.35%	88.65%	88.50%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.02%	97.05%	97.04%
25 Months - 6 Years	88.23%	87.28%	87.76%

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
7-11 Years	92.46%	90.73%	91.60%
12-19 Years	89.78%	96.68%	93.23%
Annual Dental Visit (adv)			
2-3 Years	48.93%	48.91%	48.92%
4-6 Years	71.12%	70.68%	70.90%
7-10 Years	71.38%	70.59%	70.99%
11-14 Years	67.75%	65.97%	66.86%
15-18 Years	58.41%	57.44%	57.93%
19-20 Years	44.87%	40.35%	42.61%
Total	64.98%	64.04%	64.51%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	72.41%	64.79%	68.60%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	8.74%	4.69%	6.72%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	42.67%	29.26%	35.97%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	6.57%	4.47%	5.52%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.89%	32.57%	39.23%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.80%	4.49%	5.65%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.49%	91.69%	91.09%
Postpartum Care	62.93%	62.95%	62.94%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	35.90%	65.71%	50.81%
6-11 Years	65.69%	72.15%	68.92%
12-17 Years	68.74%	66.62%	67.68%

Measure/Data Element	United CAN MY 2016 Rates	Magnolia CAN MY 2016 Rates	Statewide Average
Total	66.42%	68.93%	67.68%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	4.15%	10.81%	7.48%
21-40 Percent	1.95%	4.58%	3.27%
41-60 Percent	3.41%	7.07%	5.24%
61-80 Percent	8.29%	15.07%	11.68%
81+ Percent	82.20%	62.48%	72.34%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.95%	5.21%	3.58%
1 Visit	3.89%	5.24%	4.57%
2 Visits	6.08%	6.01%	6.05%
3 Visits	9.00%	7.96%	8.48%
4 Visits	10.46%	13.75%	12.11%
5 Visits	17.03%	24.39%	20.71%
6+ Visits	51.58%	37.43%	44.51%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	60.74%	51.21%	55.98%
Adolescent Well-Care Visits (awc)	45.01%	34.03%	39.52%

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

When comparing the Measurement Year (MY) 2015 CAN rates to the MY 2016 CAN rates, United had a substantial improvement of greater than 10% in rates for Body Mass Index (BMI) Percentile documentation for children/adolescents and Persistence of Beta-Blocker Treatment After a Heart Attack, among others. CCME noted a decline in rates for Asthma Medication compliance and Antidepressant Medication Management.

Adult Body Mass Index (BMI) Assessments, BMI Percentile for children/adolescents, Counseling for Nutrition, Counseling for Physical Activity, Rotavirus Immunizations, and several other categories had a substantial improvement (greater than 10%) for Magnolia.

The Statin Adherence measure was the only measure with a substantial decrease in rate for Magnolia.

Table 11, HEDIS® Performance Measure Data for CHIP Programs, displays the most recent measurement rates for the United and Magnolia CHIP Programs.

Table 11: HEDIS® Performance Measure Data for CHIP Programs

Measure/Data Element	United CHIP MY 2016 Rates	Magnolia CHIP MY 2016 Rates	Statewide Average
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	46.23%	49.64%	47.94%
Counseling for Nutrition	46.72%	45.78%	46.25%
Counseling for Physical Activity	42.34%	38.07%	40.21%
Childhood Immunization Status (cis)			
DTaP	81.02%	87.26%	84.14%
IPV	89.78%	93.03%	91.41%
MMR	91.97%	93.75%	92.86%
HiB	87.59%	91.35%	89.47%
Hepatitis B	88.56%	92.31%	90.44%
VZV	90.27%	93.27%	91.77%
Pneumococcal Conjugate	82.48%	85.58%	84.03%
Hepatitis A	79.56%	78.37%	78.97%
Rotavirus	78.10%	83.17%	80.64%
Influenza	31.63%	33.41%	32.52%
Combination #2	76.89%	85.58%	81.24%
Combination #3	74.94%	82.69%	78.82%
Combination #4	64.48%	69.23%	66.86%
Combination #5	67.64%	75.72%	71.68%
Combination #6	27.98%	31.25%	29.62%

Measure/Data Element	United CHIP MY 2016 Rates	Magnolia CHIP MY 2016 Rates	Statewide Average
Combination #7	57.91%	63.46%	60.69%
Combination #8	26.28%	28.13%	27.21%
Combination #9	26.76%	29.57%	28.17%
Combination #10	25.06%	26.68%	25.87%
Immunizations for Adolescents (ima)			
Meningococcal	54.26%	49.52%	51.89%
Tdap/Td	85.40%	78.61%	82.01%
HPV	13.63%	9.62%	11.63%
Combination #1	54.01%	48.32%	51.17%
Combination #2	12.65%	8.65%	10.65%
Lead Screening in Children (lsc)	63.50%	62.42%	62.96%
Chlamydia Screening in Women (chl)			
16-20 Years	37.56%	43.25%	40.41%
*21-24 Years**	NA	NA	NA
Total	37.56%	43.25%	40.41%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	66.05%	66.70%	66.38%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	62.16%	45.45%	53.81%
5-11 Years: Medication Compliance 75%	30.81%	15.91%	23.36%
*12-18 Years: Medication Compliance 50%**	50.81%	41.67%	46.24%
*12-18 Years: Medication Compliance 75%**	25.41%	16.67%	21.04%
Total Medication Compliance 50%	56.49%	44.12%	50.31%
Total Medication Compliance 75%	28.11%	16.18%	22.15%
Asthma Medication Ratio (amr)			

Measure/Data Element	United CHIP MY 2016 Rates	Magnolia CHIP MY 2016 Rates	Statewide Average
5-11 Years	86.39%	NR	NA
12-18 Years	77.11%	NR	NA
Total	81.63%	NR	NA
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	38.71%	NR	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	47.62%	NR	NA
Effective Continuation Phase Treatment	33.33%	NR	NA
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	50.00%	41.18%	45.59%
Continuation and Maintenance (C&M) Phase	60.87%	60.98%	60.93%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-day follow-up	76.97%	55.29%	66.13%
7-day follow-up	53.95%	27.06%	40.51%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	50.00%	NR	NA
6-11 Years	28.33%	NR	NA
12-17 Years	28.46%	NR	NA
Total	28.65%	NR	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.78%	NR	NA
Appropriate Treatment or Children with URI (uri)	54.17%	57.47%	55.82%
Use of Imaging Studies for Low Back Pain (lbp)	63.33%	NR	NA
Access/Availability of Care			

Measure/Data Element	United CHIP MY 2016 Rates	Magnolia CHIP MY 2016 Rates	Statewide Average
Children and Adolescents'' Access to Primary Care Practitioners (cap)			
12-24 Months	99.80%	98.83%	99.32%
25 Months-6 Years	91.38%	90.49%	90.94%
7-11 Years	94.24%	90.44%	92.34%
12- 19 Year	92.72%	96.24%	94.48%
Annual Dental Visit (adv)			
2-3 Years	53.34%	47.40%	50.37%
4-6 Years	75.82%	70.45%	73.14%
7-10 Years	80.69%	74.65%	77.67%
11-14 Years	75.35%	69.13%	72.24%
15-18 Years	67.14%	58.67%	62.91%
19-20 Years	51.69%	59.65%	55.67%
Total	72.95%	66.05%	69.50%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	61.76%	NR	NA
Engagement of AOD Treatment: 13-17 Years	5.88%	NR	NA
Initiation of AOD Treatment: 18+ Years	43.75%	NR	NA
Engagement of AOD Treatment: 18+ Years	3.13%	NR	NA
Initiation of AOD Treatment: Total	53.03%	NR	NA
Engagement of AOD Treatment: Total	4.55%	NR	NA
Prenatal and Postpartum Care (ppc)			
*Timeliness of Prenatal Care**	50.00%	57.14%	53.57%
*Postpartum Care**	16.67%	42.86%	29.77%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
*<21 Percent**	0.00%	14.29%	7.15%

Measure/Data Element	United CHIP MY 2016 Rates	Magnolia CHIP MY 2016 Rates	Statewide Average
*21-40 Percent**	0.00%	28.57%	14.29%
*41-60 Percent**	33.33%	0.00%	16.67%
*61-80 Percent**	16.67%	14.29%	15.48%
*81+ Percent**	50.00%	42.86%	46.43%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.59%	2.88%	2.24%
1 Visit	2.87%	2.47%	2.67%
2 Visits	0.96%	1.23%	1.10%
3 Visits	3.18%	3.70%	3.44%
4 Visits	10.83%	9.88%	10.36%
5 Visits	15.29%	29.63%	22.46%
6+ Visits	65.29%	50.21%	57.75%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	61.35%	51.11%	56.23%
Adolescent Well-Care Visits (awc)	47.45%	34.01%	40.73%

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

United had several measures that had improvement of greater than 10%, including BMI percentile documentation, lead screening, and antidepressant medication management. Measures with a substantial decrease in rate include dental visits for 19-20 year-olds and Initiation and Engagement of AOD Dependence Treatment (iet) for the 18+ age group.

Magnolia also had several measures that had a substantial improvement of greater than 10%, including BMI percentile documentation, immunization rates, and dental visits. Measures with a substantial decrease in rate include prenatal and postpartum care and ongoing prenatal care.

Non-HEDIS Performance Measures

Non-HEDIS performance measures selected by the Mississippi Division of Medicaid (DOM) include Asthma Related Emergency Room (ER) visits, Asthma Related Readmissions, EPSDT Screening, CHF Readmissions, Pre/Post Natal Complications, and Pregnancy

Outcome. Validation of the non-HEDIS measure required CCME to review the following for each measure:

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

This process assesses the production of these measures by the CCOs to verify that what is submitted to DOM complies with the measure specifications defined by DOM. Each CCO was provided a Microsoft® Excel (Excel) reporting template prepared by a DOM vendor for reporting CAN non-HEDIS rates. During the onsite visit, CCME determined that the Excel formulas in the reporting template were incorrect and did not provide the measure rates in accordance with the DOM specifications. Based on this determination, CCME did not validate the CAN non-HEDIS measures for the current review cycle.

The non-HEDIS performance measure, as per the *CHIP Contract*, includes the measure *Developmental Screening in the First Three Years of Life*. The MY 2016 rates for the Non-HEDIS CHIP measure are reported in *Table 12: CHIP Non-HEDIS Performance Measure Report Rates*.

Table 12: CHIP Non-HEDIS Performance Measure Reported Rates

Measure	United CHIP MY 2016 Rates	Magnolia CHIP MY 2016 Rates
Developmental Screening in the First Three Years of Life (DEV-CH)		
Age 12 months	15.21%	0.00%
Age 24 months	25.33%	3.36%
Age 36 months	15.63%	1.17%
Total	Not Reported	2.07%

CCME found both CCOs were fully compliant and met all the requirements for the CHIP non-HEDIS measures. *Table 13: CHIP Non-HEDIS Performance Measure Validation Results* provides an overview of the validation scores for the CHIP measures.

Table 13: CHIP Non-HEDIS Performance Measure Validation Results

Measure	United CHIP Validation Scores	Magnolia CHIP Validation Scores
Developmental Screening in the First Three Years of Life (DEV-CH)	91% FULLY COMPLIANT	100% FULLY COMPLIANT

Performance Improvement Project Validation

Each health plan is required to submit its PIPs to CCME for review annually. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. CCME reviewed 16 projects submitted by the two plans for the CAN and CHIP Programs. These projects as well as each project validation score are displayed in *Table 14: Results of the Validation of PIPs*.

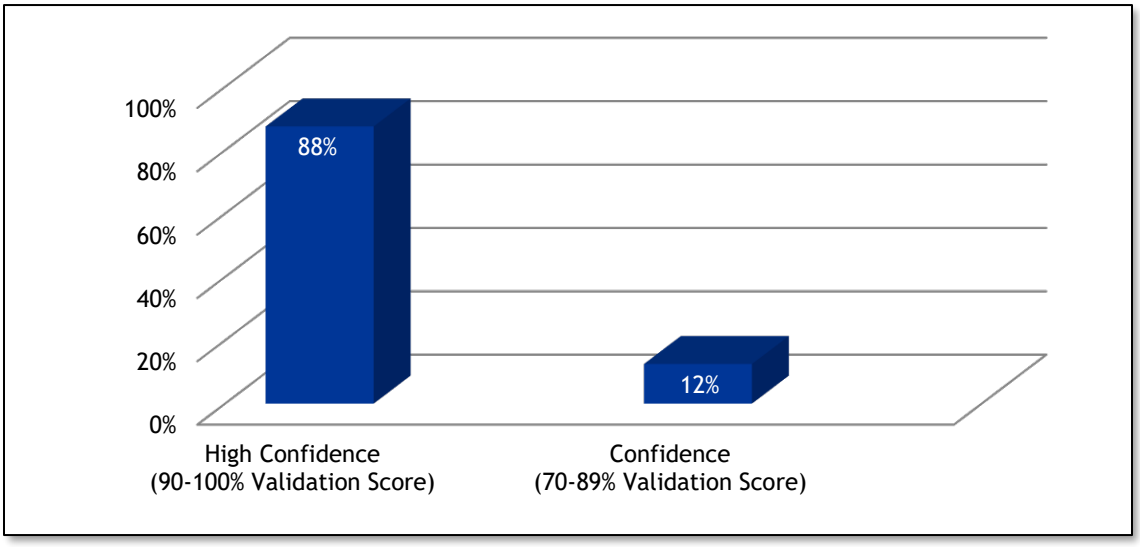
Table 14: Results of the Validation of PIPs

Project	Validation Score
United CAN	
Adult, Adolescent and Childhood Obesity	116/116=100% High Confidence in Reported Results
Comprehensive Diabetes Care	116/116=100% High Confidence in Reported Results
CHF-Annual Monitoring for Patients on Ace/ARB Inhibitors	96/96=100% High Confidence in Reported Results
Adult Member Satisfaction	92/98=94% High Confidence in Reported Results
United CHIP	
Adolescent Well Child Visits	111/111=100% High Confidence in Reported Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- formerly called Reducing Adolescent and Childhood Obesity	111/111=100% High Confidence in Reported Results
Getting Needed Care CAHPS	92/98=94% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	95/95=100% High Confidence in Reported Results

Project	Validation Score
Magnolia CAN	
Congestive Heart Failure (CHF) Readmissions	78/85 = 92% High Confidence in Reported Results
Obesity	96/111 = 86% Confidence in Reported Results
Diabetes	95/97 = 98% High Confidence in Reported Results
Asthma	84/85 = 99% High Confidence in Reported Results
Magnolia CHIP	
EPSDT	86/91 = 95% High Confidence in Reported Results
Obesity for Children	87/104 = 84% Confidence in Reported Results
ADHD	86/91 = 95% High Confidence in Reported Results
Use of Appropriate Medications for People with Asthma	86/91 = 95% High Confidence in Reported Results

Of the 16 PIPs, 14 receive a score in the High Confidence Range and two projects scored in the Confidence Range. No projects scored in the Low Confidence or Not Credible Range. *Figure 2: Percent of Performance Improvement Projects* displays the aggregated validation scores for the PIPs across the two plans.

Figure 2: Percent of Performance Improvement Projects



Issues for Performance Improvement Projects

The most common issue found with United's PIPs was that interventions to address member and provider barriers were not documented and the findings were not presented clearly. Identified issues are displayed in *Tables 15 and 16*.

Table 15: United CAN Adult Member Satisfaction

Section	Reasoning	Recommendation
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	A barriers/causal analysis was conducted, although interventions to address the member and provider barriers were not documented.	Initiate interventions to address member and provider barriers and document the interventions and start data in Section IV of the report.
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?	Baseline data did have interpretation in the Rationale section; however, the results narrative should be in Section III.	Adjust report so that analysis of baseline and remeasurement results are in Section III. Include follow-up activities based on the results in the interpretation.

Table 16: United CHIP Getting Needed Care CAHPS

Section	Reasoning	Recommendation
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Barriers are documented. Interventions to address the provider and member barriers are not documented.	Include interventions that address the barriers noted in the fishbone analysis.
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?	Conclusions were offered, and follow-up plans were documented, but they were not included in the appropriate section of the report (Section III.B).	Revise report so that interpretation of results is documented in Section III.B. of the report.

The primary issues across all of Magnolia PIPs were benchmark and baseline rate definitions. Issues exist with correct reporting of the numerator and denominator in the Findings tables, as well as a lack of analysis and interpretation of the results. Other noted issues include lack of information regarding the qualifications of the personnel who are collecting and analyzing data, as well as a lack of a clearly stated research question. Identified issues with recommendations are displayed in *Tables 17 - 24*.

Table 17: Magnolia CAN - Congestive Heart Failure (CHF) Readmissions

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly	Annual results are presented in the 2017 PDF report in the indicator section, not in the results section. The comparison of results to baseline goal and benchmark is not written clearly as the Results Table format is not used.	Include all measurement periods in the report in the Results section, not the Indicator section.
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analyses of baseline data and remeasurements are not provided in report.	Analysis of rates at each measurement period, whether the goal was met or not, and include action plans in response to the findings in the report.
Was there any documented, quantitative improvement in processes or outcomes of care?	Rate increased whereas the goal is to decrease Congestive Health Failure readmissions.	Initiate new interventions to improve rate toward goal.

Table 18: Magnolia CAN - Obesity

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

Table 19: Magnolia CAN - Diabetes

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The denominators suggest that members with unavailable data are included in the percentage. The denominator should include only those members where pre- and post- data are available for evaluation. The results should identify the number of records for each measurement year clearly, and the number of members who have records available that met the A1C < 8 goal. Also, the Table on page A-17 is labeled 2016 and it should be labeled 2017.	Ensure reporting of eligible members and denominator for rate is accurate in PIP report. Check labels for Table on page A-17.
Was there any documented, quantitative improvement in processes or outcomes of care?	There was no improvement in rate.	Initiate new interventions to increase rate

Table 20: Magnolia CAN - Asthma

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

Table 21: Magnolia CHIP - EPSDT

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

Table 22: Magnolia CHIP - Obesity for Children

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measure is defined under the measurable goal section. The baseline goal and the benchmark rate are the same. The benchmark should be the absolute best practice rate, and will likely be lower than the baseline goal rate	Review the baseline goal and benchmark to determine if reduction of 5 points in 50% of eligible population is an appropriate benchmark. For example, the baseline goal might be 50% of eligible members and the benchmark is 80% or higher of the eligible members will have a reduction of 5 percentile points.
Did the sample contain a sufficient number of enrollees?	The sample is extremely small for baseline and remeasurement 1. With such small samples, this PIP does not appear to have an impact on the health status of a broad spectrum of members.	Implement interventions to determine ways to reach the individuals who are eligible but unable to be reached.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are clearly presented in table format, but the interpretation of the baseline data are not provided in the report. The denominators appear to include all eligible members, although data were not available for all eligible members.	Include interpretation should be included for all measurements. Also, the records were only available for 21 individuals, thus, the denominator should be 21 as are the members with available data.

Table 23: Magnolia CHIP - ADHD

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

Table 24: Magnolia CHIP - Use of Appropriate Medications for People with Asthma

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

Overall, United met all the standards in the QI section for its CAN and CHIP programs. Magnolia had issues with their performance improvement projects and received a Partially Met score for CAN and CHIP. This was noted as a decrease in their validation score from the previous year for the CHIP program. *Tables 25* and *26* provides an overview of plan performance in the Quality Improvement section.

Table 25: CAN Quality Improvement Comparative Data

Section	Standard	United CAN	Magnolia CAN
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met
	The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met ↑	Partially Met

Table 26: CHIP Quality Improvement Comparative Data

Section	Standard	United CHIP	Magnolia CHIP
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met
	The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met	Partially Met ↓

Strengths

- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and the rationale for each topic was documented.
- 88% of PIPs were validated in the High Confidence range.
- HEDIS performance measures were "Fully Compliant."

Weaknesses

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

Recommendations

- Improve the PIP documentation for the next review cycle. In addition, refer to the CMS Protocol, *Validation of Performance Improvement Projects* as a guide for PIP reports.

E. Utilization Management

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

United and Magnolia have established policies describing appeal requirements and processes for the CAN and CHIP programs. Appeal requirements and processes were also

found in member handbooks and provider manuals. Information provided by the plans revealed many instances of outdated language that defined appeal terminology in both CAN and CHIP materials. Additionally, CCME noted incorrect or missing information for appeal acknowledgement timeframes in policies, member handbooks, and provider manuals. CCME identified incorrect documentation of the timeframe to request a State Fair Hearing in United's CAN letter template, a CAN policy, and the CAN *Member Handbook*.

Despite these documentation issues, CAN and CHIP appeal files revealed appropriate processes are followed by United staff when receiving, reviewing, and resolving member appeals. Magnolia's appeal files revealed the resolution timeframe for appeals began on the date the signed *Authorized Representative Form* (ARF) is received from the member. This practice is not consistent with Magnolia's CAN and CHIP appeal policies, *42 CFR § 438.408 (b)(2)*, and the MS *CAN* and *CHIP Contracts*.

Case Management (CM) policies and procedures, as well as program descriptions, provide guidance to staff performing CM activities. CAN and CHIP Care Management files reflected that United and Magnolia staff conduct appropriate activities for member conditions and assigned risk levels. CAN and CHIP Transitional Care Management programs and documentation indicated appropriate collaboration of the interdisciplinary care teams from each CCO in managing member needs.

An overview of all scores for the UM section is illustrated in *Table 27: CAN Utilization Management Services Comparative Data* and *Table 28: CHIP Utilization Management Services Comparative Data*.

Table 27: CAN Utilization Management Services Comparative Data

Section	Standard	United CAN	Magnolia CAN
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements	Met	Met
	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Partially Met
	The procedure for filing an appeal	Met ↑	Partially Met
	Review of any appeal involving medical necessity or clinical issues, including examination of all original medical	Met	Met

Section	Standard	United CAN	Magnolia CAN
	information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case		
Appeals	A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Met ↑	Partially Met
	Written notice of the appeal resolution as required by the contract	Partially Met ↓	Met
	Other requirements as specified in the contract	Partially Met	Met
	The CCO applies the appeal policies and procedures as formulated	Met	Partially Met ↓
	Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met
	Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met
Care Management	The CCO assess the varying needs and different levels of care management needs of its member population	Met ↑	Met
	The CCO uses varying sources to identify and evaluate members' needs for care management	Met	Met
	A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level	Met ↑	Met
	The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met
	Evaluation of co-morbidities or multiple complex health care conditions	Met	Met
	Demographic information	Met	Met

Section	Standard	United CAN	Magnolia CAN
Care Management	Member's current treatment provider and treatment plan if available	Met	Met
	The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments	Met ↑	Met
	The risk level assignment is periodically updated as the member's health status or needs change	Met	Met
	The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members	Met	Met
	The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract	Met ↑	Met
	The CCO provides members assigned to the high-risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met
	The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	Met	Met
	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	Met	Met
Transitional Care Management	The CCO monitors continuity and coordination of care between the PCPs and other service providers	Met	Met
	The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Met	Met
	The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care	Met	Met

Section	Standard	United CAN	Magnolia CAN
	plan, and provides oversight to the transition process		

Table 28: CHIP Utilization Management Services Comparative Data

Section	Standard	United CHIP	Magnolia CHIP
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements	Met	Met
	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Partially Met
	The procedure for filing an appeal	Partially Met	Met ↑
	Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met
	A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met ↑
	Written notice of the appeal resolution as required by the contract	Met	Met
	Other requirements as specified in the contract	Met	Met
	The CCO applies the appeal policies and procedures as formulated	Met ↑	Partially Met ↓
	Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met

Section	Standard	United CHIP	Magnolia CHIP
Appeals	Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met
Care Management	The CCO assesses the varying needs and different levels of care management needs of its member population	Met ↑	Met
	The CCO uses varying sources to identify and evaluate members' needs for care management	Met	Met
	A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level	Met ↑	Met
	The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met
	Evaluation of co-morbidities or multiple complex health care conditions	Met	Met
	Demographic information	Met	Met
	Member's current treatment provider and treatment plan if available	Met	Met
	The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments	Met ↑	Met
	The risk level assignment is periodically updated as the member's health status or needs change	Met	Met
	The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members	Met	Met
	The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract	Met ↑	Met
	The CCO provides members assigned to the high-risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met

Section	Standard	United CHIP	Magnolia CHIP
Care Management	The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	Met	Met
	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	Met	Met
Transitional Care Management	The CCO monitors continuity and coordination of care between the PCPs and other service providers	Met	Met
	The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Met	Met
	The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process	Met	Met

Strengths

- Plan websites contain valuable resources and information for members and providers, such as the *Member Handbook*, *Provider Manual*, prior authorization information and the *Preferred Drug List* (PDL).
- CM files reflected United and Magnolia use available UM resources to provide quality services to members.

Weaknesses

- Deficiencies in documentation of appeals terminology, processes for filing and handling appeals, and resolution timeframes might affect staff, member, and provider understanding of appeals processes and requirements negatively.
- Deficiencies in documentation of the types of care management services provided and lack of description of risk scores to corresponding risk levels might affect staff, member, and provider understanding of care management services and requirements negatively.

Recommendations

- Ensure documentation of appeals and case management processes and requirements are correct and consistent with requirements and terminology in the applicable Mississippi Division of Medicaid (DOM) contract and *Federal Regulations*.