Mississippi External Quality Review

ANNUAL COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR JUNE 2020 – MAY 2021

Submitted: May 26, 2021

Prepared on behalf of the
Mississippi Division of Medicaid

EXECUTIVE SUMMARY

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

The purpose of the external quality reviews was to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. This was accomplished by conducting the following activities for the CAN and CHIP programs: validation of performance improvement projects, performance measures, and surveys; compliance with state and federal regulations; and provider access studies for each health plan. This report is a compilation of the findings of the annual reviews conducted during the 2020-2021 review cycle for each CCO's applicable CAN and CHIP Programs.

A. Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Availability of Services (§ 438.206, § 457.1230)
- Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)
- Coordination and Continuity of Care (§ 438.208, § 457.1230)
- Coverage and Authorization of Services (§ 438.210, § 457.1230, § 457.1228)
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality (§ 438.224)
- Grievance and Appeal Systems (§ 438.228, § 457.1260)
- Subcontractual Relationships and Delegation (§ 438.230, § 457.1233)
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems (§ 438.242, § 457.1233)
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To access the health plan's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

Administration

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

Policies and procedures are in place that convey the health plans' general processes for compliance with applicable state and federal guidelines. Staffing is sufficient with personnel and roles clearly identifiable, and appropriate reporting structures and lines of communication in place.

The CCOs clearly define the role of their Compliance Officers and Compliance Committees. Policies and procedures define processes to monitor for, detect, and investigate suspected or reported fraud, waste, and abuse. Each of the CCOs provides compliance training to staff, including information about recognizing and reporting suspected or actual compliance violations and fraud, waste, and abuse. CCME concluded that policies and procedures for all CCOs define steps for internal monitoring, auditing, and investigations of all reported incidents, for payment suspensions, and recoupments of overpayments.

Each CCO demonstrated their information systems met the contractual requirements. Claims processing rates exceeded the state requirements and disaster recovery testing was successful.

Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Each of the CCOs has policies that define provider credentialing and recredentialing processes; however, Molina's policy did not address the contractual requirement for submission of fingerprints for certain providers. The plans have committees in place to make credentialing and recredentialing decisions; however, two members of Magnolia's committee did not meet the attendance requirement and the provider specialties represented on Molina's committee were limited.

Samples of initial credentialing files were reviewed for each health plan and samples of recredentialing files were reviewed for Magnolia and United. Molina is a new health plan in Mississippi and has not yet begun recredentialing processes for its network. Review of the files revealed issues for all of the health plans.

All the CCOs regularly measure and monitor the adequacy of their provider networks and provider compliance with appointment access standards. United was using an incorrect access standard for rural emergency medicine providers. Molina was using an incorrect appointment timeframe for appointments after discharge from an acute psychiatric hospital, and United did not implement any interventions for providers who were non-compliant with appointment access requirements. For identified network gaps, the plans are working to target and secure contracts with the needed provider types.

The three CCOs have established processes for initial and ongoing provider education, The CCOs' provider manuals and websites are additional. However, incorrect and/or inconsistent member benefit information was noted in Magnolia's and United's Provider Manuals and Member Handbooks. For United, this was a repeat finding from the previous EQR. Also, United's CHIP Care Provider Manual omitted some appointment access standards and did not clearly state the providers' responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services.

Appropriate processes are in place for the review, adoption, and revision of preventive health and clinical practice guidelines. Network providers are informed of the availability of the guidelines and the expectation that the guidelines will be followed for care of members.

Each of the CCOs have policies that define medical record documentation standards and processes to monitor provider compliance with those standards. One of Molina's policies was missing several elements. The plans are conducting appropriate monitoring of provider compliance with medical record documentation standards.

CCME conducted a validation review of the provider satisfaction surveys using the CMS protocol. Due to low response rates, the survey findings have limitations and issues with generalization of the results. CCME encouraged the CCOs to initiate methods to elicit responses from providers and determine interventions that will improve response rates, such as additional reminders and waves of data collection.

CCME conducted a validation of network access/availability and provider directory accuracy for each of the CCOs. The methodology involved two phases: (1) A telephonic survey to determine if CCO-provided primary care provider (PCP) information was accurate and to evaluate appointment availability for urgent and routine care. (2) Verification of the accuracy of information in the provider directories against access-study confirmed PCP contact information.

The overall successful contact rates were below the baseline goal of 80% for all five studies conducted. Across the CCOs, the most common reason for unsuccessful contacts was that the provider was no longer active at the location. The provider directory

validation rates were above the 80% baseline goal for three of the five studies conducted. Routine appointment availability and access ranged from 63% to 82% and urgent appointment availability and access range from 33% to 76%. *Table 1: Overview of Findings* provides a summary of the rates of successful contacts, provider directory accuracy, and appointment availability for each CCO.

Table 1: Overview of Findings

	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Successful Contact Rates	55%	26%	51%	16%	48%
Provider Directory Accuracy Rates	83%	67%	90%	71%	93%
Routine Appointment Availability	73%	63%	82%	75%	68%
Urgent Appointment Availability	69%	50%	76%	57%	33%

The results of the Provider Access and Provider Directory Validation baseline studies demonstrated an opportunity for improvement in provider contact information accuracy. Initiatives are needed to address gaps to ensure all members can contact a PCP using the online directory and receive the needed care in an efficient manner.

Member Services

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Each plan has policies and procedures that define and describe member rights and responsibilities and methods for notifying members of their rights and responsibilities. New members receive a New Member Packet with instructions for contacting Member Services, selecting a PCP, and initiating services. All members have access to information and resources in the Member Handbook, on the website, and in member newsletters that can help them utilize their benefits. The plans provide information on preventive health guidelines and encourage members to obtain recommended preventive services. CCME identified incomplete or omitted requirements with documentation of member education information and requirements.

Review of grievance policies and other documents revealed issues related to definitions of grievance terminology, filing processes and requirements, incorrect resolution timeframes, and information that was not included on the non-secured area of the website. CCME's review of grievance files from each health plan's CAN and CHIP lines of business reflected timely acknowledgement, resolution, and notification to members.

The health plans are compliant with the retention timeframe for grievance and complaint data and use the data for quality improvement activities.

United, Magnolia, and Molina continue to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys annually via third-party vendors. Member satisfaction validation for the health plans was performed based on the CMS Survey Validation Protocol. Generalizability of the survey results is difficult to discern due to low response rates. Recommendations were provided to address this issue.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Medicaid managed care plans are required to have an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to members. The Quality Improvement (QI) section of the EQR of the health plans included a review of the programs' structure, work plans, program evaluations, performance measure validation, and performance improvement project validation. Each health plan provided program descriptions that included the program structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.

An annual plan of QI activities is in place which includes areas to be studied, follow-up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). Molina's QI Work Plan (2020) only included a few references to CHIP. Also, there were errors or missing information.

A committee was established for each plan charged with oversight of the QI programs. The committees review data received from the QI activities to ensure performance meets standards and make recommendations as needed. Membership for the quality committees included health plan senior leadership, department directors and mangers, and other plan staff. Network providers with varying specialties are included as voting members. Quorums are established and minutes are recorded for each meeting.

The plans are required to track provider compliance with EPSDT services provided to the Medicaid population and the Well Baby and Well Child services provided to CHIP population. The health plan contracts with DOM also require the plans to track the diagnosis, treatment, and/or referrals provided to members, and the plans have policies and processes established to meet these requirements. United's tracking reports failed to link the identified problem with the EPSDT or Well-Baby and Well-Child exam and did not include or indicate members who received additional outreach for case management referrals. Magnolia's tracking reports did not include the Current Procedural Terminology (CPT) and/or the ICD-10 codes to identify the abnormal finding and the need for follow-

up as stated in Magnolia's policy. Molina's policies indicated Molina tracks, at a minimum, initial visits for newborns, EPSDT screenings, and reporting of all screening results and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report; however, the tracking report failed to link the identified problem with the EPSDT or Well-Baby or Well-Child service and did not include or indicate the members who received additional treatments or referrals as required by the *CAN* and *CHIP Contracts, Section 5 (D)*.

Each plan evaluates the overall effectiveness of the QI Program and reports the evaluation to the Board of Directors, the Quality Improvement Committees, and to the Division of Medicaid. Molina's evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight.

Performance Measures Validation

Health plans are required to have an ongoing improvement program and to report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. DOM also requires the CCOs to report the Adult and Child Core Set measures. To evaluate the accuracy of the performance measures (PMs) reported, CCME contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA certified HEDIS Compliance Organization. Aqurate conducted a validation review of the PMs identified by DOM to evaluate the accuracy of the rates as reported by the health plans for the CAN and CHIP populations.

To ensure HEDIS rates were accurate and reliable, DOM also required each CCO to undergo an NCQA HEDIS Compliance Audit. The three CCOs contracted with an NCQA-licensed organization to conduct the HEDIS audit. Aqurate reviewed each CCO's final audit reports, information systems capabilities assessments, and the Interactive Data Submission System files approved by the CCOs' NCQA licensed organization. Aqurate found that the CCOs' information systems and processes were compliant with the applicable information system standards and HEDIS reporting requirements for HEDIS 2020.

The CCOs' rates based on audit reports for the most recent review year are reported in the Quality Improvement Section of this report. The statewide average was calculated where applicable. Measure Year (MY) 2019 was the first year for Molina to report data for the CAN population. Since enrollment started in January 2019, there were no measure rates available for measures that needed more than one year of continuous enrollment. Many of the statewide average rates are therefore calculated with data from only two CAN CCOs.

United and Magnolia had data for comparison year over year, for MY 2018 and MY 2019, for the CAN population. There were only a few measures that showed a substantial improvement of more than 10 percent year over year. United showed an improvement for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) BMI Percentile indicator. Magnolia showed an improvement for the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) and the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) measures. United's rated for the Comprehensive Diabetes Care (CDC) HbA1c Poor Control (>9.0%) and HbA1c Control (<8.0%) indicators fell by more than 10%.

For the CHIP population, United showed more than 10 percent improvement for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators. There were no measures that showed a substantial decrease in the reported rate.

Aqurate also conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Several aspects crucial to the calculation of PM data reviewed included: data integration, data control, and documentation of PM calculations. The Adult and Child Core Set Measure rates for the CAN and CHIP populations reported by the CCOs for 2019 are listed in the Quality Improvement Section of this report. Statewide averages have been included where applicable.

While the CCOs have sufficient systems and processes in place, the rates reported for the Adult and Child Core Set measures indicate that the CCOs may need to monitor for gaps in data and services provided to improve performance and measure rates.

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validation of Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

Each health plan is required to submit performance improvement projects to CCME for review annually. CCME validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Twenty-three projects were validated for the three health plans. Results of the validation and project status for each project are displayed in *Table 2: Results of the Validation of PIPs*. Interventions for each project are included in the Quality Improvement Section.

Table 2: Results of the Validation of PIPs

Project	Validation Score	Project Status
United CAN		
Behavioral Health Readmissions	73/74=99% High Confidence in Reported Results	The Behavioral Health Readmissions PIP showed an increase in readmission rates from the previous measurement. The goal is to reduce the readmission rate 5% from baseline to remeasurement 1. The annual report shows an increase from 18% to 19.2% for the first remeasurement period. A continuation of the currently planned interventions was recommended given the barriers of contact due to COVID 19 restrictions.
Improved Pregnancy Outcomes: Care Management to Reduce Preterm Deliveries	67/72=93% High Confidence in Reported Results	The Pregnancy Outcomes PIP had baseline measurement data only and the baseline rate of 92.21% was above the goal of 89.20%. The interventions will continue to determine if the improvement rate is sustained.
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	66/71=93% High Confidence in Reported Results	The Sickle Cell Disease PIP also reported baseline data only and the rate was above the target rate of 58.23% with a rate of 70.22%. The recommendations were to continue the current interventions to sustain the above-goal rate.
Respiratory Illness: COPD/Asthma	72/72=100% High Confidence in Reported Results	The COPD PIP contains two HEDIS indicators and baseline data were presented in the PIP report. The indicators were below the target rate and recommendations were to continue the interventions to determine if improvement is yielded at the remeasurement period.
United CHIP		
Adolescent Well Child Visits (AWC)	100/100=100% High Confidence in Report Results	The Adolescent Well Child Visits PIP showed improvement in the rate from last year to this year (HEDIS 2020). The rate improved from 48.18% to 50.36%.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity)	100/100=100% High Confidence in Report Results	The obesity PIP has three HEDIS indicators: BMI percentile, counseling for nutrition, and counseling for physical activity. All rates improved from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate.
Getting Needed Care CAHPS	99/100=99% High Confidence in Report Results	For the Getting Needed Care CAHPS PIP, the goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019. This rate was higher than the NCQA rate but lower than United's goal rate.

Project	Validation Score	Project Status
Follow Up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	The Follow-Up After Hospitalization PIP showed that the 30-day follow up rate improved from 61.39% to 64.55%, which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.1.5% to 37.27%, which is above the goal rate of 36.20%.
Magnolia CAN		
Asthma	80/80=100% High Confidence in Report Results	The asthma PIP did have improvement in the indicator rates. However, the HEDIS measure, Medication Management for People with Asthma (MMA) used as the study indicator for this PIP was retired. Magnolia closed this PIP and will implement a new Adult and Child Respiratory Disease PIP. Magnolia indicated the new PIP will include child asthma and adult COPD as required by DOM.
Behavioral Health Readmissions	73/74=99% High Confidence in Report Results	PIP did not show improvement in the indicator rates.
Improved Pregnancy Outcomes with Makena	73/74=99% High Confidence in Report Results	PIP did not show improvement in the indicator rates.
Sickle Cell Disease Outcomes	73/74= 99% High Confidence in Report Results	PIP did not show improvement in the indicator rates.
Molina CAN		
Behavioral Health Readmissions	80/80=100% High Confidence in Reported Results	For the Behavioral Health Readmissions PIP, Molina did report a reduction (improvement) in the quarterly readmission rate from 34.2% to 9.5%. The next remeasurement will help determine if this decrease is sustained.
Medication Management for People with Asthma (MMA)	28/62=45.2% Reported Results Not Credible	Rates were tracked and interventions were reported, but this information was contained in separate documents. The PIP reports only contained three of the required elements per the CMS protocol. The topic, the indicator definitions, and the study question was included. All other elements were not documented.
Pharmacotherapy Management of COPD Exacerbation (PCE)	28/62=45.2% Reported Results Not Credible	
Follow-up After Hospitalization for Mental Illness (FUH)	28/62=45.2% Reported Results Not Credible	
Obesity	28/62=45.2% Reported Results Not Credible	
Prenatal and Postpartum Care	28/62=45.2% Reported Results Not Credible	

Project	Validation Score	Project Status
Case Management and Follow-up (30 days) Services for Sickle Cell Disease	28/62=45.2% Reported Results Not Credible	
Molina CHIP		
Medication Management for People with Asthma	28/62=45.2% Reported Results Not Credible	Rates were tracked and interventions were reported, but information was contained in separate documents which resulted in missing validation elements. Several elements required by the CMS Protocol for Validation of Performance Improvement Projects were not included in the PIP reports. Corrective actions were given to create a PIP report for each project using the template that Molina uses for the Behavioral Health (BH) Readmissions Project.
Follow Up After Hospitalization for Mental Illness	28/62=45.2% Reported Results Not Credible	
Obesity	28/62=45.2% Reported Results Not Credible	
Well Care	28/62=45.2% Reported Results Not Credible	

All CCOs had reports or proposals for PIPs on the topics required by DOM. The CCOs that submitted reports included the required elements per the CMS protocol including the study topic, study question/aim, indicator definitions, identified study population, sampling methodology if applicable, data collection procedures, sources, and instrumentation, findings, and intervention strategies.

United's Behavioral Health readmissions rate increased, and the COPD rates declined, both of which are indicative of a lack of improvement. The reported rates in United's CHIP projects showed a lack of improvement in the Getting Needed Care CAHPS composite score.

The primary issue for Magnolia is improving the outcomes for the PIP indicators. The BH readmissions rate increased, the Sickle Cell Disease rate decreased, and the Pregnancy outcomes PIP rates decreased, all of which indicate lack of improvement.

Molina's performance improvement projects did not contain sufficient information as required by the CMS protocols, and thus most of the PIPs received a validation score within the "Not Credible" range.

Further monitoring of interventions is recommended for the CCOs due to the restrictions for person-to-person contacts that are essential for many of the proposed interventions to be successful. The subsequent review cycle will allow a better evaluation of the strategies to address the identified barriers.

Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

United, Molina, and Magnolia have appropriate program descriptions, policies, and procedures that define and describe how utilization management (UM) services are operationalized and provided to members. The respective UM program descriptions outline the purpose, goals, objectives, and staff roles for physical and behavioral health services.

Policies and procedures provide guidance to staff about handling service authorization requests. Review of approval and denial files confirmed the plans met criteria and timeframe requirements. However, CCME noted minor documentation issues for service authorization timeframes and use of medical terminology and codes in adverse benefit determinations letters to members.

The CAN and CHIP Care Management (CM) program descriptions and policies appropriately document care management processes and services provided. CM files indicate care gaps are identified and addressed consistently and services are provided for various risk levels. The plans incorporate Population Health Management activities to identify and provide physical and behavioral health services to select populations and to address issues related to social determinants of health.

The health plans have established policies for appeals of adverse benefit determinations. Review of documentation in policies, Member Handbooks, Provider Manuals, etc. revealed numerous issues of incomplete, incorrect, and missing information about appeals processes and requirements. CCME's review of appeal files revealed only isolated issues and, overall, appeals are handled correctly. Each health plan tracks, monitors, and analyzes specific UM metrics and conducts an evaluation of their respective CAN and CHIP UM Programs to determine effectiveness and identify opportunities to improve quality of care and service.

Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

The CCOs implement written agreements with delegates that describe the roles and responsibilities of the health plan and the delegated entity, activities being delegated, reporting requirements, processes for evaluating delegate performance, and actions that may be taken for substandard performance. CCME's review of oversight and assessment documentation revealed that for credentialing delegates, all contractual elements were not included in monitoring and oversight.

Corrective Action Plans from Previous EQR

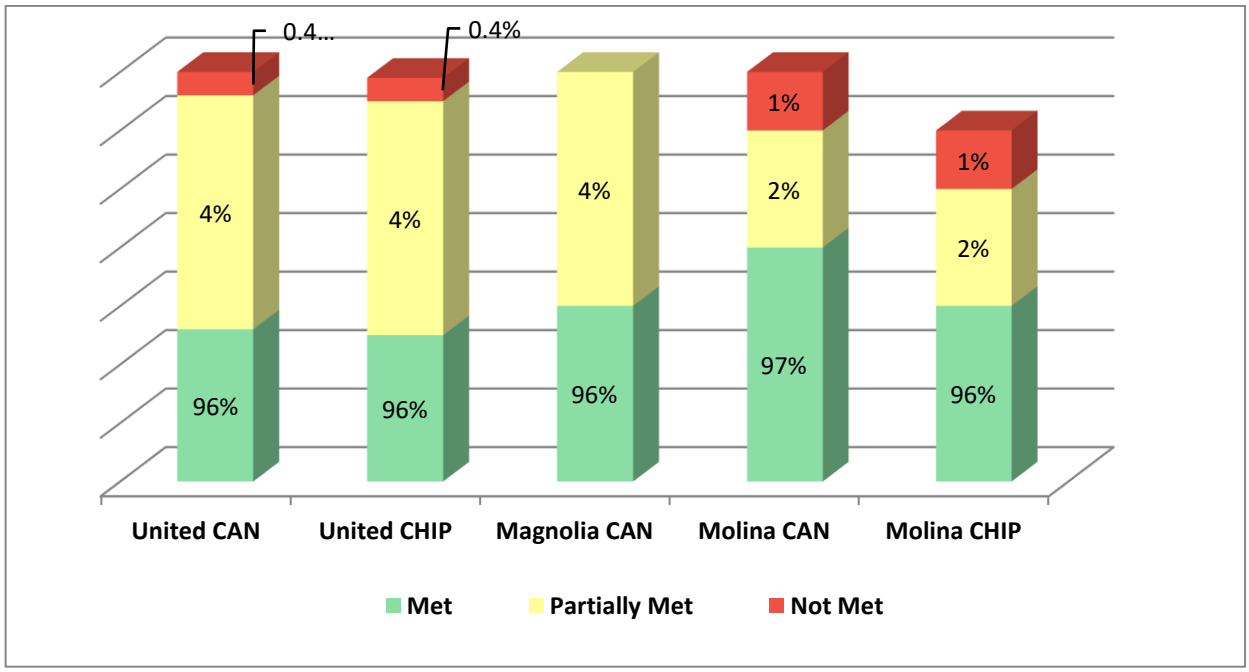
For a health plan not meeting requirements, CCME requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. CCME also provides technical assistance to each health plan until all deficiencies are corrected. Following the initial acceptance of the CAP items, quarterly CAP reviews are completed to evaluate whether the health plan has fully implemented the corrective action items.

During the current EQR, CCME assessed the degree to which United and Magnolia implemented the actions to address deficiencies identified during the previous EQR. United was found to have one corrective action item from the 2019 EQR that was not implemented. This was related to discrepancies in documentation of member benefit information in the CAN Care Provider Manual and CAN Member Handbook, as well as in the CHIP Care Provider Manual and CHIP Member Handbook.

B. Conclusions

Overall, the CCOs met the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. As indicated in *Figure 1: Overall Results for 2020 EQR*, the percentage of "Met" scores ranged from 96% to 97%, while scores of "Partially Met" ranged from 2% to 4% and scores of "Not Met" ranged from 0.4% to 1%.

Figure 1: Overall Results for 2020 EQR



Scores were rounded to the nearest whole number

The following tables provide an overview of the scoring of the current annual reviews for CAN and CHIP, respectively.

Table 3: Overall Scoring—CAN

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
Administration						
United	31	0	0	0	31	100%
Magnolia	31	0	0	0	31	100%
Molina	31	0	0	0	31	100%
Provider Services						
United	83	2	1	0	86	97%
Magnolia	83	3	0	0	86	97%
Molina	67	1	1	17	86	97%
Member Services						
United	29	4	0	0	33	88%
Magnolia	29	4	0	0	33	88%
Molina	30	0	3	0	33	91%
Quality Improvement						
United	19	0	0	0	19	100%
Magnolia	19	0	0	0	19	100%
Molina	15	2	2	0	19	79%
Utilization						
United	51	3	0	0	54	94%
Magnolia	53	1	0	0	54	98%
Molina	53	1	0	0	54	98%
Delegation						
United	2	0	0	0	2	100%
Magnolia	2	0	0	0	2	100%
Molina	1	1	0	0	2	50%
Totals						
United	**215**	**9**	**1**	**0**	**225**	**96%**
Magnolia	**217**	**8**	**0**	**0**	**225**	**96%**
Molina	**197**	**5**	**6**	**17**	**225**	**97%**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Table 4: Overall Scoring—CHIP

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
Administration						
United	31	0	0	0	31	100%
Molina	31	0	0	0	31	100%
Provider Services						
United	81	3	1	0	85	95%
Molina	64	2	2	17	85	95%
Member Services						
United	28	4	0	0	32	88%
Molina	28	0	0	4	32	100%
Quality Improvement						
United	19	0	0	0	19	100%
Molina	14	2	2	1	19	78%
Utilization						
United	52	2	0	0	54	96%
Molina	53	1	0	0	54	98%
Delegation						
United	2	0	0	0	2	100%
Molina	1	1	0	0	2	50%
Totals						
United	**213**	**9**	**1**	**0**	**223**	**96%**
Molina	**191**	**6**	**4**	**22**	**223**	**96%**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Because Molina is a new plan in Mississippi, standards related to recredentialing, member satisfaction surveys, and performance measures were not evaluated. Standards scored as "Not Evaluated" were not included in the calculation of the percentages of "Met," "Partially Met," and "Not Met" scores.

The following is a summary of key findings and recommendations or opportunities for improvements. Additional details of strengths, weaknesses, and recommendations can be found in the individual report sections that follow.

- Molina has not developed or implemented processes for collection of fingerprints for CHIP providers designated as "high-risk" by DOM.

- Molina's Professional Review Committee, which makes recommendations for credentialing decisions and serves as a peer review committee, includes external providers with limited specialties.
- Credentialing and recredentialing file reviews revealed the following issues:
  - Missing verification of malpractice insurance coverage and expired provider licensure at the time of the recredentialing decision date (Magnolia).
  - No admitting plan for nurse practitioners, failure to verify whether laboratory services are conducted at provider locations when applications were incomplete, and failure to conduct provider office site visits prior to implementation of restrictions from COVID 19 (Molina CAN and CHIP).
  - No evidence of submission of fingerprints for high-risk providers (Molina CHIP).
  - Lack of evidence of required queries and undated queries for sanctions and exclusions (United CAN and CHIP).
  - Incorrect parameters used for measuring geographic access to specialists (United) and for appointments after discharge from an acute psychiatric hospital (Molina).
- United did not develop or implement interventions to address provider non-compliance with appointment availability standards.
- Errors in member benefit information documented in member and provider materials were noted for Magnolia and United. This was a repeat finding for United.
- The PCP Responsibilities section of the United's CHIP Care Provider Manual was incomplete.
- Molina's Standards of Medial Record Documentation policy does not include all medical record documentation standards and does not define the frequency of medical record documentation audits.
- The requirements for member materials to use a minimum 12-point font size and 18-point font size for large print were not documented in policies or other documents.
- Program education information about changes in benefits and network providers was incomplete or missing in Member Handbooks and policies.
- The toll-free telephone numbers and hours of operation for Contact Centers were incorrect or omitted in various member materials and the Provider Manual.
- Issues were noted with definitions of grievance terminology, filing processes and requirements, resolution timeframes, and information required to be included on the non-secured area of websites.
- Response rates for the member satisfaction surveys were below the NCQA target rate of 40%.

- The CCOs' QI program descriptions described program structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.
- The CCOs were fully compliant with all information systems standards and HEDIS determination standards for the CAN and CHIP HEDIS performance measures.
- Based on Aqurate's validation of performance measure rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported.
- The CCOs did not report some of the Adult and Child Core Set measures as required by DOM.
- Molina's performance improvement projects did not contain sufficient information as required by the CMS protocols; therefore, most of the PIPs received a validation score within the "Not Credible" range.
- The EPSDT and the Well-Baby and Well-Child tracking reports for problems identified during the exams failed to link the identified problems with the EPSDT or Well-Baby and Well-Child service and did not include or indicate the members who received additional outreach for case management referrals.
- Service authorization timeframes and processes were documented incorrectly or incompletely.
- Adverse benefit determination notices used medical terminology and codes instead of easy-to-understand language.
- Issues with appeals documentation included incomplete, incorrect, or missing definitions, timeframes, and procedures.
- Some of Molina's appeals were reviewed by the same physician reviewer who issued the initial determination.
- Documentation of the Transition of Care requirements for pregnant members entering the health plans was incomplete.
- Delegation monitoring tools do not include all required elements or incorrectly indicate elements are not applicable.
- Delegation monitoring documentation does not indicate all delegated activities are included in the monitoring and oversight conducted.

Recommendations and Opportunities for Improvements

Corrections and recommendations to address identified issues include:

- Molina should develop and implement a process to address the contractual requirement for collecting fingerprints from providers designated as "high-risk" by DOM.
- Molina should consider recruiting providers with additional specialties to serve on the Professional Review Committee.
- Include all required elements in credentialing and recredentialing processes.
- Use correct parameters for measuring geographic access for providers and for monitoring provider appointment availability standards.
- When goals are not met for provider after-hours access, develop and implement interventions to address identified deficiencies.
- Update provider manuals to reflect complete information about provider responsibilities.
- Routinely review member benefit information in member and provider materials and revise as needed to ensure the information is current and correct.
- Ensure member rights and responsibilities and member program education information are completely documented.
- Document the required font size for member materials in a policy or elsewhere.
- Ensure correct toll-free telephone numbers and hours of operation are documented in various member materials and the Provider Manual.
- Revise documentation of grievance processes to ensure information is correct and consistent with state and federal requirements and terminology.
- Work with vendors and initiate interventions to identify methods that improve survey response rates.
- Work proactively with DOM for clarification on Core Set measures that are required to be reported.
- Monitor the ongoing interventions and consider revising interventions as needed for PIPs not showing improvements in the indicator rates.
- Performance Improvement Projects should be documented on the project template provided by CCME and include all required elements.
- The EPSDT and Well-Baby and Well-Child tracking reports should include the date the exams were provided, ICD 10 or CPT codes, treatment/referral, if any provided, and members who received additional outreach for case management referrals.
- Correctly document all service authorization and resolution timeframes.
- Adverse benefit determination notices should be written in layman's terms.

- Correctly document all terms, definitions, instructions, and procedures for filing an appeal in CAN and CHIP documents and on websites.
- Ensure individuals who make appeal decisions were not involved in any previous level of the review.
- Document the requirements for Transition of Care activities for pregnant members entering the health plans in a policy or other document.
- Delegation monitoring tools should include all required elements and accurately reflect contractual requirements.
- Monitoring must be conducted for all activities delegated to each entity.

BACKGROUND

The Mississippi Division of Medicaid (DOM) contracted with three coordinated care organizations (CCOs) to administer the Mississippi Coordinated Access Network (MississippiCAN) and the Mississippi Children's Health Insurance Program (Mississippi CHIP) Medicaid managed care programs. The CCOs include UnitedHealthcare Community Plan – Mississippi (United), Magnolia Health Plan (Magnolia), and Molina Healthcare of Mississippi (Molina). The Balanced Budget Act of 1997 requires State Medicaid agencies that contract with Medicaid managed care organizations to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*.

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

In addition to the mandatory activities, CCME validates network adequacy and consumer and provider surveys conducted by the CCOs.

Annually, CCME prepares an annual comprehensive technical report, which is a compilation of the individual annual review findings, for the State. This comprehensive technical report for contract year 2020 through 2021 contains data regarding results of the EQRs conducted for the CAN and CHIP programs for United, Magnolia, and Molina.

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, conducted virtually due to restrictions related to the COVID19 pandemic. After completing the annual review of the required EQR activities for each health plan, CCME submits a detailed technical report to DOM and the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addressed the corrective action from the prior year's review, if applicable. For a health plan not meeting requirements, CCME requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. CCME also provides technical assistance to each health plan until all deficiencies are corrected. Following the initial acceptance of the CAP items, quarterly CAP reviews are completed to evaluate whether the health plan has fully implemented the corrective action items.

FINDINGS

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

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.

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

Policies and procedures are in place that convey the health plans' general processes for compliance with applicable state and federal guidelines. Staffing is sufficient with personnel and roles clearly identifiable, and appropriate reporting structures and lines of communication in place.

The CCOs clearly defined the role of their Compliance Officers and Compliance Committees. Policies and procedures define processes to monitor for, detect, and investigate suspected or reported fraud, waste, and abuse. Each of the CCOs provides compliance training to staff, including information about recognizing and reporting suspected or actual compliance violations and fraud, waste, and abuse. CCME concluded that policies and procedures for all CCOs define steps for internal monitoring, auditing, investigations, payment suspensions and recoupments.

Information Systems Capabilities Assessment

Information Systems Capabilities Assessment (ISCA) documentation completed by each CCO demonstrated their information systems met contractual requirements. Claims processing rates exceeded the state requirements and each of the plans has processes in place for disaster recovery and business continuity in the event of a disaster. Disaster recovery testing was successful for all plans.

An overview of the scores for the Administration section is illustrated in *Table 5: Administration Comparative Data*. When comparing the 2019 review scores for United and Magnolia, both CCOs showed improvements and are now meeting all of the standards in the Administration section.

Table 5: Administration Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
General Approach to Policies and Procedures					
The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met ↑	Met ↑	Met	Met	Met
Organizational Chart / Staffing					
The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: Chief Executive Officer	Met	Met	Met	Met	Met
Chief Operating Officer	Met	Met	Met	Met	Met
Chief Financial Officer	Met	Met	Met	Met	Met
Chief Information Officer	Met	Met	Met	Met	Met
Information Systems personnel	Met	Met	Met	Met	Met
Claims Administrator	Met	Met	Met	Met	Met
Provider Services Manager	Met	Met	Met	Met	Met
Provider credentialing and education	Met ↑	Met ↑	Met	Met	Met
Member Services Manager	Met	Met	Met	Met	Met
Member services and education	Met	Met	Met	Met	Met
CAN: Complaint/Grievance Coordinator CHIP: Grievance and Appeals Coordinator	Met	Met	Met	Met	Met
Utilization Management Coordinator	Met	Met	Met	Met	Met
Medical/Care Management Staff	Met	Met	Met	Met	Met
Quality Management Director	Met	Met	Met	Met	Met
CAN: Marketing, member communication, and/or public relations staff CHIP: Marketing and/or Public Relations	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Medical Director	Met	Met	Met	Met	Met
Compliance Officer	Met	Met	Met	Met	Met
Operational relationships of CCO staff are clearly delineated	Met	Met	Met	Met	Met
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*					
The CCO processes provider claims in an accurate and timely fashion	Met ↑	Met ↑	Met	Met	Met
The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met
The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met
The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met	Met	Met	Met
Compliance/Program Integrity					
The CCO has a Compliance Plan to guard against fraud, waste and abuse	Met	Met	Met	Met	Met
The Compliance Plan and/or policies and procedures address requirements	Met ↑	Met ↑	Met ↑	Met	Met
The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Met	Met	Met	Met
The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met	Met
The CCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met
The CCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO implements and maintains a Pharmacy Lock-In Program	Met	Met	Met	Met	Met
Confidentiality *42 CFR § 438.224*					
The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met

Strengths

- Appropriate policy management processes are in place. The CCOs review policies at least annually and revise when needed.
- United conducts disaster recovery exercises twice annually, which is above average (once a year is most common).
- Claims payment rates exceeded DOM's contractual requirements.
- Molina has a detailed security plan that establishes the overall security posture for the organization. The plan is backed by standard operating procedures that address the tasks necessary to maintain that security posture.

B. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Reviews of Provider Services encompass credentialing and recredentialing, network adequacy and availability, provider education, preventive health and clinical practice guidelines, practitioner medical records, and provider satisfaction surveys.

Each of the CCOs has policies that define processes and requirements for provider credentialing and recredentialing. Molina's policies did not address the requirement from the *CHIP Contract, Section 7 (E) (6)* regarding submission of fingerprints for high-risk providers and persons with a 5% or more direct or indirect ownership interest in the provider. Onsite discussion confirmed that Molina is not obtaining fingerprints from CHIP providers identified as high-risk by DOM.

Credentialing and recredentialing decisions for all the CCOs are made by committees that meet at specified intervals and include peers of the applicant under consideration. Plan policies and committee charters define committee membership, quorum requirements, and attendance expectations for members. For Magnolia, it was noted that two committee members did not meet the attendance requirement. Molina's Professional Review Committee includes network providers, but the specialties represented are limited to family medicine, internal medicine, and obstetrics and gynecology. Molina has not attempted to recruit providers with additional specialty types.

A sample of initial credentialing files were reviewed for each health plan. Because Molina is a new health plan in Mississippi, recredentialing is not expected to begin until mid-2021; therefore, recredentialing files were reviewed for Magnolia and United only. Review of provider credentialing and recredentialing files revealed issues such as:

- Missing verification of malpractice insurance coverage and expired provider licensure at the time of the recredentialing decision date (Magnolia).
- No admitting plan for nurse practitioners, failure to verify whether laboratory services are conducted at provider locations when applications were incomplete, and failure to conduct provider office site visits prior to implementation of restrictions from COVID 19 (Molina CAN and CHIP).
- No evidence of submission of fingerprints for high-risk providers (Molina CHIP).
- Lack of evidence of required queries and undated queries for sanctions and exclusions (United CAN and CHIP).

All of the CCOs regularly measure and monitor the adequacy of their provider networks. It was evident that Magnolia and Molina used contractually compliant parameters to measure the various provider types; however, United was using an incorrect access standard for rural emergency medicine providers. Molina does not compile a report to identify gaps within the network or an annual summary of findings. Recommendations were offered to improve these processes. For identified network gaps, the plans are working to target and secure contracts with the needed provider types.

To monitor provider compliance with appointment access standards, the CCOs employ various processes such as CAHPS survey results, grievance and appeal data, and onsite and telephonic surveys and audits. During CCME's review of the monitoring documentation, it was noted that Molina was using an incorrect appointment timeframe for appointments after discharge from an acute psychiatric hospital. United did not implement any interventions for providers who were non-compliant with appointment access requirements.

Appropriate processes are in place for notifying primary care providers of the members assigned, for ensuring out-of-network providers can verify enrollment, and for tracking and monitoring the number of providers that are accepting new patients. Providers in each of the CCOs' networks have access to secure provider portals to obtain current member information.

The three CCOs have established policies defining requirements and processes for initial provider orientation and education, as well as ongoing provider education. In addition to formal provider education processes, the health plans' Provider Manuals and websites serve as resources for providers to access necessary information. Regarding information given to providers about member benefits, CCME noted the following:

- Magnolia had incorrect member benefit information about Plastic Surgeon services in the Provider Manual. (The incorrect information was also noted in the Member Handbook.)
- United had numerous discrepancies in the member benefit information documented in the CAN Care Provider Manual and CAN Member Handbook, as well as in the CHIP Care Provider Manual and CHIP Member Handbook. This was a repeat finding for both the CAN and CHIP Programs for United.
- United's CHIP Care Provider Manual omitted required appointment access standards for routine and urgent dental provider visit standards, urgent care provider visits, and behavioral health/substance use disorder provider visits after discharge from an acute psychiatric hospital.
- United's CHIP Care Provider Manual did not clearly state the providers' responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule.

Appropriate processes are in place for the review, adoption, and revision of preventive health and clinical practice guidelines. The guidelines are based on scientific evidence from recognized sources, are relevant to the CCOs' membership, and are subjected to appropriate physician review and adoption through various CCO committees. Network providers are informed of the availability of the guidelines and the expectation that the guidelines will be followed for care of members.

The CCOs have policies that define medical record documentation standards and processes to monitor provider compliance with those standards. However, one of Molina's policies did not include any health education provided to members as a medical record documentation standard, and another did not include the frequency of the monitoring conducted. Recommendations were offered to address these issues. The plans are

conducting appropriate monitoring of provider compliance with medical record documentation standards.

Provider Satisfaction Survey

CCME conducted a validation review of the provider satisfaction surveys using the protocol developed by CMS titled, *Protocol 6: Administration or Validation of Quality of Care Surveys*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid.

The validation protocol is broken down into seven activities:

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

Table 6 provides an overview of the provider survey validation results.

Table 6: Provider Satisfaction Survey Validation Results

Plan	Reason	Recommendations
United	Only 45 providers (2%) completed the survey. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution.	Determine if there is an easier method to elicit responses. Find methods to improve responses by providers.
Magnolia	The total sample size was 2000 and 198 were ineligible. A total of 395 providers responded for a response rate of 6.6% for mail/internet surveys (n= 82 and n=37, respectively) and 28% for the phone (n=376) surveys. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings.	Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the provider population on the satisfaction surveys.
Molina	Provider satisfaction survey occurred in November 2019. 205 providers completed the survey: 79 mail, 24 internet (7.6% response rate) and 102 by phone (18.6%) response rate. Overall, the response rate is 15.6%.	Determine if there is an easier method to elicit responses. Find methods to improve responses by providers by updating provider addresses and phone numbers.

Provider Access Study and Provider Directory Validation

CCME conducted a validation of network access/availability and provider directory accuracy for each of the CCOs. The objectives were to determine if provider contact information was accurate and assess appointment availability. The methodology involved two phases:

- Phase 1: CCME conducted a telephonic survey to determine if CCO-provided PCP contact information was accurate with regard to telephone, address, accepting the CCO, and accepting new Medicaid patients. Appointment availability for urgent and routine care was also evaluated.
- Phase 2: CCME verified the accuracy of provider directory-listed address, phone, and panel status against access-study confirmed PCP contact information. An overall accuracy rate was determined.

United CAN Summary. Phase 1 results found that 63 of 87 (72%) providers contacted confirmed the file contained the correct address and phone number. Of those 63, 48 (76%) confirmed they accepted United CAN. Of those 48, 27 (56%) indicated they were accepting new patients.

Access and availability for routine appointments was 73% and availability for urgent appointments was 69%.

The 48 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for the 48 providers, 79% (n=38) had accurate information for all three of the components evaluated: address, phone number, and panel status information. There were providers with some specific elements listed accurately and with inaccuracies in other elements.

Of the 48 CAN providers evaluated in the provider directory: 40 (83%) had the provider's name listed in the directory. Of the 40, 38 (79%) providers had the correct phone number listed, 39 (81%) had the correct address, and 38 (79%) had accurate panel status information. Discrepancies in the directory were most common for telephone and status for accepting new patients (21% reported a different phone number during the access study call from the phone number provided in the directory and 21% reported a different panel status). When compared to the access study results, 19% reported a different address in the provider directory.

United CHIP Summary. Phase 1 results found that 57 of 93 (61%) providers contacted confirmed the file contained the correct address and phone number. Of those 57, 24 (51%) confirmed they accept United CHIP. Of those 24, 16 (67%) indicated they were

accepting new patients. Access and availability for routine appointments was 70% and availability for urgent appointments was 58%.

The 24 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found 67% (n=16) of the 24 providers that were evaluated for provider directory validation had accurate information for all three of the components evaluated including address, phone number, and panel status information. There were providers with specific elements listed accurately, but with inaccuracies in other elements.

Of the 24 CHIP providers evaluated in the provider directory: 22 (92%) had the provider's name listed in the directory with the correct phone number and address. Sixteen of 24 (67%) had accurate panel status information. Discrepancies in the directory were most common in status for accepting new patients (33% reported a different panel status). When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

Magnolia CAN Summary. Phase 1 results found that 47 of 78 (60%) providers contacted confirmed the file contained the correct address and phone number. Of those 47, 40 (85%) confirmed they accepted Magnolia. Of those 40, 35 (88%) indicated they were accepting new patients. Access and availability for routine appointments was 82% and availability for urgent appointments was 76%.

The 40 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for 40 providers evaluated, 90% (n=36) had accurate information for all three of the components evaluated: address, phone number, and panel status information. There were providers with some specific elements listed accurately but with inaccuracies in other elements.

Of the 40 providers evaluated in the provider directory: 37 (93%) had the provider's name listed in the directory and 36 (90%) had the correct phone number, address, and panel status information. When compared to the telephone access study results, only 10% reported a different address and phone number in the provider directory.

Molina CAN Summary. For Phase 1, Phase 1 results found that 21 of 89 (24%) providers contacted confirmed the file contained the correct address and phone number. Of those 21, 14 (83%) confirmed they accepted Molina CAN. Of those 14, 12 (86%) indicated they were accepting new patients. Access and availability for routine appointments was 75% and availability for urgent appointments was 67%.

The 14 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for the 14 providers, 71%

(n=10) had correct information for all three of the components evaluated: address, phone number, and panel status information. There were providers with some specific elements listed accurately and with inaccuracies in other elements.

Of the 14 CAN providers evaluated in the provider directory: 12 (86%) had the provider's name listed in the directory; 10 (71%) providers had the correct phone number listed; 10 (71%) had the correct address; and 10 (71%) had accurate panel status information. Discrepancies in the directory were most common for telephone, location, and status for accepting new patients (29% reported a different phone number during the access study call compared to the phone number provided in the directory and 29% reported a different panel status). When compared to the access study results, 29% (4 out of 14) reported a different address in the provider directory.

Molina CHIP Summary. Phase 1 results found that 55 of 83 (66%) providers contacted confirmed the file contained the correct address and phone number. Of those 55, 40 (72%) confirmed they accept Molina CHIP. Of those 40, 34 (85%) indicated they were accepting new patients. Access and availability for routine appointments was 68% and availability for urgent appointments was 33%.

The 40 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found 93% (n=37) of the 40 providers that were evaluated for provider directory validation had correct information for all three of the components evaluated including address, phone number, and panel status information. There were providers with specific elements listed accurately, but with inaccuracies in other elements.

Of the 40 CHIP providers evaluated in the provider directory: 38 (95%) had the provider's name listed in the directory; 37 (93%) had an accurate phone number, address, and panel status information. Discrepancies in the directory were most common in status for accepting new patients (33% reported a different panel status). When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

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

Table 7: Provider Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*					
The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met ↑	Met ↑	Met	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	Met	Met	Met	Met
The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate and/or CDS Certificate	Met	Met	Met	Met	Met
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met
Work history	Met	Met	Met	Met	Met
Malpractice insurance coverage/claims history	Met	Met	Met	Met	Met
Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
Query of the System for Award Management (SAM)	Met	Met	Met	Met	Met
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List	Met	Met	Met ↑	Met	Met
Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met	Met	Met	Met
Query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met
CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services	Met	Met	Met	Met	Met
Ownership Disclosure Form	Met ↑	Met ↑	Partially Met ↓	Not Evaluated	Not Evaluated
Fingerprints, when applicable.	N/A	Met	N/A	N/A	Met
Site assessment	Met ↑	Met	Met ↑	Not Met	Not Met
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met
Recredentialing processes include all elements required by the contract and by the CCO's internal policies	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Recredentialing every three years	Met	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Not Evaluated	Not Evaluated
Valid DEA certificate and/or CDS Certificate	Met	Met	Met	Not Evaluated	Not Evaluated
Board certification if claimed by the applicant	Met	Met	Met	Not Evaluated	Not Evaluated
Malpractice claims since the previous credentialing event	Met	Met	Met	Not Evaluated	Not Evaluated
Practitioner attestation statement	Met	Met	Met	Not Evaluated	Not Evaluated
Re-query the National Practitioner Data Bank (NPDB)	Met	Met	Met	Not Evaluated	Not Evaluated
Re-query the System for Award Management (SAM)	Met	Met	Met	Not Evaluated	Not Evaluated
Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List	Met	Met	Met	Not Evaluated	Not Evaluated
Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met	Met	Not Evaluated	Not Evaluated
Re-query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Not Evaluated	Not Evaluated
Re-query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Not Evaluated	Not Evaluated
CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services	Met	Met	Met	Not Evaluated	Not Evaluated
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Not Evaluated	Not Evaluated

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Ownership Disclosure form	Met ↑	Met ↑	Partially Met ↓	Not Evaluated	Not Evaluated
Provider office site reassessment, when applicable	Met	Met	Met	Not Evaluated	Not Evaluated
Review of practitioner profiling activities	Met	Met	Met	Not Evaluated	Not Evaluated
The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues	Met	Met	Met	Met	Met
Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met	Partially Met	Met	Not Met
Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.10 (h), 42 CFR § 457.1230(a)*					
The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met	Met	Met	Met
The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met	Met	Met	Met
The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Met	Met	Met	Met	Met
Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties	Met	Met	Met ↑	Met	Met
Members have access to specialty consultation from network providers located within the contract specified geographic access standards	Partially Met ↓	Partially Met ↓	Met ↑	Met	Met
The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Providers are available who can serve members with special needs, foreign language/cultural requirements, complex medical needs, and accessibility considerations	Met	Met	Met	Met	Met
The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met
The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met ↑	Met	Partially Met	Partially Met
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*					
The CCO formulates and acts within policies and procedures related to initial education of providers	Met ↑	Met ↑	Met	Met	Met
Initial provider education includes: A description of the Care Management system and protocols	Met	Met	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met	Met	Met
CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	Not Met ↓	Not Met ↓	Met ↑	Met	Met
Procedure for referral to a specialist including standing referrals and specialists as PCPs	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Met	Met	Met	Met
CAN: Recommended standards of care including EPSDT screening requirements and services CHIP: Recommended standards of care including Well-Baby and Well-Child screenings and services	Met	Met	Met	Met	Met
CAN: Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services CHIP: Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services	Met	Partially Met ↓	Met	Met	Met
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met	Met
Provider and member complaint, grievance, and appeal procedures including provider disputes	Met	Met	Met	Met	Met
Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Met	Met ↑	Met	Met	Met
Prior authorization requirements including the definition of medically necessary	Met	Met	Met	Met	Met
A description of the role of a PCP and the reassignment of a member to another PCP	Met	Met	Met	Met	Met
The process for communicating the provider's limitations on panel size to the CCO	Met	Met	Met	Met	Met
Medical record documentation requirements	Met	Met	Met	Met	Met
Information regarding available translation services and how to access those services	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Provider performance expectations including quality and utilization management criteria and processes	Met	Met	Met	Met	Met
A description of the provider web portal	Met	Met	Met	Met	Met
A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Met	Met	Met	Met	Met
The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements	Met	Met	Met	Met	Met
The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures	Met	Met	Met	Met	Met
Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*					
The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Met	Met	Met
The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members	Met	Met	Met	Met	Met
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: CAN: Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services CHIP: Pediatric and Adolescent preventive care with a focus on Well-Baby and Well-Child services	Met	Met	Met	Met	Met
Recommended childhood immunizations	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Pregnancy care	Met	Met	Met	Met	Met
Adult screening recommendations at specified intervals	Met	N/A	Met	Met	N/A
Elderly screening recommendations at specified intervals	Met	N/A	Met	Met	N/A
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met
Behavioral health	Met	Met	Met	Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management *42 CFR § 438.236, 42 CFR § 457.1233(a)*					
The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met
The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers	Met	Met	Met ↑	Met	Met
Practitioner Medical Records					
The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians	Met	Met	Met	Met	Met
The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers	Met	Met	Met	Met	Met
Provider Satisfaction Survey					
A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met	Met	Met	Met
The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified	Met	Met	Met	Met	Met

Strengths

- All health plans follow appropriate processes for adopting and ongoing review of clinical practice and preventive health guidelines.
- The CCOs analyzed data obtained from the provider satisfaction survey to identify quality problems and reported results of the surveys to the quality improvement committees.
- Documentation to address provider satisfaction areas of improvement were noted for all CCOs in the desk materials and during the onsite interviews.

Weaknesses

- Molina has not developed or implemented processes for collection of fingerprints for CHIP providers designated as “high-risk” by DOM.
- Molina’s Professional Review Committee, which makes recommendations for credentialing decisions and serves as a peer review committee, includes external providers with limited specialties.
- Credentialing and recredentialing file reviews revealed the following issues:
  - Missing verification of malpractice insurance coverage and expired provider licensure at the time of the recredentialing decision date (Magnolia).
  - No admitting plan for nurse practitioners, failure to verify whether laboratory services are conducted at provider locations when applications were incomplete, and failure to conduct provider office site visits prior to implementation of restrictions from COVID 19 (Molina CAN and CHIP).
  - No evidence of submission of fingerprints for high-risk providers (Molina CHIP).
  - Lack of evidence of required queries and undated queries for sanctions and exclusions (United CAN and CHIP).

- Incorrect parameters were used for measuring geographic access to specialists (United) and for appointments after discharge from an acute psychiatric hospital (Molina).
- United did not develop or implement interventions to address provider non-compliance with appointment availability standards.
- Errors in member benefit information documented in member and provider materials were noted for Magnolia and United. This was a repeat finding for United.
- The PCP Responsibilities section of the United's CHIP Care Provider Manual was incomplete.
- Molina's Standards of Medial Record Documentation policy does not include all Molina's medical record documentation standards and does not define the frequency of medical record documentation audits.
- Provider satisfaction survey findings have many limitations and issues with generalization of the results due to low response rates.

Recommendations

- Molina should develop and implement a process to address the contractual requirement for collecting fingerprints from provider types designated as "high-risk" by DOM.
- Molina should consider recruiting providers with additional specialty types to serve on the Professional Review Committee.
- Ensure the credentialing and recredentialing processes include all required elements.
- Ensure correct parameters are used for measuring geographic access and for monitoring appointment availability standards.
- When goals are not met for provider after-hours access, develop and implement interventions to address any identified deficiencies.
- Ensure provider responsibilities are complete in Provider Manuals.
- Routinely review member benefit information in member and provider materials and revise as needed to ensure the information is current and correct.
- For the provider satisfaction surveys, initiate methods to elicit responses from providers and determine interventions that will improve response rates, such as additional reminders and additional waves of data collection.

C. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Review of Member Services focused on United's and Molina's CAN and CHIP programs, and Magnolia's CAN program. Areas reviewed include policies and procedures, member rights, member informational materials, grievance processes and files, and the Member Satisfaction Survey. Each plan has appropriate policies and procedures that define and describe Member Services activities and provide guidance to staff conducting those activities. For Magnolia and Molina, CCME identified incomplete documentation of member rights and responsibilities in policies and on the website.

Within 14 days of the plan receiving the enrollment notice, members receive a Welcome Packet with instructions for accessing the Member Handbook, Provider Directory, website, and member education information. Each of the plans' websites have quick links and resources for members to access information. Members can create an account for the secure member portals where they can chat with Member Services Representatives and perform many self-service functions such as print ID cards, view claims, etc.

Member Handbooks are located on the plans' websites, are written in language that is easily understood, and meet the sixth grade reading level requirement. The plans primarily inform members of their rights and responsibilities in the Member Handbook, but the information is also included in member newsletters and on the plans' websites. Additionally, the Member Handbook provides information on topics such as Advance Directives, preventive health guidelines, appointment guidelines, routine benefits, emergency services, and requesting disenrollment.

Member Handbooks are available in Spanish and alternate formats including large font, audio, and Braille. For United, CCME could not identify documentation of the requirement for minimum 12-point font for regular print member materials and 18-point font for large print member materials.

Each Member Handbook includes at least the minimum information required according to specifications in the *CAN* and *CHIP Contract, Section 6 (D)*. However, CCME noted documentation issues with Molina's CAN and CHIP Member Handbooks. Information that female members can obtain services from a women's health provider was omitted; the term "will" was used instead of the term "living will" in the section for Advance Directives; and the timeframe for notifying members of changes to programs, benefits, and the provider network was not included.

Member Services staff are available via a toll-free number and text telephone (also known as TTY 711) services are available for members with hearing impairments.

Members are informed that translation services are available for calls and during appointments with providers. The toll-free Member Services telephone number routes calls to appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. CT, Monday through Friday. Callers also have the option to transfer to a 24-hour line to speak with a nurse. Call Center functions are conducted according to requirements in the *CAN* and *CHIP Contracts*. However, CCME identified instances in various United and Magnolia materials where the toll-free telephone numbers and Call Center hours of operation were incorrect, omitted, or had discrepancies.

Members can access the CCOs' websites or Member Handbooks for information on preventive health services, available case management programs, and instructions for obtaining educational support for medical, behavioral health, and pharmaceutical services. The plans use other methods to provide preventive health and disease management education such as outreach calls, targeted mailers, the member portal, and their respective mobile apps. As a result of restrictions due to COVID 19, in-person educational events were not conducted for most of 2020. Members were strongly encouraged to access the websites to obtain the most current information and updated materials. Molina monitors website activity to evaluate if newsletters and other member materials are being accessed.

Grievances

The CCOs have policies that define requirements for receiving, handling, and responding to member complaints and grievances. In addition to policies, grievance information is provided in the Member Handbooks, Provider Manuals, and on the CCOs' websites. Molina's websites did not include grievance definitions and information on grievance filing procedures. The Provider Manual did not clearly convey the requirement that grievance resolutions may be extended only up to 14 calendar days by the health plan. Magnolia's policies incorrectly documented timeframes for grievance acknowledgments and record retention. The Provider Manual did not include the name of the grievance form. United did not have grievance procedures and instructions on the website.

CCME's review of the CAN and CHIP grievance files reflected timely acknowledgement, resolution, and notification to members. The CCOs track, trends, and analyze grievances for medical and behavioral health services, and report results to their respective Quality Improvement Committees quarterly.

Member Satisfaction Survey

As contractually required, the health plans conducted the Adult, Child and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Using the protocol developed by CMS titled, *Protocol 6: Administration or Validation of Quality of Care Surveys*, CCME validated to ensure that

the results of the surveys were reliable and valid. The results of the validation found the generalizability of the survey results was difficult to discern due to low response rates. The CCO's were advised to work with their survey vendors on strategies to increase the response rates.

Overall, review of Member Services found areas needing improvements in member materials, the call centers, satisfaction surveys and the grievance process. An overview of the scores for the Member Services section is illustrated in *Table 8: Member Services Comparative Data*.

Table 8: Member Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*					
The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met	Met
All member rights included	Met	Met	Partially Met ↓	Met	Met
All member responsibilities included	Met ↑	Met ↑	Partially Met	Met	Met
Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*					
Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled	Met	Met	Met	Met	Met
Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Met	Met	Met	Met
Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract	Partially Met ↓	Partially Met ↓	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages	Met	Met	Met	Met	Met
Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed	Met	Met	Met	Met	Met
CAN: Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members	Met	N/A	Met	Met	N/A
Call Center					
The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Partially Met ↓	Partially Met ↓	Partially Met ↓	Met	Met
Call Center scripts are in-place and staff receive training as required by the contract	Met	Met	Met	Met	Met
Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee	Met	Met	Met	Met	Met
Member Enrollment and Disenrollment *42 CFR § 438.56*					
The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met	Met	Met
Member disenrollment is conducted in a manner consistent with contract requirements	Met	Met	Met	Met	Met
Preventive Health and Chronic Disease Management Education					
The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program	Met	Met	Met	Met	Met
CAN: The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits CHIP: The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met
The CCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met
Member Satisfaction Survey					
The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met	Not Evaluated
The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Not Met	Not Evaluated
The CCO reports results of the member satisfaction survey to providers	Met	Met	Met	Not Met	Not Evaluated
The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee	Met	Met	Met	Not Met	Not Evaluated

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*					
The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to	Met	Met	Met	Met	Met
Definition of a grievance and who may file a grievance	Met ↑	Met	Met	Met	Met
The procedure for filing and handling a grievance	Partially Met ↑	Partially Met ↑	Met ↑	Met	Met
Timeliness guidelines for resolution of grievances as specified in the contract	Met	Met	Met	Met	Met
Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met	Met	Met	Met	Met
Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Partially Met ↓	Partially Met ↓	Partially Met ↓	Met	Met
The CCO applies the grievance policy and procedure as formulated	Met	Met	Met	Met	Met
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee	Met	Met	Met	Met	Met
Grievances are managed in accordance with CCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Practitioner Changes					
The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee	Met	Met	Met	Met	Met

Strengths

- Staff implemented COVID-related strategies to continue member educational programs and community engagement activities.
- Data were analyzed from the member satisfaction survey to identify potential quality problems.

Weaknesses

- Incomplete documentation of member rights and responsibilities in policies and on the CCO websites was noted for Magnolia and Molina.
- No documentation of the requirement for member materials to use a minimum 12-point font size for regular print items and 18-point font size for large print items.
- Isolated documentation issues were found in Member Handbooks regarding notifying members of changes in benefits, programs, or network providers.
- Toll-free telephone numbers and Call Center hours of operation were incorrect, omitted, or had discrepancies in various member materials and the Provider Manual.
- The grievance review revealed issues related to definitions, filing processes and requirements, incorrect resolution timeframes, and missing information on the websites.
- Response rates for the member satisfaction surveys were below the NCQA target rate of 40%.

Recommendations

- Ensure complete documentation of member rights and responsibilities is included in policies and on the websites.
- Include in policies the font requirements for member materials. Refer to the *CAN* and *CHIP Contracts, Section 6 (F)*.
- Ensure the Member Handbooks contain the required information as listed in the *CAN* and *CHIP Contracts, Section 6 (D)*.

- Member materials and the Provider Manuals should contain the correct toll-free telephone numbers and Call Center hours of operation.
- Ensure documentation of grievance processes is correct and consistent with the requirements and terminology in the applicable DOM Contract and Federal Regulations.
- Work with the member satisfaction survey vendors on strategies to increase response rates.

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

Medicaid Managed Care Organizations are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the health plans in MS included review of the programs' structure, work plans, program evaluations, performance measure validation, and performance improvement project validation.

The health plans' program descriptions explain the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.

Each health plan has an annual plan of QI activities is in place which includes areas to be studied, follow-up of previous projects, where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). Molina's QI Work Plan (2020) only included a few references to CHIP. Also, there were errors or missing information. These included:

- The objective for identifying a process for managing potential quality of care issues was incorrect.
- Goals were missing.
- Standards for measuring practitioner availability and accessibility were incorrect.
- The timeframe for notifying a member of a PCP termination was incorrect.

A committee was established for each plan charged with oversight of the QI programs. The committees review data received from the QI activities to ensure performance meets standards and make recommendations as needed. Membership for the quality committees included the health plan's senior leadership, department directors and managers, and other plan staff. Network providers of varying specialties are included as voting members. Molina's membership list included 20 internal voting members, two network pediatricians, and one internal medical physician. CCME recommends Molina recruit

additional network providers and consider including Family Practice, OB/GYN, and Behavioral Health practitioners. Quorums are established and minutes are recorded for each meeting.

The plans are required to track provider compliance with EPSDT services provided to the Medicaid population and the Well-Baby and Well-Child services provided to the CHIP population. The plans are contractually required to track the diagnosis, treatment, and or referrals provided to members. The plans have policies and processes established to meet these requirements. United's tracking reports failed to link the identified problem with the EPSDT or Well-Baby and Well-Child exam and did not include or indicate members who received additional outreach for case management referrals. Magnolia's tracking reports did not include the CPT and/or the ICD-10 codes to identify the abnormal finding and the need for follow-up as stated in Magnolia's policy. Molina's policies indicated Molina tracks, at a minimum, initial visits for newborns, EPSDT screenings, and reporting of all screening results and diagnostic and treatment services, including referrals. Molina provided a sample of the tracking report; however, the tracking report failed to link the identified problem with the EPSDT or Well-Baby or Well-Child service and did not include or indicate members who received additional treatments or referrals as required by the *CAN* and *CHIP Contracts, Section 5 (D)*.

Each plan evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the Quality Improvement Committees, and to the Division of Medicaid. Molina's evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Health plans are required to have an ongoing improvement program and report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. DOM has selected a set of performance measures (PMs) to evaluate the quality of care and services delivered by the plans to its members. To evaluate the accuracy of the PMs reported, CCME contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA-certified HEDIS Compliance Organization, to conduct a validation review. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS® measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019.

HEDIS® Measure Overview for CAN Programs

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure HEDIS rates were accurate and reliable, DOM also required each CCO to undergo an NCQA HEDIS Compliance Audit. The three CCOs contracted with an NCQA-licensed organization to conduct the HEDIS audits. Aqurate reviewed each CCO's final audit reports, Information Systems Capabilities Assessments, and the Interactive Data Submission System files approved by the CCOs' NCQA licensed organizations. Aqurate found that the CCOs' information systems and processes were compliant with the applicable information system standards and the HEDIS reporting requirements for 2020.

In addition, Aqurate conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Several aspects crucial to the calculation of PM data reviewed included: data integration, data control, and documentation of PM calculations. The following are some of the main steps conducted during the validation process:

- Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by the CCOs, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined the data integration processes were acceptable.
- Data Control—Organizational infrastructure must support all necessary information systems. Its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated the CCOs' data control processes and determined that the data control processes in place were acceptable.
- Performance Measure Documentation—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by each CCO. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmaps, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation was acceptable.

The CCOs rates based on audit reports for the most recent review year are reported in *Table 9: HEDIS® Performance Measure Data for CAN Programs*. The statewide average is calculated as the average of the health plan rates and shown in the last column of the

table. Rates highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicates a substantial decrease in the rate of more than 10 percent.

Table 9: HEDIS® Performance Measure Data for CAN Programs

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
Effectiveness of Care: Prevention and Screening				
Adult BMI Assessment (aba)	90.75%	78.59%	NA	84.67%*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)				
BMI Percentile	69.10%	54.74%	57.91%	60.58%
Counseling for Nutrition	54.74%	53.53%	50.85%	53.04%
Counseling for Physical Activity	54.99%	43.55%	46.72%	48.42%
Childhood Immunization Status (cis)				
DTaP	77.62%	78.35%	NA	77.55%◊
IPV	93.43%	91.97%	NA	92.44%◊
MMR	89.54%	89.05%	NA	89.08%◊
HiB	88.08%	87.59%	NA	87.52%◊
Hepatitis B	90.27%	91.97%	NA	90.88%◊
VZV	91.48%	88.81%	NA	89.92%◊
Pneumococcal Conjugate	83.70%	79.32%	NA	81.15%◊
Hepatitis A	76.16%	79.56%	NA	77.79%◊
Rotavirus	79.08%	79.81%	NA	79.11%◊
Influenza	32.85%	34.55%	NA	33.49%◊
Combination #2	72.75%	77.13%	NA	74.55%◊
Combination #3	72.26%	75.18%	NA	73.35%◊
Combination #4	62.77%	66.91%	NA	64.59%◊
Combination #5	66.18%	68.13%	NA	66.87%◊
Combination #6	29.93%	31.63%	NA	30.49%◊
Combination #7	57.91%	61.56%	NA	59.54%◊
Combination #8	28.22%	29.68%	NA	28.69%◊
Combination #9	27.01%	28.47%	NA	27.49%◊
Combination #10	25.30%	26.76%	NA	25.81%◊
Immunizations for Adolescents (ima)				
Meningococcal	58.64%	59.12%	48.63%	57.33%
Tdap	78.10%	75.18%	69.18%	75.52%

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
HPV	24.57%	16.79%	15.75%	19.94%
Combination #1	56.93%	58.15%	46.58%	55.89%
Combination #2	22.87%	15.82%	14.38%	18.60%
Lead Screening in Children (lsc)	72.81%	72.82%	NA	72.81%◊
Breast Cancer Screening (bcs)	46.17%	56.74%	NA	52.38%*
Cervical Cancer Screening (ccs)	56.69%	61.56%	45.26%	54.50%
Chlamydia Screening in Women (chl)				
16-20 Years	46.92%	50.29%	47.65%	48.66%
21-24 Years	59.70%	62.01%	69.15%	61.79%
Total	48.74%	52.02%	53.91%	50.67%
Effectiveness of Care: Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis (cwp)	70.48%	70.56%	72.75%	70.61%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	28.30%	28.38%	NA	28.35%*
Pharmacotherapy Management of COPD Exacerbation (pce)				
Systemic Corticosteroid	42.24%	45.77%	60.00%	45.23%
Bronchodilator	74.96%	76.02%	77.65%	75.73%
Medication Management for People with Asthma (mma)				
5-11 Years: Medication Compliance 50%	55.25%	54.75%	NA	54.98%*
5-11 Years: Medication Compliance 75%	26.43%	25.63%	NA	26.00%*
12-18 Years: Medication Compliance 50%	48.87%	50.77%	NA	49.95%*
12-18 Years: Medication Compliance 75%	24.08%	22.94%	NA	23.43%*
19-50 Years: Medication Compliance 50%	58.79%	55.45%	NA	56.70%*
19-50 Years: Medication Compliance 75%	31.32%	29.37%	NA	30.10%*
51-64 Years: Medication Compliance 50%	62.86%	64.04%	NA	63.59%*
51-64 Years: Medication Compliance 75%	40.00%	40.35%	NA	40.22%*
Total: Medication Compliance 50%	53.21%	53.57%	NA	53.39%*
Total: Medication Compliance 75%	26.36%	25.57%	NA	25.91%*
Asthma Medication Ratio (amr)				
5-11 Years	81.04%	79.47%	NA	80.19%*
12-18 Years	68.84%	71.15%	NA	70.14%*
19-50 Years	44.66%	51.37%	NA	48.78%*
51-64 Years	50.00%	43.62%	NA	45.80%*
Total	70.70%	69.99%	NA	70.30%*

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (cbp)	53.53%	41.85%	46.72%	47.36%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA	67.24%	NA	61.63%◊
Statin Therapy for Patients with Cardiovascular Disease (spc)				
Received Statin Therapy: 21-75 Years (Male)	71.16%	73.48%	NA	72.50%*
Statin Adherence 80%: 21-75 Years (Male)	52.49%	52.12%	NA	52.28%*
Received Statin Therapy: 40-75 Years (Female)	68.42%	73.36%	NA	71.32%*
Statin Adherence 80%: 40-75 Years (Female)	42.31%	48.05%	NA	45.77%*
Received Statin Therapy: Total	69.80%	73.42%	NA	71.90%*
Statin Adherence 80%: Total	47.53%	50.06%	NA	49.03%*
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (cdc)				
Hemoglobin A1c (HbA1c) Testing	84.18%	87.83%	88.37%	86.57%
*HbA1c Poor Control (>9.0%)***	58.88%	55.23%	57.36%	57.13%
HbA1c Control (<8.0%)	34.55%	35.28%	36.05%	35.19%
Eye Exam (Retinal) Performed	57.42%	70.32%	53.88%	61.48%
Medical Attention for Nephropathy	91.24%	93.67%	90.31%	91.94%
Blood Pressure Control (<140/90 mm Hg)	49.39%	47.45%	55.43%	50.09%
Statin Therapy for Patients with Diabetes (spd)				
Received Statin Therapy	54.66%	58.41%	NA	56.89%*
Statin Adherence 80%	41.04%	44.61%	NA	43.22%*
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (amm)				
Effective Acute Phase Treatment	41.72%	40.34%	73.49%	41.60%
Effective Continuation Phase Treatment	25.64%	24.98%	66.27%	26.09%
Follow-Up Care for Children Prescribed ADHD Medication (add)				
Initiation Phase	53.69%	60.67%	NA	57.37%◊
Continuation and Maintenance (C&M) Phase	66.81%	72.36%	NA	69.76%◊
Follow-Up After Hospitalization for Mental Illness (fuh)				
6-17 years - 30-Day Follow-Up	62.00%	67.52%	53.91%	64.05%

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
6-17 years - 7-Day Follow-Up	38.82%	39.85%	30.45%	38.50%
18-64 years - 30-Day Follow-Up	52.33%	56.33%	37.23%	52.70%
18-64 years - 7-Day Follow-Up	27.77%	31.41%	20.07%	28.77%
65+ years - 30-Day Follow-Up	NA	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	NA
Total 30-Day Follow-Up	57.92%	62.96%	46.68%	59.33%
Total 7-Day Follow-Up	34.17%	36.39%	25.95%	34.45%
Follow-Up After Emergency Department Visit for Mental Illness (fum)				
6-17 years - 30-Day Follow-Up	51.09%	56.65%	47.06%	53.20%
6-17 years - 7-Day Follow-Up	31.52%	36.95%	25.49%	33.33%
18-64 years - 30-Day Follow-Up	39.39%	43.97%	23.93%	39.40%
18-64 years - 7-Day Follow-Up	25.42%	25.63%	13.68%	23.94%
65+ years - 30-Day Follow-Up	NA	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	NA
Total - 30-Day Follow-Up	43.36%	48.25%	30.95%	44.01%
Total- 7-Day Follow-Up	27.49%	29.45%	17.26%	27.08%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)				
30-Day Follow-Up: 13-17 Years	NA	NA	NA	3.23%◊
7-Day Follow-Up: 13-17 Years	NA	NA	NA	1.61%◊
30-Day Follow-Up: 18+ Years	6.06%	5.57%	4.11%	5.65%
7-Day Follow-Up: 18+ Years	3.64%	2.93%	2.74%	3.23%
30-Day Follow-Up: Total	5.87%	5.41%	3.85%	5.46%
7-Day Follow-Up: Total	3.35%	2.97%	2.56%	3.10%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	73.09%	70.74%	77.90%	72.04%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	67.91%	69.13%	NA	68.45%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	72.22%	76.92%	NA	75.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	55.13%	57.60%	53.21%	56.42%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)				
Blood glucose testing - 1-11 Years	35.85%	39.33%	37.74%	37.82%
Cholesterol Testing - 1-11 Years	26.03%	28.65%	21.70%	27.24%

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
Blood glucose and Cholesterol Testing - 1-11 Years	23.22%	25.04%	19.81%	24.04%
Blood glucose testing - 12-17 Years	44.30%	48.18%	49.40%	46.66%
Cholesterol Testing - 12-17 Years	26.97%	32.82%	30.12%	30.28%
Blood glucose and Cholesterol Testing - 12-17 Years	24.46%	28.98%	28.31%	27.10%
Blood glucose testing - Totals	40.61%	44.30%	44.85%	42.82%
Cholesterol Testing - Totals	26.56%	31.00%	26.84%	28.96%
Blood glucose and Cholesterol Testing - Total	23.92%	27.26%	25.00%	25.77%
Effectiveness of Care: Overuse/Appropriateness				
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.09%	NR	0.60%	1.05%*
Appropriate Treatment for Upper Respiratory Infection (uri)				
3 months-17 Years	70.80%	69.69%	73.62%	70.33%
18-64 Years	56.46%	56.18%	58.78%	56.41%
65+ Years	NA	NA	NA	NA
Total	69.24%	68.02%	71.40%	68.69%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)				
3 months-17 Years	45.87%	45.29%	48.10%	45.64%
18-64 Years	37.30%	37.16%	31.71%	37.02%
65+ Years	NA	NA	NA	NA
Total	44.42%	43.76%	44.87%	44.09%
Use of Imaging Studies for Low Back Pain (lbp)	71.45%	71.96%	81.02%	72.18%
Use of Opioids at High Dosage (hdo)	1.50%	1.46%	BR	1.48%*
Use of Opioids from Multiple Providers (uop)				
Multiple Prescribers	18.37%	15.27%	BR	16.73%*
Multiple Pharmacies	3.74%	4.19%	BR	3.98%*
Multiple Prescribers and Multiple Pharmacies	2.07%	2.31%	BR	2.19%*
Risk of Continued Opioid Use (cou)				
18-64 years - >=15 Days covered	7.38%	7.79%	11.37%	7.82%
18-64 years - >=31 Days covered	3.87%	3.49%	2.98%	3.62%
65+ years - >=15 Days covered	NA	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA	NA
Total - >=15 Days covered	7.39%	7.79%	11.37%	7.83%
Total - >=31 Days covered	3.87%	3.48%	2.98%	3.61%

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (aap)				
20-44 Years	86.13%	88.06%	87.66%	87.22%
45-64 Years	90.08%	92.53%	87.40%	91.36%
65+ Years	86.84%	80.19%	NA	83.78%
Total	87.82%	90.02%	87.56%	88.98%
Children and Adolescents' Access to Primary Care Practitioners (cap)				
12-24 Months	97.59%	98.14%	94.72%	97.74%
25 Months - 6 Years	91.07%	93.07%	88.87%	91.94%
7-11 Years	92.15%	93.90%	NA	93.07%
12-19 Years	90.52%	92.08%	NA	91.33%
Annual Dental Visit (adv)				
2-3 Years	55.01%	56.15%	47.18%	55.18%
4-6 Years	76.47%	76.79%	66.11%	75.95%
7-10 Years	77.51%	77.86%	67.22%	77.15%
11-14 Years	74.23%	73.63%	60.41%	73.29%
15-18 Years	64.17%	65.24%	50.29%	64.10%
19-20 Years	43.71%	44.15%	39.47%	43.66%
Total	70.67%	71.08%	59.62%	70.31%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)				
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	83.87%	70.00%	NA	76.47%◊
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%	3.33%	NA	1.47%◊
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	63.59%	68.67%	71.43%	66.88%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.35%	3.00%	0.00%	3.27%
Total: Initiation of AOD Treatment: 13-17 Years	63.37%	66.67%	68.89%	65.53%
Total: Engagement of AOD Treatment: 13-17 Years	3.96%	3.17%	2.22%	3.41%

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	43.95%	40.77%	45.04%	42.45%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.16%	4.59%	3.82%	4.78%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	26.11%	31.97%	53.73%	30.13%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.76%	12.12%	28.36%	11.73%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	41.42%	39.90%	48.82%	41.34%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.96%	4.54%	4.04%	4.67%
Total: Initiation of AOD Treatment: 18+ Years	35.88%	36.73%	45.80%	37.05%
Total: Engagement of AOD Treatment: 18+ Years	6.10%	6.27%	7.52%	6.29%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.45%	41.69%	46.38%	43.66%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.97%	4.55%	3.62%	4.66%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	26.25%	31.98%	54.41%	30.24%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	9.70%	12.07%	29.41%	11.73%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	44.08%	43.50%	51.62%	44.47%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.88%	4.35%	3.54%	4.50%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	37.88%	39.09%	47.89%	39.25%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	5.94%	6.03%	7.04%	6.07%
Prenatal and Postpartum Care (ppc)				
Timeliness of Prenatal Care	92.21%	96.35%	99.03%	95.86%
Postpartum Care	73.24%	67.15%	69.34%	69.91%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)				
1-11 Years	63.39%	69.31%	71.19%	67.16%
12-17 Years	66.67%	66.09%	56.10%	65.80%
Total	65.33%	67.53%	62.41%	66.38%

Measure/Element	United MY2019 (HEDIS 2020)	Magnolia MY2019 (HEDIS 2020)	Molina MY2019 (HEDIS 2020)	Statewide Average
Utilization				
Well-Child Visits in the First 15 Months of Life (w15)				
0 Visits	1.46%	1.45%	7.50%	1.48%
1 Visit	2.92%	3.26%	2.50%	3.24%
2 Visits	3.65%	4.19%	2.50%	4.15%
3 Visits	5.35%	5.94%	12.50%	5.94%
4 Visits	10.46%	10.29%	10.00%	10.29%
5 Visits	16.06%	18.30%	22.50%	18.22%
6+ Visits	60.10%	56.57%	42.50%	56.68%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	57.66%	62.36%	58.64%	62.23%
Adolescent Well-Care Visits (awc)	49.64%	41.71%	44.28%	41.80%

BR: Biased Rate
NR indicates that the rate was not reported.
◊This statewide average includes CCO rates with small denominators.
*: These statewide averages were calculated with data from only two CCOs
**: Since only one health plan reported this rate, a statewide average cannot be calculated
***: For this indicator, a lower rate indicates better performance.

Measure Year (MY) 2019 was the first year for Molina to report data for the CAN population. Since enrollment started in January 2019, there were no measure rates available for measures that needed more than one year of continuous enrollment. Many of the statewide average rates are therefore calculated with data from United and Magnolia.

United and Magnolia had data for comparison year over year, for MY 2018 and MY 2019 for the CAN population. There were only a few measures that showed a substantial improvement of more than 10 percent year over year. United showed an improvement for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) BMI Percentile indicator. Magnolia showed an improvement for the Cardiovascular Monitoring for People with Cardiovascular Disease, Schizophrenia (SMC), and the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) measures. United's rates for the Comprehensive Diabetes Care (CDC) HbA1c Poor Control (>9.0%) and HbA1c Control (<8.0%) indicators fell by more than 10%.

Since Magnolia and Molina did not have enrollment in the CHIP population in 2019, the PM validation was conducted for United only. *Table 10: HEDIS® Performance Measure Data for CHIP Program* provides an overview of the rates reported by United. Rates highlighted in green indicate United had a substantial improvement (>10%) over the MY 2018 rate.

Table 10: HEDIS® Performance Measure Data for CHIP Programs

Measure/Data Element	United HEDIS 2020 (MY 2019) CHIP Rates
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	
BMI Percentile	64.96%
Counseling for Nutrition	55.96%
Counseling for Physical Activity	50.12%
Childhood Immunization Status (cis)	
DTaP	85.89%
IPV	93.92%
MMR	93.67%
HiB	90.75%
Hepatitis B	94.40%
VZV	92.94%
Pneumococcal Conjugate	86.86%
Hepatitis A	79.81%
Rotavirus	84.43%
Influenza	39.90%
Combination #2	84.91%
Combination #3	83.45%
Combination #4	72.26%
Combination #5	76.40%
Combination #6	36.74%
Combination #7	67.15%
Combination #8	34.55%
Combination #9	34.55%
Combination #10	32.60%
Immunizations for Adolescents (ima)	
Meningococcal	56.20%
Tdap/Td	80.78%
HPV	19.71%
Combination #1	55.96%
Combination #2	18.73%
Lead Screening in Children (lsc)	65.94%
Chlamydia Screening in Women (chl)	

Measure/Data Element	United HEDIS 2020 (MY 2019) CHIP Rates
16-20 Years	39.78%
21-24 Years	NA
Total	39.78%
Effectiveness of Care: Respiratory Conditions	
Appropriate Testing for Children with Pharyngitis (cwp)	
3-17 Years	76.24%
18-64 Years	62.79%
Total	75.74%
Medication Management for People with Asthma (mma)	
5-11 Years: Medication Compliance 50%	63.24%
5-11 Years: Medication Compliance 75%	29.90%
12-18 Years: Medication Compliance 50%	58.42%
12-18 Years: Medication Compliance 75%	25.26%
19-50 Years: Medication Compliance 50%	NA
19-50 Years: Medication Compliance 75%	NA
Total Medication Compliance 50%	60.96%
Total Medication Compliance 75%	27.96%
Asthma Medication Ratio (amr)	
5-11 Years	86.85%
12-18 Years	73.68%
19-50 Years	NA
Total	80.47%
Effectiveness of Care: Cardiovascular conditions	
Controlling High Blood Pressure (cbp)	NA
Effectiveness of Care: Behavioral	
Antidepressant Medication Management (amm)	
Effective Acute Phase Treatment	41.94%
Effective Continuation Phase Treatment	19.35%
Follow-up care for children prescribed ADHD Medication (add)	
Initiation Phase	52.09%
Continuation and Maintenance (C&M) Phase	66.00%
Follow-Up After Hospitalization for Mental Illness (fuh)	
6-17 years - 30-Day Follow-Up	65.58%
6-17 years - 7-Day Follow-Up	37.67%
18-64 years - 30-Day Follow-Up	NA

Measure/Data Element	United HEDIS 2020 (MY 2019) CHIP Rates
18-64 years - 7-Day Follow-Up	NA
Total-30-day Follow-Up	64.55%
Total-7-day Follow-Up	37.27%
Follow-Up After Emergency Department Visit for Mental Illness (fum)	
6-17 years - 30-Day Follow-Up	NA
6-17 years - 7-Day Follow-Up	NA
18-64 years - 30-Day Follow-Up	NA
18-64 years - 7-Day Follow-Up	NA
Total-30-day Follow-Up	NA
Total-7-day Follow-Up	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)	
1-11 Years Blood Glucose Testing	39.29%
1-11 Years Cholesterol Testing	26.79%
12-17 Years Blood Glucose and Cholesterol Testing	25.00%
12-17 Years Blood Glucose Testing	48.84%
12-17 Years Cholesterol Testing	27.91%
12-17 Years Blood Glucose and Cholesterol Testing	25.58%
Total Blood Glucose Testing	45.95%
Total Cholesterol Testing	27.57%
Total Blood Glucose and Cholesterol Testing	25.41%
Effectiveness of Care: Overuse/Appropriateness	
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.78%
Appropriate Treatment for Upper Respiratory Infections (uri)	
3 months - 17 years	67.70%
18 - 64 Years	52.05%
Total	67.13%
Use of Imaging Studies for Low Back Pain (lbp)	59.38%
Risk of Continued Opioid Use (cou)	
18-64 years - >=15 Days covered	1.23%
18-64 years - >=31 Days covered	0.00%
Total - >=15 Days covered	1.23%
Total - >=31 Days covered	0.00%
Access/Availability of Care	
Children and Adolescents' Access to Primary Care Practitioners (cap)	
12-24 Months	98.73%

Measure/Data Element	United HEDIS 2020 (MY 2019) CHIP Rates
25 Months-6 Years	92.96%
7-11 Years	94.79%
12- 19 Year	92.42%
Annual Dental Visit (adv)	
2-3 Years	57.12%
4-6 Years	77.54%
7-10 Years	82.81%
11-14 Years	78.34%
15-18 Years	69.80%
19-20 Years	55.20%
Total	75.25%
Initiation and Engagement of AOD Dependence Treatment (iet)	
Total: Initiation of AOD Treatment: 13-17 years	64.44%
Total: Engagement of AOD Treatment: 13-17 years	8.89%
Total: Initiation of AOD Treatment: 18+ years	NA
Total: Engagement of AOD Treatment: 18+ years	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	58.33%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	8.33%
Total: Initiation of AOD Treatment: Total	53.33%
Total: Engagement of AOD Treatment: Total	6.67%
Prenatal and Postpartum Care (ppc)	
Timeliness of Prenatal Care	NA
Postpartum Care	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)	
1-11 Years	60.53%
12-17 Years	58.33%
Total	59.09%
Utilization	
Well-Child Visits in the First 15 Months of Life (w15)	
0 Visits	0.97%
1 Visit	1.46%
2 Visits	3.16%
3 Visits	2.68%
4 Visits	5.35%
5 Visits	12.90%

Measure/Data Element	United HEDIS 2020 (MY 2019) CHIP Rates
6+ Visits	73.48%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	62.50%
Adolescent Well-Care Visits (awc)	50.36%

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

United showed more than 10 percent improvement for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) BMI Percentile indicators. There were no measures that showed a substantial decrease in the reported rate.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by the CCOs for 2019 are listed in *Table 11: CAN Adult and Child Core Set Measure Rates*. The statewide averages have been included where applicable.

Table 11: CAN Adult and Child Core Set Measure Rates

Measure	United MY 2019 Rate	Magnolia MY 2019 Rate	Molina MY 2019 Rate	Statewide Average
Adult Core Set Measures				
Primary Care Access and Preventative Care				
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)				
Ages 18-65	0.34%	0.19%	0.19%	0.26%
Ages 65+	0.00%	0.00%	NA	0.00%
Total	0.34%	0.19%	0.19%	0.26%
Maternal and Perinatal Health				
PC-01: ELECTIVE DELIVERY (PC-01)				
Women with elective vaginal deliveries or elective cesarean sections	NR	24.19%	NR	Not Available**
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)				
Most or moderately effective contraception - 3 days	15.35%	12.65%	12.78%	13.70%
Most or moderately effective contraception - 60 days	52.01%	37.11%	53.53%	49.71%
LARC - 3 Days	0.61%	0.76%	0.87%	0.75%
LARC - 60 Days Reported	9.45%	7.32%	11.07%	9.72%

Measure	United MY 2019 Rate	Magnolia MY 2019 Rate	Molina MY 2019 Rate	Statewide Average
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)				
Most or moderately effective contraception - 3 days	27.91%	0.00%	0.00%	10.24%
Most or moderately effective contraception - 60 days	0.00%	17.45%	28.78%	11.74%
LARC - 3 Days	3.53%	0.00%	0.00%	1.29%
LARC - 60 Days Reported	0.00%	1.34%	5.26%	1.09%
Care of Acute and Chronic Conditions				
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)				
Ages 18-65	25.72%	12.24%	28.19%	19.80%
Ages 65+	106.27%	0.00%	NA	32.87%◊
Total	25.87%	12.20%	28.19%	19.83%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)				
Ages 40-64	62.78%	52.30%	113.36%	60.77%
Ages 65+	0.00%	47.82%	NA	32.87%◊
Total	62.49%	52.26%	113.33%	60.59%
HEART FAILURE ADMISSION RATE (PQI-08)				
Ages 18-65	45.73%	29.88%	48.65%	38.76%
Ages 65+	212.54%	0.00%	NA	65.75%◊
Total	46.03%	29.77%	48.64%	38.82%
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)				
Ages 18-39	3.39%	1.38%	NR	2.33%*
HIV VIRAL LOAD SUPPRESSION (HVL - AD)				
Ages 18-65	18.46%	4.60%	0.00%	9.64%
Ages 65+	NA	NA	NA	NA
Total	18.11%	4.49%	0.00%	9.46%
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)				
Ages 18-65	1.55%	2.39%	BR	1.85%*
Ages 65+	NA	NA	BR	NA
Total	1.55%	2.38%	BR	1.85%*
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)				
Ages 18-65	6.81%	2.90%	3.35%	5.25%
Ages 65+	NA	NA	NA	NA
Total	6.80%	2.90%	3.35%	5.24%

Measure	United MY 2019 Rate	Magnolia MY 2019 Rate	Molina MY 2019 Rate	Statewide Average
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)				
Overall	57.14%	18.92%	NA	29.92%◊
Prescription for Buprenorphine	57.14%	0.00%	NA	12.12%◊
Prescription for Oral Naltrexone	3.57%	0.00%	NA	0.76%◊
Prescription for Long-acting, injectable naltrexone	1.79%	0.00%	NA	0.38%◊
Prescription for Methadone	0.00%	0.00%	NA	0.00%◊
Child Core Set Measures				
Primary Care Access and Preventative Care				
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 to 17 (CDF-CH)				
Ages 12-17	0.68%	0.49%	9.84%	2.01%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)				
Age 1 Screening	28.58%	2.34%	7.30%	17.44%
Age 2 Screening	43.85%	5.38%	0.00%	22.47%
Age 3 Screening	39.43%	5.28%	7.89%	20.27%
Total Screening	35.16%	4.27%	7.29%	19.68%
Maternal and Perinatal Health				
PC-02: CESAREAN BIRTH (PC02-CH)				
Ages 9-17	NR	29.84%	22.57%	22.87%*
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)				
Total (Newborn < 91 Days at Dx)	NA	NA	NR	NA
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CW)				
Deliveries covered by MD/CHP	NR	NA	NR	Not Available
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)				
Most or moderately effective contraception - 3 days	2.74%	2.27%	1.72%	2.20%
Most or moderately effective contraception - 60 days	53.06%	33.81%	49.47%	47.57%
LARC - 3 Days	1.29%	1.14%	0.66%	0.98%
LARC - 60 Days Reported	13.87%	9.38%	12.83%	12.50%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)				
Most or moderately effective contraception - 3 days	32.91%	0.00%	0.00%	13.20%
Most or moderately effective contraception - 60 days	0.00%	20.46%	29.89%	12.62%
LARC - 3 Days	3.05%	0.00%	0.00%	1.22%

Measure	United MY 2019 Rate	Magnolia MY 2019 Rate	Molina MY 2019 Rate	Statewide Average
LARC - 60 Days Reported	0.00%	1.00%	4.15%	0.72%
Dental and Oral Health Services				
DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)				
Ages 6-9	21.22%	5.18%	NR	13.14%*
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)				
Ages 1-20	54.94%	35.78%	2.32%	44.59%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.
◊This statewide average includes CCO rates with small denominators.
*: These statewide averages were calculated with data from only two health plans
**: Since only one health plan reported this rate, a statewide average cannot be calculated

Table 12: CHIP Adult and Child Core Set Measure Rates, provides an overview of rates reported by United for the CHIP population.

Table 12: CHIP Adult and Child Core Set Measure Rates

Measure	United MY 2019 Rate
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-CH)	
Ages 12-17	0.51%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	33.33%
Age 2 Screening	53.09%
Age 3 Screening	44.46%
Total Screening	48.36%
Maternal and Perinatal Health	
PC-02: CESEAREAN BIRTH (PC02-CH)	
Ages 9-17	NR
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CW)	
Deliveries covered by MD/CHP	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	

Measure	United MY 2019 Rate
Most or moderately effective contraception - 3 days	0.00%
Most or moderately effective contraception - 60 days	38.46%
LARC - 3 Days	0.00%
LARC - 60 Days Reported	7.69%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception - 3 days	33.14%
Most or moderately effective contraception - 60 days	0.00%
LARC - 3 Days	2.45%
LARC - 60 Days Reported	0.00%
Dental and Oral Health Services	
DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)	
Ages 6-9	22.40%
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1-20	59.86%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting

While the CCOs have sufficient systems and processes in place, the rates reported for the Adult and Child Core Set measures indicate that the CCOs may need to monitor for gaps in data and services provided to improve performance and measure rates.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validation of Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

The DOM-required topics for PIPs include: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Each health plan is required to submit their PIPs to CCME

for review annually. CCME validates and scores the submitted projects using the CMS designed protocol that evaluates the validity and confidence in the results of each project. Twenty-three projects were validated for the three health plans. Results of the validation and interventions underway for each project are displayed in the tables that follow.

Table 13: United CAN Results of the Validation of PIPs

Project	Validation Score	Interventions
United CAN		
Behavioral Health Readmissions	73/74=99% High Confidence in Reported Results	• Meds to Beds Program • Case Management High Needs Protocol • CHOICE Program • Transportation Benefit • Provider Collaboration
Improved Pregnancy Outcomes: Care Management to Reduce Preterm Deliveries	67/72=93% High Confidence in Reported Results	• Telephonic Contacts for Prenatal Visit Reminders • National Healthy Starts Program • Member Education • Patient Care Opportunity Reports • Member Incentives
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	66/71=93% High Confidence in Reported Results	• Pharmacy Reports • Medication Education to Members • Community Health Worker Contacts • Daily ER Census Report to Providers
Respiratory Illness: COPD/Asthma	72/72=100% High Confidence in Reported Results	• Authorization Review • Provider Education on Clinical Practice Guidelines • Reports to identify non-compliant members • Member Outreach via Transition Care Program

The Behavioral Health Readmissions PIP showed an increase in readmission rates from the previous measurement. The goal is to reduce the readmission rate five percent from baseline to Remeasurement 1. The annual report showed an increase from 18% to 19.2% for the first remeasurement period. A continuation of the currently planned interventions was recommended given the barriers of contact due to COVID 19 restrictions.

The Pregnancy Outcomes PIP had baseline measurement data only and the baseline rate of 92.21% was above the goal of 89.20%. Interventions will continue to determine if the rate is sustained.

The Sickle Cell Disease PIP also reported baseline data only and the rate of 70.22% was above the target rate of 58.23%. The recommendations were to continue the current interventions to sustain the above-goal rate.

The COPD PIP contains two HEDIS indicators and baseline data were presented in the PIP report. The indicators were below the target rate and recommendations were to continue the interventions to determine if improvement is yielded at the remeasurement period.

Table 14: United CHIP Results of the Validation of PIPs

Project	Validation Score	Interventions
United CHIP		
Adolescent Well Child Visits (AWC)	100/100=100% High Confidence in Report Results	• Member Outreach Events and Brochures • Provider Incentive Program • Clinical Transformation Consultants
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity)	100/100=100% High Confidence in Report Results	• Member Education through Heart Health Education • Community Outreach Events • Provider Education on Billing Codes and Documentation
Getting Needed Care CAHPS	99/100=99% High Confidence in Report Results	• Clinical Practice Consultants Program • Provider Education • Member Education
Follow Up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	• Member Education • Telehealth Contact • Care Advocate and case Management Collaboration • Reduced caseloads for care managers

The Adolescent Well Child Visits PIP showed improvement in the rate from last year to this year (HEDIS 2020). The rate improved from 48.18% to 50.36%.

The Obesity PIP has three HEDIS indicators: BMI percentile, counseling for nutrition, and counseling for physical activity. All rates improved from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate.

For the Getting Needed Care CAHPS PIP, the goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period, from 90% in 2018 to 88.54% in 2019. This rate was higher than the NCQA rate but lower than United's goal rate.

The Follow-Up After Hospitalization PIP showed that the 30-day follow-up rate improved from 61.39% to 64.55%, which is above the goal rate of 63.23%. The seven-day follow up rate improved from 35.1.5% to 37.27%, which is above the goal rate of 36.20%.

Issues for United's PIPs

United's Behavioral Health readmissions rate increased, and the COPD rates declined, both of which indicate lack of improvement.

The reported rates in United's CHIP projects showed a lack of improvement in the Getting Needed Care CAHPS composite score. The current interventions may need to be revised to improve member perceptions regarding this element of member satisfaction.

Table 15: Magnolia CAN Results of the Validation of PIPs

Project	Validation Score	Interventions
Magnolia CAN		
Asthma	80/80=100% High Confidence in Report Results	• Member Education • Onsite visits with Providers • Care Management Outreach
Behavioral Health Readmissions	73/74=99% High Confidence in Report Results	• Risk Stratification at CCO Level • Medication Reconciliation • Post-Discharge Contact with • Member within 72 hours • Case Management Enrollment
Improved Pregnancy Outcomes with Makena	73/74=99% High Confidence in Report Results	• Care Management Outreach • Notification of Pregnancy Forms to Members • Member Handbooks to Members
Sickle Cell Disease Outcomes	73/74= 99% High Confidence in Report Results	• 90-day Hydroxyurea Prescriptions • Pharmacy Team Outreach to Members • Care management Outreach • Member Educational Letters

All projects received scores in the "High Confidence" range, although three of the four PIPs did not show improvement in the indicator rates. The asthma PIP did have improvement in the indicator rates. However, the Medication Management for People with Asthma (MMA) HEDIS measure used as the study indicator for this PIP was retired.

Magnolia has closed this PIP and will implement a new Adult and Child Respiratory Disease PIP. Magnolia indicated the new PIP will include child asthma and adult COPD as required by DOM.

Issues for Magnolia's PIPs

The primary issue for Magnolia is improving the outcomes for the PIP indicators. The BH readmissions rate increased, the Sickle Cell Disease rate decreased, and the Pregnancy outcomes PIP rates decreased, all of which indicate lack of improvement.

Table 16: Molina CAN Results of the Validation of PIPs

Project	Validation Score	Interventions
Molina CAN		
Behavioral Health Readmissions	80/80=100% High Confidence in Reported Results	• Tele-visit Contacts • Transition of Care Collaborative for On-site discharge Planning • Community Connector Follow-Up • Case Manager Initiative • Local BH Provider Initiative
Medication Management for People with Asthma (MMA)	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Pharmacotherapy Management of COPD Exacerbation (PCE)	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Follow-up After Hospitalization for Mental Illness (FUH)	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Obesity	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Prenatal and Postpartum Care	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Case Management and Follow-up (30 days) Services for Sickle Cell Disease	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education

All the PIPs received a validation score within the "Not Credible" range except for the Behavioral Health Readmission PIP. Rates were tracked and interventions were reported, but this information was contained in separate documents. The PIP reports only contained three of the required elements per the CMS protocol: topic, indicator definitions, and study question. All other elements were not documented in the PIP

reports. CCME required Molina to correct the issues in the PIPs and recommended the health plan use the project template Molina currently uses for their Behavioral Health Readmission PIP.

For the Behavioral Health Readmissions PIP, Molina did report a reduction (improvement) in the quarterly readmission rate from 34.2% to 9.5%. The next remeasurement will help determine if this decrease is sustained.

Table 17: Molina CHIP Results of the Validation of PIPs

Project	Validation Score	Interventions
Molina CHIP		
Medication Management for People with Asthma	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Follow Up After Hospitalization for Mental Illness	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Obesity	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education
Well Care	28/62=45.2% Reported Results Not Credible	• Member Outreach • Provider Education

The Asthma MMA, Follow-Up After Hospitalization for Mental Illness (FUH), Obesity, and Well-Care/Well-Child Visit PIP reports were submitted for validation. Rates were tracked and interventions were reported, but information was contained in separate documents which resulted in missing validation elements. Several elements required by the CMS Protocol for Validation of Performance Improvement Projects were not included in the PIP reports. Corrective actions were given to create PIP reports for each project using the template that Molina uses for the BH Readmissions Project.

Issues for Molina's PIPs

The CAN PIP reports did not contain sufficient information as required by the CMS protocol, and thus most of the PIPs received a validation score within the "Not Credible" range. Corrective actions were given to Molina to improve the PIP reports to ensure all required CMS elements were present. A template was provided to assist Molina with the reporting format. The Behavioral Health Readmission PIP received a validation score within the "High Confidence" range and no issues were found.

For CHIP, Molina submitted proposals with well-defined indicators on the priority topics identified by DOM. The PIP reports did not contain sufficient information as required by

the CMS protocols, and thus all PIPs were scored as "Not Credible." Corrective actions were given to Molina to improve the PIP reports to ensure all required CMS elements were present in the PIP reports. A template was provided to assist Molina with reporting format.

Table 18: Quality Improvement Comparative Data, provides an overview of each health plan's scores for the Quality Improvement standards. Molina had several areas needing improvement or not meeting the standards.

Table 18: Quality Improvement Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*					
The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met	Met
The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities	Met	Met	Met	Met	Met
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Partially Met	Partially Met
Quality Improvement Committee					
The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met	Met
The QI Committee meets at regular intervals	Met	Met	Met	Met	Met
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met	Met
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*					
Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures"	Met	Met	Met	Met	Not Evaluated
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*					
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met	Met	Met	Met
The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met	Met	Met	Not Met	Not Met
Provider Participation in Quality Improvement Activities					
The CCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met
The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Initial visits for newborns CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Initial visits for newborns	Met	Met	Met	Met	Met
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: EPSDT screenings and results CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Well-Baby and Well-Child screenings and results	Met	Met	Met	Met	Met
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Diagnosis and/or treatment for children CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Diagnosis and/or treatment for children	Met	Met	Met	Not Met	Not Met
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*					
A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Met	Met	Partially Met	Partially Met
The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met	Met

Strengths

- The CCOs have QI program descriptions that described the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.

- The CCOs were fully compliant with all information systems standards and HEDIS determination standards for the CAN and CHIP HEDIS performance measures.
- Based on Aqurate's validation of performance measure rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures reported.
- United and Magnolia's performance improvement projects scored in the "High Confidence" range.
- The rationale for conducting the performance improvement projects was well documented.
- Network providers receive interpretation of their QI performance data and feedback regarding QI activities.

Weaknesses

- There were errors or missing information noted in Molina's QI Work Plan. These errors included:
  - The objective for identifying a process for managing potential quality of care issues was incorrect.
  - Goals were missing.
  - Standards for measuring practitioner availability and accessibility were incorrect.
  - The timeframe for notifying a member of the termination of a PCP was incorrect.
- The CCOs did not report some of the Adult and Child Core Set measures required by DOM for reporting.
- United's Behavioral Health readmissions rate increased and COPD rates declined, both of which indicate a lack of improvement. The reported rates in United's CHIP projects showed a lack of improvement in the Getting Needed Care CAHPS composite score.
- The primary issue for Magnolia is improving the outcomes for the PIP indicators. The BH readmissions rate increased, the Sickle Cell Disease rate decreased, and the Pregnancy outcomes PIP rates decreased, all of which indicate lack of improvement.
- Molina's performance improvement projects did not contain sufficient information as required by the CMS protocols, and thus most of the PIPs received a validation score within the "Not Credible" range.
- The EPSDT and the Well-Baby and Well-Child tracking reports for any problems identified during the exams failed to link the identified problems with the EPSDT or Well-Baby and Well-Child service and did not include or indicate members who received additional outreach for case management referrals.

- Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight.

Recommendations

- Review the QI Work Plans to ensure all QI activities are included and goals and objectives are correct.
- The CCOs should work proactively with DOM for clarification on Core Set measures that are required to be reported.
- Monitor ongoing interventions and consider revising interventions as needed for PIPs not showing improvements in the indicator rates.
- Performance improvement projects should be documented on the CCME-provided project template and include all required elements.
- The EPSDT and Well-Baby and Well-Child tracking reports should include the date the exams were provided, ICD 10 or CPT codes, treatment/referral, if any, and members who received additional outreach for case management referrals.
- The Quality Improvement Program Evaluation must meet all the requirements contained in the *CAN* and *CHIP Contracts, Section 10 (D)* and *Exhibit G*. Specifically, it should include a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.

E. Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

The Utilization Management review of included various documents, medical necessity determination processes, pharmacy requirements, the Care Management Program, and file review. Each plan has a UM Program Description and appropriate policies and procedures that define and describe UM activities and provide guidance to staff.

Appropriate staff conduct reviews of service authorization requests using InterQual guidelines or other criteria, in an established clinical hierarchy. Each health plan assesses the consistency in criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers.

United had minor documentation issues with requirements for requesting additional information from providers, with incorrectly referencing working days instead of calendar days, and with procedure requirements. Review of the plans' approval and denial files

reflected timely and consistent decision-making using evidenced-based criteria and relevant medical information. CCME identified that the adverse benefit determination notices in Molina's files used CPT codes to reference the service requested, rather than describing the service in terms that can be easily understood by the member.

Caremark is delegated to provide pharmacy services for Molina, Envolve Pharmacy Solutions (EPS) provides pharmacy services for Magnolia, and Optum RX is delegated to provide pharmacy services for United. The health plans use the most current version of the Mississippi Medicaid Program Preferred Drug List on the State's website to fulfill pharmacy requirements. CCME noted that Molina's website incorrectly states that pharmacy prior authorizations will be responded to in 72 hours.

The plans have established policies defining processes for handling both CAN and CHIP appeals of adverse benefit determinations. CCME's review of appeal files confirmed timely acknowledgement, resolution, and notification of resolution. However, appeals documentation and files revealed issues such as:

- Outdated, incomplete, and missing definitions of appeal terminology and use of the term "adverse benefit determination."
- Incorrect and incomplete information about the appeal filing timeframe and filing requirements, including lack of information that members can present evidence or review the case file for an appeal and who can be a member's authorized representative and who can file an appeal.
- Incomplete or no information about continuation of benefits pending the resolution of an initial member appeal or a State Fair Hearing or Independent External Review. (Molina)
- Appeals cases reviewed by the same physician reviewer who issued the initial determination. (Molina)

The plans monitor, evaluate, and report appeals data and activities at least annually, to assess strength and effectiveness. Magnolia and Molina report results and analysis to their respective Quality Improvement Committee and United reports to the Healthcare Quality and Utilization Committee and the Quality Management Committee to identify opportunities to improve quality of care and service.

The CAN and CHIP Care Management Program Description and policies outline the framework for the program's goals, scope, and lines of responsibility. The plans use care management techniques to ensure comprehensive, coordinated care for all members in various risk levels, and follows a standard outreach process as it applies to continual care, transitional care, and discharge planning. CCME noted incomplete documentation of the Transition of Care requirement that pregnant members are allowed access to their

prenatal care provider and any provider currently treating the members chronic condition through the postpartum period. Additionally, the plans incorporate Population Health Management activities into the UM Program to assist with identifying and providing physical and behavioral health services to members most at risk. Care Management files indicate care management activities are conducted as required and HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed.

Even though isolated instances of staff not following UM guidelines were noted, CCME did not identify trends or patterns of non-compliance. Overall, no major issues were identified with review of the UM Program, and UM services are provided according to established processes and DOM requirements.

An overview of all scores for the Utilization Management section is illustrated in *Table 19: Utilization Management Services Comparative Data*.

Table 19: Utilization Management Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Utilization Management (UM) Program					
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Met	Met	Met	Met	Met
Structure of the program	Met	Met	Met	Met	Met
Lines of responsibility and accountability	Met	Met	Met	Met	Met
Guidelines/standards to be used in making utilization management decisions	Met	Met	Met	Met	Met
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met ↓	Partially Met ↓	Met	Met	Met
Consideration of new technology	Met	Met	Met	Met	Met
The appeal process, including a mechanism for expedited appeal	Met	Met	Met	Met	Met
The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met
Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*					
Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met	Met
The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Met	Met	Met	Met	Met
The CCO has established policies and procedures for prior authorization of medications	Met	Met	Met	Met	Met
Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Met
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Met	Met	Met	Met
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*					
The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including	Met	Met	Met	Met	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met ↑	Met ↑	Partially Met ↑	Met	Met
The procedure for filing an appeal	Partially Met	Partially Met	Met ↑	Partially Met	Partially Met
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Met ↑	Met ↑	Met	Met
Written notice of the appeal resolution as required by the contract	Partially Met ↓	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Other requirements as specified in the contract	Met ↑	Met ↑	Met ↑	Met	Met
The CCO applies the appeal policies and procedures as formulated	Met	Met	Met	Met	Met
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met
Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*					
The CCO has developed and implemented a Care Management and a Population Health Program	Met	Met	Met	Met	Met
The CCO uses varying sources to identify members who may benefit from Care Management	Met	Met	Met	Met	Met
A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level	Met	Met	Met	Met	Met
The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met	Met	Met	Met
Evaluation of co-morbidities or multiple complex health care conditions	Met	Met	Met	Met	Met
Demographic information	Met	Met	Met	Met	Met
Member's current treatment provider and treatment plan, if available	Met	Met	Met	Met	Met
The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment	Met	Met	Met	Met	Met
The risk level assignment is periodically updated as the member's health status or needs change	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met	Met
The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract	Met	Met	Met	Met	Met
The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met	Met	Met	Met
The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	Met	Met	Met	Met	Met
CAN: The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants. CHIP: The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants	Met	Met	Met	Met	Met
Transitional Care Management					
The CCO monitors continuity and coordination of care between PCPs and other service providers	Met	Met	Met	Met	Met
The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Met	Met	Met ↑	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process	Met	Met	Met	Met	Met
The CCO meets other Transition of Care contract requirements	Met	Met	Met	Met	Met
Annual Evaluation of the Utilization Management Program					
A written summary and assessment of the effectiveness of the UM program is prepared annually	Met	Met	Met	Met	Met
The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met	Met

Strengths

- Member files reflect individual circumstances are considered during review of service authorization requests.

Weaknesses

- Policies did not include the complete requirement of resolution timeframe extensions for service authorization processes.
- CAN adverse benefit determination notices used medical terminology instead of easy-to-understand terms.
- CAN and CHIP websites have incorrect pharmacy prior authorization resolution timeframes.
- Issues with appeals documentation in policies, programs descriptions, and on websites included:
    - Incomplete and missing definitions of appeal terminology, use of terminology that is not consistent with definitions in the CAN and CHIP Contracts and Federal Regulations.
    - Lack of information about who can file an appeal, incorrect and incomplete information about the appeal filing timeframe and filing requirements.
    - Incomplete information about continuation of benefits pending the resolution of an initial member appeal, State Fair Hearing, and Independent External Review.

- Some of Molina's appeals were reviewed by the same physician reviewer who issued the initial determination.
- Incomplete documentation of Transition of Care requirements for pregnant members entering the health plans.

Recommendations

- Ensure all service authorization timeframe requirements are correctly documented in policies and on the CAN and CHIP websites according to requirements in the *CAN Contract, Section 5 (J) (6*) and *CHIP Contract, Section 5 (I) (4)*.
- Ensure adverse benefit determination notices are written in terms that are easily understood by members, according to requirements in *CAN and CHIP Contracts Section 6 (F) (1)* and *42 CFR § 438.10*.
- Edit policies and websites to indicate current terminology of "adverse benefit determination" instead of "action." Include the correct definition of "adverse benefit determination" in the Provider Manuals and websites.
- Edit websites to include all definitions, instructions, and procedures for filing an appeal, according to requirements in the *CAN* and *CHIP Contracts, Section 6 (H)* and *(K)*.
- For CHIP, ensure that individuals who make appeal decisions were not involved in any previous level of review. Refer to *CHIP Contract Exhibit E (D)*.
- Ensure requirements for Transition of Care activities for pregnant members entering the health plans are completely documented in policies or other documents. Refer to the *CAN Contract, Section 9 (B) (5)*.

F. Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

For each delegated entity, the CCOs implement written agreements that describe the roles and responsibilities of both the health plan and the delegated entity, the activities being delegated, reporting requirements, processes for evaluating delegate performance, and actions that may be taken for substandard performance.

United has delegation agreements with the entities identified in *Table 20: United Delegated Entities and Services*.

Table 20: United Delegated Entities and Services

United Delegated Entities	United Delegated Services
OptumHealth	Behavioral Health Case Management Utilization Management Quality Management Network Contract Management Claims Processing
Dental Benefit Providers	Dental Network Services 3rd Party Dental Administrator
eviCore National	Radiology and Cardiology Management Services
MARCH Vision Care	Vision and Eye Care Benefit Administration Services Vision Network Contract Management Call Center Operations Claims Processing
Optum Rx	Pharmacy Benefit Administration Services
Medical Transportation Management	Non-Emergency Transportation
Hattiesburg Clinic River Region Health System HubHealth University Physicians, PLLC HCA Physician Services Health Choice, LLC North Mississippi Medical Center Ochsner Premier Health	Credentialing

Magnolia has delegation agreements with the entities identified in *Table 21: Magnolia Delegated Entities and Services*.

Table 21: Magnolia Delegated Entities and Services

Magnolia Delegated Entities	Magnolia Delegated Services
Envolve Dental	Dental claims Dental network Utilization management Credentialing Quality management

Magnolia Delegated Entities	Magnolia Delegated Services
Medical Transportation Management, Inc.	Non-emergency transportation claims Non-emergency transportation network Utilization management Credentialing Quality management
National Imaging Associates, Inc.	Radiology utilization management
EPC-NurseWise	24/7 Nurse call center
EPC-Nurtur	Disease management
Envolve Vision	Vision services claims Vision services network Utilization management Credentialing Quality management
Envolve Pharmacy Solutions	Pharmacy claims Pharmacy network Utilization management Credentialing
Hattiesburg Clinic, PA LSU Healthcare Network (New Orleans) North Mississippi Medical Clinic/North MS Healthlink Rush Health Systems Ochsner Clinic Foundation St. Judes Research Hospital Baptist Memorial Health Care-Baptist Health Services Group Magnolia Regional Medical Center Mississippi Physicians Care Network Mississippi Health Partners University of Mississippi Medical Center Memorial Hospital at Gulfport	Credentialing

Molina has delegation agreements with the following entities:

Table 22: Delegated Entities and Services

Molina Delegated Entities	Molina Delegated Services
Avesis	Dental and Hearing Benefit Administration Services
Caremark	Pharmacy Benefit Administration Services
MARCH Vision Care	Vision and Eye Care Benefit Administration Services
Southeastrans Medical Transportation Management	Non-Emergency Transportation
Baptist Memorial Medical Center George Regional Health System Hattiesburg Memorial Medical Group Magnolia Regional Health Mississippi Physician Care Network Memorial Hospital at Gulfport North Mississippi Health Services Ochsner Health System Premier Health University of Mississippi Medical Center	Credentialing

CCME reviewed documentation of pre-delegation assessments and annual oversight conducted by the health plans for the delegated entities.

For Magnolia, the monitoring tools for seven credentialing delegates indicated site visits for primary care providers as not applicable, which is inconsistent with requirements in the *CAN Contract, Section E (3) (a)*. Also, annual monitoring documentation did not include a review of delegated credentialing activities for three delegates to whom Magnolia delegated credentialing functions.

For Molina, the monitoring tools for credentialing delegates did not include several sanctions and exclusions queries. Molina staff indicated these requirements are the responsibility of the health plan and are not required functions for the delegates, which is inconsistent with documentation in Molina's Credentialing Delegation Requirements policy. Also, site assessments and reassessments required by the *CHIP Contract, Section 7 (E)* and fingerprinting requirements for high-risk providers required by the *CHIP Contract, Section 7 (E) (6),* were not included on the monitoring tools.

For United, the monitoring tools used for annual oversight included all Mississippi credentialing requirements. Several of the credentialing and recredentialing files

reviewed during monitoring of credentialing delegates contained ambiguous notations regarding the verification of the providers' CLIA certificates. Oversight documentation for three credentialing delegates did not include a file review of the delegates' credentialing and recredentialing files.

Table 23: Delegation Services Comparative Data, illustrates the scoring for each standard reviewed.

Table 23: Delegation Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*					
The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Met	Met
The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions	Met ↑	Met ↑	Met	Partially Met	Partially Met

Strengths

- Pre-delegation assessments are conducted, and appropriate written delegation agreements are in place for all delegated entities.

Weaknesses

- Monitoring tools do not include all required elements or incorrectly indicate elements are not applicable.
- Monitoring documentation does not indicate all delegated activities are included in the monitoring and oversight conducted.

Recommendations

- Ensure delegation monitoring tools include all required elements and accurately reflect contractual requirements.
- Ensure monitoring is conducted for all activities delegated to each entity.