The State of Mississippi

Division of Medicaid

Magnolia Health Plan

2013 External Quality Review

JUNE 2014

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Executive Summary

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The following report contains a description of the process and the results of the 2013 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid. The purpose of this review was to determine the level of performance demonstrated by Magnolia Health Plan and to provide feedback for potential areas of further improvement.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review included a desk review of documents, a three-day onsite visit to the Magnolia Health Plan office, validation of performance improvement projects, validation of performance measures, validation of consumer and provider surveys, and a review of the health plans' Information System Capabilities Assessment.

Findings

The findings of the 2013 EQR indicate that Magnolia Health Plan received Met scores for 84.29 percent of the standards. This is an increase of 4.19 percent in Met scores from the previous EQR. Some areas of concern were Magnolia's performance improvement projects did not pass the validation review and the corrective action plan that addressed the deficiencies identified during the previous EQR was not fully implemented. As a result, several standards received a Not Met score.

STRENGTHS

Strengths of Magnolia Health Plan's performance at the time of this review include the following:

- Organizational charts and onsite discussion demonstrate sufficient staff is in place to meet the needs of Magnolia members.
- Magnolia has a solid disaster recovery program in place that is tested regularly and they do an excellent job of laying out the test parameters.
- The provider website portal has extensive resource information including forms and applications, credentialing materials, practice guidelines, notification and training information, etc.
- GEO Access reports are run on a monthly basis, deficiencies are identified, and outreach is made via a recruitment plan to further the adequacy of Magnolia's provider base.
- The MemberConnections program provides valuable service to members by encouraging preventive health, and supports members by helping them locate and access providers and services in their communities. MemberConnections representatives engage members one-on-one in the setting most convenient for members, including the members' homes, and staff are also available to the members by phone.
- The Start Smart for Your Baby program provides support to members both during and after pregnancy. Staff provide education and support to pregnant members by phone and can

arrange one-on-one visits with members. The program has a dedicated website on which a variety of educational materials can be accessed through the site's health library, and contains a link to the Magnolia Health Plan website.
- All complaints and grievances are logged, including Level II grievances which are counted as a separate grievance from the initial one. Grievances are categorized, monitored for trends, and are reported to the QIC and to DOM.
- Topics selected for the performance improvement projects were pertinent to Magnolia's member population.
- The Quality Improvement Committee meets regularly and includes participating practitioners.
- The Plan was found to be fully compliant and met all the CMS validation requirements for their performance measures.
- Magnolia has a comprehensive Case Management program that encompasses prevention, care coordination, intensive care planning, and monitoring that serves members with medical and behavioral health needs. Case management files demonstrate excellent documentation of assessments, care planning, monitoring, and progress reports for the members enrolled in Case Management.
- The Medical Management staff consistently exceeds inter-rater reliability and auditing benchmarks.

WEAKNESSES

Weaknesses identified included the following:
- Credentialing and/or recredentialing issues were identified in policies CC.CRED.01, CC.CRED.04, CC.CRED.06, and CC.CRED.04.01.
- Policy CC.CRED.02, Credentialing Committee, and the 2013 Credentialing Program Description state an incorrect voting quorum for the Credentialing Committee. This was identified in the previous EQR and never corrected.
- Two Credentialing Committee meeting minutes did not document Dr. Waterer's attendance. Because of this issue, it appeared that a quorum was not met for the 5/16/13 meeting.
- Credentialing and/or recredentialing files reviewed onsite did not contain disclosure of ownership forms or site visits for initial credentialing. Some files did not have proof of malpractice insurance, proof of valid license, DEA verification, or CLIA certificates/ waivers, if applicable.
- In the previous EQR, CCME identified an issue with policies CC.CRED.10 and MS.ELIG.08 and they were never corrected. Also, policy MS.ELIG.08 has not been reviewed since 11/26/12.
- The majority of the GEO Access reports received in the desk materials appeared to utilize a criteria of one PCP in 30 miles for urban/suburban and one in 60 miles for rural instead of the two PCP guideline. In addition, the Practitioner Availability Analysis (July 1, 2012 to June 30, 2013) report reflected analysis measuring the one PCP guideline.
- Cenpatico policy CQI.103, Quality Improvement Evaluation of the Accessibility of Services, stated access standards that do not match the standards used in the appointment availability quarterly audits. The audits showed 48 hours for urgent and the policy showed 24 hours; the audit showed routine appointments not to exceed 3 weeks and the policy showed 10 business days (14 calendar days). In addition, the only behavioral health access standard mentioned in the Provider Manual is listed on page 15, "Behavioral Health within 7 days".
- The 2014 Quality Improvement Program Description, 2013 Quality Improvement work plan, committee charters, and the committee matrix received in the desk materials contained

inconsistent information regarding Magnolia's committee structure, what constitutes a quorum and the committees' membership.

- The performance improvement projects did not meet the CMS validation protocol. Some of the issues included:
    - Study documentation is not always consistent within the study, which confuses what the results mean and what the follow up should be.
    - Data analysis plan is not always followed.
- Policy MS QI. 23, Provider Profiling Program, discusses the process Magnolia follows for reporting Quality Improvement performance data to network providers. Sample copies of the provider profile reports were provided. During the previous EQR, this was discussed and the health plan stated their physicians would receive a profile report at least quarterly. However, the health plan has not implemented this process for providing their network providers with their performance data.
- Some of the sections of the 2013 Quality Improvement Program Evaluation contained a description of the program and did not always include the results of the evaluation.
- A discrepancy was noted in documentation of the quorum for the UM Committee.
- Discrepancies were noted in documentation of the timeframe requirement for urgent, pre-service requests.
- Inaccuracies and/or lack of information was noted in policies regarding:
    - Issuing an administrative denial if all the necessary information is not provided within the timeframe.
    - Enrollees' and practitioners' ability to request an extension of review determination timeframes.
    - Incomplete definition of an appeal.
    - A definition of an adverse determination as a form of Medicare organizational determination.
- The Member Handbook definition of an action on page 52 is incomplete.
- Errors were noted in the timeframe to file an appeal in the adverse determination letters in the denial files reviewed onsite and in the Member Handbook.
- Errors in the timeframe to follow an oral appeal request with a written request were noted in policy MS.UM.08 and in the Provider Manual, page 45.
- Policy MS.UM.08 contains documentation of information that is included in the appeal acknowledgement letters, but some of the items listed are not found in the acknowledgement letters.
- Errors were noted in the documentation of timeframes for requesting State Fair Hearings in the Utilization Management Program Description and in policy MS.UM.08.
- Issues were noted in the appeals files reviewed onsite, including:
    - Acknowledgement letters for expedited appeal requests listing the standard timeframe for resolution with no documentation that the requests for expedited appeals were denied.
    - An expedited appeal request had a 26-day resolution and notification timeframe with no documentation that the request for an expedited appeal was denied.
    - One standard appeal file contained documentation that the member requested a copy of the criteria used in the determination but no documentation that the criteria were provided to the member.
- Staff was unsure if policy MS. UM.16, which was submitted with the desk materials, is an active policy. A recommendation was made during the previous EQR to retire this policy because it is not applicable to Mississippi Medicaid members.

- While evidence of annual delegation oversight was presented, the delegation oversight tools for ancillary services and credentialing/recredentialing delegation appeared to address NCQA requirements and did not appear to reflect Mississippi-specific requirements.
- Magnolia did not fully implement the corrective action plan that addressed the deficiencies identified during the previous EQR.

Comparative Data

A comparison review of the scored standards by review category for the previous EQR conducted by CCME in 2012 with the current review results is shown in the table that follows.

TABLE 1

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Administration					
2012	25	0	0	0	25
2013	25	0	0	0	25
Provider Services					
2012	45	12	1	11	69
2013	54	7	8	0	69
Enrollee Services					
2012	33	4	0	0	37
2013	33	4	0	0	37
Quality Improvement					
2012	15	0	0	0	15
2013	12	2	1	0	15
Utilization Management					
2012	31	8	0	0	39
2013	33	4	2	0	39
Delegation					
2012	1	1	0	0	2
2013	1	1	0	0	2
State-Mandated Services					
2012	3	0	0	1	4
2013	3	0	1	0	4

Recommendations for Improvement

CCME made the following recommendations that Magnolia Health Plan should implement to improve their processes and comply with state and federal requirements.

- Address the issues identified in policies CC.CRED.01, CC.CRED.04, CC.CRED.06, and CC.CRED.04.01.
- Update policy CC.CRED.02 to reflect the quorum of 50 percent of voting members for the Credentialing Committee, or implement policy MS.CRED.02 received during the CAP in the previous review.
- Update policy CC.CRED.01, Credentialing Program Description, to reflect the 50 percent quorum for the Credentialing Committee.
- Ensure that all voting members of the Credentialing Committee are accounted for on the committee meeting roster and that a quorum has been met for the meetings.
- Proof of the following information should be included in the credentialing and recredentialing files:
    - Disclosure of ownership forms
    - Site assessments for initial credentialing of MS practitioners.
    - Copy of the malpractice insurance coverage face sheet
    - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificates/waivers or proof of verification for all providers that indicate they perform laboratory services. If the Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services and include that documentation in the file.
    - A copy of the license or proof of the license verification.
    - A copy of the Drug Enforcement Administration (DEA)/ Controlled Dangerous Substances (CDS) certificate or proof of the DEA/CDS verification.
- Under the new contract that will be implemented in 2014, the plan must verify that NPs acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.
- Update policy CC.CRED.10 to remove the incorrect policy reference.
- Update policy MS.ELIG.08 to reflect the provider notification timeframe that complies with contract guidelines, and ensure the policy is reviewed annually.
- Ensure that network analysis is measured utilizing the two PCP guideline as defined in the *DOM Contract, Section 5.4 (c).*
- Review the Provider Manual, policies, and reporting criteria for behavioral health appointment access standards, and ensure they are consistent and comply with the standards in the *DOM Contract, Section 5.16*.
- Medical record audits should be conducted to assess provider compliance with medical record documentation standards.
- Implement interventions to address the low results of the CCME conducted Provider Access and Availability Study.
- Implement interventions to increase the provider survey response rate and include the quality assurance plan in the documentation.
- The following corrections are needed in the Member Handbook:
    - Add information that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health.

    - Correct the information on member hospitalizations to indicate that members are requested rather than required to notify MHP of an admission.
    - Add the timeframe to file a grievance.
    - Include a clear description of the expedited appeals process. This should include information that an extension of up to 14 calendar days may be requested by MHP or by the member and that if MHP requests the extension, the member will be notified in writing of the reason for the extension.
    - Add information on how to access the Member Handbook in alternate formats, such as large font, braille, etc.
    - Update the information on acknowledgement of written grievances to indicate that acknowledgement occurs within 5 working days.
    - Add information about enrollees' right to make decisions regarding organ donation.
- Update the lists of items included in the new member packet in policies MS.MBRS.01 and MS.MBRS.05 so that they are consistent.
- Update the MHP website with:
    - Correct information regarding symptoms that require routine versus emergency care.
    - Update the link to the ACEP list of emergency symptoms.
- Update policy MS.MBRS.05 with information that Provider Directories are not sent to new enrollees because DOM waived the requirement.
- Correct the discrepancy in policy MS.MBRS.07 regarding the timeframe for clinically urgent Level II grievances.
- Increase the response rate for the child survey by using strategies that promote high response rates, such as including feedback based on previous surveys and documentation of the Plan's response to the feedback when sending the survey to the recipients.
- Update the Quality Improvement Program Description, work plan, committee charters, and the committee matrix to ensure all documents include all committees, each committee description, and that the quorums are consistent.
- Correct the deficiencies identified in the Quality Improvement Project validation results.
- Develop a plan to implement the process for providing network providers with a copy of their performance data.
- Ensure that the Quality Improvement Program Evaluation includes the results of the health plan's evaluation or results of the effectiveness of the quality improvement activities from the previous year.
- Correct the quorum requirement for the UM Committee to be consistent across all documents.
- Correct the timeframe requirement for urgent, pre-service requests in policy MS.UM.05, the UM Program Description, and the Provider Manual.
- Correct policy MS.UM.05 to indicate that if requested information is not received, a review will be performed on the information received and a determination will be issued. Include information in policy MS.UM.05 that enrollees and practitioners may also request an extension of review determination timeframes.
- Correct the definition of an action and appeal in the Member Handbook. Correct the definition of an appeal in policy MS.UM.07. Remove the sentence from policy MS.UM.07 that discusses an appeal as a form of Medicare organizational determination.
- Correct the timeframe for filing an appeal in the adverse determination letters and in the Member Handbook.
- Correct the timeframe for following an oral appeal request with a written request in policy MS.UM.08 and the Provider Manual.

- Correct the appeal acknowledgement letters to contain information on a member's right to submit comments, documents or other information relevant to the appeal and a member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.
- Correct the timeframe to request a State Fair Hearing in the Utilization Management Program Description and policy MS.UM.08.
- Develop processes to ensure that requests for expedited appeals are processed in compliance with DOM Contract requirements and to provide criteria used in the review when requested.
- Determine if policy MS.UM.16 is an active policy. If so, update it with current information. If not active, retire the policy.
- Update the delegation oversight tools to ensure they reflect the actual standards being evaluated and that those standards are the same requirements that Magnolia Health Plan is being held to as an organization.
- Implement a process to ensure that deficiencies identified during the EQR are addressed and corrected.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which may include validation of encounter data, administration and validation of member and provider surveys, calculation of additional performance measures, and conduct performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; comparative information from previous reviews; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

Introduction

On January 1, 2011, the Mississippi Division of Medicaid (DOM) established the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Mississippi Medicaid beneficiaries. The goals of the program are to improve access to needed medical services, improve quality of care, and improve program efficiencies and cost effectiveness. The Mississippi Division of Medicaid has contracted with Magnolia Health Plan to provide services to individuals enrolled in the MississippiCAN Program.

In June 2012, 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 Program. The purpose of this review was to determine the level of performance demonstrated by Magnolia Health Plan since the EQR was completed in 2012.

Goals of the review were:

1. To determine Magnolia Health Plan's compliance with service delivery as mandated in the contract with DOM.

2. To evaluate the status of deficiencies identified during the 2012 annual review and any ongoing corrective action taken to remedy those deficiencies.

3. To provide feedback on potential areas for further improvement.

The overriding goal of the annual EQR process is to ensure that contracted health care services are actually being delivered and are of good quality.

Process

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.
On February 3, 2014, CCME sent notification to Magnolia Health Plan (MHP) that the annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Magnolia Health Plan to ask questions regarding the EQR process and the desk materials being requested. The teleconference was held on February 14, 2014 with Magnolia Health Plan, CCME, and DOM in attendance.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia Health Plan on March 5, 2014 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs.

The second segment was an onsite review conducted on May 19th, 20th, and 21st at the Magnolia Health Plan office located in Jackson, Mississippi. The onsite visit focused on areas not covered in the desk review or areas needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Magnolia Health Plan's administration and staff; and a file review of denials, appeals, utilization approvals, case management, credentialing, recredentialing and grievances. At the conclusion of the onsite review, an exit conference was held to discuss preliminary evaluation results and address areas of concern. All interested parties were invited to the entrance and exit conferences.

Findings

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Magnolia Health Plan and DOM. Strengths and weaknesses are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), or the standard was not evaluated (Not Evaluated) and are recorded on the tabular spreadsheet. (*Attachment 4*)

I. ADMINISTRATION

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance, and confidentiality. Christopher Bowers is the Senior Vice President of Health Plan Operations and Dr. Jason Dees is the Plan President and Chief Executive Officer. Dr. Dees is responsible to the area board for the overall management and day-to-day administration of the Health Plan. Dr. Rebecca Waterer, Chief Medical Director, is responsible for providing medical leadership through direct medical/clinical oversight of the Utilization Management, Case Management, and Quality Improvement departments. The organizational chart showed a vacant medical director position. Onsite discussion confirmed that Magnolia is actively seeking to fill this position which will report to Dr. Waterer. Organizational charts and onsite discussion demonstrate sufficient staff is in place to meet the needs of Magnolia's members.

The 2013 Compliance and Ethics Program Description outlines the organization's strategic plan to prevent, detect, and correct incidents and practices that do not comply with the law; establishes ethical standards for employees; and delineates the manner in which ethical conduct will be promoted throughout the organization. The Compliance Officer, located in MS, is charged with the administration and management of the organization's compliance efforts. The Compliance Officer also chairs MHP's Compliance Committee which consists of a cross-functional team of individuals from within the organization, and other ad hoc members as needed, who have the authority to implement corrective actions. The Compliance Committee meets at least quarterly and on an ad hoc basis when needed. Employees are initially educated on the Compliance Program; identifying fraud, waste and abuse and mechanisms of reporting; the Code of Conduct; the Business Ethics and Conduct policy; and other compliance related policies, procedures, and standards in the new employee orientation. Employees receive additional compliance education on an annual basis.

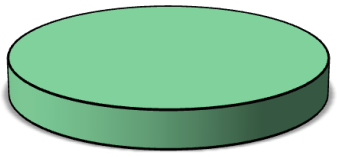
As part of the MS EQR activities, CCME performed an evaluation of the Information System Capabilities Assessment (ISCA) and other associated documentation provided by Magnolia. Based on the contents of the ISCA and the additional documentation submitted, we evaluated Magnolia's ability to handle and process claims appropriately and in a timely manner, meet the state guidelines for the delivery of health care services, collect health care data securely and accurately, and provide reports on those activities as required by DOM. Magnolia's systems function well for their intended purposes and appear to be capable of delivering the required performance.

Reviewing Magnolia's completeness and accuracy data for claims showed that they have established guidelines for claims processing and handling, and reviewing their performance data shows that they consistently perform above the targeted levels. Magnolia does extensive analyses of the demographics and enrollment of their members. They track their membership and compare it against their provider database to ensure that they are providing adequate coverage in a variety of medical specialties, and if not, that they have undertaken activities to enhance those ratios.

Magnolia has a solid disaster recovery program in place. They engaged a third party to provide assistance during a disaster, which is both cost-effective and logistically efficient. They test regularly and do an excellent job of laying out the test parameters. CCME's review found Magnolia's information systems capabilities to fully meet the ISCA specifications.

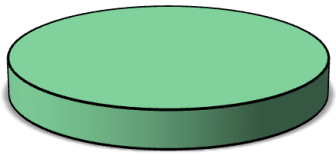
Magnolia Health Plan continues to meet all of the requirements in the Administration section of the EQR as shown in the chart below.

2012 RESULTS



Met – 100%

2013 RESULTS



Met – 100%

STRENGTHS

- Organizational charts and onsite discussion demonstrate sufficient staff is in place to meet the needs of Magnolia members.
- Magnolia has a solid disaster recovery program in place that is tested regularly and they do an excellent job of laying out the test parameters.

II. PROVIDER SERVICES

A review of all policies and procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines was conducted for Provider Services. Dr. Becky Waterer, Chief Medical Director is the chair of the Credentialing Committee. The chief Executive Officer, Dr. Dees, is a committee member along with four participating network physicians with specialties such as pediatrics and family medicine, and one nurse practitioner. The committee meets monthly (at least 10 times per year) and minutes received showed the committee met 10 times in 2013. A quorum is 50 percent of the voting members. A review of the Credentialing Committee minutes showed detailed documentation; however, two meetings (5/16/13 and 4/18/13) did not document Dr. Waterer's attendance. Because of this issue, it appeared that a quorum was not met for the 5/16/13 meeting.

Magnolia Health Plan has adopted the Centene Corporate Credentialing Program Description 2013 for credentialing and recredentialing of providers/practitioners. Additional policies address credentialing and recredentialing, and attachments to the policies include MS-specific requirements. In the previous EQR, recommendations were made to implement or update the policies/riders with MS-specific requirements, and to date, many of the recommendations were never implemented. A review of the credentialing and recredentaling files reflected some issues that had been addressed in the previous EQR. Details of the deficiencies are explained in the weaknesses section that follows and in *Attachment 4* of this report.

PROVIDER SATISFACTION SURVEY VALIDATION

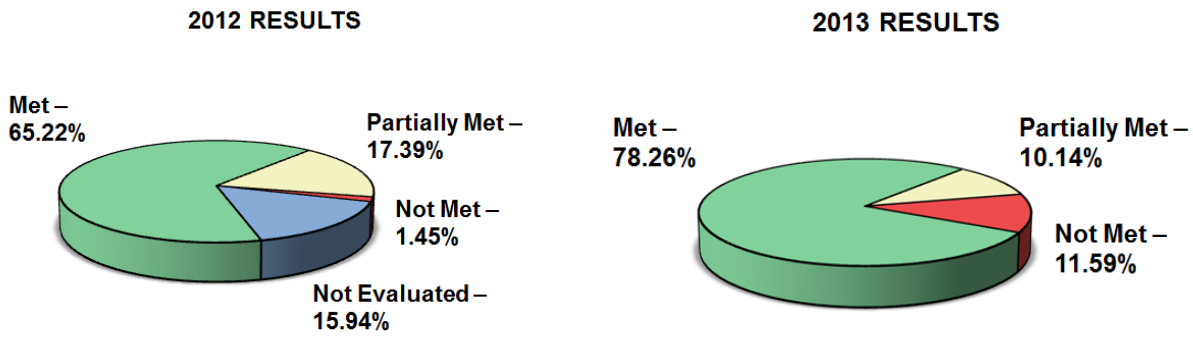
Magnolia Health Plan-Mississippi performed a provider satisfaction survey administered by The Myers Group (TMG), a survey vendor. As a part of this EQR, this survey was validated using the EQR Protocol 5, Validation and Implementation of Surveys (*version 2.0, September 2012*). The survey met the CMS protocol requirements and was found to be valid. In the table that follows we have identified areas that should be corrected to improve the survey documents and process.

Section	Reasoning	Recommendation
Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison)	Regression Analysis The regression analysis accounted for approximately 39% of the variation in ratings of overall satisfaction with the health plan. This is similar to what we find for other satisfaction surveys. CMS recommends that test/retest comparison be made to demonstrate reliability of the survey instrument. There was no documentation on test/retest comparison.	Conduct a test-retest comparison.
Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	A sample of 1,289 providers was pulled according to the stratification instructions given by Magnolia Health Plan. While the sampling size was reported, the sampling process was not documented.	Document the sampling process more clearly. Include whether the sampling process was simple random, stratified random, or non-probability.
Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error. Level of certainty required.	Sample size is 1289. While this is a large sample, the logic for the sample size, such as documenting the acceptable margin of error and the level of certainty required, was not included in the documentation.	Document the logic for the Sample size. Include acceptable margin of error and/or level of certainty required.
Review that the procedures used to select the sample were appropriate and protected against bias.	A random sample was used. No documentation of the representativeness of the sample was provided. While, sample characteristics were compared to characteristics of other provider satisfaction surveys conducted by the contractor, there was no comparisons with the characteristics of the population or the frame.	Compare sample recipient characteristics to frame characteristics.
Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails	A quality assurance plan was not clearly documented.	Clearly document a quality assurance plan.

Section	Reasoning	Recommendation
edits?		
Were confidentiality procedures followed?	Magnolia Health cannot attest to adherence of confidentiality procedures by The Myers Group. Only aggregated results were displayed that did not identify individuals so confidentiality is maintained in published results.	Clearly document a quality assurance plan that includes confidentiality procedures.
Identify the technical weaknesses of the survey and its documentation.	Quality assurance plan was not included in the documentation.	Clearly document a quality assurance plan.
Do the survey findings have any limitations or problems with generalization of the results?	A low response rate could bias the results. It appears that the completed questionnaire target was 200. This also could bias the results with responses from those easiest to contact.	Focus on strategies that promote high response rates. Consider providing survey feedback from previous surveys and how the plan addressed those concerns in the survey solicitation.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report.

The chart below shows 78.26 percent of the standards in the Provider Services section were scored as Met. In the previous review, some standards relating to recredentialing files were coded as Not Evaluated because Magnolia did not have recredentialing files. However, recredentialing files were reviewed for this EQR.



Percents may not total 100% due to rounding

TABLE 2: PROVIDER SERVICES

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
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	Not Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO	Partially Met	Not Met
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Not Met
	Malpractice claims history	Met	Partially Met
	Query for Medicare and/or Medicaid sanctions; Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)	Partially Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Partially Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Met	Partially Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Not Evaluated	Not Met
	Recredentialing every three years	Not Evaluated	Met
	Current valid license to practice in each state where the practitioner will treat enrollees	Not Evaluated	Partially Met
	Valid DEA certificate and/or CDS Certificate	Not Evaluated	Partially Met
	Board certification if claimed by the applicant	Not Evaluated	Met
	Malpractice claims since the previous credentialing event	Not Evaluated	Met
	Practitioner attestation statement	Not Evaluated	Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Credentialing and Recredentialing	Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM)	Not Evaluated	Met
	Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)	Not Evaluated	Met
	Query for Medicare and/or Medicaid sanctions; Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)	Not Evaluated	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	Not Evaluated	Partially 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	Partially 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	Partially Met	Not Met
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the enrollees assigned	Partially Met	Not Met
	The PCP to enrollee ratio does not exceed one (FTE) PCP per every 2500 enrollees	Partially Met	Met
	Enrollees have a PCP located within a 30-mile radius or travel no more than 30-minutes of their residence. For rural regions, Enrollees have a PCP located within a 60-mile radius or travel no more than 60-minutes of their residence	Met	Partially Met
	The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met
Provider Education	Provider and enrollee grievance and appeal procedures	Partially Met	Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Primary and Secondary Preventive Health Guidelines	The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO enrollees to providers	Partially Met	Met
Practitioner Medical Records	The CCO formulates policies and procedures outlining standards for acceptable documentation in the enrollee medical records maintained by primary care physicians	Partially Met	Met
	The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Not Met
	The CCO ensures that the enrollees' medical records or copies thereof are available within 14 business days from receipt of a request to change providers	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

PROVIDER ACCESS AND AVAILABILITY STUDY

As a part of the annual EQR process for Magnolia Health, a provider access study was performed focusing on primary care physicians in MS. A list of current list of providers was given to CCME by the plan, from which a population of 1541 unique PCPs was found. A sample of 315 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that Magnolia members have with the contracted providers.

Calls were successfully answered 57 percent of the time by personnel at the correct practice, which estimates to between 54 and 59 percent for the entire population. For those not answered successfully, 27 percent of the time (estimates to 25 to 30 percent for the entire population) the caller was informed that the physician was no longer at the number or practice.

Out of the successful calls, 84 percent (82, 87) of the providers indicated they specifically accept Magnolia. Of those, 88 percent (85, 90) of the providers responded they are accepting new Medicaid patients. When those providers were asked about any screening process for new patients, only 18 percent (14, 21) indicated that an application or prescreen was necessary. When the office was asked about the next available routine appointment, 92 percent (90, 94) of the appointment answers met within the plan's contract requirements.

STRENGTHS

- The provider website portal has extensive resource information including forms and applications, credentialing materials, practice guidelines, notification and training information, etc.

- GEO Access reports are run on a monthly basis, deficiencies are identified, and outreach is made via a recruitment plan to further the adequacy of Magnolia's provider base.

WEAKNESSES

- Policy CC.CRED.01, Credentialing Program Description had the following issues:
    - Page 9 states primary source verification may include oral verification, but proof of verification is required.
    - Page 10 states the application attestation is acceptable for malpractice insurance and this is also mentioned in Attachment B, but a copy of the face sheet is required.
    - Page 11 states an onsite visit will be performed within 60 days of receipt of a complaint related to a practitioner's office, but in MS the timeframe is 45 days.
    - Page 13 has a statement regarding Medicare Plans that should also apply to Medicaid.
    - Attachment B, page 22, mentions the EPLS but this list is now called SAM.
    - Attachment B states that the application attestation is acceptable for review of the Clinical Laboratory Improvement Amendments (CLIA) certificates/waivers, but a copy of the certificate/waiver or proof of website verification should be in the files for all providers that indicate they perform laboratory services. If the Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services and include that documentation in the file. This was an issue in the previous EQR.
    - The following are required and not addressed in the policy or Attachment B: site visits at initial credentialing and hospital arrangements for NPs acting as PCPs. Please note that under the new contract the plan must verify that NPs acting as PCPs have a formal, written collaborative/ consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.
- Policy CC.CRED.04, Initial Credentialing Process, states in section C that the application attestation is an acceptable source for proof of professional liability coverage; however, a copy of the face sheet is required. In addition, Attachment F needs to be updated to address MS-specific criteria.
- Policy CC.CRED.06, Practitioner Office Site Review, states that if applicable, the plan may conduct an initial visit to the office of all potential PCPs and OB/GYNs prior to making the credentialing decision. The addendum for this policy does not specify if site visits are performed at initial credentialing. This was an issue in the previous EQR and the CAP response indicated they would recommend adding provider office site visits at initial credentialing to policy CC.CRED.01 and policy CC.CRED.06. However, this information was never updated, and onsite discussion confirmed that provider site visits have not been performed.
- Policy CC.CRED.04.01, Practitioner's Right to Review and Correct Information, states a 30 day timeline for providers to respond to errors or differences in credentialing/ recredentialing information, but the Provider Manual (page 38) states the provider will have 14 calendar days to respond.
- The Credentialing Committee list and charter received in the desk materials showed the quorum as 50 percent of voting members; however, policy CC.CRED.02, Credentialing Committee, and the 2013 Credentialing Program Description say a minimum of three voting members must be present for a quorum. This was an issue in the previous EQR and draft policy MS.CRED.02 was presented to address the issue in the CAP review process. However, this policy was not received for the current review so the issue was never addressed.

- A review of the Credentialing Committee minutes showed detailed documentation; however, two meetings (5/16/13 and 4/18/13) did not document Dr. Waterer's attendance. Because of this issue, it appeared that a quorum was not met for the 5/16/13 meeting.
- Credentialing and recredentialing files reviewed onsite had the following issues:
    - Disclosure of ownership forms were not provided. This was an issue in the previous EQR. Onsite discussion confirmed MHP did not implement the process of collecting disclosure of ownership forms for MS.
    - Site assessments were not performed during the credentialing process for MS practitioners. This was an issue in the previous EQR.
    - One credentialing file did not have proof of the malpractice insurance coverage.
    - One credentialing file did not have proof of the CLIA certificate/waiver when the application indicated laboratory services are performed. Three recredentialing files did not have the CLIA section completed on the application and proof of verification was not in the files.
    - Two recredentialing files reviewed onsite did not have proof of valid license.
    - One recredentialing file did not contain proof of DEA verification even though it was listed as verified on the checklist.
- In the previous EQR, CCME identified an issue with Policy CC.CRED.10, Practitioner Disciplinary Action and Reporting. This policy references policy CC.UM.19, Continuity of Care: Termination of a Provider, which is no longer an active policy. According to onsite discussion, this policy was replaced with policy MS.MBRS.27, Member Advisory of Provider Termination. CCME received an updated policy during the previous EQR CAP, but we received the old policy for this EQR so the updated policy was never implemented.
- Policies MS.PRVR.09 and MS.ELIG.08 were identified in the previous EQR as incorrectly stating that PCPs will be mailed their PCP Panel/Patient List within 7 days of receiving the monthly enrollment file when the *DOM Contract, Sections 4.1* and *4.7* state 5 business days. The policies were corrected during the previous EQR CAP; however, policy MS.ELIG.08 received for this review still reflected the incorrect timeframe and was not reviewed in the last year. The policy shows a last review date of 11/26/12.
- The majority of the GEO Access reports received in the desk materials appeared to utilize the criteria of one PCP in 30 miles for urban/suburban and one in 60 miles for rural instead of the two PCP required guideline. In addition, the Practitioner Availability Analysis (July 1, 2012 to June 30, 2013) report reflected analysis measuring the one PCP guideline.
- Cenpatico policy CQI.103, Quality Improvement Evaluation of the Accessibility of Services, stated access standards that do not match the standards used in the appointment availability quarterly audits. The audits showed 48 hours for urgent and the policy showed 24 hours; the audit showed routine appointments not to exceed 3 weeks and the policy showed 10 business days (14 calendar days). In addition, the only behavioral health access standard mentioned in the Provider Manual is listed on page 15, "Behavioral Health within 7 days".
- Onsite discussion confirmed that MHP has not conducted audits to assess provider compliance with medical record documentation standards.
- Results of the Provider Access and Availability Study conducted by CCME continued to be low in the areas of calls being answered successfully by personnel at the correct practice (57%) and the reason for unsuccessful calls was because the physician was not at the practice or phone number listed (27%).
- For the provider survey, low response rates could bias results and the quality assurance plan was not included in the documentation.

III. ENROLLEE SERVICES

The review of Enrollee Services included all policies and procedures, enrollee rights, enrollee training and educational materials, and Magnolia Health Plan's (MHP's) processes for handling grievances, enrollee satisfaction and practitioner changes.

Magnolia does an excellent job of providing orientation and education to both new and established enrollees. The Member Handbook is well designed, detailed, and provides necessary information regarding benefits, services, and availability of the Member Services department and NurseLine staff. There were a few minor issues that need to be corrected in the Member Handbook, and these are detailed in the weaknesses section below. The members section of the MHP website is well-organized and information is easy to locate. An area of concern noted on the website, however, is that the list of symptoms documented as requiring only routine care includes symptoms that warrant an emergency visit, including such things as uncontrolled bleeding, suicidal thoughts, and difficulty breathing. The information on the website should be updated immediately.

Although there were a few issues noted in MHP's documentation of their grievance policies and other documents, onsite file review confirmed that grievances are being processed correctly and in a timely manner. The grievance log contains the required information, and grievances are tracked and analyzed for trends and potential opportunities for improvement.

ENROLLEE SATISFACTION SURVEY VALIDATION

An enrollee satisfaction survey was performed on behalf of Magnolia Health Plan by The Myers Group, an NCQA-certified vendor, using the CAHPS® 5.0H instrument. As a part of this EQR, the survey was validated using the CMS protocol for Administering or Validating Survey (*Final Protocol Version 2.0, September 2012*).

The survey met the CMS protocol requirements and was found to be valid. In the table that follows, we have identified areas that should be corrected to improve the survey documents and process.

Section	Reasoning	Recommendation
Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	Sample Size: Adult Survey: 1755 Child Survey: 5235 The acceptable margin of error and level of certainty were not clearly documented.	Include in the documentation the acceptable margin of error and the level of certainty required.
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	The overall response rate is 40.9% for the adult survey and 26.6% for the child survey. The response rate for the child survey is lower than the recommended target response rate of between 40% and 50%.	Increase the response rate for the child survey to between 40% and 50% as recommended by CMS.

Section	Reasoning	Recommendation
Identify the technical weaknesses of the survey and its documentation.	The statistical logic for the sample size is not well documented.	Include in the documentation the acceptable margin of error and the level of certainty required.
Do the survey findings have any limitations or problems with generalization of the results?	The response rate for the child survey is lower than CMS's recommendation of between 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample.	Focus on strategies that promote high response rates, such as including feedback based on previous surveys and documentation of the Plan's response to the feedback when sending surveys to recipients.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report.

The chart below shows 89.19 percent of the standards in the Enrollee Services section were scored as Met. The standards scored as Partially Met were related to enrollee education requirements, incorrect information on the MHP website, and errors in the Member Handbook and policies. Details are provided in the weaknesses section below.

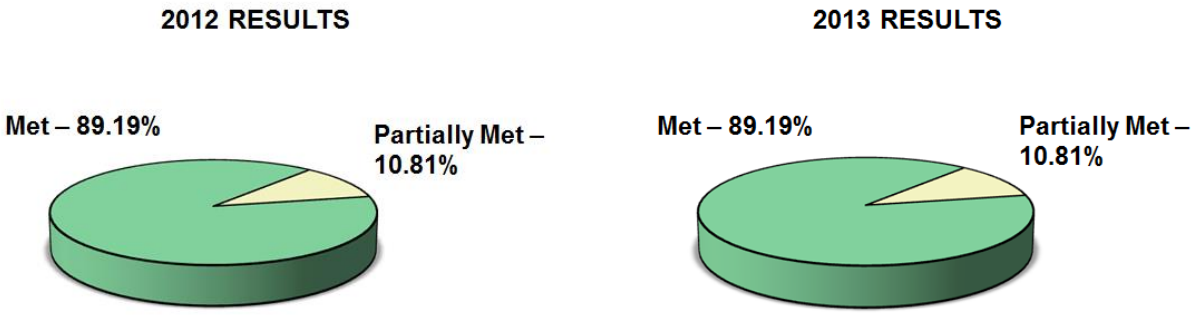


TABLE 3: ENROLLEE SERVICES

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Enrollee Rights and Responsibilities	All Enrollee rights included	Met	Partially Met
Grievances	The procedure for filing and handling a grievance	Met	Partially Met
	Notification to the enrollee of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated	Partially Met	Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Grievances	The CCO applies the grievance policy and procedure as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- The MemberConnections program provides valuable service to members by encouraging preventive health, and supports members by helping them locate and access providers and services in their communities. MemberConnections representatives engage members one-on-one in the setting most convenient for members, including the members' homes, and staff are also available to the members by phone.
- The Start Smart for Your Baby program provides support to members both during and after pregnancy. Staff provides education and support to pregnant members by phone and can arrange one-on-one visits with members. The program has a dedicated website on which a variety of educational materials can be accessed through the site's health library, and contains a link to the Magnolia Health Plan website.
- All complaints and grievances are logged, including Level II grievances which are counted as a separate grievance from the initial one. Grievances are categorized, monitored for trends, and are reported to the QIC and to DOM.

WEAKNESSES

- The following issues were noted in the Member Handbook:
  - There is no indication that enrollees may file complaints concerning noncompliance with advance directive requirements with the State Survey and Certification Division of the State Department of Health. This requirement can be found in the *DOM Contract, Section 5.11*.
  - The Member Handbook instructs members that when they are hospitalized, the member or someone acting on the member's behalf must call the member's PCP and MHP within 48 hours of the admission. Although MHP can request to be notified, members cannot be required to notify MHP of an admission.
  - The timeframe to file a grievance is not documented in the Member Handbook. The *DOM Contract, Section 7.2*, allows members to file a grievance within 30 calendar days of the date of the event causing the dissatisfaction.
  - The Member Handbook does not clearly explain the expedited appeals process, including the use of an extension of the determination timeframe. Requirements for expedited appeals may be found in the *DOM Contract, Section 7.4*.
  - The *DOM Contract, Section 4.6 (m) (iii)*, requires the Member Handbook to contain information on how to access the Member Handbook in an alternative format for special needs individuals including individuals with visual impairments. There is no notice in the handbook that alternate formats, such as braille or large font formats, are available.
  - The handbook indicates that grievances will be acknowledged within five days, but doesn't specify the timeframe is five business days.

- The *DOM Contract, Section 4.8*, requires that enrollees be informed within 14 calendar days following enrollment of their right to make decisions on organ donation. This information was not found in the Enrollee Handbook or in other new enrollee education/orientation materials.
- Discrepancies were noted in the lists of items included in the new member packet in policies MS.MBRS.01 and MS.MBRS.05.
- The MHP website information on "When to Use the ER" contains a list of symptoms for which routine care is appropriate; however, many symptoms in this list are emergency situations for which a visit to the ER is warranted, including but not limited to, difficulty breathing, chest pain, uncontrolled bleeding, difficulty speaking, mental status changes, coughing or vomiting blood, and suicidal thoughts. This list should be corrected immediately.
- Also, in the information on the website regarding emergencies, a hyperlink that is supposed to take members to a list of emergency warning signs published by the American College of Emergency Physicians (ACEP) takes members to the American College of Emergency Physicians home page, and not to a list of emergency symptoms. This link is not appropriate for members and should be updated to direct members to the information specified rather than to the ACEP home page.
- A discrepancy was noted regarding sending Provider Directories to new enrollees. Policy MS.MBRS.05, Orientation of New Enrollees, indicates on page one that new enrollees are provided with written information on provider qualifications, service locations, addresses, phone numbers, office hours and procedures for scheduling appointments. Policy MS.MBRS.01, New Member Packet/Member ID Card, contains a footnote that provider directories are not sent to new enrollees due to the requirement being waived by DOM. Onsite discussion confirmed that Provider Directories are not sent routinely because DOM waived the requirement, but that members can request one to be mailed. For consistency, policy MS.MBRS.05 should be updated with information that the requirement has been waived.
- Policy MS.MBRS.07, Member Grievance and Complaints Process, addresses MHP's processes for handling member grievances. The policy states on page five, item six, that Level II grievances deemed to be clinically urgent have resolution within "three 72 hours" of receipt. The chart on the same page, however, states clinically urgent Level II grievances are resolved within three business days of receipt.
- The low response rate for the child consumer satisfaction survey could bias results.

IV. QUALITY IMPROVEMENT

Magnolia Health Plan has a Quality Improvement (QI) program in place that actively involves the entire organization in the responsibility of improving the quality of care and services the health plan delivers to its providers and members. Some of these activities include measuring turnaround times for authorizations, trending appeal and grievances to identify any quality of care or service issues, and monitoring call center metrics. In 2013, Magnolia experienced changes in the senior leadership team that affected the QI program. The Vice President of Medical Management, responsible for the Quality Improvement department, was a vacant position that has now been filled. The Director of Quality Improvement was still listed as a vacant position on the organizational chart; however, the health plan indicated this position had recently been filled.

The program operates with three main documents: the Quality Improvement Program Description, Quality Improvement Program Evaluation, and a work plan. Each document is reviewed, revised, updated, and approved by the Quality Improvement Committee annually. It was noted in reviewing

these documents there were areas that needed to be revised or corrected. The committee structure discussed in the program description did not match the information listed in the work plan, committee charter, and/or the committee matrix received with the desk materials. There were many instances where the health plan's designated quorum for voting members of the committees was different in the program description and in the committee charters. Some committees were included in the program description and on the work plan but not included on the committee matrix. Magnolia's committee structure and charters should be reviewed and all documents that include information regarding the committees should be updated to reflect how Magnolia's committees are structured and operated.

Some of the sections of the 2013 program evaluation contained information describing the program but did not always include the results of the evaluation. The program evaluation should always include the health plan's evaluation or results of the effectiveness of the quality improvement activities from the previous year. The evaluation did identify that some of the Healthcare Effectiveness Data and Information Set (HEDIS®) measures were not meeting the goals set by the health plan. Barriers and interventions were identified to help improve their HEDIS scores.

CCME conducted a validation review of the performance measures and the performance improvement projects following the protocols developed by CMS. Magnolia uses an NCQA-certified HEDIS® software vendor for their performance measures. The plan was found to be fully compliant and met all the CMS validation requirements for the performance measures. The quality improvement projects included topics for asthma, congestive heart failure (CHF), diabetes, hypertension, and obesity. The results of the validation of these projects are summarized in the table below.

PERFORMANCE IMPROVEMENT PROJECTS

PROJECT	VALIDATION SCORE
Asthma	83 / 99 = 84% CONFIDENCE
Congestive Heart Failure	99/104 = 95% HIGH CONFIDENCE
Diabetes	107/124 = 86% CONFIDENCE
Hypertension	92/124 = 74% LOW CONFIDENCE
Obesity	112/124 = 90% HIGH CONFIDENCE

Two of the projects (obesity and CHF) scored within the *High Confidence* range. Two projects (asthma and diabetes) scored within the *Confidence* range, and the hypertension project received a score within the *Low Confidence* range. The results of the validation found that the projects failed to meet the CMS validation protocol. There were numerous errors found in the project documents regarding the measure indicators, source data, data analysis plan, the study question, measurement methodology, sample size, interventions, numerators, and denominators. Some of the interventions and population sampled for the hypertension project were interventions or included a population related to other chronic diseases such as diabetes and CHF. In the table that follows we have listed the specific errors by project and included our recommendations to correct the errors.

Asthma		
Section	**Reasoning**	**Recommendation**
Did the study use objective, clearly defined, measurable indicators?	Study used a HEDIS® measure for its indicator. However, there is documentation regarding the denominator of two different age groups (5-64 years and 18-75). The HEDIS documentation uses 5-64 years, so it is not clear what role the 18-75 years plays. Also, there is conflicting documentation regarding continuous enrollment: twelve months of continuous enrollment is referenced as well as two years. HEDIS documentation uses two years.	Clearly define the denominator population being used.
Did the study design clearly specify the sources of data?	Documentation refers to the hybrid method being used, but there is no evidence that it actually is being used.	Clearly document the data sources.
Was an analysis of the findings performed according to the data analysis plan?	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented.	Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.
Congestive Heart Failure		
Section	**Reasoning**	**Recommendation**
Was an analysis of the findings performed according to the data analysis plan?	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented.	Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.
Diabetes		
Section	**Reasoning**	**Recommendation**
Was/were the study question(s) stated clearly in writing?	While a study question is present in the documentation, it appears to not address the actual focus of the study. Where the study question is stated as investigating the quality and longevity of life of diabetes patients, the study appears to be measuring the use of screenings for diabetes patients but not the results of such screenings. It is unclear whether looking solely at screenings alone correlates with higher quality of life or longer life. This was also an issue in the previous EQR.	Revise study question to reflect the focus of the measurement.
Was an analysis of the findings performed according to the data analysis plan?	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented.	Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.
Was the same methodology as the baseline measurement used when measurement was repeated?	The plan switched to the hybrid methodology. The major purpose of the hybrid measure is to increase the accuracy of the reported rates, so it is not valid to compare with the administrative method for quality improvement. This change was noted in the documentation.	The baseline for this project should be reestablished as remeasurement 1 so that future measurements will be comparable.
Hypertension		
Section	**Reasoning**	**Recommendation**
Did the MCO/PIHP	The study used a HEDIS® measure for its indicator.	Clearly define the

clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	However, there is documentation regarding the denominator of different age groups (18-85 years, 18-75, and 18-84). The true age group is not known. Also, Attachment #1 (HEDIS documentation) pertains to diabetes care. Although there is a blood pressure measure included, it does not match the plan denominator documentation.	denominator population being used.
Did the sample contain a sufficient number of enrollees?	The numbers in the table regarding sample size and population pertain to HbA1c testing, not hypertension.	Clearly define the sample size and population being used for this project.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Some of the interventions listed are geared towards CHF and diabetes, not hypertension.	Be sure that implemented interventions will actually benefit this topic.
Was an analysis of the findings performed according to the data analysis plan?	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented. Diabetes and obesity are also mentioned in this section.	Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring. Clearly define the topic being studied.
Did the MCO/PIHP present numerical PIP/FS results and findings accurately and clearly?	On page A-17, the indicator is referenced as members who received a blood pressure screening, but the actual indicator is members with hypertension whose blood pressure is controlled.	Clearly document the indicator in all places it is referenced.
Was the same methodology as the baseline measurement used when measurement was repeated?	The plan switched to the hybrid methodology. The major purpose of the hybrid measure is to increase the accuracy of the reported rates, so it is not valid to compare with the administrative method for quality improvement. This change was noted in the documentation.	The baseline for this project should be reestablished as remeasurement 1 so that future measurements will be comparable.
Obesity		
Section	**Reasoning**	**Recommendation**
Did the study use objective, clearly defined, measurable indicators?	Child indicator is written as one measure – members who had BMI documentation, nutrition counseling, and counseling for physical activity. This is actually three (3) indicators assessed separately. Also, the denominator seems to be a rewording of the numerator when it should be members who had a visit.	Clearly define the indicators with appropriate numerators and denominators.
Was an analysis of the findings performed according to the data analysis plan?	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented.	Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.
Was the same methodology as the baseline measurement used when measurement was repeated?	The plan switched to the hybrid methodology. The major purpose of the hybrid measure is to increase the accuracy of the reported rates, so it is not valid to compare with the administrative method for quality improvement. This change was noted in the documentation.	The baseline for this project should be reestablished as remeasurement 1 so that future measurements will be comparable.

Complete details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3.*

The chart below shows that 80 percent of the scored standards for the Quality Improvement section of this EQR received a Met score. The Not Met score is related to the performance improvement project validation and the Partially Met scores are related to documentation inconsistencies and provider performance data. All of these issues are further discussed in the weaknesses section that follows.

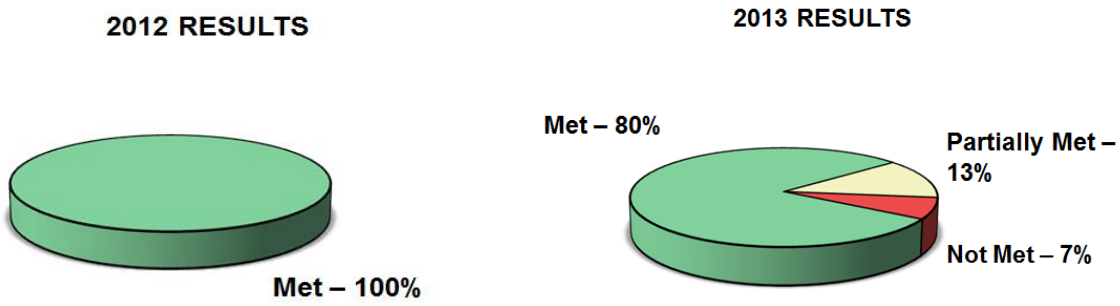


TABLE 4: QUALITY IMPROVEMENT

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The 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 enrollees	Met	Partially Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Not Met
Provider Participation in Quality Improvement Activities	Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- Topics selected for the performance improvement projects were pertinent to Magnolia's member population.
- The Quality Improvement Committee meets regularly and includes participating practitioners.
- The Plan was found to be fully compliant and met all the CMS validation requirements for their performance measures.

WEAKNESSES

- The 2014 Quality Improvement Program Description, 2013 Quality Improvement work plan, committee charters, and the committee matrix received in the desk materials contained inconsistent information regarding Magnolia's committee structure, what constitutes a quorum and the committees' membership.
- The performance improvement projects did not meet the CMS validation protocol. Some of the issues included:
    - Study documentation is not always consistent within the study, which confuses what the results mean and what the follow up should be.
    - Data analysis plan is not always followed.
- Policy MS QI. 23, Provider Profiling Program, discusses the process Magnolia follows for reporting Quality Improvement performance data to network providers. Sample copies of the provider profile reports were provided. During the previous EQR, this was discussed and the health plan stated their physicians would receive a profile report at least quarterly. However, the health plan has not implemented this process for providing their network providers with their performance data.
- Some of the sections of the 2013 Quality Improvement Program Evaluation contained a description of the program and did not always include the results of the evaluation.

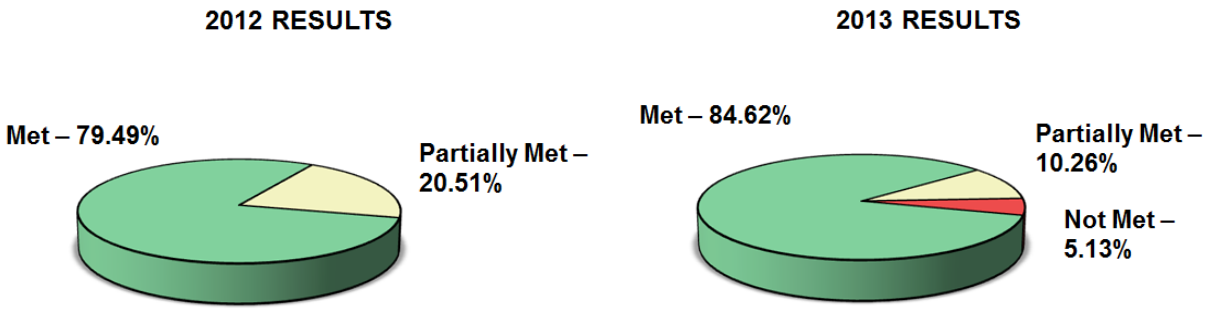
V. UTILIZATION MANAGEMENT

The Utilization Management review included a review of policies, the program description, and approval, denial, appeal, and case management files. The 2013 Utilization Management (UM) Program Description defines the program's objectives, scope, structure, and lines of responsibility and accountability. The program description is well written and detailed, but a few issues were noted, including an error in the quorum requirement for the UM Committee, an error in the timeframe for determinations of urgent, pre-service requests, and an error in the timeframe for requesting State Fair Hearings. These are detailed in the weaknesses section below.

Utilization Management approval, denial, and case management files reviewed during the onsite visit were very well documented, and demonstrated that both utilization and case management activities are handled as required. With an overall turn-around time average for 2013 of 2.25 days, MHP has significantly exceeded the timeliness requirement of 14 calendar days for pre-service requests.

Although the review of appeal files also demonstrated that, overall, appeals requests are handled according to requirements, a few issues were identified. Of three expedited appeal files reviewed, acknowledgement letters for two provided a resolution timeframe for standard appeals and contained no documentation that the requests for expedited appeals were denied. One of the three expedited appeal files had a 26-day resolution with no documentation that the request for an expedited appeal was denied. Also, one standard appeal file contained documentation that the member requested a copy of the criteria used in the determination, but no documentation that the criteria were provided to the member.

Magnolia achieved a Met score of 84.62 percent of the standards for UM, which represents an increase of 5.13 percent. The percentage of Partially Met scores decreased by 10.25 percent, but the standards scored as Not Met increased from 0 to 5.13 percent. Details of the scores of the Partially Met and Not Met standards can be found in the weaknesses section below.



Percents may not total 100% due to rounding

TABLE 5: UTILIZATION MANAGEMENT

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Utilization Management (UM) Program	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Not Met
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all enrollees across all reviewers	Partially Met	Met
Appeals	The definitions of an action and an appeal and who may file an appeal	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	Partially Met	Met
	A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay	Partially Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met
	Other requirements as specified in the contract	Partially Met	Not Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Case Management/Disease Management	The CCO utilizes case management techniques to insure comprehensive, coordinated care for all enrollees through the following minimum functions: Determination of the need for non-covered services and referral of Enrollees to the appropriate service setting, utilizing assistance as needed from the Division	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- Magnolia has a comprehensive Case Management program that encompasses prevention, care coordination, intensive care planning, and monitoring that serves members with medical and behavioral health needs. Case management files demonstrate excellent documentation of assessments, care planning, monitoring, and progress reports for the members enrolled in Case Management.
- The Medical Management staff consistently exceeds inter-rater reliability and auditing benchmarks.

WEAKNESSES

- A discrepancy was noted in documentation of the quorum for the UM Committee. The 2013 Quality Assessment and Performance Improvement Program Description and the committee matrix list the quorum as no less than 50 percent of voting members who are present by teleconference, fax, e-mail, or in person. The 2013 Utilization Management Program Description states the quorum requirement as a minimum of one voting member.
- Discrepancies were noted in the timeframe requirement for urgent, pre-service requests listed in these documents:
    - The UM Program Description, page 16, states the timeframe as within 24 hours of receipt of all necessary information, not to exceed 48 hours.
    - Policy MS.UM.05 and the Provider Manual document the timeframe as within two working days of receipt of all necessary information, not to exceed 72 hours.
- Additional issues noted in policy MS.UM.05 include:
    - Page three, item 2 (C) states that MHP may issue an administrative denial if all the necessary information is not provided within the timeframe. However, if some information is received a medical necessity determination should be done based on the information that has been submitted. During onsite discussion this was acknowledged as a mistake in the policy.
    - Page two, item 1 (C), discusses the 14-day extension period for the contractor but does not include information that enrollees and practitioners may also request an extension.
- The definitions of an action and an appeal can be found in *Federal Regulation § 438.400 (a) (3) (b)* and the *DOM Contract Section 7.3*. Issues identified with MHP's definitions of action and appeal include:

    - Policy MS.UM.07, Adverse Determinations (Denial) Notices, includes an incomplete definition of an appeal. It does not include "for a resident of a rural area with only one CCO, the denial of an enrollee's right to request to obtain services outside the network".
    - Also, the last sentence of the definition of an appeal in policy MS.UM.07 states "An adverse determination is a form of Medicare organizational determination as defined below." This sentence does not appear to apply to Medicaid and should be removed.
    - The Member Handbook definition of an action on page 52 is incomplete. It does not include the denial for a resident of a rural area with only one CCO to obtain services outside the network as part of the definition.
- The *DOM Contract, Section 7.3 (C)*, documents the timeframe for requesting an appeal as within 30 calendar days of receiving the notice of action letter. Errors were noted in the timeframe to file an appeal in the following:
    - The adverse determination letters in the denial files reviewed onsite documented the timeframe for requesting an appeal as within 30 days from the date of the letter.
    - The Member Handbook, page 52, states members may file an appeal within 30 days from the date of the adverse notice of action.
- Errors in the timeframe to follow an oral appeal request with a written request were noted in policy MS.UM.08, Appeal of UM Decisions, page one, and the Provider Manual, page 45. Both state that unless the appeal is expedited, an oral appeal shall be followed by a written request that is signed by the member within ten (10) calendar days. The *DOM Contract Section 7.3 (E)*, states that members must be allowed 30 calendar days to submit the written request after the oral request.
- Policy MS.UM.08, Appeal of UM Decisions, page four, lists information that will be included in the appeal acknowledgement letters. The following items on that list are not found in the appeal acknowledgement letter.
    - The member's right to submit comments, documents, or other information relevant to the appeal.
    - The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.
- *The DOM Contract, Section 7.5*, documents the timeframe to request a State Fair Hearing as within 30 days of receiving the notice of the action or within 30 days of the final decision by the Contractor. Errors were noted in the documentation of timeframes for requesting State Fair Hearings in the following:
    - The Utilization Management Program Description, page 18, indicates that members have the right to request a State Fair Hearing within thirty (30) calendar days from the Notice of Appeal Resolution.
    - Policy MS.UM.08, Appeal of UM Decisions, page three, states that State Fair Hearings must be requested "within 30 days of the denial notice."
- Review of appeals files onsite confirmed that most policies and procedures are being followed as formulated. However, the following issues were noted in the files reviewed:
    - Three of the 20 files reviewed were expedited appeal requests. The following were noted for the three files:
        - The acknowledgement letters for two of the three files gave the standard timeframe for resolution, and there was no documentation that the requests for expedited appeals were denied.
        - Two of the three files had determination and notification documented within the required timeframe for expedited appeals, but one of the files had a 26-day

resolution and notification timeframe. For this file, there was no documentation that the request for an expedited appeal was denied or that the member was notified of the denial of the expedited appeal request.

- One standard appeal file contained documentation that the member requested a copy of the criteria used in the determination. The file contained no documentation that the criteria were provided to the member.

- Policy MS. UM.16, Transition of Members to FFS or SSI, was submitted with the desk materials. It was noted that in the previous EQR, a recommendation was made to retire this policy as it is not applicable to members enrolled in MHP under the MississippiCAN program. Onsite discussion confirmed that staff were unsure if this is still an active policy or if it has been retired.

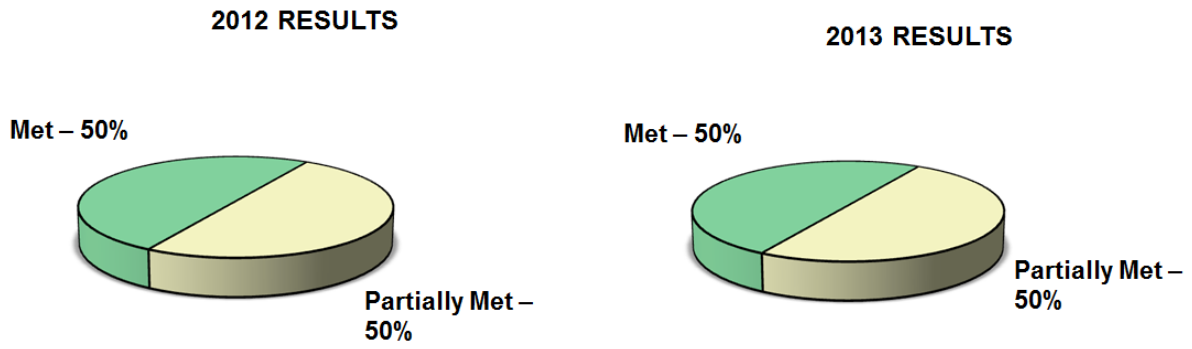
VI. DELEGATION

Magnolia Health Plan utilizes the following vendors and sister companies for ancillary services:

Univita: DME, Home Infusion, Home Health
Cenpatico: Behavioral Health
DentaQuest: Dental Services
National Imaging Associates (NIA): Radiology Services
Nurtur: Disease Management
Nursewise: 24 Hour Nurse Call Center
OptiCare: Vision Services
US Script: Pharmacy Benefit Management

Delegated credentialing has also been approved for the Hattiesburg Clinic, Health Choice, Mississippi Physicians Care Network, Rush Health Systems, St. Jude Children's Research Hospital, University Physicians_UMMC, VerifPoint/CreDENTALs Services, and CAQH Sanctions Track. Policy MS.QI.14, Oversight of Delegated Vendor Services, defines the procedures for the written delgation agreement, pre-delegation review, reporting and ongoing monitoring, annual evaluation, and deficiencies/ corrective action. Evidence of annual oversight was presented for the ancillary services and for the delegated credentialing entities. Issues were identified with the oversight tools and they are discussed in the weaknesses section below.

Of the two standards scored in the Delegation section, one standard continued to receive a Partially Met score as represented in the chart below.



WEAKNESSES

- A review of the oversight tools for ancillary services showed the following issues:
    - There was no annual oversight monitoring tool received for Univita.
    - The annual delegation oversight tools used for Cenpatico, NIA, US Script, and OptiCare list incorrect standards for timeframes for determination and notification of both standard and expedited, pre-service requests. The standards used on the tools appear to be NCQA standards, but don't reflect the Mississippi-specific requirements. It was noted that additional standards were added to the tools for other states, but none have been added to address the Mississippi requirements.
    - The annual delegation oversight tools used for Cenpatico, NIA, DentaQuest, and OptiCare list incorrect timeframes for members to file appeal requests and for appeal determinations. The standards listed on the tools appear to be NCQA standards, but don't reflect the Mississippi-specific requirements. It was noted that additional standards were added to the tools for other states, but none have been added to address the Mississippi requirements.
- Evidence of annual monitoring for credentialing/recredentialing delegation was received but a review of the tools showed NCQA requirements and no information specific to Mississippi requirements. The tools should include requirements for the following: proof of primary/secondary source verifications (i.e. license, DEA/CDS, board certification, if applicable, etc.) and proof of queries (NPDB, SAM, OIG, State Sanctions) must be in the file; site reviews for initial credentialing; site reviews for member complaints within 45 days; proof of malpractice insurance; signed attestation and current re-attestment if using CAQH; copy of CLIA certificate/waiver; hospital privileges should be addressed for nurse practitioners acting as PCPs; and delegates should be collecting ownership disclosure forms for credentialing and recredentialing.

VII. STATE-MANDATED

Magnolia Health Plan provides enrollees with all the benefits required in the DOM Contract, and has adequate processes in place for monitoring provider compliance with providing required immunizations and EPSDT services.

The standard in this section that was scored as Not Met is related to deficiencies from the previous EQR not being corrected. There were three deficiencies in utilization management standards that were not corrected, including errors in review determination and notification timeframes for urgent requests, required information not included in appeal acknowledgement letters, and errors in the timeframe to request a State Fair Hearing. Deficiencies not corrected in the area of credentialing are related to the collection of copies of CLIA Certificates/Waivers, conduction of office site visits for initial credentialing, the admitting plan for nurse practitioners who act as PCPs, collection of Disclosure of Ownership forms, the Credentialing Committee quorum, errors in policies, and the need for Mississippi-specific information in policies and/or attachments/addendums.

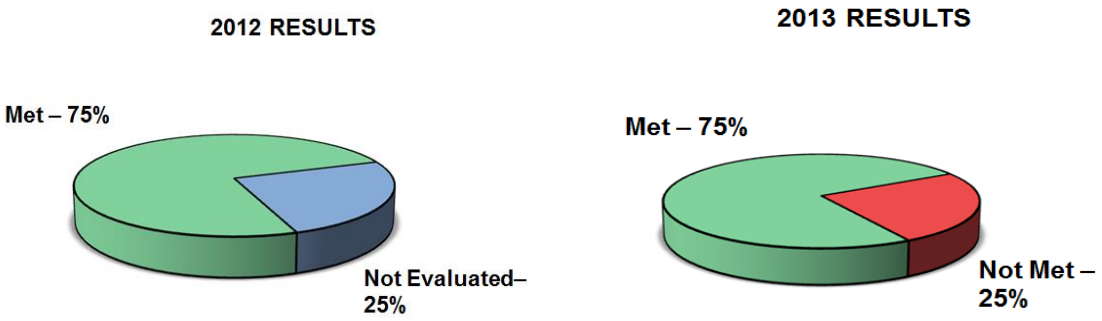


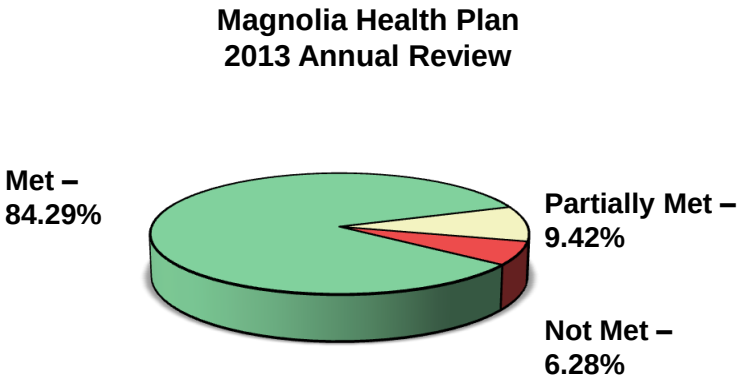
TABLE 6: STATE-MANDATED SERVICES

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
State-Mandated Services	The CCO addresses deficiencies identified in previous independent external quality reviews.	Not Evaluated	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

Summary and Recommendations

The findings of the 2013 EQR indicate that Magnolia Health Plan received Met scores for 84.29 percent of the standards. This is an increase of 4.19 percent in Met scores from the previous EQR. Some areas of concern were Magnolia's performance improvement projects did not pass the validation review and the corrective action plan that addressed the deficiencies identified during the previous EQR was not fully implemented. As a result, several standards received a Not Met score.



Percents may not total 100% due to rounding

CCME recommends that Magnolia Health Plan implement the following recommendations to improve their processes and comply with all Federal Regulations and DOM Contract requirements.

1. Address the issues identified in policies CC.CRED.01, CC.CRED.04, CC.CRED.06, and CC.CRED.04.01.

2. Update policy CC.CRED.02 to reflect the quorum of 50 percent of voting members for the Credentialing Committee, or implement policy MS.CRED.02 received during the CAP in the previous review.

3. Update policy CC.CRED.01, Credentialing Program Description, to reflect the 50 percent quorum for the Credentialing Committee.

4. Ensure that all voting members of the Credentialing Committee are accounted for on the committee meeting roster and that a quorum has been met for the meetings.

5. Proof of the following information should be included in the credentialing and recredentialing files:
    a. Disclosure of ownership forms
    b. Site assessments for initial credentialing of MS practitioners.
    c. Copy of the malpractice insurance coverage face sheet.
    d. Copy of Clinical Laboratory Improvement Amendments (CLIA) certificates/waivers or proof of verification for all providers that indicate they perform laboratory services. If the Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services and include that documentation in the file.
    e. A copy of the license or proof of the license verification.
    f. A copy of the Drug Enforcement Administration (DEA)/ Controlled Dangerous Substances (CDS) certificate or proof of the DEA/CDS verification.

6. Under the new contract that will be implemented in 2014, the plan must verify that NPs acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.

7. Update policy CC.CRED.10 to remove the incorrect policy reference.

8. Update policy MS.ELIG.08 to reflect the provider notification timeframe that complies with contract guidelines, and ensure the policy is reviewed annually.

9. Ensure that network analysis is measured utilizing the two PCP guideline as defined in the *DOM Contract, Section 5.4 (c).*

10. Review the Provider Manual, policies, and reporting criteria for behavioral health appointment access standards, and ensure they are consistent and comply with the standards in the *DOM Contract, Section 5.16*.

11. Medical record audits should be conducted to assess provider compliance with medical record documentation standards.

12. Implement interventions to address the low results of the CCME conducted Provider Access and Availability Study.

13. Implement interventions to increase the provider survey response rate and include the quality assurance plan in the documentation.

14. The following corrections are needed in the Member Handbook:
    a. Add information that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health.
    b. Correct the information on member hospitalizations to indicate that members are requested rather than required to notify MHP of an admission.
    c. Add the timeframe to file a grievance.
    d. Include a clear description of the expedited appeals process. This should include information that an extension of up to 14 calendar days may be requested by MHP or by the member and that if MHP requests the extension, the member will be notified in writing of the reason for the extension.
    e. Add information on how to access the Member Handbook in alternate formats, such as large font, braille, etc.
    f. Update the information on acknowledgement of written grievances to indicate that acknowledgement occurs within 5 working days.
    g. Add information about enrollees' right to make decisions regarding organ donation.

15. Update the lists of items included in the new member packet in policies MS.MBRS.01 and MS.MBRS.05 so that they are consistent.

16. Update the MHP website with:
    a. Correct information regarding symptoms that require routine versus emergency care.
    b. Update the link to the ACEP list of emergency symptoms.

17. Update policy MS.MBRS.05 with information that Provider Directories are not sent to new enrollees because DOM waived the requirement.

18. Correct the discrepancy in policy MS.MBRS.07 regarding the timeframe for clinically urgent Level II grievances.

19. Increase the response rate for the child survey by using strategies that promote high response rates, such as including feedback based on previous surveys and documentation of the Plan's response to the feedback when sending the survey to the recipients.

20. Update the Quality Improvement Program Description, work plan, committee charters, and the committee matrix to ensure all documents include all committees, each committee description, and that the quorums are consistent.

21. Correct the deficiencies identified in the Quality Improvement Project validation results.

22. Develop a plan to implement the process for providing network providers with a copy of their performance data.

23. Ensure that the Quality Improvement Program Evaluation includes the results of the health plan's evaluation or results of the effectiveness of the quality improvement activities from the previous year.

24. Correct the quorum requirement for the UM Committee to be consistent across all documents.

25. Correct the timeframe requirement for urgent, pre-service requests in policy MS.UM.05, the UM Program Description, and the Provider Manual.

26. Correct policy MS.UM.05 to indicate that if requested information is not received, a review will be performed on the information received and a determination will be issued. Include information in policy MS.UM.05 that enrollees and practitioners may also request an extension of review determination timeframes.

27. Correct the definition of an action and appeal in the Member Handbook. Correct the definition of an appeal in policy MS.UM.07. Remove the sentence from policy MS.UM.07 that discusses an appeal as a form of Medicare organizational determination.

28. Correct the timeframe for filing an appeal in the adverse determination letters and in the Member Handbook.

29. Correct the timeframe for following an oral appeal request with a written request in policy MS.UM.08 and the Provider Manual.

30. Correct the appeal acknowledgement letters to contain information on a member's right to submit comments, documents or other information relevant to the appeal and a member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.

31. Correct the timeframe to request a State Fair Hearing in the Utilization Management Program Description and policy MS.UM.08.

32. Develop processes to ensure that requests for expedited appeals are processed in compliance with DOM Contract requirements and to provide criteria used in the review when requested.

33. Determine if policy MS.UM.16 is an active policy. If so, update it with current information. If not active, retire the policy.

34. Update the delegation oversight tools to ensure they reflect the actual standards being evaluated and that those standards are the same requirements that Magnolia Health Plan is being held to as an organization.

35. Implement a process to ensure that deficiencies identified during the EQR are addressed and corrected.

Magnolia Health Plan

External Quality Review

Attachment 1

Initial Notice

The Carolinas Center *for* Medical Excellence
100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

February 3, 2014

Dr. Jason Dees
Plan President Magnolia Health Plan
Magnolia Health Plan
111 East Capitol Street, Suite 500
Jackson, MS 39201

Dear Dr. Dees:

This letter serves as your notification that the 2013 External Quality Review (EQR) Compliance review of Magnolia Health Plan is being initiated at this time at the request of the Mississippi Division of Medicaid (DOM). An external quality review conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with the DOM. It will include both a desk review at CCME and a multi-day onsite review at Magnolia Health Plan's office in Jackson, and will address all contractually required services. Please note that CCME's review methodology will include the protocols required by the Centers for Medicare and Medicaid Services for the external quality review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans.

In preparation for the desk review, the items on the enclosed list are due at CCME no later than **March 5, 2014**. The CCME EQR team plans to conduct the onsite visit at Magnolia Health Plan on **May 19, 2014 through May 21, 2014.** To prepare your organization for the upcoming review, we would like to schedule a conference call with your management staff, in conjunction with DOM, to describe our process and answer any questions you may have. Please contact me at 800-682-2650, ext. 5588 or 919-461-5588 with dates your staff will be available for this conference call.

Sincerely,

Karen Smith

Karen Smith
Project Manager

Enclosure

cc: DOM

Magnolia Health Plan

2013 External Quality Review

Attachment 1

Materials Requested for Desk Review

EXTERNAL QUALITY REVIEW 2013

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.
2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.
3. Current membership demographics including total enrollment, category of eligibility and distribution by age ranges, sex, and county of residence.
4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current enrollee-to-PCP ratios and enrollee-to-specialist ratios.
5. A complete list of network providers for the MississippiCAN enrollees. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.
6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.
7. A current provider list/directory as supplied to enrollees.
8. A copy of the current Compliance plan.
9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.
10. The Quality Improvement work plans for 2013 and 2014.
11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.
12. Documentation of all Performance Improvement Projects (PIPs) completed or planned as required by DOM, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc…).

    For any project using NON-HEDIS measures include the following items with your PIP documentation:
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plans IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 record sample from those abstracted charts.
    c. For projects measures derived from administrative electronic systems:

- full source code documentation of how the measure was processed and calculated for the PIP, and
- any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

13. Minutes of all committee meetings for the past twelve months for all committees reviewing or taking action on Health Plan related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.
14. Membership lists and a committee matrix for all committees in #13 above, including the professional specialty of any non-staff members. Please indicate which members are voting members.
15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.
16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.
17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.
18. A complete list of all enrollees enrolled in the case management program from January 1, 2013 – December 31, 2013. Please include open and closed case management files, the enrollee's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.
19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Enrollee Services Representatives and/or Call Center personnel.
20. A copy of the enrollee handbook and any statement of the enrollee bill of rights and responsibilities if not included in the handbook.
21. A report of findings from the most recent enrollee and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.
22. A copy of any enrollee and provider newsletters, educational materials and/or other mailings.
23. A copy of the Grievance, Complaint and Appeal logs for the months of January 1, 2013 – December 31, 2013.
24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.
25. Service appointment availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards.
26. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other CCO services and covered benefits is assessed.
27. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other CCO services and covered benefits is assessed.
28. A list of physicians currently available for utilization consultation/review and their specialty.
29. A copy of the provider handbook or manual.
30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the organization in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A description of the organization's data security policy with respect to email and PHI.
32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.
33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.
34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., enrollee ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);
    d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

These materials:

- **should be organized and submitted on a CD or thumb drive (any material not available electronically may be submitted hardcopy);**
- **should be submitted in the categories listed.**

The Carolinas Center *for* Medical Excellence

Magnolia Health Plan

2013 External Quality Review

Attachment 2

Materials Requested for Onsite Review

External Quality Review 2013

MATERIALS REQUESTED FOR ONSITE REVIEW

Items with an * should be provided as copies that can be retained by CCME. If possible, please provide these copies on a CD or flash drive.

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

2. Credentialing files (including signed Ownership Disclosure Forms) for:

    a. Ten PCP's; (include two NPs/PAs acting as PCPs)
    b. Two OB/GYNs;
    c. Two specialists;
    d. Two network hospitals; and
    e. One file for each additional type of facility in the network.

3. Recredentialing files (including signed Ownership Disclosure Forms), if applicable for:
    a. Ten PCP's; (include two NPs/PAs acting as PCPs)
    b. Two OB/GYNs;
    c. Two specialists;
    d. Two network hospitals; and
    e. One file for each additional type of facility in the network.

4. Grievance and Case Management files for enrollees on the attached list.

5. Documentation of any involuntary disenrollments for cause, including documentation of counseling provided and notices issued, if applicable.

6. Appeal files for enrollees on the attached list. Please include all information related to the initial denial.

7. All files for requests for State Fair Hearings.

8. Twenty medical necessity denial files from the months of January 2013 through December 2013. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.

9. Twenty five utilization approval files (acute care and behavioral health) from the months of January 2013 through December 2013, including any medical information and approval criteria used in the decision.

12. *A copy of the Advance Directive flyer that is included in the new member packet.

13. Copies of all complaint logs for 2013.

14. *Minutes for all Level II Grievance Review Committee meetings held in 2013.

15. *Policy/Procedure concerning benefit coverage for new technologies, new application of existing technologies or technologies for which no InterQual criteria exists.

16. *Copy of the Practitioner Site Evaluation Tool and the Facility Site Evaluation Tool mentioned as attachments to policy CC.CRED.06, Practitioner Office Site Review.

17. *List of entities (e.g. provider practices) where credentialing/recredentialing is delegated, if applicable.

18. *Proof of oversight monitoring and copies of the tools for entities where credentialing/recredentialing is delegated, if applicable.

19. *Copy of the most recent Mississippi Physician Quality Measurement Report.

20. *Evidence/outcome of the Ambulatory Medical Record Compliance Audits conducted in 2013.

The Carolinas Center *for* Medical Excellence

Magnolia Health Plan

2013 External Quality Review

Attachment 3

EQR Validation Worksheets

Attachment 3

EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Name of PIP/FS	**ASTHMA**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**NOT MET**	Study used a HEDIS® measure for its indicator. However, there is documentation regarding the denominator of two different age groups (5-64 years and 18-75). The HEDIS documentation uses 5-64 years, so it is not clear what role the 18-75 years plays. Also, there is conflicting documentation regarding continuous enrollment; twelve months of continuous enrollment is referenced as well as two years. HEDIS documentation uses two years. ***RECOMMENDATION*** *Clearly define the denominator population being used.*
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA/HEDIS software to calculate their HEDIS measures. The relevant population was captured.

STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Documentation refers to the hybrid method being used, but there is no evidence that it actually is. ***RECOMMENDATION*** *Clearly document the data sources.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was specified.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Collection was through HEDIS software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NOT MET**	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented. ***RECOMMENDATION*** *Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.*
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in the documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of successes and barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The denominator definition uses continuous enrollment. However, being a new plan, the baseline did not take this into account due to only having one year of data. This is noted in the documentation.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Not able to judge. Too early in the project cycle.

9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not able to judge. Too early in the project cycle.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not able to judge. Too early in the project cycle.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not able to judge. Too early in the project cycle.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	0
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	0
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	0	NA
Step 7		
7.1	10	10
Step 8		
8.1	5	0
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	83
Project Possible Score	99
Validation Findings	84%

CONFIDENCE

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

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Name of PIP/FS	**CONGESTIVE HEART FAILURE**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIP/FSs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used a HEDIS® measure for its indicator.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA/HEDIS software to calculate their HEDIS measures. The relevant population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was specified.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Collection was through HEDIS software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NOT MET**	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented. ***RECOMMENDATION*** *Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.*
8.2 Did the MCO/PIHP present numerical PIP/FS results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in the documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP/FS was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of successes and barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Not able to judge. Too early in the project cycle.

9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not able to judge. Too early in the project cycle.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	Not able to judge. Too early in the project cycle.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Not able to judge. Too early in the project cycle.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	0
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	99
Project Possible Score	104
Validation Findings	95%

HIGH CONFIDENCE

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

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Name of PIP/FS	**DIABETES**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIP/FSs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**NOT MET**	While a study question is present in the documentation, it appears to not address the actual focus of the study. Where the study question is stated as investigating the quality and longevity of life of diabetes patients, the study appears to be measuring the use of screenings for diabetes patients but not the results of such screenings. It is unclear whether looking solely at screenings alone would correlate with higher quality of life or longer life. This was also an issue last time this PIP was reviewed. **RECOMMENDATION** *Revise study question to reflect the focus of the measurement.*
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used HEDIS® measures for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.

STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS hybrid methodology
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NOT MET**	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented. ***RECOMMENDATION*** *Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.*
8.2 Did the MCO/PIHP present numerical PIP/FS results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in the documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP/FS was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**PARTIALLY MET**	The plan switched to the hybrid methodology. With the major purpose of the hybrid measure to increase the accuracy of the reported rates, it is not valid to compare with administrative method for quality improvement. This change was noted in the documentation. ***RECOMMENDATION*** *The baseline for this project should be reestablished as remeasurement 1 so that future measurements will be comparable.*
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to methodology change.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge due to methodology change.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to judge due to methodology change.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge due to methodology change.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	0
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	0
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	3
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	107
Project Possible Score	124
Validation Findings	86%

CONFIDENCE

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

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Name of PIP/FS	**HYPERTENSION**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIP/FSs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used HEDIS® measures for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**NOT MET**	Study used a HEDIS® measure for its indicator. However, there is documentation regarding the denominator of different age groups (18-85 years, 18-75, and 18-84). The true age group is not known. Also, Attachment #1 (HEDIS documentation) pertains to diabetes care. Although there is a BP measure included, it does not match the plan denominator documentation. ***RECOMMENDATION*** *Clearly define the denominator population being used.*
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid Methodology
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NOT MET**	The numbers in the table regarding sample size and population pertain to HbA1c testing, not hypertension. ***RECOMMENDATION*** *Clearly define the sample size and population being used for this project.*

STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**PARTIALLY MET**	Some of the interventions listed are geared towards CHF and diabetes, not hypertension. ***RECOMMENDATION*** *Be sure that implemented interventions will actually benefit this topic.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NOT MET**	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented. Diabetes and obesity are also mentioned in this section. ***RECOMMENDATION*** *Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring. Clearly define topic being studied.*
8.2 Did the MCO/PIHP present numerical PIP/FS results and findings accurately and clearly? **(10)**	**NOT MET**	On page A-17, the indicator is referenced as to members who received a blood pressure screening, but the actual indicator is members with hypertension whose BP is controlled. ***RECOMMENDATION*** *Clearly document the indicator in all places it is referenced.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP/FS was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**PARTIALLY MET**	The plan switched to the hybrid methodology. With the major purpose of the hybrid measure to increase the accuracy of the reported rates, it is not valid to compare with administrative method for quality improvement. This change was noted in the documentation. ***RECOMMENDATION*** *The baseline for this project should be reestablished as remeasurement 1 so that future measurements will be comparable.*
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to methodology change.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge due to methodology change.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to judge due to methodology change.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge due to methodology change.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	0
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	0
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	5
Step 8		
8.1	5	0
8.2	10	0
8.3	1	1
8.4	1	1
Step 9		
9.1	5	3
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	92
Project Possible Score	124
Validation Findings	74%

LOW CONFIDENCE

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

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Name of PIP/FS	**OBESITY**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIP/FSs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALLY MET**	Child indicator is written as one measure – members who had BMI documentation, nutrition counseling, and counseling for physical activity. This is actually three (3) indicators assessed separately. Also, the denominator seems to be a rewording of the numerator when it should be members who had a visit. ***RECOMMENDATION*** *Clearly define the indicators with appropriate numerators and denominators.*
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.

STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid Methodology
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NOT MET**	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented. ***RECOMMENDATION*** *Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.*
8.2 Did the MCO/PIHP present numerical PIP/FS results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in the documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP/FS was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**PARTIALLY MET**	The plan switched to the hybrid methodology. With the major purpose of the hybrid measure to increase the accuracy of the reported rates, it is not valid to compare with administrative method for quality improvement. This change was noted in the documentation. ***RECOMMENDATION*** *The baseline for this project should be reestablished as remeasurement 1 so that future measurements will be comparable.*
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to methodology change.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge due to methodology change.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to judge due to methodology change.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge due to methodology change.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

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

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	0
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	3
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	112
Project Possible Score	124
Validation Findings	90%

HIGH CONFIDENCE

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

EQR PM Validation Worksheets

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Name of PM	**HEDIS MEASURES**
Reporting Year	2013
Review Performed	3/2014

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2013

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight from Inovalon. Review requirements for documentation have been met.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight from Inovalon. Review requirements for documentation have been met.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight from Inovalon. Review requirements for documentation have been met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight from Inovalon. Review requirements for documentation have been met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight from Inovalon. Review requirements for documentation have been met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Not being done.
S2. Sampling	Sample treated all measures independently.	**NA**	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Not being done.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software Quality Spectrum Insight from Inovalon. Review requirements for documentation have been met.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	State does not require any additional reporting requirements.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	50
Measure Weight Score	50
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

EQR Survey Validation Worksheets

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Survey Validated	**CONSUMER SATISFACTION**
Validation Period	2013
Review Performed	03/2014

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	ANA_Magnolia_Consumer_SatisfactionSurveyQuestions_received from Magnolia.docx The purpose of the CAHPS survey is to ask consumers and patients to report and evaluate their experience with health care. The CAHPS survey gives a way to access and benchmark a Plan against others in the industry and in the U.S., both regionally and nationally.
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	ANA_Magnolia_Consumer_SatisfactionSurveyQuestions_received from Magnolia.docx The survey covers topics that are important to consumers and focuses on aspects of quality that consumers are best qualified to assess, such as communication skills of providers and ease of access to health care services. The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with health care. The survey aims to measure how well plans meet their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which could aid plans in increasing the quality of provided care.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	ANA_Magnolia_Consumer_SatisfactionSurveyQuestions_received from Magnolia.docx This survey drives further quality improvement activities and programs throughout all departments of the Plan.

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Used as existing survey. The Myers Group administered the Adult Medicaid version of the 2013 HEDIS/CAHPS Health Plan Survey on behalf of Magnolia Health Plan.
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Used as existing survey. HEDIS/CAHPS 5.0H HEALTH PLAN SURVEY

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.1	Review that the definition of the study population was clearly identified.	**MET**	ANA_Magnolia_Consumer_SatisfactionSurveyQuestions_received from Magnolia.docx ADULT: The sampled population met the following criteria: Adult Survey - All members 18 years or older as of December 31st of the reporting year; and Members currently enrolled in Magnolia Health Plan as of December 31st. The member may not have a gap more than one (1) month in coverage and must be enrolled for 5 of the last 6 months of the reporting year. CHILD: The sampled population met the following criteria: Child Survey - All members 17 years or younger as of December 31st of the reporting year and Members currently enrolled in Magnolia Health Plan as of December 31st. In Mississippi where enrollment is verified monthly, the member may not have a gap of more than one (1) month in coverage and must be enrolled for 5 of the last 6 months of the reporting year.
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	The specifications for the sample frame were clearly defined and appropriate.
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	The sampling strategy was appropriate.

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	ANA_Magnolia_Consumer_SatisfactionSurveyQuestions_received from Magnolia.docx Adult - The required sample size is 1,350 in accordance with NCQA protocol for Adult Medicaid plans. Magnolia's sample size was 1,755. Child - For the Medicaid Child Survey (MCS), The Myers Group surveyed 5,235 (2,475 General Population + 2,760 supplemental sample = 5,235) eligible child members. **The acceptable margin of error and the level of certainly were not clearly documented.** ***RECOMMENDATION*** *Include in the documentation the acceptable margin of error and the level of certainty required.*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Used a CAHPS certified vendor.

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	The calculation of the response rate was clear and appropriate.

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	414747,_Magnolia_Health_Plan,_2013_CAHPS_MAS_Report[1].pdf ADULT - Using a mixed (mail and phone) survey administration methodology, per NCQA protocol. The Myers Group collected 708 valid surveys from the eligible member population from January through May of 2013, yielding a response rate of 40.9%. 614748,_Magnolia_Health_Plan,_2013_CAHPS_MCS_CCC_Report[1].pdf CHILD - The Myers Group surveyed 5,235 (2,475 General Population + 2,760 supplemental sample) of eligible child members using a mixed (mail and phone) survey administration methodology, per NCQA protocol, yielding a total response rate of 26.6%. The response rate should be between 40% and 50%. The response rate for the child survey is below 40%. ***RECOMMENDATION*** *Increase response rate for the Child survey to between 40% and 50% as recommended by CMS.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The Myers Group is a CAHPS certified vendor.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	The Myers Group is a CAHPS certified vendor.
5.3	Were confidentiality procedures followed?	**MET**	The Myers Group is a CAHPS certified vendor.

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
6.1	Was the survey data analyzed?	**MET**	The survey data was analyzed.
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were used and applied correctly.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	All survey conclusions were supported by the data and analysis.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.1	Identify the technical strengths of the survey and its documentation.	The Myers Group is a CAHPS certified vendor. The sample was randomly drawn.
7.2	Identify the technical weaknesses of the survey and its documentation.	The statistical logic for the sample size is not well documented. ***RECOMMENDATION*** *Include in the documentation the acceptable margin of error and the level of certainty required.*
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The response rate for the child survey is lower than CMS's recommendation of between 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample. ***RECOMMENDATION*** *Focus on strategies that promote high response rates.* *One strategy would be to include feedback based on previous surveys and a discussion of the plan's response to the feedback, during the solicitation for completing the survey.*

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.4	What conclusions are drawn from the survey data?	414747,_Magnolia_Health_Plan,_2013_CAHPS_MAS_Report[1].pdf, pages 1-2,1-3 ADULT - In general the satisfaction ratings were on par with the 2012 survey and on par with the 2013 Myers Group benchmark, and the 2012 Medicaid Adult Public Report benchmark. 614748,_Magnolia_Health_Plan,_2013_CAHPS_MCS_CCC_Report[1].pdf page 1-3. CHILD - In general the satisfaction ratings were better when compared to 2012; however, in general satisfaction was less than the 2012 All Plans benchmark. Children with chronic conditions rated satisfaction on par with the general population. The driver analysis identified three opportunities to increase satisfaction: "How well Doctors communicate", "Customer Service", and "Getting Needed Care".
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	The original survey report addressed assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO.
7.6	Comparative information about all MCOs (as appropriate).	For both the adult and child survey, survey results were compared to Magnolia's performance in 2012 and the 2013 Myers Group benchmark, and for the adult survey, 2012 Medicaid Adult Public Report benchmark, and for the child survey 2012 Quality Compass ® All Plans benchmark.

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	**Magnolia Health Plan**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2013
Review Performed	03/2014

Review Instructions

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

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	916008_Magnolia_Health_Plan_2013_Provider_Satisfaction_FINAL_Report (2).pdf Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs.
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	916008_Magnolia_Health_Plan_2013_Provider_Satisfaction_FINAL_Report (2).pdf Based on the data collected, this report summarizes the results and assists in identifying plan strengths and opportunities.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Magnolia is the audience.

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	New-Provider-Sat-Research-and-Best-Practices.pdf Page 12. Based on findings from in-depth focus groups, additional interviews with physicians and office managers, pilot study results, and comprehensive analysis and testing.
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**PARTIALLY MET**	New-Provider-Sat-Research-and-Best-Practices.pdf Page 10. Reliability Analysis Cronbach's alpha is the most commonly used estimate of reliability of questions in a survey. Regression Analysis - The regression analysis accounted for approximately 39% of the variation in ratings of overall satisfaction with the health plan. This is similar to what we find for other satisfaction surveys. CMS recommends that test/retest comparison be made to demonstrate reliability of the survey instrument. There was no documentation on test/retest comparison. ***RECOMMENDATION*** *Conduct a test-retest comparison*.

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.1	Review that the definition of the study population was clearly identified.	**MET**	916008_Magnolia_Health_Plan_2013_Provider_Satisfaction_FINAL_Report (2).pdf Page 2-1 Centene provided The Myers Group with a database consisting of 142,099 providers. Magnolia Health Plan providers were eligible for inclusion in the sample based on plan code, specialty, and provider type criteria. The Myers Group cleaned the database by removing duplicate providers from the database according to the provider's National Provider ID. A sample of 1,289 providers was pulled according to the stratification instructions given by Magnolia Health Plan.
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	916008_Magnolia_Health_Plan_2013_Provider_Satisfaction_FINAL_Report (2).pdf Page 2-1 Centene provided The Myers Group with a database consisting of 142,099 providers. Magnolia Health Plan providers were eligible for inclusion in the sample based on plan code, specialty, and provider type criteria.
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	916008_Magnolia_Health_Plan_2013_Provider_Satisfaction_FINAL_Report (2).pdf Page 2-1 A sample of 1,289 providers was pulled according to the stratification instructions given by Magnolia Health Plan. While the sampling size was reported, the sampling process was not documented. ***RECOMMENDATION*** *Document the sampling process more clearly. Include whether the sampling process was simple random, stratified random, or non-probability.*

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**PARTIALLY MET**	Sample size is 1289. While this is a large sample, the logic for the sample size, such as documenting the acceptable margin of error and the level of certainty required, was not included in the documentation. ***RECOMMENDATION*** *Document the logic for the Sample size. Include acceptable margin of error and/or level of certainty required.*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**PARTIALLY MET**	A random sample was used. No documentation of the representativeness of the sample was provided. While, sample characteristics were compared to characteristics of other provider satisfaction surveys conducted by the contractor, there was no comparisons with the characteristics of the population or the frame. ***RECOMMENDATION*** *Compare sample recipient characteristics to frame characteristics.*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	916008_Magnolia_Health_Plan_2013_Provider_Satisfaction_FINAL_Report (2).pdf Page 2-2. To calculate the response rate, ineligible surveys are subtracted from the sample size: Response rate = Completed surveys / (Sample size – Ineligible surveys)

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	The mail response was very low, 7.2%. Most of the responses were from office managers (via telephone): response rate (27.5%). Magnolia included the following plan to maximize the response rate: Phone outreach to non-respondents, One incentive (drawing for an iPad) was offered, The possibility of non-financial provider incentives is being discussed for future surveys, and Provider Relations promoted the Provider Satisfaction Survey in provider communications.

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was not clearly documented. ***RECOMMENDATION*** *Clearly document a quality assurance plan.*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	The plan contracted with The Myers Group which is a CAPHS certified vendor.
5.3	Were confidentiality procedures followed?	**MET**	ANA_Magnolia_Provider_SatisfactionSurveyQuestions _received from Magnolia.docx Magnolia Health cannot attest to adherence of confidentiality procedures by The Myers Group. Only aggregated results were displayed that did not identify individuals so confidentiality is maintained in published results. ***RECOMMENDATION*** *Clearly document a quality assurance plan that includes confidentiality procedures.*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
6.1	Was the survey data analyzed?	**MET**	The survey data was analyzed
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical test were used.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	All conclusions were supported by data.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.1	Identify the technical strengths of the survey and its documentation.	The Myers Group is a CAHPS certified vendor.
7.2	Identify the technical weaknesses of the survey and its documentation.	A quality assurance plan was not included in the documentation. ***RECOMMENDATION*** *Clearly document a quality assurance plan.* .
7.3	Do the survey findings have any limitations or problems with generalization of the results?	A low response rate could bias the results. It appears that the completed questionnaire target was 200. This also could bias the results with responses from those easiest to contact. ***RECOMMENDATION*** *Focus on strategies that promote high response rates. Consider providing survey feedback from previous surveys and how the plan addressed those concerns in the survey solicitation.*
7.4	What conclusions are drawn from the survey data?	In general, providers were less satisfied than the vendors, The Myers Group, other customers. Notability satisfaction with the pharmacy and drug benefits was very low. The sources of concern were: the ease of using the formulary, the clarity of pharmaceutical management procedures, and the variety of drugs available in the formulary.
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	The original survey report addressed assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.6	Comparative information about all MCOs (as appropriate).	Provider satisfaction with Magnolia was compared to “All other Medicaid Plans”. Also Provider satisfaction was compared to The Myers Group book of business. Magnolia scored similar satisfaction to “All other Medicaid Plans”; but scored less satisfied when compared to The Myers Group book of business.

The Carolinas Center *for* Medical Excellence

Magnolia Health Plan

2013 External Quality Review

Attachment 4
Tabular Spreadsheet

CCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to enrollees, both directly and indirectly.	X					Magnolia Health Plan has developed a comprehensive set of policies which are written and organized in a consistent manner. Policies are reviewed annually, but policy MS.ELIG.08, PCP Notification, did not appear to meet the annual review standard. November 26, 2012 was the last review date listed on the policy. *Recommendation: Consider adding the policy last review date to your policy index to assist in annual oversight monitoring.*
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						Organizational charts demonstrate sufficient staff is in place to meet the needs of Magnolia members.
1.1 Full time Chief Executive Officer, and/or Chief Operations Officer located in Mississippi;	X					Christopher Bowers is the Senior Vice President of Health Plan Operations and Dr. Jason Dees is the Plan President and Chief Executive Officer. Dr. Dees is responsible to the area board for the overall management and day-to-day administration of the Health Plan.
1.2 Chief Financial Officer;	X					Trip Peeples is the Vice President, Finance.
1.3 Chief Information Officer;	X					Magnolia Health Plan has a local IT liaison to assist with any information systems issues. The Chief Information Officer is located in St. Louis in the Centene corporate office.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Information Systems personnel;	X					The Centene corporate office in St. Louis provides information systems support to Magnolia.
1.5 Claims Administrator;	X					
1.6 Provider Services Manager;	X					David Willard is the Vice President of Network Development and Contracting.
1.7 Enrollee Services Manager;	X					Lucretia Causey is the Director of Member and Provider Services.
1.8 Intake, investigation, resolution, and reporting of enrollee and provider complaints and grievances;	X					The Call Center receives enrollee and provider complaints and grievances and attempts to resolve the issues. Each issue that cannot be resolved during the initial phone call is routed to the appropriate department for investigation and resolution.
1.9 Utilization management functions;	X					Andrea Thomas is the Director of Utilization Management and she reports to Paula Whitfield, Vice President of Medical Management.
1.10 A designated health care practitioner, qualified by training and experience, to serve as Quality Management Director;	X					Leann Griffin was recently hired as the Director of Quality Improvement and she reports to Paula Whitfield, VP Medical Management.
1.11 Provider credentialing and education;	X					Provider credentialing is conducted through the Centene Corporate Credentialing department.
1.12 Enrollee service and education;	X					
1.13 Marketing and/or Public Relations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					The Chief Medical Director is Dr. Rebecca Waterer, a board certified Internist. Dr. Waterer is responsible for providing medical leadership through direct medical/clinical oversight of the Utilization Management, Case Management, and Quality Improvement departments. The organizational chart showed a vacant medical director position. Onsite discussion confirmed that Magnolia is actively seeking to fill this position which will report to Dr. Waterer.
1.15 A designated compliance officer and a compliance committee that are accountable to senior management and that have effective lines of communication with all the CCO's employees.	X					Terrica Miller is the Compliance Officer in charge of the administration and management of the organization's compliance efforts. Ms. Miller chairs the Compliance Committee which meets at least quarterly. The Compliance Committee reports all actions to Centene's Compliance Officer.
1.16 Medical records system supervisor/director	X					
2. Operational relationships of CCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions.	X					
4. A professionally staffed all service/HelpLine/Nurse Line which operates 24 hours per day, 7 days per week.	X					The NurseWise toll free number is available to members 24/7 for healthcare assistance and advice.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Reviewing Magnolia's completeness and accuracy data for claims showed that they have established guidelines for claims processing and handling, and reviewing their performance data shows that they consistently perform above the targeted levels. Additionally, where there have been issues with the completeness or accuracy showing even a slight dip, Magnolia takes the initiative to dig into the problem and uncover the cause. In short, they expect

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						their systems and processes to function at peak levels at all times, so any deviation from those expectations warrants examination. This is a best practice and should be continued.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia does extensive analysis of the demographics and enrollment of their members. They track their membership and compare it against their provider database to ensure that they are providing adequate coverage in a variety of medical specialties and if not, that they have undertaken activities to enhance those ratios.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Magnolia has a solid disaster recovery program in place. They engaged a third party to provide assistance during a disaster, which is both cost-effective and logistically efficient. They test regularly and do an excellent job of laying out the test parameters (e.g., what is in scope and what is not). The test exercise itself was audited/observed/monitored by a member of the internal audit team, which is a commendable procedure. They appear to have done a reasonable test (short of a full disaster, but useful nonetheless) and found their systems to be restorable and recoverable.
I D. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					The Magnolia Health Plan Compliance and Ethics Program Description for 2013 was received in the desk materials along with other policies that address use and disclosure of PHI. Employees are initially educated on standards of conduct and confidentiality policies in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						new employee orientation and receive additional education on an annual basis.
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.			X			Magnolia Health Plan has adopted the Centene Corporate Credentialing Program Description 2013 for credentialing and recredentialing of providers/practitioners. Additional policies address credentialing/recredentialing. Attachments to the policies state MS specific requirements. The following issues were identified: •Policy CC.CRED.01, Credentialing Program Description had the following issues: -Page 9, states Primary source verification may include oral, but proof of verification is required. -Page 10 states the application attestation is acceptable for malpractice insurance and this is also mentioned in Attachment B, but a copy of the face sheet is required. -Page 11 states an onsite visit will be performed within 60 days of receipt of a complaint related to a practitioner's office but in MS the timeframe is 45 days. -Page 13 has a statement regarding Medicare Plans that should also apply to Medicaid. -Attachment B, page 22, mentions the EPLS but this list is now called SAM. -Attachment B, states that the application attestation is acceptable for review of the Clinical Laboratory Improvement Amendments (CLIA) certificates/waivers but a copy of the certificate/waiver or proof of website verification should be in the files for all providers that indicate they perform laboratory services. If the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services and include that documentation in the file. This was an issue in the previous EQR. -The following are required and not addressed in the policy or Attachment B: site visits at initial credentialing and hospital arrangements for NPs acting as PCPs. Please note that under the new contract the plan must verify that NPs acting as PCPs have a formal, written collaborative/ consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. •Policy CC.CRED.04, Initial Credentialing Process states in section C that the application attestation is an acceptable source for proof of professional liability coverage; however, a copy of the face sheet is required. In addition, Attachment F needs to be updated to address MS specific criteria. •Policy CC.CRED.06, Practitioner Office Site Review, states that if applicable, the plan may conduct an initial visit to the office of all potential PCP and OB/GYNs prior to making the credentialing decision. The addendum for this policy does not specify if site visits are performed at initial credentialing. This was an issue in the previous EQR and the CAP response said they would recommend to add provider office site visits at initial credentialing to policy CC.CRED.01 and policy CC.CRED.06. However, this information was never updated and onsite discussion confirmed that provider site visits have not been performed. •Policy CC.CRED.04.01, Practitioner's Right to Review and Correct Information, states a 30 day timeline for providers to respond to errors or differences in credentialing/recredentialing information but the Provider Manual (page 38) states the provider will have 14 calendar days to respond.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Address the issues identified in policies CC.CRED.01, CC.CRED.04, CC.CRED.06, and CC.CRED.04.01.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.			X			Dr. Becky Waterer, Chief Medical Director is the chair of the Credentialing Committee. The chief Executive Officer, Dr. Dees is a committee member along with four participating network physicians with specialties such as pediatrics and family medicine, and one nurse practitioner. The committee meets monthly (at least 10 times per year) and minutes received showed the committee met 10 times in 2013. Quarterly credentialing reports are presented to the Quality Improvement Committee. The Credentialing Committee list and charter received in the desk materials showed the quorum is 50 percent of voting members; however, policy CC.CRED.02, Credentialing Committee, and the 2013 Credentialing Program Description say a minimum of three voting members must be present for a quorum. <u>This was an issue in the previous EQR</u> and draft policy MS.CRED.02 was presented to address the issue in the CAP review process. However, this policy was not received for the current review so the issue was never addressed. A review of the Credentialing Committee minutes showed detailed documentation; however, two meetings (5/16/13 and 4/18/13) did not document Dr. Waterer's attendance. Because of this issue, it appeared that a quorum was not met for the 5/16/13 meeting. *Corrective Action: Update policy CC.CRED.02 to reflect the quorum of 50 percent of voting members for the Credentialing Committee or implement policy MS.CRED.02 received during the CAP in the previous review. Update policy CC.CRED.01, Credentialing*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Description to reflect the 50 percent quorum for the Credentialing Committee. Also, ensure that all voting members of the Credentialing Committee are accounted for on the committee meeting roster and that a quorum has been met for the meetings.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.			X			Disclosure of ownership forms were not found in the credentialing files. Onsite discussion confirmed MHP did not implement the process of collecting disclosure of ownership forms for MS. *Corrective Action: Disclosure of ownership forms should be collected at credentialing.*
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;		X				One credentialing file reviewed onsite did not have proof of the malpractice insurance coverage in the file. All the other files did contain proof of the coverage. *Corrective Action: Proof of malpractice insurance coverage should be in all the credentialing files.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					All the credentialing files reviewed onsite contained a copy of the signed attestation and the appropriate updated electronic re-attestments were present in the CAQH files.
3.1.7 Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM);	X					
3.1.8 Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)	X					
3.1.9 Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE);	X					
3.1.10 In good standing at the hospital designated by the provider as the primary admitting facility.	X					
3.1.11 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.		X				All of the credentialing files reviewed onsite except one, had proof of the CLIA certificate/waiver, if indicated on the application. This one file indicated yes to laboratory services but proof of the CLIA was not in the file and it was not indicated as verified on the VerifPoint Magnolia Credentialing Report. *Corrective Action: All credentialing files should have proof of the CLIA certificate/waiver if the provider indicates they perform laboratory services.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Site assessments were not performed during the credentialing process for MS practitioners. This was an issue in the previous EQR. *Corrective Action: Site assessments should be performed for initial credentialing of MS practitioners. This was an issue in the previous EQR.*
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.			X			Disclosure of ownership forms were not found in the recredentialing files. This was an issue in the previous EQR. One NP recredentialing file reviewed indicated they use a hospitalist for admitting patients which is currently acceptable for NPs but under the new contract the plan must verify that NPs acting as PCPs have a formal, written collaborative/ consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. *Corrective Action: Disclosure of ownership forms should be collected at recredentialing. This was an issue in the previous EQR.* *Also, under the new contract that will be implemented in 2014, the plan must verify that NPs acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.*
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat enrollees;		X				Two recredentialing files reviewed onsite did not have proof of valid license. *Corrective Action: A copy of the license or proof of the license verification should be in each recredentialing file.*
4.2.2 Valid DEA certificate and/or CDS Certificate;		X				One recredentialing file did not contain proof of DEA verification even though it was listed as verified on the checklist. *Corrective Action: Proof of DEA/CDS verification should be in the recredentialing files.*
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM);	X					
4.2.7 Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)	X					
4.2.8 Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE);	X					
4.2.9 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.		X				Four of the recredentialing files reviewed onsite did not have the laboratory section of the application filled out. The CLIA was verified for one of them but proof of verification was not in the files for the remaining three.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Ensure that CLIA verification is performed for providers that do not indicate if they perform laboratory services on the application.
4.3 Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space if the health plan established complaint/grievance threshold has been met.	X					Policy CC.CRED.06, Practitioner Office Site Review, defines the process for monitoring deficiencies regarding member complaints related to physical accessibility, physical appearance, adequacy of exam room and waiting room space, and adequacy of medical/treatment record keeping. The policy states that Magnolia must complete site visits within 45 calendar days of receipt of notification that the threshold for member complaint/grievances related to the quality of practitioner's office site have been met. This is also mentioned in the Provider Manual.
4.4 Review of practitioner profiling activities.	X					Policy MS.QI.23, Provider Profiling Program, defines the profiling activities. A sample report from the Georgia plan was received in the desk materials. Onsite discussion confirmed that MHP has been working on profiling reports and CCME received a Magnolia provider specific report at the onsite. The reports will be sent out in the near future and providers also have access to see live care gaps in real time for their enrollees via the web-based provider portal.
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.			X			In the previous EQR, CCME identified an issue with Policy CC.CRED.10, Practitioner Disciplinary Action and Reporting, which defines the procedures for disciplinary action which could include suspension, restriction, or termination of a practitioner's network participation. This policy references policy CC.UM.19, Continuity of Care: Termination of a Provider, which is no longer an active policy. According to onsite discussion, this policy was replaced with policy MS.MBRS.27, Member Advisory of Provider Termination. CCME received an updated policy during

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the previous EQR CAP, but we received the old policy for this EQR so the updated policy was never implemented. *Corrective Action: Update policy CC.CRED.10 to remove the incorrect policy reference. This issue was addressed in the previous EQR.*
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					The credentialing and recredentialing process for Organizational Providers is defined in policy CC.CRED 11, Organizational Providers.
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the enrollees assigned.			X			Policies MS.PRVR.09 and MS.ELIG.08 were identified in the previous EQR as incorrectly stating that PCPs will be mailed their PCP Panel/Patient List within 7 days of receiving the monthly enrollment file when the *DOM Contract, Sections 4.1* and *4.7* state 5 business days. The policies were corrected during the previous EQR CAP; however, policy MS.ELIG.08 received for this review still reflected the incorrect timeframe and was not reviewed in the last year. The policy shows a last review date of 11/26/12. *Update policy MS.ELIG.08 to reflect the provider notification timeframe that complies with contract guidelines and ensure the policy is reviewed annually. This was an issue in the previous EQR.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MS.PRVR.09, Verification of Member Eligibility, defines this process. All providers may contact the toll-free telephone number on the member's card to verify eligibility.
1.3 The PCP to enrollee ratio does not exceed one (FTE) PCP per every 2500 enrollees.	X					Policy MS.QI.04, Evaluation of Practitioner Availability, states that all PCP types combined reflect the standards of 2 per 2500. Pediatricians are measured 1 per 2500 under the age of 18 and Internists are measured 1 per 2500 for over the age of 18. Network evaluation information received in the desk materials for 2014 showed the current enrollee to PCP ratio is 1:42. Specialists are measured as 1 per 5000 and the current ratio is 1:16.
1.4 Enrollees have a PCP located within a 30-mile radius or travel no more than 30-minutes of their residence. For rural regions, Enrollees have a PCP located within a 60-mile radius or travel no more than 60-minutes of their residence.		X				Policies MS.CONT.01, Provider Network, and policy MS.QI.04, Evaluation of Practitioner Availability, both define the geographic definitions that comply with contract requirements. However, the majority of the GEO Access reports received in the desk materials appeared to utilize a criteria of one PCP in 30 miles for urban/suburban and one in 60 miles for rural instead of the two PCP required guideline. In addition, the Practitioner Availability Analysis (July 1, 2012 to June 30, 2013) report reflected analysis measuring the one PCP guideline. *Corrective Action: Ensure that network analysis is measured utilizing the two PCP guideline as defined in the DOM Contract, Section 5.4 (c).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The Member Handbook states if there is not a network provider that can treat the member's medical condition, Magnolia will help find an out-of-network provider. GEO Access reports are used to analyze the availability of specialty care practitioners.
1.6 The sufficiency of the provider network in meeting enrolleeship demand is formally assessed at least biennially.	X					The network is formally assessed on an annual basis.
1.7 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Cultural Competency is addressed in policy MS.QI.22. The Cultural Competency Plan attached to the policy defines the goals and objectives for ensuring cultural competency, as well as education and training for plan staff and providers. Policy MS.MBRS.03, Hearing-Impaired/Language-Specific Interpreter Services, defines the availability for free access to interpreter services for enrollees.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting enrolleeship demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MS.QI.05, Evaluation of the Accessibility of Services, defines the appointment access standards that comply with contract guidelines. The policy states at least annually, the plan analyzes appointment accessibility including routine, urgent and after-hours care against the standards it has defined. The Practitioner and Telephone Access Analysis July, 2012-June 2013 was received in the desk materials. The report showed that 744 providers were called for the After-Hours survey and 65% (486) of the physicians scored below standards in having adequate after-hours service. Onsite

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussion confirmed that provider education is being targeted to address the issue with corrective action for consistent noncompliance. Cenpatico policy CQI.103, Quality Improvement Evaluation of the Accessibility of Services, was received at the onsite to show behavioral health appointment standards are addressed in a policy. However, the access standards listed in this policy do not match the standards used in the appointment availability quarterly audits. The audits showed 48 hours for urgent and the policy showed 24 hours; the audit showed routine appointments not to exceed 3 weeks and the policy showed 10 business days (14 calendar days). In addition, the only behavioral health access standard mentioned in the Provider Manual is listed on page 15, "Behavioral Health within 7 days". *Corrective action: Review the Provider Manual, policies, and reporting criteria for behavioral health appointment access standards and ensure they are consistent and comply with the standards in the DOM Contract, Section 5.16.*
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Provider orientations are scheduled within 30 days of execution of a new provider contract per policy CC.PRVR.13, Provider Orientations. Provider Relations Specialists conduct regularly scheduled face-to-face visits per policy MS.PRVR.14, Provider Visit Schedule. The Provider Manual and MHP website provider portal contains detailed educational information.
2. Initial provider education includes:						
2.1 CCO health care program goals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					
2.3 Enrollee benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and enrollee grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of an enrollee to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its enrollees that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, establishes the process by which Magnolia adopts/develops and distributes preventive health and clinical practice guidelines. Guidelines are presented to the QIC for appropriate physician review and adoption. The guidelines are reviewed at a minimum every two years or upon significant new scientific evidence or change in national standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO enrollees to providers.	X					The preventive guidelines are posted on the MHP website and listed in the Provider Manual.
3. The preventive health guidelines include, at a minimum, the following if relevant to enrollee demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to enrollee high-risk groups.	X					
4. The CCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, defines the guidelines for monitoring practitioner compliance.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, establishes the process by which Magnolia adopts/develops and distributes preventive health and clinical practice guidelines. Guidelines are presented to the QIC for appropriate physician review and adoption. The guidelines are reviewed at a minimum every two years or upon significant new scientific evidence or change in national standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO enrollees to providers.	X					The adopted clinical practice guidelines are posted on the website and listed in the Provider Manual.
3. The CCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					The 2013 QI Program Evaluation states that Magnolia measured practitioner compliance for two chronic conditions Asthma and Diabetes. HEDIS measures were utilized to monitor practitioner compliance with the adopted clinical practice guidelines.
II F. Continuity of Care						
1. The CCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy MS.QI.09, Continuity & Coordination of Medical Care, defines this standard.
II G. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the enrollee medical records maintained by primary care physicians.	X					Policy MS.QI.13, Medical Record Review, defines minimum standards for practitioner medical record keeping practices which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information and are outlined in the Provider Manual. The policy states the plan will assess network medical record keeping practices against the established standards at least annually. Physicians sampled must meet 80% of the requirements for medical record keeping or be subject to corrective action.
2. Medical Record Audit						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.			X			The Provider Manual states that Magnolia will conduct random medical record audits as part of its QI program to monitor compliance with the medical record documentation standards. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Onsite discussion confirmed that MHP has not conducted audits to assess provider's compliance with medical record documentation standards. *Corrective Action: Medical record audits should be conducted to assess provider's compliance with medical record documentation standards.*
3. The CCO ensures that the enrollees' medical records or copies thereof are available within 14 business days from receipt of a request to change providers.	X					
III. ENROLLEE SERVICES						
III A. Enrollee Rights and Responsibilities						
1. The CCO formulates policies outlining enrollee rights and responsibilities and procedures for informing enrollees of these rights and responsibilities.	X					Policy MS.MBRS.25, Member Rights and Responsibilities, details Enrollee Rights and Responsibilities information and indicates that enrollees are informed of their rights and responsibilities in the new member packet and in the Member Handbook upon enrollment, yearly, and when changes occur. Member rights and responsibilities are available on the MHP website.
2. Enrollee rights include, but are not limited to, the right:		X				The score of Partially Met for this standard is related of enrollees not being informed of their right to file

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						complaints concerning noncompliance with the advance directive requirements. Refer to standard 2.8 below for further details and corrective action requirements.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.4 To participate in decision-making regarding their health care without prohibitions or restrictions on the clinical dialogue between patient and provider;						
2.5 To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;						
2.6 To voice grievances about the CCO or about the medical care and/or services they receive;						
2.7 To appeal decisions adversely affecting coverage, benefits, services, or their relationship with the CCO;						
2.8 To formulate advance directives;						The *DOM Contract, Section 5.11*, requires that enrollees be informed that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health. Policy MS.CM.10, Advance Directives, indicates on page four that this information would be included in the Member Handbook. This information is not found in the Enrollee Handbook or in information specific to advance directives provided in the new member packet.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Update the Member Handbook with the information that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health.
2.9 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.10 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.11 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.12 To have free exercise of rights and the exercise of those rights do not adversely affect the way the CCO and its providers treat the enrollee.						
2.13 To be furnished with health care services in accordance with 42 CFR § 438.206 – 438.210.						
3. Enrollee Responsibilities include, the responsibility;	X					Enrollee responsibilities are detailed in policy MS.MBRS.25, Member Rights and Responsibilities. All responsibilities are communicated to enrollees and plan providers.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To corporate with those providing health care services by supplying information essential to the rendition of optimal care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 To follow instructions and guidelines for care the Enrollee has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff.						
III B. Enrollee CCO Program Education						
1. Enrollees are informed in writing within 14 days from CCO's receipt of enrollment data from the Division of all benefits to which they are entitled, including:		X				The score of Partially Met for this standard is related to incorrect information on the MHP website, information on grievances in the Member Handbook, information regarding sending Provider Directories to new members, and deficiencies in information required by the DOM Contract and by Federal Regulations. These deficiencies are discussed in the standards below. The Enrollee Handbook is provided to new enrollees within 14 days of enrollment, and contains sufficient information to for enrollees to navigate the plan. Discrepancies were noted in the lists of items included in the new member packet in policies MS.MBRS.01, New Member Packet/Member ID Card, and MS.MBRS.05, Orientation of New Enrollees. *Recommendation: Update the list of items included in the new member packet in policies MS.MBRS.01 and MS.MBRS.05.*
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The Enrollee Handbook contains a listing of benefits, including benefit limitations.
1.1.1 Benefits include direct access for female enrollees to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage, maximum allowable benefits and claim submission procedures; includes that no cost is passed on to the enrollee for OON services;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The Member Handbook, page 37, indicates that when a member is hospitalized, the member or someone acting on the member's behalf must call the member's PCP and MHP within 48 hours of the admission. Although MHP can request to be notified, members cannot be required to notify MHP of an admission. *Recommendation: Update the Member Handbook to indicate that members are requested rather than required to notify MHP of an admission.*
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The MHP website information on "When to Use the ER" contains a list of symptoms for which routine care is appropriate; however, many symptoms in this list are emergency situations for which a visit to the ER is warranted, including but not limited to, difficulty breathing, chest pain, uncontrolled bleeding, difficulty speaking, mental status changes, coughing or vomiting blood, and suicidal thoughts. This list should be corrected immediately. Also, in the information on the website regarding emergencies, a hyperlink that is supposed to take members to a list of emergency warning signs published by the American College of Emergency Physicians (ACEP) takes members to the American College of Emergency Physicians home page, and not to a list of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						emergency symptoms. This link is not appropriate for members and should be updated to direct members to the information specified rather than to the ACEP home page. *Corrective Action: Correct the information on the MHP website regarding symptoms that require only routine care. Update the MHP website link to the ACEP list of emergency symptoms.*
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						
1.8 Policies and procedures for notifying enrollees affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.10 Procedures for disenrolling from the CCO;						
1.11 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						The timeframe to file a grievance is not documented in the Member Handbook or in other new enrollee education materials. The *DOM Contract, Section 7.2,* allows enrollees to file grievances within 30 calendar days of the date of the event causing the dissatisfaction. The Member Handbook does not clearly explain the expedited appeals process, including the use of an extension of the determination timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the Member Handbook with the timeframe to file a grievance. Include a clear description of the expedited appeals process. This should include information that an extension of up to 14 calendar days may be requested by MHP or by the member, and that if MHP requests the extension, the member will be notified in writing of the reason for the extension.
1.12 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						A discrepancy was noted regarding sending Provider Directories to new enrollees. Policy MS.MBRS.05, Orientation of New Enrollees, indicates on page one that new enrollees are provided with written information on provider qualifications, service locations, addresses, phone numbers, office hours and procedures for scheduling appointments. Policy MS.MBRS.01, New Member Packet/Member ID Card, contains a footnote that provider directories are not sent to new enrollees due to the requirement being waived by DOM. Onsite discussion confirmed that Provider Directories are not sent routinely because DOM waived the requirement, but that members can request one to be mailed. For consistency, policy MS.MBRS.05 should be updated with information that the requirement has been waived. *Corrective Action: Update policy MS.MBRS.05 with information that Provider Directories are not sent to new enrollees because DOM waived the requirement.*
1.13 Additional information as required by the contract and by federal regulation.						The *DOM Contract, Section 4.6 (m) (iii)* requires the Member Handbook to contain information on how to access the Member Handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments. The Member Handbook indicates other languages are available, but there is no mention of alternate formats, such as braille

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or large font formats. Onsite discussion confirmed that these alternate formats are available. The *DOM Contract, Section 4.8,* requires that enrollees be informed within 14 calendar days following enrollment of their right to make decisions regarding organ donation. This information was not found in the Member Handbook or in other new enrollee education/orientation materials. *Corrective Action Plan: Update the Member Handbook with the information the handbook is available in alternate formats and information on enrollees' right to make decisions regarding organ donation.*
2. Enrollees are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Policy MS.MBRS.12, Member Notification of Plan Changes, documents MHP's process for notifying enrollees of changes in benefits, the provider network, and other significant changes to information in the DOM Contract. Onsite discussion confirmed that the online Provider Directory is updated in real-time.
3. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					
4. The CCO maintains and informs enrollees of how to access a toll-free vehicle for 24-hour enrollee access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					
5. Enrollee grievances, denials, and appeals are reviewed to identify potential enrollee misunderstanding of the CCO program, with reeducation occurring as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Materials used in marketing to potential enrollees are consistent with the state and federal requirements applicable to enrollees and enrollees.	X					Policy MS.COMM.01, Marketing, General Guidelines for Marketing Activities, indicates that all marketing and informational materials are written at or below the 6th grade reading level.
III C. Enrollee Disenrollment						
1. Enrollee disenrollment is conducted in a manner consistent with contract requirements.	X					MS.ELIG.05, Disenrollment, defines the process and criteria for member and health plan initiated disenrollment. The Member Handbook provides basic information on disenrollment and informs members that requests for disenrollment must be directed to DOM.
III D. Preventive Health and Chronic Disease Management Education						
1. The CCO enables each enrollee to choose a PCP upon enrollment and provides assistance as needed.	X					
2. The CCO informs enrollees about the preventive health and chronic disease management services that are available to them and encourages enrollees to utilize these benefits.	X					MHP uses several methods to notify members of and encourage them to participate in wellness, preventive health, and chronic disease management programs. Information is available on the website, and also distributed via member mailings, informational telephone on-hold messages, in-person, and via newsletters and postcards.
3. The CCO identifies pregnant enrollees; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant enrollees in their recommended care, including participation in the WIC program.	X					
4. The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages enrollees to utilize these benefits.	X					Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic Notification System indicates that monthly reports identify newly enrolled members, members who appear to be behind on the immunization schedule and EPSDT screenings. These

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members are contacted by the EPSDT Coordinator to explain benefits and advise of needed services. Outreach calls include member education, identification of barriers, and assistance with EPSDT screenings and immunizations. Three failed attempts to reach the member telephonically prompt a mailing requesting the member to follow-up. If the member remains past due for services and no response from the mailed letter, the case will be referred to a local MemberConnections representative for a home visit. An incentive for participation in routine well-child visits and immunizations is provided by the CentAccount program that rewards members financially for healthy behaviors.
5. The CCO provides educational opportunities to enrollees regarding health risk factors and wellness promotion.	X					
III E. Enrollee Satisfaction Survey						
1. The CCO conducts a formal annual assessment of enrollee satisfaction with CCO benefits and services. Such assessment includes, but is not limited to:	X					The CAHPS survey is performed by The Myers Group, an NCQA-certified vendor. Version 4.0 was used for the survey. The survey met the CMS protocol requirements and was found to be valid. The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3*.
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total enrolleeship;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from CCO providers;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Adverse decisions regarding CCO claim decisions.	X					
2. The CCO analyzes data obtained from the enrollee satisfaction survey to identify quality problems.	X					Results are analyzed by the vendor and reported to the plan.
3. The CCO implements significant measures to address quality problems identified through the enrollee satisfaction survey.	X					The QIC reviews the results and implements a plan to work through issues identified in the survey results. Internal goals are set, and performance is compared to those goals to improve domains of the survey for the next measurement.
4. The CCO reports the results of the enrollee satisfaction survey to providers.	X					Survey results are reported to providers in newsletters and on the website. Results will be published next in the Winter 2014 newsletter.
5. The CCO reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Minutes confirm that results were reported to the QIC during the meeting held on 8/29/13.
III F. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07, Member Grievances and Complaints Process, details Magnolia's processes for handling and responding to member grievances and complaints.
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;		X				Policy MS.MBRS.07, Member Grievance and Complaints Process, details the Plan's processes for filing and handling of both oral and written grievances. All grievances will be acknowledged within 5 business days of receipt, and oral grievances can be acknowledged

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						verbally. The Member Handbook provides this information, but doesn't specify that the timeframe for acknowledging grievances is working days. *Corrective Action Plan: Update the Member Handbook information on acknowledgement of written grievances to indicate that acknowledgement occurs within 5 working days.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				Policy MS.MBRS.07, Member Grievance and Complaints Process, states on page 5, item 6, that level II grievances deemed to be clinically urgent have resolution within "three 72 hours" of receipt. The chart on the same page, however, states clinically urgent Level II grievances are resolved within 3 business days of receipt. *Corrective Action Plan: Correct the discrepancy in policy MS.MBRS.07 regarding the timeframe for clinically urgent Level II grievances.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Clinical issues and complaints about providers are reviewed by the medical director. Level II grievances involving potential clinical or quality of care issues are reviewed by the Level II Grievance Review Committee, which consists of Plan staff, the Compliance Officer, the Grievance and Appeal Coordinator, and the Quality Improvement Manager. Level II grievances involving potential clinical or quality of care issues are reviewed by appropriate clinical staff who were not involved in the review of the initial grievance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Notification to the enrollee of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated;	X					
1.6 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					All complaints and grievances are logged, including Level II grievances which are counted as a separate grievance from the initial one. Grievances are categorized, monitored for trends, and are reported to the QIC and to DOM.
2. The CCO applies the grievance policy and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Monthly grievance logs are organized by category and totals are given for each. Review of PIT committee minutes confirmed that grievances and appeals are discussed at each meeting, including trends, and quality of care issues are reported separately in the meetings. Totals for grievances are presented at each QIC meeting with discussion following regarding trends and interventions for improvement.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The CCO investigates all enrollee requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Requests for PCP changes are documented along with the reason for the request. Staff can monitor requests for PCP changes due to dissatisfaction via the reporting of the documentation system. Appropriate follow-up action is taken when trends are noted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.		X				Magnolia's 2014 Quality Assessment and Performance Improvement Program Description outlines the quality improvement program Magnolia has established to improve the quality of care and services provided to its members and providers. Magnolia's committee structure is included in the 2014 QI program description. The program description, 2013 QI work plan, committee charters, and the committee matrix received in the desk materials contained inconsistent information regarding Magnolia's committee structure, what constitutes a quorum, and the committees' membership. For example, the committee matrix received in the desk materials and shown in the program description (page six) included the Compliance Committee. However, the program description did not include a description of this committee. The Grievance and Appeal Committee, the HEDIS Steering Committee, and Joint Oversight Committee were included in the work plan; two of these committees were listed in the program description but were not included in the committee matrix. The information regarding the committees' quorum listed in the program description was inconsistent with the quorums listed in the committee charter for the Quality Improvement Committee, Credentialing Committee, and the Performance Improvement Team.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the Quality Improvement Program Description, work plan, committee charters, and committee matrix to ensure all documents include all committees, each committee description, and consistent documentation of quorums.
2. The scope of the QI program includes monitoring of provider compliance with CCO wellness care and disease management guidelines.	X					The program description explains that at least annually, Magnolia measures practitioner compliance with at least two of its adopted clinical guidelines and preventive health guidelines.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The monitoring of utilization patterns is included in the scope of work for the QI program.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Magnolia has developed several work plans that address committee meetings and activities, performance measures, quality/performance improvement activities, and document creation and updates. Each plan includes the scope, goals, tasks, the lead for each task, frequency, and outcomes.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia has established the Quality Improvement Committee to provide oversight and direction for all quality improvement activities.
2. The composition of the QI Committee reflects the enrolleeship required by the contract.	X					The Quality Improvement Committee is a senior level management committee and includes participating network practitioners. The participating practitioners currently listed as members of the committee include

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specialties representing pediatrics, family medicine, and cardiology, and two nurse practitioners were recently added.
3. The QI Committee meets at regular quarterly intervals.	X					The committee meets at least quarterly. A review of the committee minutes demonstrated that this committee met regularly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are documented for each committee meeting and include the discussions and actions taken in each meeting.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					As part of the annual EQR of Magnolia, CCME conducted a validation of their performance measures and found that the health plan uses an NCQA-certified vendor for their HEDIS measures. The health plan was found to be fully compliant with the measures and met the validation protocol.
IV D. Quality Improvement Projects/Focused Studies						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the enrollee population or as directed by DOM.	X					The topics selected for the performance improvement projects included asthma, congestive heart failure (CHF), diabetes, hypertension, and obesity. These topics were found to be pertinent to Magnolia's population.
2. The study design for QI projects meets the requirements of the CMS protocol.			X			All of the projects were validated. Two of the projects (obesity and CHF) scored within the *High Confidence* range. Two projects (asthma and diabetes) scored within the *Confidence* range, and the hypertension project received a score within the *Low Confidence* range. The results of the validation found that the projects failed to meet the CMS validation protocol. There were numerous errors found in the project documents regarding the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						measure indicators, source data, data analysis plan, the study question, measurement methodology, sample size, interventions, numerators, and denominators. Some of the interventions and population sampled for the hypertension project were interventions for or included a population related to other chronic diseases such as diabetes and CHF. Details of the validation results may be found in the *CCME EQR Validation Worksheets*, *Attachment 3*. *Corrective Action: Correct the deficiencies identified in the Quality Improvement Project validation results.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.		X				Policy MS QI. 23, Provider Profiling Program, discusses the process Magnolia follows for reporting QI performance data to network providers. Sample copies of the provider profile reports were provided. This was discussed during the previous EQR, and the health plan stated their physicians would receive a profile report at least quarterly. However, the health plan has not implemented this process for providing network providers with their performance data. *Corrective Action: Develop a plan to implement the process for providing network providers with a copy of their performance data.*
IV F. Annual Evaluation of the Quality Improvement Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Magnolia evaluates the QI program annually .The objective of the 2013 program evaluation was to provide an analysis of the health plan's performance and to define meaningful and relevant quality improvement activities for 2014. Some of the sections of the program evaluation contained a description of the program but did not always include the results of the evaluation. *Recommendation: Ensure that the Quality Improvement Program Evaluation includes the results of the health plan's evaluation or results of the effectiveness of the quality improvement activities from the previous year.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors and DOM.	X					The evaluation is submitted to the Quality Improvement Committee and health plan board of directors for approval.
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The 2013 Utilization Management Program Description submitted with the desk materials defines the structure and processes of the Medical Management department and includes lines of responsibility and accountability for UM decision making.
1.1 structure of the program;	X					A discrepancy was noted in documentation of the quorum for the UM Committee. The 2013 Quality Assessment and Performance Improvement Program Description and the committee matrix list the quorum as no less than 50 percent of voting members who are present by teleconference, fax, e-mail, or in person. The 2013 Utilization Management Program Description states the quorum requirement as a minimum of one voting member.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Correct the quorum requirement for the UM Committee to be consistent across all documents.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					Magnolia uses evidenced based, nationally-recognized clinical decision support tools including InterQual, internal clinical policy, Hayes, Inc. health technology assessments online, and CMS National Coverage Determinations.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;			X			The *DOM Contract, Section 5.7*, specifies the determination and notification timeframe for urgent authorization requests as within three working days from receipt of the request. Discrepancies were noted in the timeframe requirement for urgent, pre-service requests listed in these documents: •The UM Program Description, page 16, states the timeframe as within 24 hours of receipt of all necessary information, not to exceed 48 hours. •Policy MS.UM.05 and the Provider Manual document the timeframe as within two working days of receipt of all necessary information, not to exceed 72 hours. Incorrect timeframes for determination and notification of urgent requests was noted as a deficiency in the previous EQR and this has not been corrected. Additional issues noted in policy MS.UM.05 include: •Page three, item 2 (C) states that MHP may issue an administrative denial if all the necessary information is not provided within the timeframe. However, if some information is received a medical necessity determination should be done based on the information that has been submitted. During onsite discussion this

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						was acknowledged as a mistake in the policy. •Page two, item 1 (C), discusses the 14-day extension period for the contractor but does not include information that enrollees and practitioners may also request an extension. *Corrective Action: Correct the timeframe requirement for urgent, pre-service requests in policy MS.UM.05, the UM Program Description, and the Provider Manual. Correct policy MS.UM.05 to indicate that if requested information is not received, a review will be performed on the information received and a determination will be issued. Include information in policy MS.UM.05 that enrollees and practitioners may also request an extension of the review determination timeframe.*
1.5 consideration of new technology;	X					
1.6 the appeal process, including a mechanism for expedited appeal;	X					
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					Found in policy MS.UM.04.01, Affirmative Statement About Incentives. Employees and providers are provided with this statement upon hire or contracting and annually thereafter.
1.8 the absence of quotas establishing a number or percentage of claims to be denied.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Oversight for the Medical Management department is provided by Dr. Rebecca Waterer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM program is evaluated and updated annually.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Magnolia uses InterQual and internal medical policy as the primary clinical decision support tools.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					Requirements for inter-rater reliability testing are documented in policy CC.UM.02.05, Inter-rater, Reliability. Physicians and nurse reviewers participate in annual testing, and the benchmark requirement is 80%. Scores below 80% result in retraining, retesting, and a possible corrective action plan. Periodic auditing also occurs for nurse reviewers.
5. Pharmacy Requirements						
5.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					The PDL indicates which drugs require prior authorizations, step therapy, quantity limits, and age and gender limits. Members can access the PDL through the MHP website. The online PDL was last updated in October of 2013.
5.2 If the CCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Policy CC.PHAR.07, Pharmaceutical Management, details the process for reviews of medications which are not part of the PDL, and for exceeding quantity limitations, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Details of MHP's coverage of emergency and post-stabilization services are found in policy MS.UM.12, Emergency Services.
7. Utilization management standards/criteria are available to providers.	X					Documented in policy MS.UM.02, Clinical Decision Criteria and Application.
8. Utilization management decisions are made by appropriately trained reviewers.	X					Defined in policy MS.UM.04, Appropriate UM/UR Professionals and in the UM Program Description.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					
10. Denials						
10.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Policy MS.UM.05, Timeliness of UM Decisions and Notifications, documents that at least two attempts to obtain necessary information are made and documented.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
10.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denial of service and the procedure for appeal.	X					Processes for denial notifications are detailed in policy MS.UM.07, Adverse Determination (Denial) Notices.
V C. Appeals						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					Policy MS.UM.08, Appeal of UM Decisions, details MHP's policy and processes for handling appeals. Issues were identified in policy MS.UM.08, the Utilization Management Program Description, the Member Handbook, and appeal notification letters. These are discussed in the standards below.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				The definitions of an action and an appeal can be found in *Federal Regulation § 438.400 (a) (3) (b)* and the *DOM Contract Section 7.3.* Policy MS.UM.08, Appeal of UM Decisions, correctly defines action and appeal, and documents who may file an appeal. Issues identified with the definition of an appeal found in policy MS.UM.07, Adverse Determinations (Denial) Notices, include: •The definition of an appeal is incomplete. It does not include "for a resident of a rural area with only one CCO, the denial of an enrollee's right to request to obtain services outside the network". •Also, the last sentence of the definition states "An adverse determination is a form of Medicare organizational determination as defined below." This sentence does not appear to apply to Medicaid and should be removed. The Member Handbook definition of an action on page 52 is incomplete. It does not include the denial for a resident of a rural area with only one CCO to obtain services outside the network as part of the definition. This requirement can be found in the *DOM Contract, Section 7.3 (A) (6).* *Corrective Action: Correct the definition of an action and appeal in the Member Handbook. Correct the definition of an appeal in policy MS.UM.07. Remove the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sentence from policy MS.UM.07 that discusses an appeal as a form of Medicare organizational determination.
1.2 The procedure for filing an appeal;		X				The *DOM Contract, Section 7.3 (C),* documents the timeframe for requesting an appeal as within 30 calendar days of receiving the notice of action letter. Errors were noted in the timeframe to file an appeal in the following: •The Member Handbook, page 52, states members may file an appeal within 30 days from the date of the adverse notice of action. •The adverse determination letters in the denial files reviewed onsite documented the timeframe for requesting an appeal as within 30 days from the date of the letter. Errors in the timeframe to follow an oral appeal request with a written request were noted in policy MS.UM.08, Appeal of UM Decisions, page one, and the Provider Manual, page 45. Both state that unless the appeal is expedited, an oral appeal shall be followed by a written request that is signed by the member within ten (10) calendar days. The *DOM Contract Section 7.3 (E),* states that members must be allowed 30 calendar days to submit the written request after the oral request. *Corrective Action: Correct the timeframe for filing an appeal in the Member Handbook and in the adverse determination letters. Correct the timeframe for following an oral appeal request with a written request in policy MS.UM.08 and the Provider Manual.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					This standard is addressed in policy MS.UM.08, Appeal of UM Decisions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					An expedited appeal is available under certain circumstances as described in policy MS.UM.08, Appeal of UM Decisions, the Provider Manual, and the Member Handbook.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Magnolia's appeal resolution timeframes are compliant with contract requirements.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.			X			Policy MS.UM.08, Appeal of UM Decisions, page four, lists information that will be included in the appeal acknowledgement letters. The following two items on that list are not found in the appeal acknowledgement letter. •The member's right to submit comments, documents, or other information relevant to the appeal. •The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired. This was listed as a deficiency on the last EQR and has not been corrected. The *DOM Contract, Section 7.5*, documents the timeframe to request a State Fair Hearing as within 30 days of receiving the notice of the action or within 30 days of the final decision by the Contractor. Errors were noted in the documentation of timeframes for requesting State Fair Hearings in the following: •The Utilization Management Program Description, page 18, indicates that members have the right to request a State Fair Hearing within thirty (30) calendar days from

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Notice of Appeal Resolution. •Policy MS.UM.08, Appeal of UM Decisions, page three, states that State Fair Hearings must be requested "within 30 days of the denial notice." This was listed as a deficiency on the last EQR and has not been corrected. *Corrective Action: Correct the appeal acknowledgement letters to contain information on a member's right to submit comments, documents or other information relevant to the appeal and a member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired. Correct the timeframe to request a State Fair Hearing in the Utilization Management Program Description and policy MS.UM.08.*
2. The CCO applies the appeal policies and procedures as formulated.		X				Review of appeals files onsite confirmed that most policies and procedures are being followed as formulated. However, three of the 20 files reviewed were expedited appeal requests. The following were noted for the three expedited appeal requests: •The acknowledgement letters for two of the three files gave the standard timeframe for resolution, and there was no documentation that the requests for expedited appeals were denied. •Two of the three files had determination and notification documented within the required timeframe for expedited appeals, but one of the files had a 26-day resolution and notification timeframe. For this file, there was no documentation that the request for an expedited appeal was denied or that the member was notified of the denial of the expedited appeal request. Also, one standard appeal file contained documentation that the member requested a copy of the criteria used in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the determination. The file, however, contained no documentation that the criteria were provided to the member. *Corrective Action: Develop processes to ensure that requests for expedited appeals are processed in compliance with DOM Contract requirements and to provide criteria used in the review when requested.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The scope of the Grievance and Appeals Committee (GAC) includes tracking and analysis of member appeals including type and timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. Results are communicated to the QIC.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. D Case Management/Disease Management						
1. The CCO utilizes case management techniques to insure comprehensive, coordinated care for all enrollees through the following minimum functions:		X				Magnolia's Case Management (CM) program and activities are detailed the Case Management Program Description (MS.CM.01). The program description documents that the purpose of the Case Management program is "to provide member specific plans of care that focus on organizing, securing, integrating, and modifying the resources necessary to maximize and support the wellness and autonomy of the member." The program description provides details on identification of members who are possible candidates for CM, initial screening processes, health risk screenings, comprehensive assessments, development and implementation of plans of care, and monitoring and evaluation of progress. There is also information on techniques to engage members, making referrals to specialists, and providing continuity and coordination of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						care. The score of Partially Met is due to a policy that appears to be active but not applicable to MS CAN enrollees of Magnolia Health Plan. This is discussed in standard 1.7 below.
1.1 Enrollee choice of primary care health professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the Enrollee requests otherwise;						
1.2 Appropriate referral and scheduling assistance for Enrollees needing specialty health care services, including those identified through EPSDT;						
1.3 Documentation of referral services and medically indicated follow-up care in each Enrollee's medical record;						
1.4 Monitoring and treatment of Enrollees with ongoing medical conditions according to appropriate standards of medical practice;						
1.5 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
1.6 Coordination of hospital discharge planning;						
1.7 Determination of the need for non-covered services and referral of Enrollees to the appropriate service setting, utilizing assistance as needed from the Division.						Policy MS. UM.16, Transition of Members to FFS or SSI, was submitted with the desk materials. It was noted that in the previous EQR, a recommendation was made to retire this policy as it is not applicable to members enrolled in MHP under the MississippiCAN program. During the onsite visits, staff were unsure if this is still an active policy or if it has been retired. *Corrective Action: Determine if policy MS.UM.16 is an*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						active policy. If so, update it with current information. If not active, retire the policy.
1.8 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), Part B and Part C; the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program;						
1.9 Ensuring that Enrollees are entitled to the full range of their health care providers' opinions and counsel about the availability of medically necessary services under the provisions of this Contract. Any contractual provisions, including gag clauses or rules, that restrict a health care provider's ability to advise patients about medically necessary treatment options violate federal law and regulations;						
1.10 Ensuring that Medicaid providers are not limited in the scope of practice, as defined by federal and state law, in providing services to Plan Enrollees;						
1.11 Ensuring that when a provider is no longer available through the Plan, the Contractor allows Enrollees who are undergoing an active course of treatment to have continued access to that provider for a limited period of time;						
1.12 The Contractor shall provide for a second opinion from a qualified health care professional within the network, or arrange for the Enrollee to obtain one outside the network, at no cost to the Enrollee;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 If the Network is unable to provide necessary medical services covered under the contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						
1.14 The Contractor must produce a treatment plan for Enrollees determined to need a course of treatment or regular care monitoring. The treatment must be developed by the Enrollee's primary care provider with Enrollee participation, and in consultation with any specialists caring for the Enrollee.						Health Risk Assessments are performed at least annually on members in the CM program and when changes are noted.
2. The CCO has disease state management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Disease Management programs are delegated to Nurtur for the diagnoses of asthma, diabetes, hypertension, obesity, and CHF.
V E. Evaluation of Over/ Underutilization						
1. The CCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					
2. The CCO monitors and analyzes utilization data for under and over utilization.	X					The Plan monitors, reviews, and analyzes utilization data at least annually to correct patterns of potential or actual inappropriate under- or over utilization.
V I. DELEGATION						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Magnolia Health Plan utilizes the following vendors and sister companies for ancillary services: •Univita: DME, Home Infusion, Home Health •Cenpatico: Behavioral Health •DentaQuest: Dental Services •National Imaging Associates (NIA): Radiology Services •Nurtur: Disease Management •Nursewise: 24 Hour Nurse Call Center •OptiCare: Vision Services •US Script: Pharmacy Benefit Management Delegated credentialing has also been approved for the Hattiesburg Clinic, Health Choice, Mississippi Physicians Care Network, Rush Health Systems, St. Jude Children's Research Hospital, University Physicians_UMMC, VerifPoint/CreDENTALs Services, and CAQH Sanctions Track. Policy MS.QI.14, Oversight of Delegated Vendor Services, defines the procedures for the written delegation agreement, pre-delegation review, reporting and ongoing monitoring, annual evaluation, and deficiencies/corrective action. The Plan retains accountability for delegated services and monitors the performance for the delegated entities.
2. The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				Evidence of annual oversight was presented in the desk materials. A review of the oversight tools for ancillary services showed the following issues: •There was no annual oversight monitoring tool received for Univita. •The annual delegation oversight tools used for Cenpatico, NIA, US Script, and OptiCare list incorrect standards for timeframes for determination and notification of both standard and expedited, pre-service requests. The standards used on the tools appear to be NCQA standards, but don't reflect the Mississippi-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specific requirements. It was noted that additional standards were added to the tools for other states, but none have been added to address the Mississippi requirements. •The annual delegation oversight tools used for Cenpatico, NIA, DentaQuest, and OptiCare list incorrect standards for timeframes for members to file appeal requests and for appeal determinations. The standards listed on the tools appear to be NCQA standards, but don't reflect the Mississippi-specific requirements. It was noted that additional standards were added to the tools for other states, but none have been added to address the Mississippi requirements. •Evidence of annual monitoring for credentialing/ recredentialing delegation was received but a review of the tools showed NCQA requirements and no information specific to MS requirements. The tools should include requirements for the following: proof of primary/secondary source verifications (i.e. license, DEA/CDS, board certification, if applicable, etc.) and proof of queries (NPDB, SAM, OIG, State Sanctions) must be in the file; site reviews for initial credentialing; site reviews for member complaints within 45 days; proof of malpractice insurance; signed attestation and current re-attestment if using CAQH; copy of CLIA certificate/waiver; hospital privileges should be addressed for nurse practitioners acting as PCPs; and delegates should be collecting ownership disclosure forms for credentialing and recredentialing. *Corrective Action: Update the delegation oversight tools to ensure they reflect the actual standards being evaluated and that those standards are the same requirements that Magnolia is being held to as an organization.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
A. The CCO tracks provider compliance with:						
1. administering required immunizations;	X					Childhood Immunizations status is monitored and reported as required by the DOM, per policy MS.QI.20, EPSDT Screening, Diagnostic & Treatment Service. Interventions include provider reports and education, birthday and reminder mailings, face to face provider education, medical record review, member connections visits, provider recognition, start smart program.
2. performing EPSDTs/Well Care.	X					As above, tracking for this measure is also carried out with similar interventions. The Plan acknowledges the goals of the DOM. The policy noted above details the mandatory components of EPSDT well visits.
B. Core benefits provided by the CCO include all those specified by the contract.	X					
C. The CCO addresses deficiencies identified in previous independent external quality reviews.			X			The following issues were identified as discrepancies in the previous EQR and were not corrected: •Incorrect timeframes for determination and notification of urgent requests in the UM Program Description, policy MS.UM.05, and the Provider Manual. •Policy MS.UM.08, Appeal of UM Decisions, lists information that will be included in the appeal acknowledgement letters; however, all of the items listed in the policy are not included in the appeal acknowledgement letter. •The timeframe to request a State Fair Hearing was incorrect in the Utilization Management Program Description and policy MS.UM.08.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The following issues were identified in the credentialing/recredentialing processes, policies, and files and not corrected: •Collect a copy of the CLIA Certificates or Certificates of Waiver for practitioners that indicate they bill laboratory services on the application. •Conduct office site visits for initial credentialing. •For Nurse Practitioners that are acting as PCPs, confirm the plan for admitting patients. •Address Disclosure of Ownership in the credentialing/ recredentialing process. •Credentialing Committee quorum is incorrect in policies CC.CRED.01 and CC.CRED.02. •Policies CC.CRED.10 and MS.ELIG.08 had an incorrect information that was not corrected. •Credentialing/recredentialing polices need to address the MS specific criteria either in the policies or attachments/addendums. *Corrective Action: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.*