Mississippi External Quality Review

ANNUAL COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR JUNE 2019 – MAY 2020

Submitted: May 11, 2020

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires each State Medicaid Agency that contracts with Managed Care Organizations (MCO) evaluate their compliance with the 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) and Magnolia Health (Magnolia).

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 access studies for each health plan. This report is a compilation of the annual review findings of the CAN and CHIP programs for each CCO conducted in 2019.

A. Overall Findings

An overview of the findings for each section follows. Additional information regarding the reviews for United and Magnolia, including strengths, weaknesses, and recommendations can be found further in the narrative of this report.

Administration

United and Magnolia have established policy management processes and require at least annual review of policies; however, some of United's policies did not reflect an annual review and did not reveal the line(s) of business to which they apply.

Although overall health plan staffing appears adequate, United was not in compliance with DOM's requirement for a minimum of eight representatives to provide face-to-face provider services and two additional representatives designated for out-of-state providers.

Both Magnolia and United have thorough, documented processes to guard against fraud, waste, and abuse (FWA) and codes of conduct defining standards of ethical behavior for staff. The health plans provide mandatory Compliance training to staff and have suitable processes for training and educating providers about compliance and FWA requirements, laws, and regulations. CCME encouraged United to revise its CAN and CHIP Member Handbooks to provide a more comprehensive explanation of FWA to enhance member understanding of these concepts. The plans provide appropriate avenues for reporting potential compliance, FWA, and ethics concerns or violations,

ensure anonymous reporting capabilities are available, and have no-retaliation policies in place.

United's reported claims payment rate of 85% to 90% completion after three months falls below the contractual requirement that 99% of clean claim payments be completed within 90 days and shows a need for United to improve its clean claim payment rate. Magnolia did not provide exact claims statistics but indicated internal claims audits ensure 100% of clean claims are finalized within 30 calendar days and 100% of all claims are processed and paid within 90 calendar days of receipt.

United's business continuity plans summarize approaches to keeping systems available during events that could cause interruptions and restoring operations if a disaster occurs. However, United conducted only limited testing on those processes. Magnolia's multi-tiered IT infrastructure is regularly maintained, frequently audited, and capable of being recovered after a disaster. Recent disaster recovery test results indicate Magnolia's ability to successfully recover systems and meet recovery time objectives.

Provider Services

The health plans define processes and requirements for provider credentialing and recredentialing in policies with state-specific credentialing addressed in attachments or in credentialing plans with addenda defining additional state-specific requirements. CCME noted policies do not address all credentialing/recredentialing requirements, contain incorrect information, and/or do not clearly reflect the processes followed by the health plan. Both United and Magnolia have committees with appropriate membership to make credentialing and recredentialing decisions. The committees are chaired by the health plan's Chief Medical Director/Officer, meet at the established frequency, and have defined quorums. CCME's review of credentialing and recredentialing files revealed several issues: lack of proof of query of the MS DOM Sanctioned Provider List (Magnolia and United), outdated, incomplete, or missing Ownership Disclosure forms (Magnolia and United) and primary source verification of a Clinical Laboratory Improvement Amendment (CLIA) certificate (Magnolia), and failure to conduct office site visits for nurse practitioners acting as PCPs (United).

During the previous EQR, United's credentialing and recredentialing files were noted with Ownership Disclosure forms signed by unauthorized persons. United responded during the corrective action process with an updated Provider Entity Disclosure of Ownership form containing a statement ensuring the signer had authority to legally bind the entity; however, findings of the current review indicated the updated Ownership Disclosure form was not implemented.

United and Magnolia regularly measure and monitor the adequacy of their provider networks using measurement standards that are compliant with contractual requirements. However, Magnolia's documentation revealed the standards documented

in policy were not the same as those used for the actual geographic distribution measurements.

Provider orientation processes are in place and ongoing provider education is provided through newsletters, webinars, and resource information available on the website's provider portal (United), and through newsletters, informational postcards and letters, resource information on the provider portal, and regularly scheduled meetings with in-network providers (Magnolia). When comparing documentation of member benefits in the health plans' Member Handbooks and Provider Manuals, CCME noted numerous discrepancies in the information provided.

The health plans conduct annual medical record audits to evaluate network medical record-keeping practices. Although Magnolia's Medical Record Review policy states an aggregate summary of medical record reviews completed are presented quarterly to Magnolia's Quality Committee, CCME could not find evidence that this information is reported to the Quality Committee.

Both health plans had noted improvements in rate of successfully answered calls for the 2019 Telephonic Provider Access Study when compared to the 2018 study. Also, as part of the EQR, CCME validated the health plans' Provider Satisfaction Surveys and identified survey response rate as an area needing improvement for both health plans.

Member Services

Magnolia and United have policies and procedures for CAN and CHIP that define and describe member rights and responsibilities, as well as methods for notifying members of their rights and responsibilities. Information is included in Member Handbooks, Provider Manuals, on websites, and in member newsletters. However, CCME identified incomplete or omitted requirements with documentation of member's rights and responsibilities.

The health plans provide toll-free telephone numbers and descriptions for Member Services and for the 24-hour nurse lines in Member Handbooks and websites. CAN and CHIP members are also encouraged to obtain recommended preventive services (including well-child services) via the website, at community events, and through reminder phone calls, Member Handbooks, and mailings.

Review of the grievance policies and related information in Member Handbooks, Provider Manuals, and on Magnolia's and United's CAN and CHIP websites revealed issues such as incomplete definitions of grievance terminology, use of outdated terminology, and incomplete and incorrect information about requirements for grievance acknowledgement and resolution timeframes.

Issues identified in the review of grievance files included untimely acknowledgment letters, incorrectly stating the grievance in the resolution letter, and resolution letters that contained outdated information, typographical errors, or improper resolutions.

The health plans appropriately retain grievance and complaint data for the contractually-required timeframe and use the data for quality improvement activities.

Magnolia and United continue to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys annually via a third-party vendor. 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 and recommendations were provided to address this issue.

Quality Improvement

Quality Improvement (QI) program descriptions adequately described the programs Magnolia and United have implemented to monitor, evaluate, and improve the quality of clinical care and services provided to their members. Both plans provided their 2018 and 2019 work plans. The activities or scope of work in Magnolia's Behavioral Health work plans were identical to the CAN and CHIP work plans and not specific to Behavioral Health.

Committees responsible for implementing, monitoring, and directing QI activities were established for both health plans. Membership includes a variety of network providers, senior executives, directors, and other health plan staff.

Magnolia and United conducted an evaluation of the effectiveness of the QI programs. Program evaluations included the QI activities conducted in 2018, results of those activities, any barriers identified, interventions, and recommendations for 2019.

Health plans are required to have an ongoing program of Performance Improvement Projects (PIPs) and to report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population.

CAN Performance Measures

When evaluating specific measures for each CAN program, the timing of the reviews created a one-year gap in performance measure reporting. Thus, the year over year trending for each plan included MY 2016 (HEDIS 2017) and MY 2018 (HEDIS 2019). As shown in Table 1: Magnolia CAN HEDIS Measures with Substantial Changes in Rates, for Magnolia, there were several measures that had substantial improvement of greater than 10%: BMI Percentile for Children/Adolescents, Counseling for Physical Activity, HPV vaccines, and Well Child Visits in the First 15 Months of Life. The only measure with a substantial decrease in rate was the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

Table 1: Magnolia CAN HEDIS Measures with Substantial Changes in Rates

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

For United, there were several measures that had substantial improvement of greater than 10% in that time frame, including HPV and Combination #2 Immunizations for Adolescents, and A1C Control. The measures with a substantial decrease in rate were Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5 year-olds and Alcohol Abuse or Dependence: Initiation of AOD Treatment: Total. Table 2: United CAN HEDIS Measures with Substantial Changes in Rates.

Table 2: United CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescents (ima)			
HPV	6.81%	18.98%	12.17%
Combination #2	6.08%	17.27%	11.19%
Comprehensive Diabetes Care (cdc)			

Measure/Data Element	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
HbA1c Control (<8.0%)	35.04%	46.23%	11.19%
Substantial Decrease in Rate (>10% decrease)			
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	56.93%	45.50%	-11.43%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	35.42%	23.91%	-11.51%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.89%	34.37%	-11.52%

Non-HEDIS performance measures were uploaded to the desk materials and reviewed in comparison to target rates. Table 3: CAN Non-HEDIS Performance Measure Rates displays the CY 2018 rate and the State target rate. Magnolia met the target rate for two of the five measures, and United met the target rate for one of the five measures.

Table 3: CAN Non-HEDIS Performance Measure Rates

Measure/Data Element	Magnolia CAN (CY 2018)	United CAN (CY 2018)	MS CAN Target Rate
EPSDT Screening (<1 Year)	313.60%	116.74%	85%
EPSDT Screening (>1, >21 Years)	59.78%	54.13%	75%
Well-Child Visits in the 1st 15 months of life	52.45%	59.44%	59.76%
Nephropathy Screening	90.51%	89.78%	90.33%
Screening for Clinical Depression	21.49%	5.87%	25%

CHIP Performance Measures

For Magnolia CHIP, when comparing the MY2016 CHIP rates to the MY2018 CHIP rates, there were several measures that had substantial improvement of greater than 10%: Asthma Medication Compliance, Follow Up Care for Children on ADHD Medication Continuation Phase, Follow up after Hospitalization for Mental Illness, and Well-Child Visits. The measure of 5 Well-Child Visits in the First 15 Months of Life did have a substantial decrease, but the 6+ well child visits increased substantially.

Table 4: Magnolia CHIP HEDIS Measures with Substantial Changes in Rates

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

As noted in Table 5: United CHIP HEDIS Measures with Substantial Changes in Rates, United did not have any measures with a substantial improvement of greater than 10%, although many rates improved. The Antidepressant Medication Management and Follow-Up After Hospitalization for Mental Illness measures declined substantially (>10%).

Table 5: United CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Substantial Decrease in Rate (>10% decrease)			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	47.62%	32.35%	-15.27%

Measure/Data Element	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Effective Continuation Phase Treatment	33.33%	17.65%	-15.68%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total-30-day Follow-Up	76.97%	61.39%	-15.58%
Total-7-day Follow-Up	53.95%	35.15%	-18.80%

Table 6: CHIP Non-HEDIS® Performance Measure Rates, displays the most recent measurement rates for the United and Magnolia CHIP Programs. Magnolia met the target rate for two of the three measures, and United met the target rate for one of the three measures.

Table 6: CHIP Non-HEDIS Performance Measure Rates

Measure	Magnolia CHIP CY2018	United CHIP CY2018	MS CHIP Target Rate
EPSDT Screening (<1 Year)	366.67%	107.27%	85%
EPSDT Screening (>1, <21 Years)	38.92%	47.92%	75%
Well-Child Visits in the 1st 15 months of Life	70.02%	48.18%	59.76%

Plan rates for the most recent review year with the statewide averages are reported in Section D: Quality Improvement of this report.

Performance Improvement Projects

Each health plan is required to submit their performance improvement projects (PIPs) to CCME for review annually. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The 16 projects reviewed for the CAN and CHIP programs for the two plans are displayed in Table 7: Results of the Validation of PIPs.

Table 7: Results of the Validation of PIPs

Project	Validation Score
Magnolia CAN	
Asthma	91/91=100% High Confidence in Reported Results
Behavioral Health Readmissions	67/72=93% High Confidence in Report Results

Project	Validation Score
Improved Pregnancy Outcomes with Makena	62/62=100% High Confidence in Report Results
Sickle Cell Disease Outcomes	67/72=93% High Confidence in Report Results
Magnolia CHIP	
EPSDT	91/91=100% High Confidence in Report Results
Obesity for Children	102/105= 97% High Confidence in Report Results
ADHD	90/91=99% High Confidence in Report Results
Use of Appropriate Medications for People with Asthma	91/91=100% High Confidence in Report Results
United CAN	
Behavioral Health Readmissions	78/78=100% High Confidence in Reported Results
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	62/62=100% High Confidence in Reported Results
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	57/62=92% High Confidence in Reported Results
Respiratory Illness: COPD/Asthma	62/62=100% High Confidence in Reported Results
United CHIP	
Adolescent Well Child Visits	104/105=99% High Confidence in Reported Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- formerly called Reducing Adolescent and Childhood Obesity	111/111=100% High Confidence in Reported Results
Getting Needed Care CAHPS	111/111=100% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	84/85=99% High Confidence in Reported Results

Magnolia and United CAN and CHIP plans scored in the “High Confidence” range for all 16 submitted and validated PIPs. Scores ranged from 92% to 100%. There were no PIPs that scored in the “Confidence,” Low Confidence,” or “Not Credible” scoring categories.

Utilization Management

For Magnolia and United, assessment of utilization management (UM) included reviews of CAN and CHIP program descriptions and evaluations, policies, Member Handbooks, Provider Manuals, approval, denial, appeal, and case management files, and plan websites. Policies and procedures define how 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. Review of approval and denial files met criteria and timeframe requirements.

The CAN and CHIP Care Management (CM) program description and policies appropriately document care management processes and services provided. CM files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

The health plans have established policies defining processes for handling both CAN and CHIP appeals of adverse benefit determinations. Review of documentation in policies, Member Handbooks, Provider Manuals, etc. revealed numerous issues of incomplete, incorrect, and missing information about appeals processes and requirements. Several of Magnolia's issues were identified during the 2018 EQR and have not been corrected. CCME's review of appeal files revealed only isolated issues and, overall, appeals are handled correctly. Both health plans use appeal data to identify opportunities to improve quality of care and service.

Delegation

Magnolia and United ensure all delegation arrangements are governed by written agreements between the delegate and the health plan that describe the roles and responsibilities of the health plan and the delegated entity, delegated activities, reporting requirements, processes by which the delegated entity's performance is evaluated, and terms for revoking delegation.

For credentialing and recredentialing oversight, United conducted annual audits to assess compliance with defined standards. The audit tool was comprehensive and included file review. However, the delegated credentialing and recredentialing tools omit the requirement for ensuring the entities collect Ownership Disclosure forms and query the Social Security Death Master File.

B. Overall Scoring

To objectively compare the CCOs, CCME applied a numerical score (points) to each standard's rating within a section to derive the overall score (percentage) for each plan and each Medicaid program. Using the Centers for Medicare & Medicaid Services (CMS)

Protocol, External Quality Review Protocol for Accessing Compliance with Medicaid Managed Care Regulation, the overall score was calculated based on the following method:

Points were assigned to each rating ("Met" = 2 points and "Partially Met" = 1 point), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.

1. The total points achieved for each section was calculated by adding the earned points together.
2. The final section score was derived by dividing the section's total points (total number achieved) by the total possible points for that section.
3. The overall score (percentage) was then calculated by averaging the final section scores for the six sections reviewed.

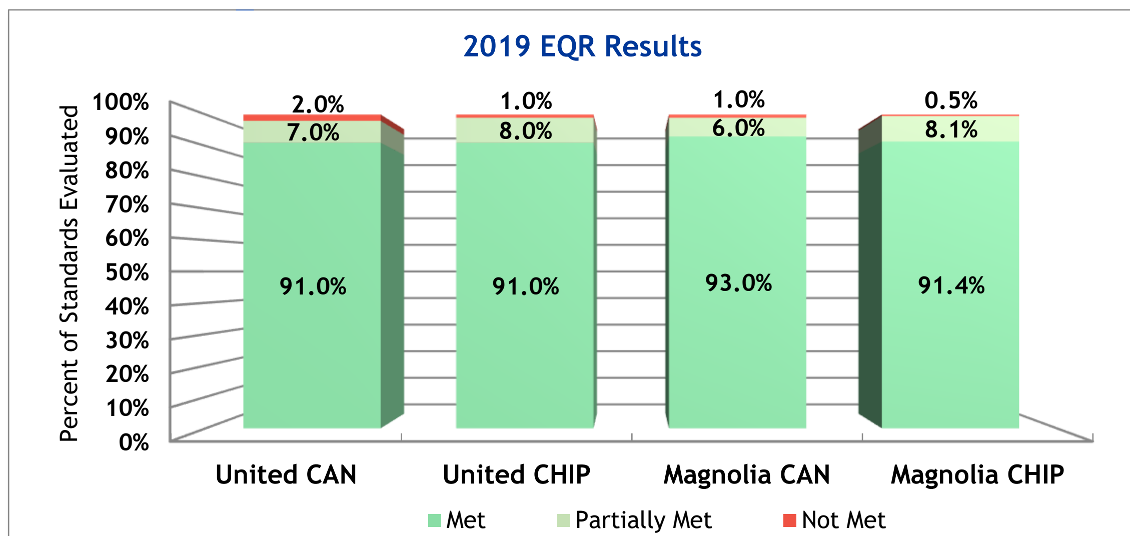
Results of the scoring matrix are included in Table 8: Overall Scoring Matrix.

Table 8: Overall Scoring Matrix

United		Magnolia	
CAN	CHIP	CAN	CHIP
91%	91%	93%	91.4%

Figure 1, Overall Results for 2019 EQR, provides an overview of the percentage of "Met," "Partially Met," "Not Met," "Not Evaluated," or "Not Applicable" scores by health plan and Medicaid program.

Figure 1: Overall Results for 2019 EQR



BACKGROUND

The Mississippi Division of Medicaid (DOM) contracted with two 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) and Magnolia Health (Magnolia). The Balanced Budget Act of 1997 requires State Medicaid agencies that contract with Medicaid managed care organizations 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 (PIPs), validation of performance measures (PMs), and an evaluation of compliance with state and federal regulations for each health plan.

In addition to the required mandatory activities, CCME validates consumer and provider surveys conducted by the CCOs and performs telephonic provider access studies for the CAN and CHIP programs for each CCO.

After completing the annual review of the required EQR activities, CCME submits a detailed technical report to DOM and to the health plan reviewed. This report describes the data aggregation and analysis and the manner that 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 any corrective action(s) from the prior year's review. Annually, CCME prepares an annual comprehensive technical report for the State which is a compilation of the individual annual review findings.

The comprehensive technical report for contract year 2019 through 2020 contains data regarding results of the EQRs conducted for the CAN and CHIP programs for United and Magnolia.

METHODOLOGY

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

FINDINGS

CCME conducted an annual review for United and Magnolia for the CAN and CHIP programs 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. The 2018 EQRs were conducted as modified reviews, as requested by DOM, that did not include all standards reviewed in the 2019 EQR; therefore, scores without arrows indicate that there was no change in the score from the previous review or that the standard was not reviewed in the previous EQR.

A. Administration

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

UnitedHealthcare and Magnolia have policy management processes in place. Both plans require at least annual review of policies; however, CCME identified multiple United policies that did not reflect an annual review. Additionally, CCME noted some United policies do not reveal the line(s) of business or programs to which they apply.

In general, the health plans' staffing appears adequate to ensure that all required health care products and services are provided to members. United was not in compliance with DOM's requirement for a minimum of eight representatives to provide face-to-face provider services and two additional representatives designated for out-of-state providers; however, United has since added additional provider services representatives to meet these requirements.

Both Magnolia and United have thorough, documented processes to guard against fraud, waste, and abuse (FWA). In addition to the documented FWA plans, each health plan has documented codes of conduct defining standards of ethical behavior for staff. The health plans provide mandatory Compliance training to staff and have suitable processes for training and educating providers about compliance and FWA requirements, laws, and regulations. CCME encouraged United to revise its CAN and CHIP Member Handbooks to provide a more comprehensive explanation of FWA so that members have an appropriate understanding of these concepts. Many avenues for reporting potential compliance, FWA, and ethics concerns or violations are available to

staff, members, and providers. Both health plans ensure anonymous reporting capabilities are available and have no-retaliation policies in place. It was not clear in the plans' documentation how they monitor the exclusion status of any person with an ownership or control interest or who is an agent or managing employee.

Information Systems Capabilities Assessment

United reported an estimated claims payment rate of 85% to 90% completion after three months. This falls below the contractual requirement that 99% of clean claim payments be completed within 90 days and shows a need for United to improve its clean claim payment rate. While not a contractual requirement, United reported a claim payment accuracy average of 98.90% for a recent 12-month period. Magnolia did not provide exact claims statistics but indicated internal claims audits ensure 100% of clean claims are finalized within 30 calendar days and 100% of all claims, including adjustments, are processed and paid within 90 calendar days of receipt.

United's business continuity plans summarize approaches to keeping systems available during events that could cause interruptions and restoring operations if a disaster occurs. However, United conducted only limited testing on those processes. Magnolia's multi-tiered IT infrastructure is regularly maintained, frequently audited, and capable of being recovered after a disaster. Magnolia's infrastructure controls have been assessed by an independent third-party who found the infrastructure controls to be effective at controlling data access. Recent disaster recovery test results demonstrate Magnolia's ability to successfully recover systems and meet recovery time objectives.

United received "Met" scores for 87.1% of the standards reviewed for both CAN and CHIP in the Administration section of the review. Magnolia received "Met" scores for 96.8% of the standards reviewed for both CAN and CHIP. An overview of the scores for the Administration section is illustrated in Table 9: Administration Comparative Data.

Table 9: Administration Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia 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	Partially Met	Partially Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
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
	Chief Operating Officer	Met	Met	Met	Met
	Chief Financial Officer	Met	Met	Met	Met
	Chief Information Officer	Met	Met	Met	Met
	Information Systems personnel	Met	Met	Met	Met
	Claims Administrator	Met	Met	Met	Met
	Provider Services Manager	Met	Met	Met	Met
	Provider credentialing and education	Partially Met	Partially Met	Met	Met
	Member Services Manager	Met	Met	Met	Met
	Member services and education	Met	Met	Met	Met
	CAN: Complaint/Grievance Coordinator CHIP: Grievance and Appeals Coordinator	Met	Met	Met	Met
	Utilization Management Coordinator	Met	Met	Met	Met
	Medical/Care Management Staff	Met	Met	Met	Met
	Quality Management Director	Met	Met	Met	Met
	CAN: Marketing, member communication, and/or public relations staff CHIP: Marketing and/or Public Relations	Met	Met	Met	Met
	Medical Director	Met	Met	Met	Met
	CAN: Compliance Officer CHIP: Fraud and Abuse/Compliance Officer	Met	Met	Met	Met
	Operational relationships of CCO staff are clearly delineated	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Organizational Chart / Staffing	A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week	Met	Met	Met	Met
Management Information Systems	The CCO processes provider claims in an accurate and timely fashion	Partially Met	Partially Met	Met	Met
Management Information Systems	The CCO tracks enrollment and demographic data and links it to the provider base	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
	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
Compliance/ Program Integrity	The CCO has a Compliance Plan to guard against fraud, waste and abuse	Met	Met	Met	Met
	The Compliance Plan and/or policies and procedures address requirements	Partially Met	Partially Met	Partially Met	Partially Met
	The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	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
	The CCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met
	The CCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Confidentiality	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

Strengths

- The health plans provide many avenues for reporting potential compliance, FWA, and ethics concerns or violations, ensure anonymous reporting capabilities are available, and have no-retaliation policies in place.

Weaknesses

- United was not following its own policy requiring at least annual review of all policies, procedures, and standard operating procedures.
- United was not in compliance with the *CAN Contract, Section 7 (H) (3)* which requires a minimum of eight provider representatives with two additional representatives designated for out-of-state providers.
- Processes for exclusion status monitoring were unclear in submitted documentation.

Recommendations

- United should ensure all policies are reviewed annually and that this is reflected on each policy.
- Ensure the contractual requirement for the minimum number of provider representatives is met.
- Ensure documentation in policies, procedures, etc. clearly reflects processes for monitoring exclusion status for any person with an ownership or control interest or who is an agent or managing employee of vendors and providers.

B. Provider Services

CCME's review of Provider Services focused on policies and procedures, provider training and educational materials, provider network information, credentialing and recredentialing processes, practice guidelines, the Provider Access and Availability Study, and the Provider Satisfaction Survey for the MSCAN and MSCHIP lines of business.

Magnolia's processes for provider credentialing and recredentialing are addressed in a policy with state-specific credentialing requirements included in an attachment. United defines processes for credentialing and recredentialing in various credentialing

plans with addenda that define additional federal and state-specific credentialing requirements. CCME noted several United credentialing and recredentialing policies did not include the requirement to query the State Medicaid Provider Sanction List. The health plans have committees chaired by the Chief Medical Director/Officer to make credentialing and recredentialing decisions. Committee membership includes network providers of various specialties. Magnolia's committee meets monthly and United's meets quarterly. Appropriate quorums are established by both plans.

Review of credentialing and recredentialing files for providers revealed issues such as lack of proof of query of the MS DOM Sanctioned Provider List (Magnolia), an outdated Ownership Disclosure form (United), and failure to conduct office site visits for nurse practitioners acting as a PCP (United). Issues identified in organizational credentialing and recredentialing files included: lack of proof of CLIA (Magnolia), outdated, incomplete, or missing Ownership Disclosure forms (Magnolia and United), and missing queries of the MS DOM Sanctioned Provider List (United). During the previous EQR, CCME noted Ownership Disclosure forms in United files contained signatures from unauthorized signers. During the corrective action process, United presented an updated Provider Entity Disclosure of Ownership form that contained a statement ensuring the signer had authority to legally bind the entity; however, findings of the current review indicated the updated Ownership Disclosure form was not implemented.

United and Magnolia regularly measure and monitor the adequacy of their provider networks. Parameters used for measurement are compliant with contractual requirements. CCME noted a discrepancy in Magnolia's documentation of the goal for the percentage of members with access to PCPs and specialists in policy and in reported measurements. The policy indicated the goal was 100% of members with access to a PCP and to specialists, while reports showed Magnolia measures the PCP compliance goal as 95% and the specialist compliance goal as 90%. Magnolia's goals for geographic access were not met for clinical psychologists (61.5%), licensed social workers (51.8%), and marriage and family counselors (51.7%), but staff reported they are working to strengthen the behavioral health network.

Both health plans have appropriate provider orientation and ongoing provider education processes. United provides ongoing provider education through newsletters, webinars, and resource information available on the website's provider portal. Magnolia representatives conduct regularly scheduled meetings with in-network providers to discuss plan initiatives and additional communication includes newsletters, informational postcards and letters, and resource information on the provider portal. CCME noted significant discrepancies in documentation of member benefits when comparing the benefits listed in Provider Manuals to Member Handbooks for the MSCAN and MSCHIP programs. Information about clinical practice guidelines is included in Provider Manuals. Adopted guidelines are posted on the plans' websites. CCME's review of clinical practice guidelines found broken links to several guidelines on Magnolia's website.

The health plans conduct annual medical record audits to evaluate network medical record-keeping practices. Magnolia's expectation is that network physicians meet 90% of the requirements for medical record keeping, and United's goal is 85%. CCME noted Magnolia's Medical Record Review policy states an aggregate summary of medical record reviews completed are presented quarterly to Magnolia's Quality Committee; however, CCME could not find evidence the medical record review had been reported to the QIC. In addition, onsite discussion confirmed that only eight providers were included in the annual medical record review. CCME noted United audited 27 PCPs. Although all the audited providers met the overall goal of 85%, two elements were found to be deficient: documentation of unclothed exams of members and obtaining labs and immunizations at the correct age.

Provider Access and Availability Study

As a part of the annual review process for all the plans, CCME performed a Telephonic Provider Access Study focusing on primary care providers (PCPs). Because a modified external quality review of the health plans was conducted in 2018, the most recent access studies for the health plans were conducted in 2016. In the time between the 2016 study and the current 2019 study, CCME adjusted the definition of successful calls. The success rate is now based on an adjusted denominator. Instead of using the total number of calls, the denominator is now the total calls made minus those answered with voicemail messages, as this is now standard for many provider offices.

For the current study, Magnolia improved the success rate from the previous study's results. The success rate of calls in 2016 was 38% (99 of 258 calls). Given the new formula, the success rate for the 2019 Provider Access Study was 60% (110 of 185 total calls). United also improved the success rate from the previous study's results. United's 2016 success rate was 40% (71 out of 177 calls) and the success rate for the 2019 Telephonic Provider Access Study was 63% (109 out of 173 total calls).

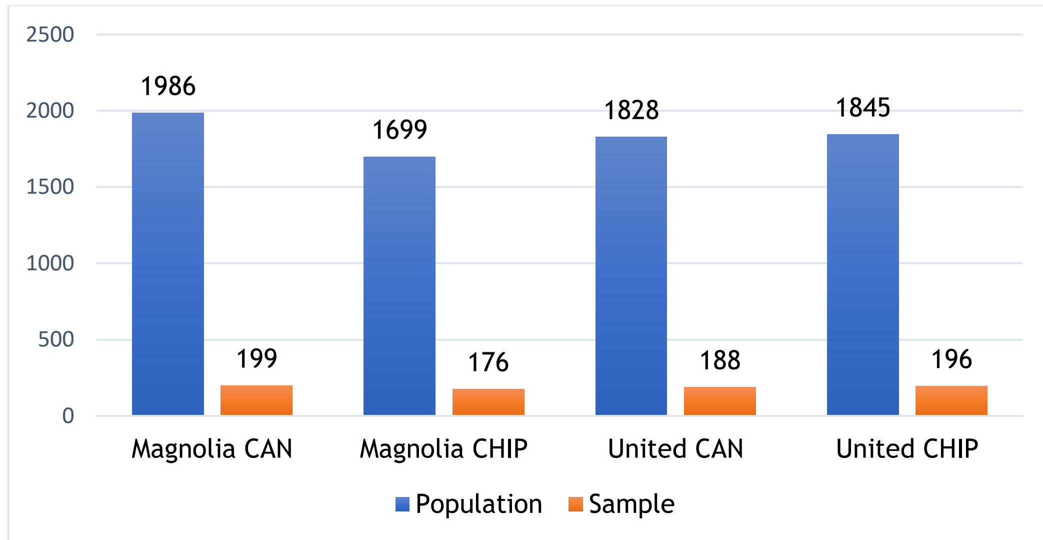
The following charts summarize CCME's Provider Access and Availability Study findings and compare the plans surveyed.

Population and Sample Size

CCME requested and received a list of network providers and contact information from each of the health plans. From each plan's list, CCME defined a population of PCPs and selected a statistically-relevant sample of providers for the study. CCME attempted to contact these providers to ask a series of questions about the access plan members have to their PCPs.

From the four CCOs reviewed, CCME identified a total population of 7,358 unique PCPs. From each plan's population, CCME drew a random sample and selected a total of 759 providers. Figure 2: Population and Sample Sizes for Each Plan illustrates the sample sizes for each plan.

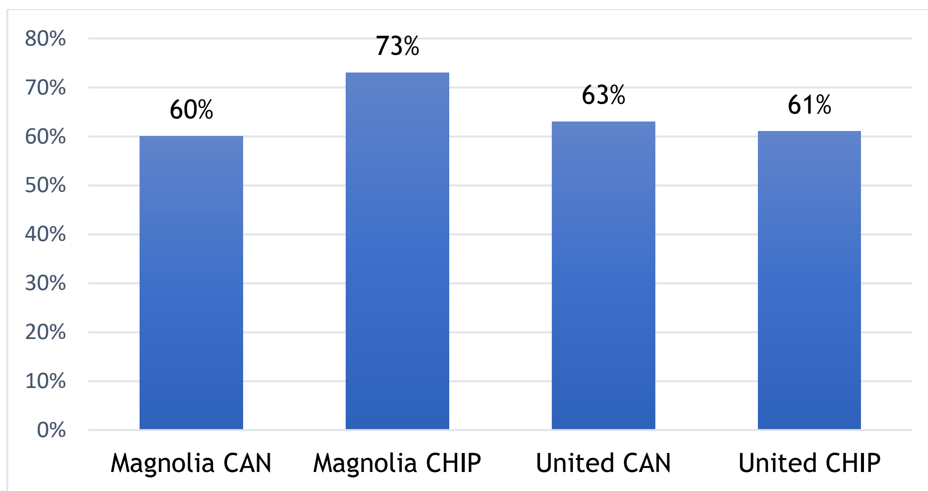
Figure 2: Population and Sample Sizes for Each Plan



Successfully Answered Calls

The percentage of successfully answered calls for each health plan is shown in Figure 3: Percentage of Successfully Answered Calls.

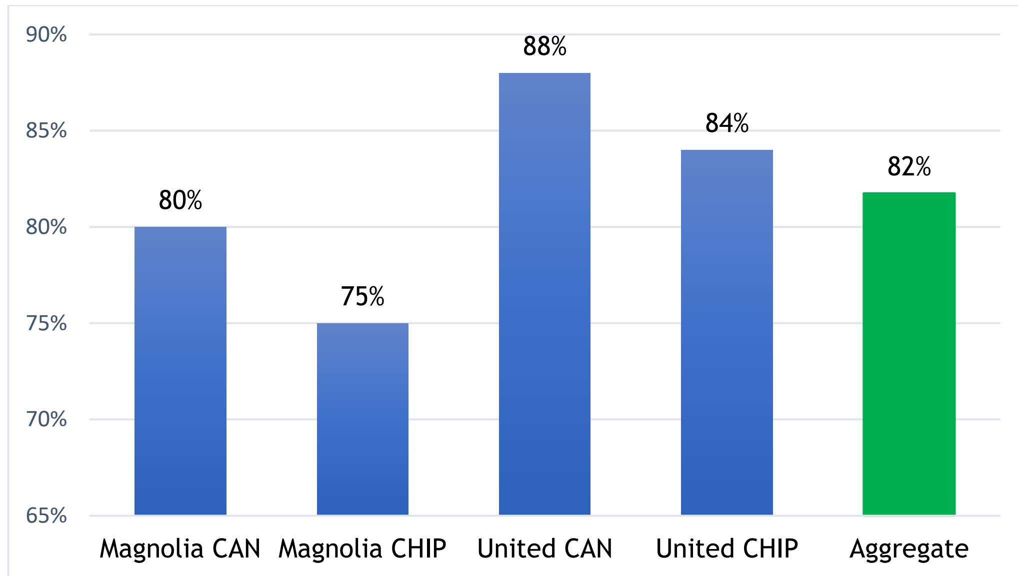
Figure 3: Percentage of Successfully Answered Calls



Currently Accepting the Plan

Of the calls answered successfully, 82% responded that the provider accepted the respective health plan. The percentages ranged from 75% for Magnolia CHIP to 88% for United CAN. Figure 4: Percentage of Providers Accepting the Plan displays the percentage of providers that indicated they accept the plan.

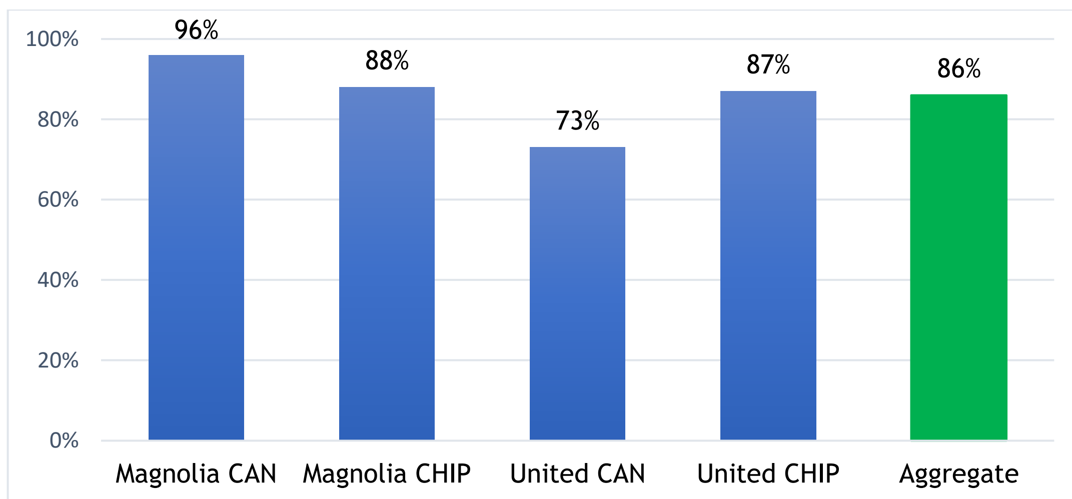
Figure 4: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

Of the providers accepting the plan, 86% responded they were accepting new Medicaid patients. The results range from 73% for United CAN to 96% for Magnolia CAN.

Figure 5: Percentage of Providers Accepting Medicaid Patients

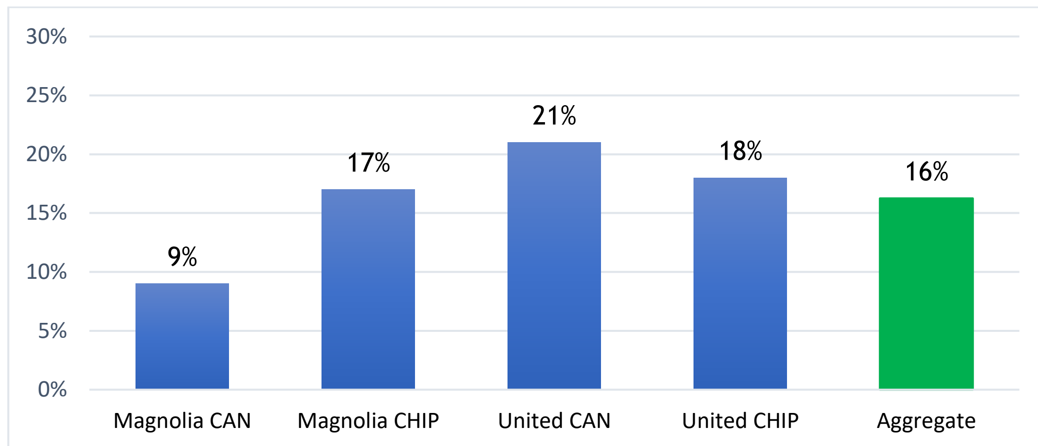


Prescreening for New Patient Appointment

Of the providers accepting new Medicaid patients, CCME asked if prescreening was required to make an appointment. Sixteen percent of all providers confirmed prescreening was required, including a copy of medical records, an application, or both.

United CAN has the highest rate of 21% in this category, and Magnolia CAN has the lowest rate at 9%.

Figure 6: Percentage of Providers for which prescreening was required for new appointments



Provider Satisfaction Survey

CCME conducted a validation review of the provider satisfaction surveys using the protocol developed by CMS titled, 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.

Magnolia and United used an NCQA-certified vendor to conduct the provider satisfaction surveys. Results of the validation found that the survey met the CMS protocol requirements for Magnolia and United. Recommendations regarding increasing response rates were offered to both plans to improve generalizability of the results. Table 10: Provider Satisfaction Survey Validation Results provides an overview of the provider survey validation results.

Table 10: Provider Satisfaction Survey Validation Results

Plan	Reason	Recommendations
Magnolia	Initial sample using mail / internet data had a low response rate (6.2%) and the latter phone data sample had a response rate of 20.8%. This is below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.	Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.

Plan	Reason	Recommendations
United	Survey had a low response rate (3%) This is well below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.	Focus on previously successful strategies that would help increase response rates for this population. Solicit the help of your survey vendor.

The primary issue for both plans was low response rates. Both plans utilized a vendor to conduct the surveys to enhance the validity and reliability of the study and allowed for well-defined reporting on the objective and purpose of the survey. CCME recommended that the plans work with the vendor to increase provider satisfaction survey response rates.

An overview of the scores for the Provider Services section is illustrated in Table 11: Provider Services Comparative Data.

Table 11: Provider Services Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met ↓	Partially Met ↓	Met	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 ↑
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	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
	Valid DEA certificate and/or CDS Certificate	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met
	Work history	Met	Met	Met	Met
	Malpractice claims history	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
	Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met
	Query of the System for Award Management (SAM)	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	Partially Met ↑	Partially Met ↑
	Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met	Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Met ↑	Met ↑	Met	Met
	Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met ↑	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Met ↑	Met	Met	Met
	Ownership Disclosure Form	Not Met ↓	Not Met ↓	Met	Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Partially Met ↓	Met	Partially Met ↑	Partially Met ↑
	Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met
	Recredentialing processes include all elements required by the contract and by the CCO's internal policies	Met	Met	Met	Met
	Recredentialing every three years	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
	Valid DEA certificate and/or CDS Certificate;	Met	Met	Met	Met
	Board certification if claimed by the applicant	Met	Met	Met	Met
	Malpractice claims since the previous credentialing event	Met	Met	Met	Met
	Practitioner attestation statement	Met	Met	Met	Met
	Re-query the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met
	Re-query the System for Award Management (SAM)	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	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 ↑	Met ↑
	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	Met
	Re-query of the Social Security Administration's Death Master File (SSDMF)	Met ↑	Met ↑	Met	Met
	Re-query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Met	Met	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met
	Ownership Disclosure form	Not Met ↓	Not Met ↓	Met	Met
	Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met	Met	Met	Met	Met
	Review of practitioner profiling activities	Met	Met	Met	Met
	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

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met ↓	Partially Met ↑	Partially Met ↑
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met	Met	Met
	The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	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
	Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties	Met	Met	Partially Met ↓	Partially Met ↓
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Met	Partially Met ↓	Partially Met ↓
	The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met	Met	Met
	Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	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
	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	Partially Met ↓	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Met	Met	Met
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers	Partially Met	Partially Met	Met	Met
	Initial provider education includes: A description of the Care Management system and protocols	Met	Met	Met	Met
	Billing and reimbursement practices	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	Partially Met	Partially Met	Partially Met	Partially Met
	Procedure for referral to a specialist including standing referrals and specialists as PCPs	Met	Met	Met	Met
	Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	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

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Provider Education	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	Met	Met	Met
	Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met
	Provider and member complaint, grievance, and appeal procedures including provider disputes	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	Partially Met	Met	Met
	Prior authorization requirements including the definition of medically necessary	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
	The process for communicating the provider's limitations on panel size to the CCO	Met	Met	Met	Met
	Medical record documentation requirements	Met	Met	Met	Met
	Information regarding available translation services and how to access those services	Met	Met	Met	Partially Met
	Provider performance expectations including quality and utilization management criteria and processes	Met	Met	Met	Met
	A description of the provider web portal	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

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Provider Education	The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements	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
Primary and Secondary Preventive Health Guidelines	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
	The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members	Met	Met	Met	Partially 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
	Recommended childhood immunizations	Met	Met	Met	Met
	Pregnancy care	Met	Met	Met	Met
	Adult screening recommendations at specified intervals	Met	N/A	Met	N/A
	Elderly screening recommendations at specified intervals	Met	N/A	Met	N/A
	Recommendations specific to member high-risk groups	Met	Met	Met	Met
	Behavioral health	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Clinical Practice Guidelines for Disease and Chronic Illness Management	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
	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	Partially Met	Partially 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
	The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers	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
	The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	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

Strengths

- For the Telephonic Provider Access Studies, both health plans showed improvement from the previous rate of successfully answered calls.
- Both health plans use NCQA-certified vendors for the Provider Satisfaction Surveys and were noted to have clear and accurate reporting of survey data, analyses, and results.

Weaknesses

- Policies do not address all credentialing/recredentialing requirements, contain incorrect information, and/or do not clearly reflect the processes followed by the health plan (Magnolia and United).
- Review of credentialing and recredentialing files revealed issues such as:
  - Lack of evidence of querying the State Medicaid Provider Sanction List (Magnolia and United)
  - Ownership Disclosure forms not updated (United and Magnolia) or incomplete (Magnolia), and failure to collect Ownership Disclosure forms (Magnolia)
  - Failure to conduct site visits for Nurse Practitioners acting as a primary care provider (United)
  - Failure to verify Clinical Laboratory Improvement Amendments (CLIA) certificates (Magnolia)
- United did not implement a process to ensure the person signing the Ownership Disclosure forms has authority to legally bind the entity. This updated process was presented by United as corrective action in response to a deficiency from the 2018 EQR.
- Magnolia policy defines incorrect standards for geographic distribution of primary care providers and specialists when compared to the measurements documented in network analysis reports.
- Some appointment availability standards listed in United's CHIP Provider Manual do not match the standards defined in policy and in its CHIP Member Handbook.
- United's policy describing its provider orientation plan was outdated and did not contain all information regarding current provider orientation requirements and processes.
- Both health plans had numerous discrepancies in member benefits documented in the Member Handbooks and Provider Manuals for the CAN and CHIP programs.
- Insufficient and/or outdated information about preventive health guidelines was noted in Magnolia's CHIP Provider Manual, and Magnolia's website contained broken links to clinical practice guidelines.
- Both Magnolia and United had low response rates for Provider Satisfaction Surveys.

Recommendations

- Ensure all credentialing requirements are addressed and are correct in credentialing policies and that processes followed are clearly described.
- Ensure credentialing files include all required elements.

- United should implement a process to ensure the person signing the Ownership Disclosure forms has authority to legally bind the entity.
- Magnolia policies should be updated to reflect the actual standards used for measuring geographic distribution of primary care providers and specialists.
- United should ensure appointment availability standards are consistently documented across its policies, Provider Manuals, and Member Handbooks.
- United should develop a policy describing its current provider orientation plan, including provider orientation requirements and processes.
- Revise Member Handbooks and Provider Manuals to reflect consistent member benefit information.
- Provide complete, current information about preventive health guidelines in the CHIP Provider Manual, and ensure the website contains current, correct links to clinical practice guidelines (Magnolia).
- Focus on strategies that would help increase response rates for the Provider Satisfaction Surveys. Solicit the help of survey vendors for methods to increase response rates.

C. Member Services

CCME's Member Services review of Magnolia and United focused on the following areas of the CAN and CHIP programs: policies and procedures, member rights, member informational materials, grievances processes and files, and the Member Satisfaction Survey.

Magnolia's and United's websites have quick links and resources for members to access information. CCME identified the Member Handbook link on Magnolia's CHIP member website takes the user to a Member Handbook dated 2015. It was noted that United had information on the CAN and CHIP websites that was limited or not easily located, such as Advance Directive forms and Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)/Well-Child Care services. CCME provided recommendations for improvement to both plans.

The Member Handbooks are thorough, easily understood, and meet the sixth grade reading comprehension level. Both Magnolia and United's Member Handbook informs members about rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions for how to access benefits. Additionally, the handbooks provide information on Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The Member Handbooks are available in Spanish and alternate formats including large font, audio, and Braille. For Magnolia, CCME noted CAN and CHIP documentation issues with member rights and responsibilities and offered recommendations to address them.

Magnolia and United's Member Services staff are available per contract requirements via a toll-free number. Text telephone (also known as TTY 711) services are available for members with hearing impairments. Members are informed that translation services are available for calls and during appointments with providers. The toll-free Member Services telephone number routes calls to reach appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. 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 as contractually required.

The plans have established CAN and CHIP policies that define processes for receiving, handling, and responding to member requests for informal and formal complaints and grievances. Review of Magnolia's policies and related information about complaints and grievances in Member Handbooks, Provider Manuals, and on Magnolia's websites revealed issues such as incomplete definitions of grievance terminology and use of outdated terminology (CHIP), incomplete and incorrect information about requirements for grievance acknowledgement (CAN and CHIP), and incorrect documentation of grievance resolution timeframes (CHIP). United staff reported that as of October 1, 2018, Optum was no longer delegated to conduct appeal and grievance functions for members.

United's documentation revealed several issues related to definitions of grievance terminology, filing processes, and requirements. Of note, these issues were previously identified during the 2018 EQR, resulting in scores of "Not Met" for the applicable review standards. CCME's review of United's CAN and CHIP grievance files reflected timely resolutions and notification of resolutions; however, files contained acknowledgement letters sent beyond the five-calendar day acknowledgement timeframe required by United policy and noted an improper resolution in one CHIP grievance file. Magnolia's CAN and CHIP grievance files revealed issues that included incorrectly stating the grievance in the resolution letter (CAN) and grievance resolution letters that contained references to an outdated three-step grievance process, as well as typographical errors that change the meaning of the information supplied, incorrect dates, and incomplete sentences. CCME suggested implementing a quality review process for member letters to address these issues.

CCME's review of United's Service Quality Improvement Committee (SQIC) meeting minutes did not identify how the SQIC monitors member complaints and grievances, as indicated in the CAN and CHIP 2019 Quality Improvement Program Descriptions. For two SQIC meetings, minutes indicated a grievance report was not available, and minutes for the remaining three meetings did not clearly reflect discussion and monitoring of member complaint and grievance trends.

Overall, majority of Magnolia's and United's Member Services standards follow *CAN* and *CHIP Contract* requirements, and state and federal guidelines. CCME addresses identified issues in the Weaknesses section that follows.

Member Satisfaction Survey

As required by contract, both health plans conducted member satisfaction surveys. As part of the annual EQR of both health plans, CCME conducted a validation review of the member satisfaction surveys using the protocol developed by CMS titled, 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

The validation results are displayed in Table 12: Results of the Validation of CCO Satisfaction Surveys below.

Table 12: Results of the Validation of CCO Satisfaction Surveys

Enrollee Satisfaction Survey Validation			
Magnolia CAN	**Magnolia CHIP**	**United CAN**	**United CHIP**
The generalizability of the survey results is diminished due to low response rates for all three population surveys. Response rates were: 24% for Adults 18% for Child 18% for Child-CCC	The generalizability of the survey results is diminished due to low response rates for all three population surveys. Response rates were: 19% for Child 20% for Child-CCC	The generalizability of the survey results is diminished due to low response rates for all three population surveys. Response rates were: 22.9% for Adults 18.8% for Child CCC total sample 17.7% for Child CCC general population	The generalizability of the survey results is diminished due to low response rates for the Child CCC survey. Response rates were: 25.5% for total sample 23.46% for general population

An overview of the scores for the Member Services section is illustrated in Table 13: Member Services Comparative Data.

Table 13: Member Services Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Member Rights and Responsibilities	The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met
	All member rights included	Met	Met	Met	Met
	All member responsibilities included	Partially Met	Partially Met	Partially Met	Partially Met
Member CCO Program Education	Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled	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
	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	Met	Met	Met	Met
	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
	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
	Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members	Met	N/A	Met	N/A

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Call Center	The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Met	Met	Met	Met
	Call Center scripts are in-place and staff receives training as required by the contract	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
Member Enrollment and Disenrollment	The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met	Met
	Member disenrollment is conducted in a manner consistent with contract requirements	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
	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
	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
	The CCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Member Satisfaction Survey	The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met
	The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Met
	The CCO reports results of the member satisfaction survey to providers	Met	Met	Met	Met
	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	Met
Grievances	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
	Definition of a grievance and who may file a grievance	Not Met ↓	Met ↑	Met	Partially Met ↓
	The procedure for filing and handling a grievance	Not Met ↓	Not Met ↓	Partially Met	Partially Met
	Timeliness guidelines for resolution of grievances as specified in the contract	Met	Met ↑	Met ↑	Partially 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
	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met ↑	Met	Met	Met
	The CCO applies the grievance policy and procedure as formulated	Met	Met	Met ↑	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Grievances	Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee	Met	Met	Met	Met
	Grievances are managed in accordance with CCO confidentiality policies and procedures	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
	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

Strengths

- Both Magnolia and United host community events for members, such as baby showers, member workshops, and community health fairs.
- CCOs analyzed data obtained from Member Satisfaction Surveys to identify quality problems.
- Results of Member Satisfaction Surveys were reported to providers.
- Documentation of measures taken to address quality problems were provided by all CCOs.

Weaknesses

- Websites were noted to have information that was outdated, limited, or not easily located.
- Deficiencies were noted in documentation of member's rights and responsibilities in Member Handbooks, Provider Manuals, policies, and websites.
- Magnolia's and United's grievance documentation revealed:
  - Issues related to definitions of grievance terminology, filing processes and requirements, incorrect resolution timeframes, and incorrect website information.
  - Grievance resolution notices incorrectly stating a member's grievance, including references to an outdated three-step grievance process, and containing typographical errors, or sent out of timeframe.

- CCME noted isolated issues with missing or incomplete benefit information in the Member Handbook and on the website. Magnolia did not have Care Management program information on the CAN and CHIP websites.
- The plans did not document the required font sizes for standard and large print member materials.
- Both plans listed incorrect hours of operation for Provider Services in their Provider Manuals.
- For both Magnolia and United, generalizability of the CAHPS Survey results is difficult to discern due to low response rates.

Recommendations

- Ensure websites contain adequate information for members and that information is current and easy to locate.
- Ensure members rights and responsibility are correctly documented in Member Handbooks, Provider Manuals, in policies, and on websites.
- Ensure documentation of grievance processes is correct and consistent with requirements and terminology in the applicable *DOM Contract* and *Federal Regulations*.
- Ensure grievance resolution letters contain correct information regarding the member's grievance and are completed within required timeframes.
- Ensure complete information about member benefits and programs is documented in Member Handbooks and on websites.
- Ensure the requirements to print written material using a minimum 12-point font size, and 18-point font for large print materials, are documented, as required by the *DOM Contract* and *Federal Regulations*.
- Ensure Provider Manuals reflect correct hours for Provider Services.
- Continue to work on interventions to increase CAHPS Survey response rates, such as website banners and reminders on call center scripts.

D. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed program descriptions, committee structures and minutes, performance measures, performance improvement projects (PIPs), and the QI program evaluations for the CAN and CHIP programs

Quality Improvement program descriptions adequately described the programs Magnolia and United have implemented to monitor, evaluate, and improve the quality of clinical care and services provided to their members. Program descriptions are

updated annually and submitted to the applicable committee(s) for review and approval, including the Board of Directors, Quality Management Committee (QMC), and to DOM for review and approval.

Both plans provided their 2018 and 2019 work plans. Magnolia's work plans were divided into four tabs: Committees, P&P Doc Reports, Performance Measures, and QIPI Activities. Each tab contained the goals/objectives, planned activities, responsible party, frequency, and completion date. The activities or scope of work in the BH work plans were identical to CAN and CHIP and not specific to BH. For example, the Performance Improvement Projects state at least one project is related to obesity. United included the PIPs in the CHIP QI work plan; however, the projects listed were not the ongoing CHIP projects. The CAN projects were listed in error.

Committees responsible for implementing, monitoring, and directing QI activities were established for both health plans. Membership includes a variety of network providers, senior executives, directors, and other health plan staff. CCME identified a discrepancy between the United's CAN and CHIP QI Program Descriptions, the committee charter, and committee minutes regarding who chairs United's Quality Management Committee.

Both plans have a policy or standard operating procedures that address how Early and Periodic Screening, Diagnostic and Treatments (EPSDTs) are monitored. Magnolia's policy was not specific to the MS CHIP requirements. The policy does not specifically list Well-Baby and Well-Child. The policy only used the term "EPSDT". United's standard operating procedures titled, EPSDT Services – Tracking Process and Well Child Services – Tracking Process, explained that any problem identified during EPSDT and Well-Child exams that required referrals are tracked quarterly. The tracking reports did not contain EPSDT or Well-Child visits in the result samples United provided. The reports appeared to include encounters not related to a diagnosis found on the EPSDT or Well-Child exams, such as emergency room visits or unspecified effects of drowning and nonfatal submersion.

Magnolia and United conducted an evaluation of the effectiveness of the QI programs. Program evaluations included the QI activities conducted in 2018, results of those activities, any barriers identified, interventions, and recommendations for 2019.

Performance Measure Validation

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. To evaluate the accuracy of the performance measures (PMs) reported, CCME uses the CMS Protocol titled, Validation of Performance Measures. This validation balances the subjective and objective parts of the review and provides a review that is fair to the plans and provides the State with information about how each plan is operating.

HEDIS® Measure Overview for CAN Programs

Both CCOs use a HEDIS-certified vendor or software to collect and calculate the measures and were fully compliant. Plan rates based on audit reports for the most recent review year are reported in Table 14: HEDIS® Performance Measure Data for CAN Programs. The statewide average is calculated as the average of the plan rates and shown in the last column of the below table.

Table 14: HEDIS® Performance Measure Data for CAN Programs

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	86.86%	88.75%	87.81%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	57.42%	54.99%	56.21%
Counseling for Nutrition	51.58%	50.85%	51.22%
Counseling for Physical Activity	47.45%	46.23%	46.84%
Childhood Immunization Status (cis)			
DTaP	79.32%	83.21%	81.27%
IPV	93.92%	94.65%	94.29%
MMR	94.16%	93.67%	93.92%
HiB	89.05%	91.24%	90.15%
Hepatitis B	93.19%	94.65%	93.92%
VZV	94.65%	92.94%	93.80%
Pneumococcal Conjugate	82.73%	86.86%	84.80%
Hepatitis A	76.40%	81.27%	78.84%
Rotavirus	80.54%	81.27%	80.91%
Influenza	32.36%	31.63%	32.00%
Combination #2	77.37%	80.78%	79.08%
Combination #3	75.18%	79.32%	77.25%
Combination #4	62.53%	69.59%	66.06%
Combination #5	65.94%	70.07%	68.01%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
Combination #6	27.98%	27.49%	27.74%
Combination #7	55.47%	62.04%	58.76%
Combination #8	25.30%	26.03%	25.67%
Combination #9	24.82%	24.33%	24.58%
Combination #10	22.87%	23.36%	23.12%
Immunizations for Adolescents (ima)			
Meningococcal	53.77%	54.26%	54.02%
Tdap/Td	74.70%	77.13%	75.92%
HPV	20.19%	18.98%	19.59%
Combination #1	52.07%	51.34%	51.71%
Combination #2	18.73%	17.27%	18.00%
Lead Screening in Children (lsc)	71.88%	72.51%	72.20%
Breast Cancer Screening (bcs)	56.57%	48.49%	52.53%
Cervical Cancer Screening (ccs)	56.20%	54.90%	55.55%
Chlamydia Screening in Women (chl)			
16-20 Years	45.90%	46.84%	46.37%
21-24 Years	61.14%	59.53%	60.34%
Total	48.52%	49.04%	48.78%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	68.19%	68.64%	68.42%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.91%	32.89%	31.90%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	41.53%	41.33%	41.43%
Bronchodilator	77.06%	76.77%	76.92%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	49.43%	48.92%	49.18%
5-11 Years - Medication Compliance 75%	23.65%	23.29%	23.47%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
12-18 Years - Medication Compliance 50%	49.71%	50.35%	50.03%
12-18 Years - Medication Compliance 75%	24.04%	22.75%	23.40%
19-50 Years - Medication Compliance 50%	52.22%	57.73%	54.98%
19-50 Years - Medication Compliance 75%	25.60%	30.41%	28.01%
51-64 Years - Medication Compliance 50%	60.78%	57.89%	59.34%
51-64 Years - Medication Compliance 75%	30.39%	31.58%	30.99%
Total - Medication Compliance 50%	50.25%	50.47%	50.36%
Total - Medication Compliance 75%	24.25%	23.91%	24.08%
Asthma Medication Ratio (amr)			
5-11 Years	77.38%	82.28%	79.83%
12-18 Years	66.32%	67.85%	67.09%
19-50 Years	47.29%	48.75%	48.02%
51-64 Years	40.11%	44.83%	42.47%
Total	67.23%	71.62%	69.43%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	45.26%	53.53%	49.40%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	58.00%	65.00%	61.50%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	73.69%	67.14%	70.42%
Statin Adherence 80% - 21-75 years (Male)	46.68%	45.42%	46.05%
Received Statin Therapy - 40-75 years (Female)	70.19%	66.17%	68.18%
Statin Adherence 80% - 40-75 years (Female)	41.99%	35.98%	38.99%
Received Statin Therapy - Total	71.95%	66.67%	69.31%
Statin Adherence 80% - Total	44.41%	40.88%	42.65%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	88.08%	84.43%	86.26%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
HbA1c Poor Control (>9.0%)	47.93%	45.50%	46.72%
HbA1c Control (<8.0%)	45.01%	46.23%	45.62%
HbA1c Control (<7.0%)	NR	NR	NA
Eye Exam (Retinal) Performed	68.37%	55.72%	62.05%
Medical Attention for Nephropathy	90.51%	89.78%	90.15%
Blood Pressure Control (<140/90 mm Hg)	47.45%	52.31%	49.88%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	57.19%	49.62%	53.41%
Statin Adherence 80%	39.86%	34.61%	37.24%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	NR	71.63%	NA
Effectiveness of Care: Behavioral Health Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	38.76%	39.66%	39.21%
Effective Continuation Phase Treatment	23.88%	21.59%	22.74%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	57.06%	58.11%	57.59%
Continuation and Maintenance (C&M) Phase	70.50%	69.09%	69.80%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	66.53%	66.04%	66.29%
6-17 years - 7-Day Follow-Up	40.24%	41.03%	40.64%
18-64 years - 30-Day Follow-Up	56.16%	53.09%	54.63%
18-64 years - 7-Day Follow-Up	28.15%	29.59%	28.87%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total 30-Day Follow-Up	61.92%	60.37%	61.15%
Total 7-Day Follow-Up	34.89%	35.94%	35.42%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	56.71%	42.79%	49.75%
6-17 years - 7-Day Follow-Up	34.63%	30.77%	32.70%
18-64 years - 30-Day Follow-Up	41.46%	41.34%	41.40%
18-64 years - 7-Day Follow-Up	23.99%	25.05%	24.52%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	46.14%	41.78%	43.96%
Total- 7-Day Follow-Up	27.26%	26.78%	27.02%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	0.00%	9.09%	4.55%
7-Day Follow-Up: 13-17 Years	0.00%	9.09%	4.55%
30-Day Follow-Up: 18+ Years	5.16%	8.41%	6.79%
7-Day Follow-Up: 18+ Years	3.80%	5.53%	4.67%
30-Day Follow-Up: Total	4.74%	8.46%	6.60%
7-Day Follow-Up: Total	3.49%	5.79%	4.64%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	72.45%	70.53%	71.49%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	69.47%	68.60%	69.04%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	64.15%	70.59%	67.37%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	57.21%	55.79%	56.50%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	24.32%	23.91%	24.12%
6-11 Years	19.25%	18.36%	18.81%
12-17 Years	28.04%	24.38%	26.21%
Total	24.23%	21.80%	23.02%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	89.56%	88.86%	89.21%
Diuretics	89.68%	88.18%	88.93%
Total	89.61%	88.55%	89.08%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	1.49%	NA
Appropriate Treatment for Children With URI (uri)	65.20%	65.15%	65.18%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.96%	37.09%	35.03%
Use of Imaging Studies for Low Back Pain (lbp)	68.79%	66.67%	67.73%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	2.63%	NA
6-11 Years	0.28%	0.47%	0.38%
12-17 Years	0.35%	0.14%	0.25%
Total	0.31%	0.36%	0.34%
Use of Opioids at High Dosage (uod)	1.25%	1.45%	1.35%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	17.14%	19.74%	18.44%
Multiple Pharmacies	10.85%	5.82%	8.34%
Multiple Prescribers and Multiple Pharmacies	4.68%	3.16%	3.92%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	9.93%	10.31%	10.12%
18-64 years - >=31 Days covered	3.83%	4.39%	4.11%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	9.94%	10.31%	10.13%
Total - >=31 Days covered	3.83%	4.39%	4.11%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	88.17%	86.84%	87.51%
45-64 Years	92.25%	90.88%	91.57%
65+ Years	84.04%	93.62%	88.83%
Total	89.95%	88.54%	89.25%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.82%	97.72%	97.77%
25 Months - 6 Years	91.70%	90.12%	90.91%
7-11 Years	92.74%	92.10%	92.42%
12-19 Years	90.95%	90.90%	90.93%
Annual Dental Visit (adv)			
2-3 Years	54.89%	53.87%	54.38%
4-6 Years	76.66%	75.63%	76.15%
7-10 Years	76.52%	76.75%	76.64%
11-14 Years	72.61%	73.46%	73.04%
15-18 Years	63.52%	64.53%	64.03%
19-20 Years	45.02%	45.90%	45.46%
Total	70.10%	70.20%	70.15%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	76.09%	79.41%	77.75%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	2.17%	2.94%	2.56%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	69.72%	63.68%	66.70%

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	7.57%	9.45%	8.51%
Total: Initiation of AOD Treatment: 13-17 Years	67.26%	62.15%	64.71%
Total: Engagement of AOD Treatment: 13-17 Years	7.12%	8.88%	8.00%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	45.13%	42.20%	43.67%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	4.09%	4.46%	4.28%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	22.41%	20.54%	21.48%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	7.73%	6.55%	7.14%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	38.37%	40.70%	39.54%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.73%	5.61%	5.67%
Total: Initiation of AOD Treatment: 18+ Years	34.00%	32.41%	33.21%
Total: Engagement of AOD Treatment: 18+ Years	6.02%	5.86%	5.94%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	46.46%	43.71%	45.09%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.01%	4.39%	4.20%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	22.54%	20.81%	21.68%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	7.66%	6.51%	7.09%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	42.09%	43.45%	42.77%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	5.95%	6.07%	6.01%
Total: Initiation of AOD Treatment: Total	36.48%	34.37%	35.43%
Total: Engagement of AOD Treatment: Total	6.10%	6.06%	6.08%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.27%	88.29%	89.28%
Postpartum Care	57.91%	68.29%	63.10%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			

Measure/Data Element	Magnolia CAN (MY 2018)	United CAN (MY 2018)	Statewide Average
1-5 years	66.67%	NA	NA
6-11 years	71.56%	63.05%	67.31%
12-17 years	67.70%	63.43%	65.57%
Total	69.34%	62.68%	66.01%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.58%	0.00%	1.29%
1 Visit	3.12%	3.06%	3.09%
2 Visits	4.39%	5.36%	4.88%
3 Visits	6.25%	4.59%	5.42%
4 Visits	11.34%	7.91%	9.63%
5 Visits	19.87%	19.64%	19.76%
6+ Visits	52.45%	59.44%	55.95%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	60.43%	54.98%	57.71%
Adolescent Well-Care Visits (awc)	39.67%	45.50%	42.59%

NA: Indicates denominator was too small or data not available; NR: Not reported. *Indicates audit report noted measure as “NA” due to small denominator

When evaluating specific measures for each CAN program, the timing of the reviews created a one-year gap in performance measure reporting. Thus, the year over year trending for each plan included MY 2016 (HEDIS 2017) and MY 2018 (HEDIS 2019). For United, there were several measures that had substantial improvement of greater than 10% in that time frame, including HPV and Combination #2 Immunizations for Adolescents, and A1C Control. The measures with a substantial decrease in rate were Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5 year-olds and Alcohol Abuse or Dependence, Initiation of AOD Treatment, and Total. For Magnolia, there were also several measures that had substantial improvement of greater than 10%, including BMI Percentile for Children/Adolescents, Counseling for Physical Activity, HPV Vaccines, and Well Child Visits in the First 15 Months of Life. The only measure with a substantial decrease in rate was the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

NON-HEDIS Overview for CAN Programs

Non-HEDIS performance measures were uploaded to the desk materials and reviewed in comparison to target rates. Table 15: CAN Non-HEDIS Performance Measure Rates displays the CY 2018 rate and the State target rate. Magnolia met the target rate for two of the five measures, and United met the target rate for one of the five measures.

Table 15: CAN Non-HEDIS Performance Measure Rates

Measure/Data Element	Magnolia CAN (CY 2018)	United CAN (CY 2018)	MS CAN Target Rate
EPSDT Screening (<1 Year)	313.60%	116.74%	85%
EPSDT Screening (>1, >21 Years)	59.78%	54.13%	75%
Well-Child Visits in the 1st 15 months of life	52.45%	59.44%	59.76%
Nephropathy Screening	90.51%	89.78%	90.33%
Screening for Clinical Depression	21.49%	5.87%	25%

Table 16: HEDIS® Performance Measure Data for CHIP Programs displays the most recent measurement rates for the United and Magnolia CHIP Programs and the Statewide average for MY2018.

Table 16: HEDIS® Performance Measure Data for CHIP Programs

Measure/Data Element	Magnolia CHIP (MY 2018)	United CHIP (MY 2018)	Statewide Average
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	58.39%	54.26%	56.33%
Counseling for Nutrition	50.85%	41.12%	45.99%
Counseling for Physical Activity	47.69%	36.50%	42.10%
Childhood Immunization Status (cis)			
DTaP	87.59%	85.89%	86.74%
IPV	95.86%	93.92%	94.89%
MMR	93.19%	93.67%	93.43%
HiB	93.92%	90.75%	92.34%

Measure/Data Element	Magnolia CHIP (MY 2018)	United CHIP (MY 2018)	Statewide Average
Hepatitis B	95.38%	94.40%	94.89%
VZV	93.19%	92.94%	93.07%
Pneumococcal Conjugate	88.56%	86.86%	87.71%
Hepatitis A	80.05%	79.81%	79.93%
Rotavirus	86.62%	84.43%	85.53%
Influenza	38.20%	39.90%	39.05%
Combination #2	86.62%	84.91%	85.77%
Combination #3	84.91%	83.45%	84.18%
Combination #4	74.70%	72.26%	73.48%
Combination #5	80.29%	76.40%	78.35%
Combination #6	35.28%	36.74%	36.01%
Combination #7	71.05%	67.15%	69.10%
Combination #8	32.12%	34.55%	33.34%
Combination #9	34.06%	34.55%	34.31%
Combination #10	30.90%	32.60%	31.75%
Immunizations for Adolescents (ima)			
Meningococcal	52.88%	54.26%	53.57%
Tdap/Td	81.20%	82.48%	81.84%
HPV	17.92%	16.30%	17.11%
Combination #1	52.13%	53.04%	52.59%
Combination #2	16.42%	14.36%	15.39%
Lead Screening in Children (lsc)	62.05%	63.99%	63.02%
Chlamydia Screening in Women (chl)			
16-20 Years	34.75%	37.13%	35.94%
*21-24 Years**	NA	NA	NA

Measure/Data Element	Magnolia CHIP (MY 2018)	United CHIP (MY 2018)	Statewide Average
Total	34.75%	37.13%	35.94%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	73.63%	71.99%	72.81%
Medication Management for People with Asthma (mma)			
5-11 Years - Medication Compliance 50%	64.84%	59.48%	62.16%
5-11 Years - Medication Compliance 75%	32.81%	30.48%	31.65%
12-18 Years - Medication Compliance 50%	50.45%	54.59%	52.52%
12-18 Years - Medication Compliance 75%	27.03%	26.09%	26.56%
Total - Medication Compliance 50%	58.51%	57.23%	57.87%
Total - Medication Compliance 75%	29.88%	28.51%	29.20%
Asthma Medication Ratio (amr)			
5-11 Years	NR	87.73%	NA
12-18 Years	NR	74.55%	NA
Total	NR	81.87%	NA
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	NR	NA	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	NR	32.35%	NA
Effective Continuation Phase Treatment	NR	17.65%	NA
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	50.86%	50.00%	50.43%
Continuation and Maintenance (C&M) Phase	71.70%	58.51%	65.11%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	65.79%	63.44%	64.62%

Measure/Data Element	Magnolia CHIP (MY 2018)	United CHIP (MY 2018)	Statewide Average
6-17 years - 7-Day Follow-Up	45.61%	36.02%	40.82%
*18-64 years - 30-Day Follow-Up**	NA	NA	NA
*18-64 years - 7-Day Follow-Up**	NA	NA	NA
Total 30-Day Follow-Up	66.10%	61.39%	63.75%
Total 7-Day Follow-Up	44.92%	35.15%	40.04%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	NA	NA
6-17 years - 7-Day Follow-Up	NR	NA	NA
18-64 years - 30-Day Follow-Up	NR	NA	NA
18-64 years - 7-Day Follow-Up	NR	NA	NA
Total-30-day Follow-Up	NR	NA	NA
Total-7-day Follow-Up	NR	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NR	NA	NA
6-11 Years	NR	21.43%	NA
12-17 Years	NR	23.33%	NA
Total	NR	23.04%	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	0.77%	NA
Appropriate Treatment or Children with URI (uri)	61.88%	58.21%	60.04%
Use of Imaging Studies for Low Back Pain (lbp)	NR	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NA	NA
6-11 Years	NR	2.04%	NA
12-17 Years	NR	0.00%	NA

Measure/Data Element	Magnolia CHIP (MY 2018)	United CHIP (MY 2018)	Statewide Average
Total	NR	0.75%*	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	3.39%	NA
18-64 years - >=31 Days covered	NR	0.00%	NA
Total - >=15 Days covered	NR	3.39%	NA
Total - >=31 Days covered	NR	0.00%	NA
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	98.76%	98.56%	98.66%
25 Months - 6 Years	94.21%	92.30%	93.26%
7-11 Years	94.06%	95.51%	94.79%
12-19 Years	91.96%	93.13%	92.55%
Annual Dental Visit (adv)			
2-3 Years	56.37%	55.52%	55.95%
4-6 Years	78.72%	77.98%	78.35%
7-10 Years	80.81%	83.04%	81.93%
11-14 Years	75.73%	79.34%	77.54%
15-18 Years	65.17%	70.37%	67.77%
19-20 Years	57.58%	58.65%	58.12%
Total	73.04%	75.75%	74.40%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Total Initiation of AOD Treatment: 13-17 years	NR	56.25%	NA
Total Engagement of AOD Treatment: 13-17 years	NR	3.13%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	NR	51.02%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total	NR	2.04%	NA

Measure/Data Element	Magnolia CHIP (MY 2018)	United CHIP (MY 2018)	Statewide Average
Initiation of AOD Treatment: Total	NR	45.61%	NA
Engagement of AOD Treatment: Total	NR	1.75%	NA
Prenatal and Postpartum Care (ppc)			
*Timeliness of Prenatal Care**	NA	NA	NA
*Postpartum Care**	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NR	NA	NA
6-11 Years	NR	42.86%	NA
12-17 Years	NR	54.69%	NA
Total	NR	51.00%	NA
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.75%	0.31%	1.03%
1 Visit	0.66%	2.18%	1.42%
2 Visits	1.53%	1.56%	1.55%
3 Visits	4.16%	2.49%	3.33%
4 Visits	8.10%	9.03%	8.57%
5 Visits	13.79%	13.71%	13.75%
6+ Visits	70.02%	70.72%	70.37%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	60.27%	62.50%	61.39%
Adolescent Well-Care Visits (awc)	40.22%	48.18%	44.20%

*NA: Indicates denominator was too small or data not available; NR: Not reported. *Indicates audit report noted measure as "NA" due to small denominator*

When comparing the MY2016 CHIP rates to the MY2018 CHIP rates, United did not have any measures with a substantial improvement of greater than 10%, although many rates improved. The measures of Antidepressant Medication Management and Follow-Up After Hospitalization for Mental Illness declined substantially (>10%). For Magnolia

CHIP, there were several measures that had substantial improvement of greater than 10%, including Asthma Medication Compliance, Follow Up Care for Children on ADHD Medication Continuation Phase, Follow up after Hospitalization for Mental Illness, and Well-Child Visits. The measure of 5 Well-Child Visits in the First 15 months of life did have a substantial decrease, but the 6+ well child visits increased substantially.

CHIP Non-HEDIS Overview

Table 17: CHIP Non HEDIS® Performance Measure Rates, displays the most recent measurement rates for the United and Magnolia CHIP Programs. Magnolia met the target rate for two of the three measures, and United met the target rate for one of the three measures.

Table 17: CHIP Non-HEDIS Performance Measure Rates

Measure	Magnolia CHIP CY2018	United CHIP CY2018	MS CHIP Target Rate
EPSDT Screening (<1 Year)	366.67%	107.27%	85%
EPSDT Screening (>1, <21 Years)	38.92%	47.92%	75%
Well-Child Visits in the 1st 15 months of Life	70.02%	48.18%	59.76%

Performance Improvement Project Validation

Each health plan is required to submit their performance improvement projects (PIPs) to CCME for review annually. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The 16 projects reviewed for the CAN and CHIP programs for the two plans are displayed in Table 18: Results of the Validation of PIPs.

Table 18: Results of the Validation of PIPs

Project	Validation Score
Magnolia CAN	
Asthma	91/91=100% High Confidence in Reported Results
Behavioral Health Readmissions	67/72=93% High Confidence in Report Results
Improved Pregnancy Outcomes with Makena	62/62=100% High Confidence in Report Results
Sickle Cell Disease Outcomes	67/72=93% High Confidence in Report Results
Magnolia CHIP	

Project	Validation Score
EPSDT	91/91=100% High Confidence in Report Results
Obesity for Children	102/105= 97% High Confidence in Report Results
ADHD	90/91=99% High Confidence in Report Results
Use of Appropriate Medications for People with Asthma	91/91=100% High Confidence in Report Results
United CAN	
Behavioral Health Readmissions	78/78=100% High Confidence in Reported Results
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	62/62=100% High Confidence in Reported Results
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	57/62=92% High Confidence in Reported Results
Respiratory Illness: COPD/Asthma	62/62=100% High Confidence in Reported Results
United CHIP	
Adolescent Well Child Visits	104/105=99% High Confidence in Reported Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- formerly called Reducing Adolescent and Childhood Obesity	111/111=100% High Confidence in Reported Results
Getting Needed Care CAHPS	111/111=100% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	84/85=99% High Confidence in Reported Results

Magnolia and United CAN and CHIP plans scored in the “High Confidence” range for all 16 submitted and validated PIPs. Scores ranged from 92% to 100%. There were no PIPs that scored in the “Confidence,” “Low Confidence,” or “Not Credible” scoring categories.

Issues for PIPs

There were no corrective actions for any PIPs for Magnolia nor United. A few recommendations based on the review included documentation of rates in Table format for all measurements, refining interventions to improve PIP outcome rates, and working to increase sample size for PIP topics where possible.

Table 19: Quality Improvement Comparative Data, provides an overview of each health plan's scores for the Quality Improvement standards. Both plans met all the requirements in the Quality Improvement standards.

Table 19: Quality Improvement Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Quality Improvement (QI) Program	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
	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
	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
	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	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
	The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met
	The QI Committee meets at regular intervals	Met	Met	Met	Met
	Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures"	Met	Met	Met	Met
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met	Met	Met
	The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met	Met	Met ↑	Met ↑
Provider Participation in Quality Improvement Activities	The CCO requires its providers to actively participate in QI activities	Met	Met	Met	Met
	Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met
	The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines	Met	Met	Met	Met
	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
	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

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Provider Participation in Quality Improvement Activities	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	Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Met	Met	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

Strengths

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

Weaknesses

- Performance measures that declined substantially and need to be considered for further analysis/assessment to determine how to improve quality of care.
- Some of the Non-HEDIS measure rates were below State target rate for both CCOs in the CAN and CHIP programs.

Recommendations

- Ensure performance improvement project rate results are consistent throughout the project reports.
- Include baseline and remeasurement rates in Table format for PIPs.
- Refine interventions to improve rates for PIPs that had a decline in rates.
- Continue working toward improvement of non-HEDIS measure rates such as EPSDT Screening, Nephropathy Screening, and Screening for Clinical Depression.

E. Utilization Management

CCME's review of Magnolia's and United's CAN and CHIP utilization management (UM) activities including program descriptions and evaluations, policies, Member Handbooks, Provider Manuals, approval, denial, appeal, and care management files, and health plan websites.

The Utilization Management program descriptions and policies guide staff on how to conduct UM activities for physical, behavioral health, and pharmaceutical services for members. Service authorization requests for CAN and CHIP members are conducted by appropriate reviewers, using InterQual guidelines or other criteria, in an established clinical hierarchy. CCME identified that Magnolia's Timeliness of UM Decisions and Notifications policies do not include the requirement that Magnolia must request approval from DOM to extend expedited requests beyond 24 hours.

Review of approval and denial files, for both health plans, reflect timely and consistent decision-making using evidenced-base criteria and relevant medical information. The health plans assess consistency in criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers.

Envolve Pharmacy Solutions (EPS) is delegated to provide pharmacy services for Magnolia and Optum RX is delegated to provide pharmacy services for United. Both health plans use the most current version of the Mississippi Medicaid Program Preferred Drug List (PDL) on the State's website to fulfill pharmacy requirements. However, instructions and information for accessing the PDL and other medications on United's website and Member Handbook were not clear.

Magnolia and United have established policies defining processes for handling both CAN and CHIP appeals of adverse benefit determinations. Review of appeals documentation revealed issues such as:

- Incomplete and missing definitions of appeal terminology
- Use of terminology that is not consistent with definitions in the *CAN* and *CHIP Contracts* and Federal Regulations (Magnolia)
- Lack of information about who can file an appeal
- 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
- Incorrect or unclear information about appeal resolution timeframes
- Incomplete or no information about continuation of benefits pending the resolution of an initial member appeal. Additionally, Magnolia did not include continuation of benefits pending a State Fair Hearing or Independent External Review.

Several of Magnolia's issues were previously identified during the 2018 EQR and are uncorrected. Despite issues, review of the health plans' appeal files confirmed that appeals are handled correctly.

Both plans monitor, evaluate, and report appeals data and activities. For Magnolia, summaries of appeal actions, trends, and root causes are reported to the Quality Improvement Committee (QIC) and used to identify opportunities to improve quality of care and service. The QIC reports findings to the board of directors (BOD). United's Service Quality Improvement Committee (SQIC) monitors member appeal data and activities, as indicated in the CAN and CHIP 2019 Quality Improvement Program Descriptions. However, this was not evident in the SQIC meeting minutes.

The CAN and CHIP Care Management Program Description outlines the framework for program's goals, scope, and lines of responsibility for Magnolia and United. 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. Additionally, United incorporated a Whole Person Care Management Program into their CM program. During United's Care Management file review, it was either difficult or impossible for CCME to find members' risk levels. However, onsite discussions confirmed documentation of this.

An overview of all scores for the Utilization Management section is illustrated in Table 20: Utilization Management Comparative Data.

Table 20: CAN Utilization Management Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia 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
	Structure of the program	Met	Met	Met	Met
	Lines of responsibility and accountability	Met	Met	Met	Met
	Guidelines/standards to be used in making utilization management decisions	Met	Met	Met	Met
	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Met	Met	Met
	Consideration of new technology	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Utilization Management (UM) Program	The appeal process, including a mechanism for expedited appeal	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
	Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	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
Medical Necessity Determinations	Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met
	Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met
	Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met
	Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met
	The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Met	Met	Met	Met
	The CCO has established policies and procedures for prior authorization of medications	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
	Utilization management standards/criteria are available to providers	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Medical Necessity Determinations	Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met
	Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met
	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
	All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	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
Appeals	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
	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Partially Met	Not Met	Not Met
	The procedure for filing an appeal	Partially Met	Partially 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
	A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Partially Met	Not Met	Partially Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Appeals	Written notice of the appeal resolution as required by the contract	Met ↑	Met	Met	Met
	Other requirements as specified in the contract	Partially Met	Partially Met	Partially Met	Partially Met
	The CCO applies the appeal policies and procedures as formulated	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
	Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met	Met
Care Management	The CCO has developed and implemented a Care Management Program	Met	Met	Met	Met
	The CCO uses varying sources to identify members who may benefit from Care Management	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
	The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met	Met	Met
	Evaluation of co-morbidities or multiple complex health care conditions	Met	Met	Met	Met
	Demographic information	Met	Met	Met	Met
	Member's current treatment provider and treatment plan, if available	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

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Care Management	The risk level assignment is periodically updated as the member's health status or needs change	Met	Met	Met	Met
	The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	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
	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
	The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	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
Transitional Care Management	The CCO monitors continuity and coordination of care between PCPs and other service providers	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	Partially Met	Partially Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Transitional Care Management	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
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
	The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met

Strengths

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

Weaknesses

- Policies did not include requirements for expedited service authorization requests and omitted several required process steps for Transitional Care Management (Magnolia).
- When reviewing documentation related to appeals, the plans were noted to use incomplete definitions of the term "adverse benefit determination" and to use the term "action" instead of "adverse benefit determination."
- Embedded links in United's online Member Handbook and website were noted to have issues with accessing the DOM PDL and users are not informed that the PDL is not located on United's website.
- Issues were identified regarding procedures and timeframes for filing an appeal.

Recommendations

- Magnolia should ensure requirements for expedited service authorization requests and Transitional Care Management process steps are documented in policies.
- The plans should ensure the use of current appeal terminology and complete definitions of appeal terminology.
- United should provide clear information explaining that the PDL is located on DOM's website and ensure the embedded links in the online Member Handbooks are in working order.

- The health plans should ensure correct procedures and timeframes for filing an appeal are documented as specified in *CAN* and *CHIP Contracts*.

F. Delegation

Magnolia and United ensure all delegation arrangements are governed by written agreements between the delegate and the health plan. The agreements describe the roles and responsibilities of the health plan and the delegated entity, delegated activities, reporting requirements, processes by which the delegated entity's performance is evaluated, and terms for revoking delegation. 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, network, utilization management, credentialing, and quality management
Medical Transportation Management, Inc. (MTM) (CAN Only)	Non-emergency transportation claims, network, utilization management, and quality management
National Imaging Associates, Inc. (NIA)	Radiology utilization management
EPC-NurseWise	Nurse call center
EPC-Nurtur	Disease management
Envolve Vision	Vision services claims, network, utilization management, credentialing, and quality management
Envolve Pharmacy Solutions	Pharmacy claims, network, utilization management, credentialing
Hattiesburg Clinic, PA; LSU Healthcare Network (New Orleans); North Mississippi Medical Clinic/North MS Healthlink; Rush Health Systems; Ochsner Clinic Foundation; St. Judes Research Hospital; Baptist Memorial Health Care-Baptist Health Services Group; Magnolia Regional Medical Center; Mississippi Physicians Care Network; Mississippi Health Partners; University of Mississippi Medical Center; Memorial Hospital at Gulfport	Credentialing Delegation

United has delegation agreements with the following entities:

Table 22: United Delegated Entities and Services

United Delegated Entities	United Delegated Services
OptumHealth	Behavioral health services
Optum RX	Pharmacy benefit administration services
Dental Benefit Providers	Dental network services and third-party dental administration
eviCore National	Radiology and cardiology management services and prior authorizations
MARCH Vision Care	Vision and eye care services
National MedTrans (CAN Only)	Non-emergency transportation benefit services
Hattiesburg Clinic; River Region Health System; HubHealth; University Physicians, PLLC; HCA Physician Services; Health Choice, LLC; North Mississippi Medical Clinic; Ochsner; Premier Health, Inc.	Credentialing/Recredentialing

CCME reviewed proof of annual oversight for all delegated entities. For credentialing and recredentialing oversight, United conducted annual audits to assess compliance with defined standards. The audit tool was comprehensive and included file review. However, the delegated credentialing and recredentialing tools omit the requirement for ensuring the entities collect Ownership Disclosure forms and query the Social Security Death Master File (SSDMF).

For the Delegation section, United achieved 50% “Met” scores and Magnolia Health Plan received scores of “Met” for 100% of the standards. Table 23: Delegation Services Comparative Data, illustrates the scoring for each standard reviewed.

Table 23: Delegation Services Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Delegation	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
	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	Partially Met	Partially Met	Met	Met

Strengths

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

Weaknesses

- The delegated credentialing and recredentialing tools United uses omit the requirement for ensuring the entities collect Ownership Disclosure forms and query the SSDMF.

Recommendations

- Monitor the entities where credentialing and recredentialing is delegated to ensure Ownership Disclosure forms are collected and the SSDMF is queried.
- Update the delegation oversight tools to include monitoring the delegate for Ownership Disclosure forms and querying the SSDMF.