CCME

2020 External Quality Review

MAGNOLIA HEALTH PLAN

Submitted: November 19, 2020

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Magnolia Health Plan (Magnolia). This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN).

The goals of the review were to:

- Determine if Magnolia is in compliance with service delivery as mandated in the Coordinated Care Organization (CCO) contract with DOM
- Provide feedback for potential areas of continued improvement
- Ensure contracted health care services are being delivered and are of acceptable quality

The EQR process is based on Centers for Medicare & Medicaid Services (CMS)-developed protocols for EQRs of Medicaid MCOs. The review includes a desk review of documents; results from a two-day virtual onsite visit; a compliance review; validation of performance improvement projects (PIPs) and performance measures, validation of network adequacy, member satisfaction and provider satisfaction surveys validations; and an Information System Capabilities Assessment (ISCA) audit.

OVERVIEW

The 2020 EQR review of the CAN program reflects Magnolia achieved “Met” scores for 96% of the standards reviewed. As the following chart indicates, 4% of the standards were scored as “Partially Met.”

Figure 1: 2020 Annual EQR Review Results for CAN

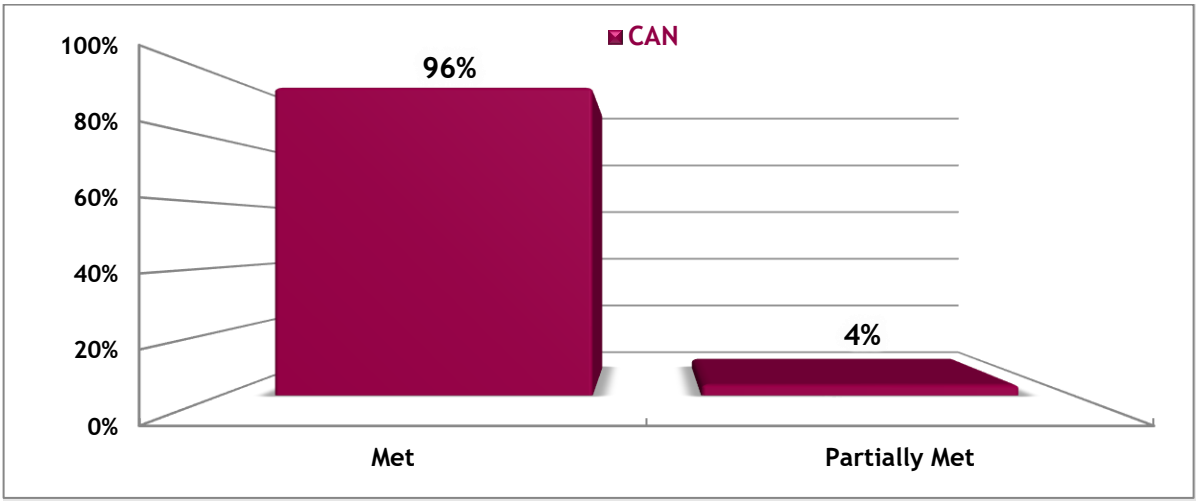


Table 1: Scoring Overview provides an overview of the scores for each review section.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2020	31	0	0	0	0	31
Provider Services						
2020	83	3	0	0	0	86
Member Services						
2020	29	4	0	0	0	33
Quality Improvement						
2020	19	0	0	0	0	19
Utilization Management						
2020	53	1	0	0	0	54
Delegation						
2020	2	0	0	0	0	2

Overall Findings

An overview of the findings for each section is included in this Executive Summary. Details of the review, including specific strengths, weaknesses, applicable corrective action items, and recommendations can be found in the respective sections and narrative of this report.

Administration

Magnolia's Organizational Chart clearly identifies the operational relationships and reporting structure for staff, and staffing appears to be adequate to ensure services required by the State of Mississippi are provided to members.

Appropriate processes are in place for policy development, review, approval, and maintenance. Policies are reviewed and approved annually and as needed for changes in state or federal laws, regulations, or contractual obligations. Magnolia uses a policy management platform to maintain and house policies.

As noted in the review of Information Systems Capabilities Assessment (ISCA) documentation, Magnolia ensures staff and systems can satisfy contractual obligations. This is evidenced, in part, by the 30-day claims rate, which exceeds State requirements, and disaster recovery testing, which demonstrated the ability to successfully restore all systems.

Magnolia's Compliance Committee, which reports directly to the Board of Directors and to Centene's Corporate Compliance Committee, provides feedback and recommendations regarding health plan compliance issues. Processes and controls that form the framework of the Compliance Program are documented in the Compliance Program Description. Processes to prevent fraud, waste, and abuse are found in the Fraud, Waste and Abuse Plan. Centene's Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace provides guidance to staff about appropriate, ethical business behavior, and discusses disciplinary actions that may result from violations. Training about compliance and fraud, waste, and abuse are included in new employee orientation and provided annually thereafter. Staff must complete and sign a questionnaire acknowledging receipt and understanding of the Code of Conduct and must complete a Conflict of Interest Disclosure annually. When reporting compliance issues and suspected fraud, waste, and abuse, confidentiality is ensured and retaliation is prohibited.

Provider Services

Magnolia's Credentialing Committee includes a variety of network providers and uses a peer review process to make recommendations regarding credentialing decisions. The committee meets monthly and reports to the Quality Improvement Committee (QIC) quarterly. The Medical Director has overall responsibility for the Credentialing Committee's activities. Two network providers on the committee appear to not meet attendance requirements.

Provider credentialing and recredentialing processes are documented in policy, and, overall, credentialing and recredentialing files reflect the policies and procedures are

followed, with only a few issues noted in individual provider files. These issues included missing verification of malpractice insurance coverage and missing or outdated Ownership Disclosure Forms. In organizational provider files, similar issues were noted.

Magnolia assesses the adequacy of its provider network quarterly through geographic access reports that use appropriate standards to measure access to primary care providers (PCPs) and specialty providers. For 2019, goals for the percentage of members with appropriate geographic access to PCPs and specialty care providers were met. Appointment availability goals were not met for routine and urgent PCP appointments and urgent behavioral health appointments. Additionally, the PCP after-hours care goal was not met. Barriers and interventions to address the barriers were documented.

Appropriate processes are in place for initial and ongoing provider education. Magnolia reported that due to restrictions related to COVID-19, processes have been adjusted to provide education to network providers through use of webinars, web-based conferences, virtual sessions. etc.

Preventive Health and Clinical Practice Guidelines are adopted from recognized sources, subjected to appropriate physician review, and are adopted through the QIC. Guidelines are distributed to practitioners and, upon request, to members. A list of adopted preventive health guidelines is included in the Provider Manual and on Magnolia's website.

Annually, Magnolia monitors providers' maintenance of medical records to ensure records are current, detailed, organized, and include the minimum documentation standards, which are found in the Provider Manual and on Magnolia's website. Magnolia works with providers who score below the benchmark to develop an action plan for improvement. Results of the annual monitoring are reported to the QIC and used in the recredentialing process. Due to COVID-19, the 2020 Medical Record Review was delayed but did resume in August 2020, and results were reported to the QIC in October 2020.

Provider Satisfaction Survey validation was performed using a validation worksheet based on the CMS Survey Validation Protocol. The response rates were 6.6% for mail/internet surveys and 28% for phone surveys. Overall satisfaction with Magnolia was 74.7%, an increase from 71.6% for the prior year. Magnolia has implemented interventions to improve satisfaction, and these were discussed during the onsite.

Member Services

Magnolia has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New members receive a New Member Packet with instructions for

contacting Member Services, selecting a PCP and initiating services. Information and resources in the Member Handbook, Provider Manual, on the Website, and in member newsletters helps members understand and use their benefits. The plan provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continue to be conducted annually via a third-party vendor. The 2019 survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.

Quality Improvement

Magnolia's Quality Improvement (QI) Program operates under a plan of continuous improvement. The 2020 MississippiCAN Quality Management Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The program description is reviewed and revised as needed on an annual basis. Magnolia's quality work plan defines the activities to be completed throughout the year. The work plan is developed annually and is based on the Quality Program Evaluation for the previous year.

The Quality Improvement Committee (QIC) performs oversight of all quality activities and is responsible for reviewing and monitoring all clinical, physical, and behavioral health quality and service functions. Membership for the QIC includes Magnolia's senior leadership, department directors and other health plan staff. Meetings are chaired by the Chief Medical Director. The committee's participant roster indicates there are five participating providers, with specialties including pediatrics, family medicine, and psychiatry, and a nurse practitioner. A minimum of five members, including three plan staff and two external physicians, must be present for a quorum. Minutes are recorded for each meeting and document committee discussion points and decisions.

Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines indicates Magnolia, on an annual basis, measures Provider performance against at least two of the clinical guidelines. The policy also indicates Magnolia provides DOM the results of the study as well as a summary of any corrective actions taken to ensure future compliance with the guidelines. Magnolia chose the guidelines for diabetes care, prenatal care, ADHD, and depression for monitoring, and provided the report of the annual monitoring. There were three measures that did not meet the goal. During the onsite discussion, staff indicated the health plan was working with this provider to implement interventions to improve the rates and new interventions would be implemented in 2021.

Per Policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Services, Magnolia's EPSDT Coordinator will monitor claims to identify members with any abnormal finding on an EPSDT screening. If there is no evidence that treatment was sought, the EPSDT Coordinator will contact the provider and member to assist in arranging an appointment for follow-up. Magnolia provided a copy of the tracking reports for members monitored and identified as having an abnormal finding on an EPSDT screening. The tracking reports did not include the CPT and ICD-10 codes to identify the abnormal finding and the need for follow-up as mentioned in Policy MS.QI.20.

Magnolia's MSCAN Quality Management Program Evaluation 2019 provides a summary of all completed and ongoing activities of the previous year. Barriers, interventions, and recommendations for 2020 were included for each activity. During the previous EQR, several recommendations were provided regarding the program evaluation, and it appears Magnolia implemented those recommendations.

Performance Measure Validation

The purpose of the performance measure validation is to assess the accuracy of the performance measures (PMs) reported by the CCOs and to determine the extent to which the PMs follow State specifications and reporting requirements. Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the PMs identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population.

Performance measure validation determines the extent to which the CCO followed the specifications established by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019 and found that Magnolia met all the data requirements to report the PMs.

All relevant HEDIS PMs for the CAN population for the current review year (MY 2019), as well as the previous year (MY 2018) and the change from 2018 to 2019 are reported in the Quality Improvement section of this report. The table that follows highlights the HEDIS measures with substantial increases in rate from 2018 to 2019 (a change in the rate of greater than 10%). There were no measures with a substantial decrease in rate.

Table 2: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	64.15%	76.92%	12.77%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.96%	43.76%	10.80%

DOM requires the CCOs to report the Adult and Child Core Set measures annually. The measure rates for the CAN population reported by Magnolia for 2019 are listed in the Quality Improvement section of this report.

Magnolia did not report two of the core set measures. The two measures were Elective Delivery (PC-01) and Cesarean Birth (PC-02 CH). The rates were provided by DOM. It is recommended that Magnolia work proactively with DOM for clarification on measures that are required to be reported.

Performance Improvement Project Validation

Magnolia submitted four projects for validation. *Table 3: CAN Performance Improvement Project Validation Scores* provides an overview of the scores for all four projects that were submitted and their current validation scores.

Table 3: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Asthma	91/91= 100% HIGH CONFIDENCE IN REPORTED RESULTS	80/80=100% HIGH CONFIDENCE IN REPORTED RESULTS
Behavioral Health Readmissions	67/72=93% HIGH CONFIDENCE IN REPORTED RESULTS	73/74=99% HIGH CONFIDENCE IN REPORTED RESULTS
Improved Pregnancy Outcomes with Makena	62/62=100% HIGH CONFIDENCE IN REPORTED RESULTS	73/74=99% HIGH CONFIDENCE IN REPORTED RESULTS
Sickle Cell Disease Outcomes	67/72=93% HIGH CONFIDENCE IN REPORTED RESULTS	73/74= 99% HIGH CONFIDENCE IN REPORTED RESULTS

All projects received scores in the "High Confidence Range," although three of the four PIPs did not show improvement in the indicator rates. The asthma PIP did have improvement in the indicator rates; however, the NCQA HEDIS measure, Medication Management for People with Asthma (MMA), used as the study indicator for this PIP was retired. Magnolia has closed this PIP and will implement a new Adult and Child Respiratory Disease PIP. Magnolia indicated the new PIP will include child asthma and adult COPD as required by DOM.

Utilization Management

The Utilization Management Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Policies and procedures define how services are operationalized and provided to members.

Service authorization requests are conducted by appropriate reviewers utilizing internal clinical guidelines or other established criteria. The Care Management (CM) Program Description and policies appropriately document care management processes and services provided. There were issues noted related to appeals, such as an incorrect definition of the term "appeal" and use of outdated terminology for the term "adverse benefit determination."

Overall, review of Utilization Management approval, denial, and appeal files provided evidence that appropriate processes are followed. CM files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Delegation

CCME's review of Delegation functions examined the submitted delegate list, delegation contracts, and delegation monitoring materials. Magnolia reported 19 current delegation agreements. Annual oversight monitoring was conducted for each delegated entity to determine whether the delegated activities are being carried out as required. The monitoring tools for seven of the credentialing delegates noted the site visits for the primary care providers as not applicable. Magnolia also indicated that credentialing was included as a function delegated to Envolve Dental, Envolve Vision, Envolve Pharmacy Solutions, and Medical Transportation Management. However, the annual monitoring did not include a review of the delegated credentialing.

METHODOLOGY

On July 2, 2020, CCME sent notification of the initiation of the annual EQR to Magnolia (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN Program.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for purposes of providing an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials CCME requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on August 3, 2020, for review at the CCME offices (see *Attachment 1*).

The second segment was a two-day, onsite teleconference conducted on October 7, 2020 and October 8, 2020 via Zoom due to issues with COVID-19. The onsite teleconference focused on areas not covered by the desk review and areas needing clarification (see *Attachment 2*). CCME's onsite activities included:

- Entrance and exit conferences (open to all interested parties)
- Interviews with Magnolia's administration and staff

The process used for the EQR is based on the CMS protocols for EQR of MCOs. This review focused on the four federally-mandated EQR activities: compliance determination, validation of performance measures, validation of network adequacy, and validation of performance improvement projects. In addition, the review included the optional activities of member and provider satisfaction survey validations.

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the contract requirements between Magnolia and DOM. Strengths, weaknesses, corrective actions, and recommendations are identified where applicable.

Areas of review are recorded in a tabular spreadsheet (*Attachment 4*) and identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated."

I. Administration

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

Aaron Sisk is Magnolia's President and Chief Executive Officer (CEO) and Sesha Mudunuri is Chief Operating Officer (COO). Magnolia's Organizational Chart clearly identifies the operational relationships and reporting structure for staff, and staffing appears to be adequate to ensure services required by the State of Mississippi are provided to members.

Processes and requirements for policy development, review, approval, and maintenance are documented in Policy CC.COMP.22, Policy Management. Policies are reviewed and approved annually and as needed, for changes in state or federal laws, regulations, or contractual obligations. The RSA Archer® policy management system is used to manage policies and house policies for staff access. Staff are advised of new and revised policies through staff meetings and training sessions.

Information Systems Capabilities Assessment (ISCA) documentation shows the organization works diligently to ensure its staff and systems can satisfy contractual obligations. Two examples of this are the organization's 30-day claims rate, which exceeds State requirements, and its disaster recovery test, which successfully restored all systems. Additionally, the documents provided by Magnolia for the ISCA review included recent revision time stamps indicating the organization performs regular document reviews.

Magnolia's Compliance Committee is a cross-functional team that reports directly to the Magnolia Board of Directors and to Centene's Corporate Compliance Committee. The Compliance Committee provides feedback and recommendations regarding health plan compliance issues. CCME noted the Compliance Committee minutes do not clearly distinguish formal committee members from attendees and do not indicate who has voting rights. Magnolia staff acknowledged this finding and agreed the minutes should be reformatted to clearly display this information. The Compliance Program Description (Compliance Plan) covers processes and controls that are the framework of the Compliance Program, and the Fraud, Waste and Abuse Plan (FWA Plan) describes processes to prevent fraud, waste, and abuse (FWA). Company values that each employee is expected to uphold are described in the Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace (Code of Conduct). The Code of Conduct states the general policy that employees "transact business in full compliance with the law and in accordance with the highest principles of business ethics and conduct" and includes a discussion of the disciplinary actions that may result from violations.

Compliance and FWA training are provided during new employee orientation and annually using a variety of methods, such as in-services, online training, and newsletters. All staff are expected to complete and sign a questionnaire acknowledging receipt and understanding of the Code of Conduct and are required to complete a Conflict of Interest Disclosure annually. Processes are in place for asking compliance-related questions and for reporting noncompliance and suspected FWA. Confidentiality and anonymity are

ensured, to the extent possible, and retaliation against anyone who reports suspected misconduct or FWA is prohibited.

In the Administration section of the review, Magnolia received "Met" scores for 100% of the standards reviewed, as illustrated in *Figure 2: Administration Findings*.

Figure 2: Administration Findings

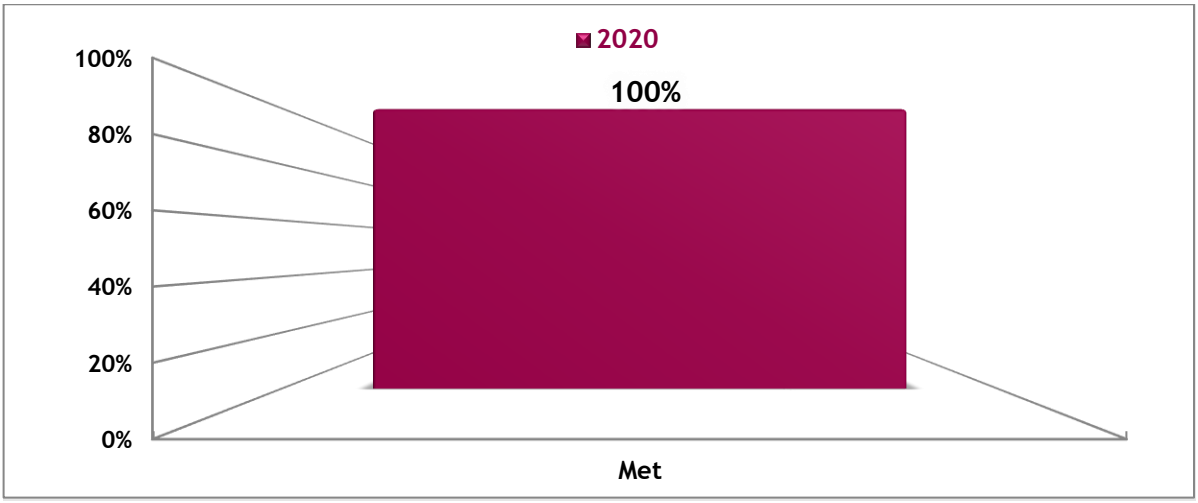


Table 4: Administration

Section	Standard	CAN 2019 Review	CAN 2020 Review
Compliance/Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including Exclusion status monitoring	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020

Strengths

- Magnolia has a thorough risk assessment process and a detailed disaster recovery plan that has been recently tested with successful results.
- Claims payment rates exceed Mississippi's contractual requirements.
- Centene's Third Party Risk Management Program promotes communication and collaboration, and ensures third party adherence to state, federal, and NCQA requirements.

Weaknesses

- Compliance Committee minutes do not clearly distinguish formal committee members from attendees, and do not indicate who has voting rights.

Recommendations

- Revise formatting for future Compliance Committee meeting minutes to clearly reflect members versus attendees, and to indicate who has voting rights.

II. Provider Services

The review for Provider Services focused on policies and procedures, provider training and educational materials, provider network information, credentialing and recredentialing processes and files, practice guidelines, and the provider satisfaction survey.

Magnolia's Credentialing Committee includes a variety of network providers and uses a peer-review process to make recommendations regarding credentialing decisions. The Medical Director has overall responsibility for the Credentialing Committee's activities. The Credentialing Committee meets monthly and reports to the Quality Improvement Committee (QIC) quarterly. Based on documentation of attendance at meetings over the past year, it appears two network providers did not meet the requirement to attend 75% of scheduled meetings. This was discussed, and Magnolia responded they would engage with the two providers to try to improve their attendance, and if necessary, replace the providers on the committee.

An overview of provider credentialing and recredentialing processes is found in the Centene Corporation Credentialing Program Description with full detail documented in policies and procedures. In general, credentialing and recredentialing files reflect the policies and procedures are followed; however, the following issues were noted in individual provider files:

- One initial credentialing file was missing verification of malpractice insurance coverage.
- Three initial credentialing files were missing a copy of the Ownership Disclosure Form, and five contained outdated Ownership Disclosure Forms with signatures up to four years prior to the credentialing decision.
- Two recredentialing files contained outdated Ownership Disclosure Forms, with signatures dates as old as four years prior to the credentialing decision date.

Issues were also noted in organizational recredentialing files, including expired licensure at the time of recredentialing in one file, and unsigned Ownership Disclosure Forms in two files.

Standards for provider geographic access and appointment availability standards are defined in policy. To assess the adequacy of the provider network, Magnolia runs quarterly geographic access reports. CCME's review of the geographic access reports reflect appropriate standards are used to measure access to PCPs and specialty providers. The MSCAN Quality Management Program Evaluation 2019 confirms goals for the percentage of members with appropriate geographic access to PCPs and specialty care providers were met. Appointment availability goals were not met for routine and urgent PCP appointments, and urgent behavioral health appointments. Additionally, the PCP after-hours care goal was not met. Barriers and interventions to address the barriers were documented.

Orientation for newly contracted providers is scheduled within 30 days of the contract execution date or the date the provider becomes participating in the network, whichever comes first. Magnolia reported that due to restrictions related to COVID-19, processes have been adjusted to provide ongoing education to network providers through use of webinars, web-based conferences, virtual sessions, etc.

Preventive Health and Clinical Practice Guidelines are adopted from recognized sources. The guidelines are subjected to appropriate physician review and adoption through the Quality Improvement Committee and are updated at least every two years and when there is new scientific evidence or change in national standards. Guidelines are distributed to practitioners and, upon request, to members. A list of adopted preventive health guidelines is maintained in the Provider Manual with a notation that the links and/or full guidelines are available on the website or hard copy upon request. Additional mechanisms to distribute guidelines include, but are not limited to, new practitioner orientation materials, newsletters, and special mailings.

Magnolia monitors providers' maintenance of medical records to ensure records are current, detailed, organized, and include the minimum documentation standards. The Provider Manual includes the required documentation components, and the Medical Record Review Template is available on Magnolia's website. Medical Record Reviews are conducted annually for a sample of providers, and Magnolia works with providers who score below the benchmark to develop an action plan for improvement. Medical record review results are reported to the QIC and shared with the Credentialing Department as needed for consideration at the time of recredentialing. Due to COVID-19, the 2020 Medical Record Review was delayed but did resume in August 2020, and results were reported to the QIC in October 2020.

Provider Access Study and Provider Directory Validation

Beginning in 2020, CCME initiated biannual validation of network access and availability and provider directory accuracy for Mississippi CCOs. The objectives of the biannual

verification activities are to determine if improvement occurred for the telephonic provider access study success rate and to evaluate the accuracy of the online Provider Directory. The methodology involves two phases:

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

For Q4 2020, Magnolia submitted a total of 2,412 unique PCPs. A random sample of 93 PCPs was drawn and Phase 1 (Provider Access Study) was conducted. For each successful call, Magnolia's online directory was reviewed to determine if the information in the directory matched the confirmed information elicited during the provider access study phase.

Phase 1 results found that 47 of 78 (60%) providers called confirmed the file contained the correct address and phone number. Of those 47, 40 (85%) confirmed they accepted Magnolia Health Plan. Of those 40, 35 (88%) indicated they were accepting new patients.

Access and availability for routine appointments was 82% and availability for urgent appointments was 76%.

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

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

Full details of the study's results, conclusions, and required corrective actions are included in the Provider Access Study and Directory Validation report.

Provider Satisfaction Survey

Provider Satisfaction Survey validation was performed using a validation worksheet based on the CMS Survey Validation Protocol. The complete worksheet is available as an attachment in this report. A total of 395 providers responded to the survey, yielding a response rate of 6.6% for mail/internet surveys (n= 82 and n=37, respectively) and 28% for phone surveys (n=376). Overall Satisfaction with Magnolia Health Plan was 74.7%. This was an increase from 71.6% for the prior year. Magnolia staff discussed interventions that had been implemented to improve satisfaction, including hiring additional Provider Relations Representatives and training them to meet the needs of providers; providing additional training to existing Provider Relations Representatives to increase knowledge of all areas of the health plan; and holding Provider Advisory Committee and Hospital Advisory Committee meetings for feedback on external communications and the online presence.

The table below offers the section of the worksheet that needs improvement, the reason, and the recommendation.

Table 5: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The total sample size was 2000 and 198 were ineligible. A total of 395 providers responded for a response rate of 6.6% for mail/internet surveys (n= 82 and n=37, respectively) and 28% for the phone (n=376) surveys. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings.	Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the provider population on the satisfaction surveys.

As noted in *Figure 3: Provider Services Findings*, Magnolia received "Met" scores for 96.5% of the Provider Services standards.

Figure 3: Provider Services Findings

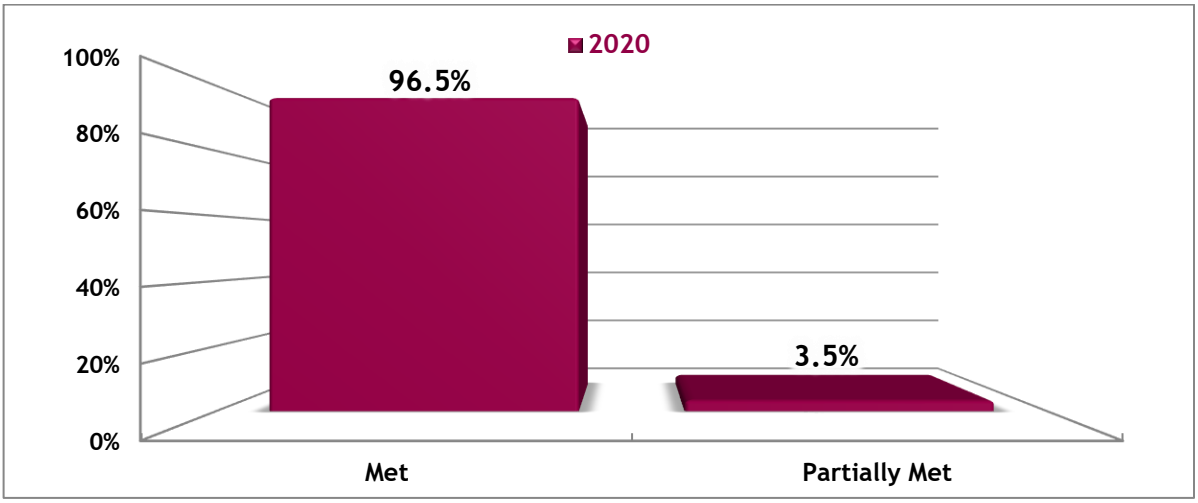


Table 6: Provider Services

Section	Standard	CAN 2019 Review	CAN 2020 Review
Credentialing and Recredentialing	Credentialing: Verification of information on the applicant, including: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List	Partially Met	Met
	Ownership Disclosure form	Met	Partially Met
	Site assessment	Partially Met	Met
	Recredentialing: Verification of information on the applicant, including: Ownership Disclosure form	Met	Partially Met
Adequacy of the Provider Network	Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties	Partially Met	Met
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	Partially Met	Met
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Partially Met	Met

Section	Standard	CAN 2019 Review	CAN 2020 Review
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020

Strengths

- Magnolia has implemented interventions to improve Provider Satisfaction, including hiring additional Provider Relations Representatives, increase training of new and existing Provider Relations Representatives, and holding Provider Advisory Committee and Hospital Advisory Committee meetings to gain feedback on external communications and Magnolia's online presence.
- Magnolia has implemented alternate methods to ensure ongoing provider education while under restrictions related to COVID-19.

Weaknesses

- Issues identified in initial credentialing and recredentialing provider files included:
  - One initial credentialing file was missing verification of malpractice insurance coverage.
  - Three initial credentialing files were missing a copy of the Ownership Disclosure Form.
  - Five initial credentialing files contained outdated Ownership Disclosure Forms with signatures dated up to four years prior to the credentialing decision. During onsite discussion, credentialing staff reported that at the time of credentialing, Ownership Disclosure Forms must have been signed within 12-14 months of the credentialing event.
  - Ownership Disclosure Forms in two provider recredentialing files were outdated, with signatures dates as old as four years prior to the credentialing decision date.
- Issues noted in organizational provider recredentialing files included:
  - One provider's license was expired at the time of recredentialing. The license expired on March 31, 2020, and primary source verification and committee approval for this provider occurred on April 14, 2020.
  - Two files contained unsigned Ownership Disclosure Forms.
- Page 29 of the Provider Manual and page 20 of the Member Handbook state that for Plastic Surgeon services, "all services must be in an office setting." CCME requested an

explanation of this statement but no explanation or follow-up information was provided. The statement that all services by a plastic surgeon must be conducted in an office setting is either incorrect and/or confusing. The benefit grids in the Provider Manual and Member Handbook include covered services that could be provided by a plastic surgeon in either an outpatient or inpatient setting.

- The Provider Satisfaction Survey Response Rate was 6.6% for mail/internet surveys and 28% for phone surveys.

Corrective Actions

- Ensure all credentialing and recredentialing files for providers include an Ownership Disclosure Form and that signature dates are current.
- Ensure all recredentialing files for organizational providers have evidence of current, unexpired licensure, and that all Ownership Disclosure Forms are signed.

Recommendations

- Ensure all credentialing files for providers include a copy of the current malpractice insurance coverage verification document.
- Correct or clarify the information regarding limitations on plastic surgeon services in the Provider Manual and Member Handbook.
- Continue efforts to improve response rates to Provider Satisfaction Surveys.

III. Member Services

Magnolia's Member Services review focused on member rights and responsibilities, member informational materials and program education, the Member and Provider Services Call Centers, grievance processes and files, and the Member Satisfaction Survey.

Magnolia has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. CCME identified that Policy MS.MBRS.25, Member Rights and Responsibilities omitted one member right and one member responsibility. New members receive a New Member Packet with instructions for contacting Member Services, selecting a PCP, and initiating services. Information and resources in the Member Handbook, Provider Manual, on the website, and in member newsletters helps members understand and utilize their benefits.

The Member Handbook, which is also located on the website, provides useful information, is easily understood, and is written at a sixth grade reading level. The handbook informs members about rights and responsibilities, preventive health guidelines, appointment guidelines, and explains how to access benefits. Magnolia ensures member program

materials are written in a clear and understandable manner and meet contractual requirements.

The toll-free Member Services telephone number routes calls to reach appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. CST., Monday through Friday. Callers also have the option to transfer to the 24-hour Nurse Line. However, CCME noted the hours of operation for Provider Services is incorrect in the Provider Manual.

Policies define requirements and processes for handling member grievances and complaints. In addition to policies, grievance information is found in the Member Handbooks, Care Provider Manuals, and on the website. Grievance documentation issues were identified, such as incomplete requirements for record retention and incorrect timeframes for sending acknowledgement letters.

Grievance files reflect timely acknowledgement, timely resolution, and reviews conducted by appropriate staff. Grievance resolution notices contained contractually required information.

Member Satisfaction Survey Validation

Member Satisfaction Survey validation for Magnolia was performed based on the CMS Survey Validation Protocol. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. Magnolia contracts with SPH Analytics, a certified CAHPS Survey vendor, to conduct the Adult and Child Surveys.

The actual sample sizes were adequate and met the NCQA minimum sample size and number of valid surveys (at least 411), but the response rates were below the NCQA target of 40%. Generalizability of the survey results is difficult to discern due to low response rate for the survey. The Adult survey response rate was 23%; the Child survey response rate was 15%; and the Children with Chronic Conditions (CCC) survey response rate was 16% for the total sample and 16% for the general population. CCME offered a recommendation to determine if there are any new barriers to completion of surveys and to continue to work with SPH Analytics to improve response rates.

Magnolia reports the results of the member satisfaction survey to providers and to appropriate committees.

As noted in *Figure 4: Member Services Findings,* Magnolia achieved "Met" scores for 87.9% of the Member Services Standards.

Figure 4: Member Services Findings

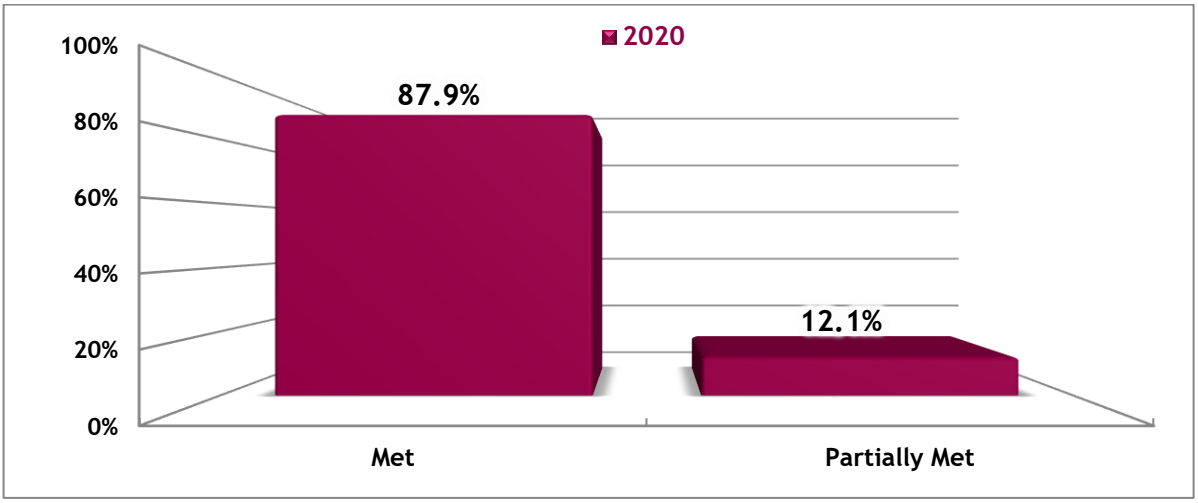


Table 7: Member Services

Section	Standard	CAN 2019 Review	CAN 2020 Review
Member Rights and Responsibilities	Member rights include, but are not limited to, the right: To privacy and confidentiality, both in their person and in their medical information	Met	Partially Met
	Member responsibilities include the responsibility: To show courtesy and respect to providers and staff	Partially Met	Met
Call Center	The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Met	Partially Met
Grievances	The procedure for filing and handling a grievance	Partially Met	Met
	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020

Strengths

- Grievance acknowledgement letters are written in easy-to-read language and clearly gives the date when the member will receive a decision from Magnolia.

- Magnolia provides the MyMobile App as an additional resource for members to obtain plan information.

Weaknesses

- Policy MS.MBRS.25, Member Rights and Responsibilities, does not include:
  - The member's right, "To privacy and confidentiality, both in their person and in their medical information".
  - The requirement that members have the responsibility to notify the plan for changes in family size, address changes, or other health care coverage.
- The Provider Manual incorrectly lists hours of operation from 8:00 a.m. – 5:00 p.m. CST instead of 7:30 am to 5:30 p.m. CST.
- Work Process, MS.HIM.11, Complaint and Grievance Process, incorrectly documents that grievance acknowledgements will occur within 10 calendar days.
- The Member Handbook, Provider Manual and the website, does not specify the name of the form required to file a grievance on a member's behalf.
- Policy MS.MBRS.07, Member Grievance and Complaints Process, does not include the complete record retention requirement, that records are retained during the entire term of the Contract.
- Response rates to the CAHPS Survey were below the NCQA target of 40%.

Corrective Actions

- Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member rights and responsibilities as required in *CAN Contract, Section 6 (J)*.
- Correct the Provider Manual to reflect Provider Services operating hours are 7:30 am to 5:30 pm CST, as required in *CAN Contract, Section 7(H)(I)*.
- Edit Policy MS.MBRS.07, Member Grievance and Complaints Process, to include the complete grievance requirement in *CAN Contract, Section 11(A)*.

Recommendations

- In the Member Handbook, Provider Manual, and the website, specify that an Authorized Representative Form is required to file a grievance on a member's behalf.
- Correct the Work Process, MS.HIM.11, Complaint and Grievance Process, to indicate grievances will be acknowledged within five (5) calendar days as required in *CAN Contract, Section 6 (K)*.
- Determine if there are new member barriers that contribute to the completion of surveys for the Adult, Child, and Child CCC populations and continue working with SPH Analytics to improve response rates.

IV. Quality Improvement

Magnolia's QI Program operates under a plan of continuous improvement. The 2020 MississippiCAN Quality Management Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The program description is reviewed and revised as needed on an annual basis. The scope of the QI program is addressed on pages one and two of the QI program description and included monitoring health care disparities for flu and primary care visits.

Magnolia's quality work plan defines the activities to be completed throughout the year. The work plan is developed annually and is based on the Quality Program Evaluation for the previous year. The work plan is updated frequently to document progress towards meeting the established goals.

The Quality Improvement Committee (QIC) performs oversight of all quality activities and is responsible for reviewing and monitoring all clinical, physical and behavioral health quality and service functions. Other committees involved in the quality improvement activities include the Performance Improvement Team and the Quality Task Force.

Membership for the QIC includes Magnolia's senior leadership, department directors and other health plan staff. Meetings are chaired by the Chief Medical Director. The committee's participant roster indicates there are five participating providers with specialties including pediatrics, family medicine, and psychiatry, and a nurse practitioner. A minimum of five members, including three plan staff and two external physicians, must be present for a quorum. Minutes are recorded for each meeting and document committee discussion points and decisions.

Providers receive interpretation of their QI performance data through Magnolia's Provider Analytic tools located on the secure provider portal. The Provider Analytic tools features care gaps, readmission data, cost utilization, performance measure results, and feedback regarding QI activities.

Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines indicates Magnolia, on an annual basis, measures Provider performance against at least two of the clinical guidelines. The policy also indicates Magnolia provides DOM the results of the study as well as a summary of any corrective actions taken to ensure future compliance with the guidelines. Magnolia chose the guidelines for diabetes care, prenatal care, ADHD, and depressions for monitoring and provided the report of the annual monitoring. There were three measures that did not meet the goal. During the onsite discussion, staff indicated the health plan was working to implement interventions to improve the rates and new interventions would be implemented in 2021.

Per policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Services, Magnolia's EPSDT Coordinator will monitor claims to identify members with any abnormal finding on an EPSDT screening. If there is no evidence that treatment was sought, the EPSDT Coordinator will contact the provider and member to assist in arranging an appointment for follow-up. Magnolia provided a copy of the tracking reports for monitoring the members identified as having an abnormal finding on an EPSDT screening. The tracking reports did not include the CPT and ICD-10 codes to identify the abnormal finding and the need for follow-up as mentioned in policy MS.QI.20.

Magnolia's MSCAN Quality Management Program Evaluation 2019 provides a summary of all completed and ongoing activities of the previous year. Barriers, interventions, and recommendations for 2020 were included for each activity. During the previous EQR, several recommendations were provided regarding the program evaluation, and it appears Magnolia implemented those recommendations.

Performance Measure Validation

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. DOM has selected a set of PMs to evaluate the quality of care and services delivered by Magnolia to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019.

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

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

calculations. The following are some of the main steps conducted during the validation process:

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

All relevant HEDIS performance measures for the current review year (MY 2019), as well as the previous year (MY 2018) and the change from 2018 to 2019 are reported in *Table 8: CAN HEDIS Performance Measure Results*. The change in rates shown in green indicate a substantial (>10%) improvement and the rates shown in red indicate a substantial (>10%) decline.

Table 8: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	86.86%	78.59%	-8.27%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	57.42%	54.74%	-2.68%
Counseling for Nutrition	51.58%	53.53%	1.95%
Counseling for Physical Activity	47.45%	43.55%	-3.90%
Childhood Immunization Status (cis)			

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
DTaP	79.32%	78.35%	-0.97%
IPV	93.92%	91.97%	-1.95%
MMR	94.16%	89.05%	-5.11%
HiB	89.05%	87.59%	-1.46%
Hepatitis B	93.19%	91.97%	-1.22%
VZV	94.65%	88.81%	-5.84%
Pneumococcal Conjugate	82.73%	79.32%	-3.41%
Hepatitis A	76.40%	79.56%	3.16%
Rotavirus	80.54%	79.81%	-0.73%
Influenza	32.36%	34.55%	2.19%
Combination #2	77.37%	77.13%	-0.24%
Combination #3	75.18%	75.18%	0.00%
Combination #4	62.53%	66.91%	4.38%
Combination #5	65.94%	68.13%	2.19%
Combination #6	27.98%	31.63%	3.65%
Combination #7	55.47%	61.56%	6.09%
Combination #8	25.30%	29.68%	4.38%
Combination #9	24.82%	28.47%	3.65%
Combination #10	22.87%	26.76%	3.89%
Immunizations for Adolescents (ima)			
Meningococcal	53.77%	59.12%	5.35%
Tdap/Td	74.70%	75.18%	0.48%
Combination #1	52.07%	58.15%	6.08%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	20.19%	16.79%	-3.40%
Lead Screening in Children (lsc)	71.88%	72.82%	0.94%
Breast Cancer Screening (bcs)	56.57%	56.74%	0.17%
Cervical Cancer Screening (ccs)	56.20%	61.56%	5.36%
Chlamydia Screening in Women (chl)			
16-20 Years	45.90%	50.29%	4.39%
21-24 Years	61.14%	62.01%	0.87%
Total	48.52%	52.02%	3.50%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	68.19%	70.56%	2.37%
Appropriate Treatment for Upper Respiratory Infection (uri)	NR	68.02%	NA

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	NR	43.76%	NA
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.91%	28.38%	-2.53%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	41.53%	45.77%	4.24%
Bronchodilator	77.06%	76.02%	-1.04%
Medication Management for People with Asthma (mma)			
5-11 Years - Medication Compliance 50%	49.43%	54.75%	5.32%
5-11 Years - Medication Compliance 75%	23.65%	25.63%	1.98%
12-18 Years - Medication Compliance 50%	49.71%	50.77%	1.06%
12-18 Years - Medication Compliance 75%	24.04%	22.94%	-1.10%
19-50 Years - Medication Compliance 50%	52.22%	55.45%	3.23%
19-50 Years - Medication Compliance 75%	25.60%	29.37%	3.77%
51-64 Years - Medication Compliance 50%	60.78%	64.04%	3.26%
51-64 Years - Medication Compliance 75%	30.39%	40.35%	9.96%
Total - Medication Compliance 50%	50.25%	53.57%	3.32%
Total - Medication Compliance 75%	24.25%	25.57%	1.32%
Asthma Medication Ratio (amr)			
5-11 Years	77.38%	79.47%	2.09%
12-18 Years	66.32%	71.15%	4.83%
19-50 Years	47.29%	51.37%	4.08%
51-64 Years	40.11%	43.62%	3.51%
Total	67.23%	69.99%	2.76%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	45.26%	41.85%	-3.41%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	58.00%	67.24%	9.24%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	73.69%	73.48%	-0.21%
Statin Adherence 80% - 21-75 years (Male)	46.68%	52.12%	5.44%
Received Statin Therapy - 40-75 years (Female)	70.19%	73.36%	3.17%
Statin Adherence 80% - 40-75 years (Female)	41.99%	48.05%	6.06%
Received Statin Therapy - Total	71.95%	73.42%	1.47%
Statin Adherence 80% - Total	44.41%	50.06%	5.65%
Effectiveness of Care: Diabetes			

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	88.08%	87.83%	-0.25%
HbA1c Poor Control (>9.0%)	47.93%	55.23%	7.30%
HbA1c Control (<8.0%)	45.01%	35.28%	-9.73%
HbA1c Control (<7.0%)	NR	NR	NR
Eye Exam (Retinal) Performed	68.37%	70.32%	1.95%
Medical Attention for Nephropathy	90.51%	93.67%	3.16%
Blood Pressure Control (<140/90 mm Hg)	47.45%	47.45%	0.00%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	57.19%	58.41%	1.22%
Statin Adherence 80%	39.86%	44.61%	4.75%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	38.76%	40.34%	1.58%
Effective Continuation Phase Treatment	23.88%	24.98%	1.10%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	57.06%	60.67%	3.61%
Continuation and Maintenance (C&M) Phase	70.50%	72.36%	1.86%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	66.53%	67.52%	0.99%
6-17 years - 7-Day Follow-Up	40.24%	39.85%	-0.39%
18-64 years - 30-Day Follow-Up	56.16%	56.33%	0.17%
18-64 years - 7-Day Follow-Up	28.15%	31.41%	3.26%
65+ years - 30-Day Follow-Up	0.00%	100.00%*	NA
65+ years - 7-Day Follow-Up	0.00%	0.00%	0.00%
30-Day Follow-Up	61.92%	62.96%	1.04%
7-Day Follow-Up	34.89%	36.39%	1.50%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	0.00%	3.45%	3.45%
7-Day Follow-Up: 13-17 Years	0.00%	3.45%	3.45%
30-Day Follow-Up: 18+ Years	5.16%	5.57%	0.41%
7-Day Follow-Up: 18+ Years	3.80%	2.93%	-0.87%
30-Day Follow-Up: Total	4.74%	5.41%	0.67%
7-Day Follow-Up: Total	3.49%	2.97%	-0.52%

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	72.45%	70.74%	-1.71%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	69.47%	69.13%	-0.34%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	64.15%	76.92%	12.77%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	57.21%	57.60%	0.39%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	24.32%	NA	NA
6-11 Years	19.25%	NA	NA
1-11 Years	NA	25.04%	NA
12-17 Years	28.04%	28.98%	0.94%
Total	24.23%	27.26%	3.03%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	NR	NR
Appropriate Treatment for Children with URI (uri)	65.20%	68.02%	2.82%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.96%	43.76%	10.80%
Use of Imaging Studies for Low Back Pain (lbp)	68.79%	71.96%	3.17%
Use of Opioids at High Dosage (hdo)	1.25%	1.46%	0.21%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	17.14%	15.27%	-1.87%
Multiple Pharmacies	10.85%	4.19%	-6.66%
Multiple Prescribers and Multiple Pharmacies	4.68%	2.31%	-2.37%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	9.93%	7.79%	-2.14%
18-64 years - >=31 Days covered	3.83%	3.49%	-0.34%
65+ years - >=15 Days covered	50.00%*	12.50%	-37.50%
65+ years - >=31 Days covered	0.00%*	0.00%	0.00%
Total - >=15 Days covered	9.94%	7.79%	-2.15%
Total - >=31 Days covered	3.83%	3.48%	-0.35%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	88.17%	88.06%	-0.11%
45-64 Years	92.25%	92.53%	0.28%

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
65+ Years	84.04%	80.19%	-3.85%
Total	89.95%	90.02%	0.07%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.82%	98.14%	0.32%
25 Months - 6 Years	91.70%	93.07%	1.37%
7-11 Years	92.74%	93.90%	1.16%
12-19 Years	90.95%	92.08%	1.13%
Annual Dental Visit (adv)			
2-3 Years	54.89%	56.15%	1.26%
4-6 Years	76.66%	76.79%	0.13%
7-10 Years	76.52%	77.86%	1.34%
11-14 Years	72.61%	73.63%	1.02%
15-18 Years	63.52%	65.24%	1.72%
19-20 Years	45.02%	44.15%	-0.87%
Total	70.10%	71.08%	0.98%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	76.09%	70.00%	-6.09%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	2.17%	3.33%	1.16%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	37.50%*	33.33%	-4.17%
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00*	0.00%	0.00%
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	69.72%	68.67%	-1.05%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	7.57%	3.00%	-4.57%
Total: Initiation of AOD Treatment: 13-17 Years	67.26%	66.67%	-0.59%
Total: Engagement of AOD Treatment: 13-17 Years	7.12%	3.17%	-3.95%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	45.13%	40.77%	-4.36%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	4.09%	4.59%	0.50%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	22.41%	31.97%	9.56%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	7.73%	12.12%	4.39%

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	38.37%	39.90%	1.53%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.73%	4.54%	-1.19%
Total: Initiation of AOD Treatment: 18+ Years	34.00%	36.73%	2.73%
Total: Engagement of AOD Treatment: 18+ Years	6.02%	6.27%	0.25%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	46.46%	41.69%	-4.77%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.01%	4.55%	0.54%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	22.54%	31.98%	9.44%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	7.66%	12.07%	4.41%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	42.09%	43.50%	1.41%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	5.95%	4.35%	-1.60%
Total: Initiation of AOD Treatment: Total	36.48%	39.09%	2.61%
Total: Engagement of AOD Treatment: Total	6.10%	6.03%	-0.07%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.27%	96.35%	6.08%
Postpartum Care	57.91%	67.15%	9.24%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 years	66.67%	NA	NA
6-11 years	71.56%	NA	NA
1-11 Years	NA	69.31%	NA
12-17 years	67.70%	66.09%	-1.61%
Total	69.34%	67.53%	-1.81%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.58%	1.45%	-1.13%
1 Visit	3.12%	3.26%	0.14%
2 Visits	4.39%	4.19%	-0.20%
3 Visits	6.25%	5.94%	-0.31%
4 Visits	11.34%	10.29%	-1.05%
5 Visits	19.87%	18.30%	-1.57%
6+ Visits	52.45%	56.57%	4.12%

Measure/Data Element	HEDIS 2019 (MY 2018)	HEDIS 2020 (MY 2019)	Change
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	60.43%	62.36%	1.93%
Adolescent Well-Care Visits (awc)	39.67%	41.71%	2.04%

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

As shown, two measures had substantial improvement of greater than 10%. Those included Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia and Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis. There were no measures with a substantial decrease in rate.

DOM requires the CCOs to report Adult and Child Core Set measures annually. The measure rates for the CAN population reported by Magnolia for 2019 are listed in *Table 9: CAN Non-HEDIS Performance Measure Rates*.

Table 9: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2019 Rate
Adult Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)	
Ages 18-65	0.19%
Ages 65+	0.00%
Total	0.19%
Maternal and Perinatal Health	
PC-01: ELECTIVE DELIVERY (PC-01)	
Women with elective vaginal deliveries or elective cesarean sections	**24.19%
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)	
Most or moderately effective contraception – 3 days	12.65%
Most or moderately effective contraception – 60 days	37.11%
LARC - 3 Days	0.76%
LARC - 60 Days Reported	7.32%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)	
Most or moderately effective contraception – 3 days	0.00%
Most or moderately effective contraception – 60 days	17.45%
LARC - 3 Days	0.00%

Measure	MY 2019 Rate
LARC - 60 Days Reported	1.34%
Care of Acute and Chronic Conditions	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)	
Ages 18-65	12.24
Ages 65+	0.00
Total	12.20
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)	
Ages 40-64	52.30
Ages 65+	47.82
Total	52.26
HEART FAILURE ADMISSION RATE **(PQI-08)**	
Ages 18-65	29.88
Ages 65+	0.00
Total	29.77
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)	
Ages 18-39	1.38
HIV VIRAL LOAD SUPPRESSION (HVL - AD)	
Ages 18-65	4.60%
Ages 65+	0.00%
Total	4.49%
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)	
Ages 18-65	2.39%
Ages 65+	0.00%
Total	2.38%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)	
Ages 18-65	2.90%
Ages 65+	0.00%
Total	2.90%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)	
Overall	18.92%
Prescription for Buprenorphine	0.00%
Prescription for Oral Naltrexone	0.00%
Prescription for Long-acting, injectable naltrexone	0.00%
Prescription for Methadone	0.00%
Child Core Set Measures	

Measure	MY 2019 Rate
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-CH)	
Ages 12-17	0.49%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	2.34%
Age 2 Screening	5.38%
Age 3 Screening	5.28%
Total Screening	4.27%
Maternal and Perinatal Health	
PC-02: CESEAREAN BIRTH (PC02-CH)	
Ages 9-17	**29.84%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CW)	
Deliveries covered by MD/CHP	NA
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or moderately effective contraception – 3 days	2.27%
Most or moderately effective contraception – 60 days	33.81%
LARC - 3 Days	1.14%
LARC - 60 Days Reported	9.38%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception – 3 days	0.00%
Most or moderately effective contraception – 60 days	20.46%
LARC - 3 Days	0.00%
LARC - 60 Days Reported	1.00%
Dental and Oral Health Services	
DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)	
Ages 6-9	5.18%
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1-20	35.78%

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

Magnolia did not report two of the Core Set measures. The two measures were Elective Delivery (PC-01) and Cesarean Birth (PC-02 CH). The rates were provided by DOM. It is recommended that Magnolia work proactively with DOM for clarification on measures that are required to be reported.

Performance Improvement Project Validation

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

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

The DOM-required PIP topics include: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult- COPD). Magnolia submitted four projects for validation. A project regarding Adult COPD was not submitted. *Table 10: CAN Performance Improvement Project Validation Scores* provides an overview of the scores for all four projects that were submitted and their current validation scores.

Table 10: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Asthma	91/91= 100% HIGH CONFIDENCE IN REPORTED RESULTS	80/80=100% HIGH CONFIDENCE IN REPORTED RESULTS
Behavioral Health Readmissions	67/72=93% HIGH CONFIDENCE IN REPORTED RESULTS	73/74=99% HIGH CONFIDENCE IN REPORTED RESULTS
Improved Pregnancy Outcomes with Makena	62/62=100% HIGH CONFIDENCE IN REPORTED RESULTS	73/74=99% HIGH CONFIDENCE IN REPORTED RESULTS
Sickle Cell Disease Outcomes	67/72=93% HIGH CONFIDENCE IN REPORTED RESULTS	73/74= 99% HIGH CONFIDENCE IN REPORTED RESULTS

All projects received scores in the "High Confidence Range," although three of the four PIPs did not show improvement in the indicator rates. The asthma PIP did have improvement in the indicator rates. However, the HEDIS measure, Medication Management for People with Asthma (MMA),used as the study indicator for this PIP was retired. Magnolia has closed this PIP and will implement a new Adult and Child

Respiratory Disease PIP. Magnolia indicated the new PIP will include child asthma and adult COPD as required by DOM.

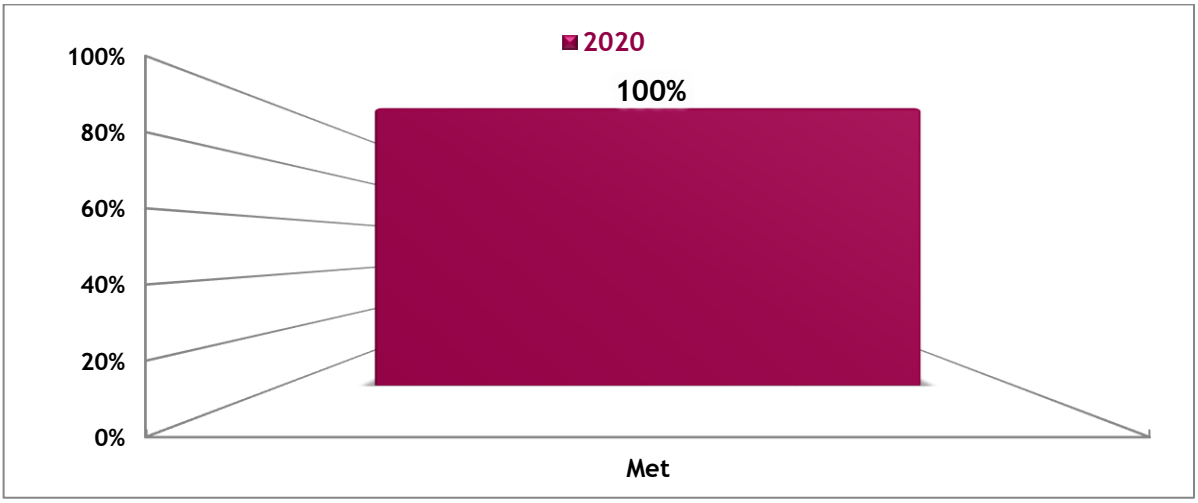
Recommendations for the Behavioral Health, Sickle Cell, and Improved Pregnancy Outcomes projects centered around revising interventions and monitoring ongoing interventions for the next cycle and are displayed in *Table 11: CAN Performance Improvement Project Recommendations*.

Table 11: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is to reduce the readmission rate to 6%. The annual report shows an increase from 7.98% to 13.05% for the first remeasurement period.	The current interventions may need to be revised for continued implementation in dealing with COVID-19. An analysis of most impactful interventions may need to be performed, and then re-focusing on those interventions until the rate decreases toward the goal rate.
Sickle Cell Disease Outcomes	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is to increase the rate of members who remain on the medication during the treatment period. The rate decreased slightly from baseline to remeasurement 1.	A barrier analysis was conducted, and interventions focused on member outreach, assistance with appointments, and education are currently active and should be continued. Discussion of any potential new interventions should be included in task force and work group meetings regarding PIPs.
Improving Pregnancy Outcomes with Makena	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is to increase the utilization of Makena and increase members that receive dose and deliver past 37 weeks. For utilization, the rate decreased from 66% to 59%. Benchmark is 79%. For delivery past 37 weeks, the rate also decreased from 59% to 27%. Benchmark is 73%.	Continue outreach interventions; and develop any provider-based interventions that might improve rates. Quality Task Force should continue to determine if current interventions are effective and initiate new interventions if current ones are not effective.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. For this EQR, all standards in the Quality Improvement section received a "Met" score.

Figure 5: Quality Improvement Findings



Strengths

- The Performance Measure validation found that Magnolia was fully compliant with all information system standards and determined that the health plan submitted valid and reportable rates for all HEDIS measures in scope of the audit.
- There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Magnolia followed the measure specifications and produced reportable rates for all measures in the scope of the validation.
- The following HEDIS 2020 measure rates were strengths for Magnolia since their rates had a greater than 10% improvement:
  - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure.
- All performance improvement project validations scored in the "High Confidence Range."

Weaknesses

- Magnolia provided a copy of the tracking reports for monitoring members identified as having an abnormal finding on an EPSDT screening. The tracking reports did not include the CPT and ICD-10 codes to identify the abnormal finding and the need for follow-up as mentioned in policy MS.QI.20, EPSDT Services.
- Magnolia did not report two Core Set measures. The two measures were Elective Delivery (PC-01) and Cesarean Birth (PC-02 CH). The rates were provided by DOM.
- Three of the four PIPs did not show improvement in the indicator rates.

- A performance improvement project regarding Adult COPD, as required by DOM, was not submitted.

Recommendations

- Update the tracking report to identify members needing follow-up care after an EPSDT screening and include the CPT and ICD-10 codes and the dates or notes regarding the contact made.
- Work proactively with DOM for clarification on Core Set measures that are required to be reported.
- Monitor the ongoing interventions and consider revising interventions as needed for PIPs not showing improvements in the indicator rates.
- Initiate a PIP focused on Respiratory Illness Management specific to the Child Asthma and Adult COPD population, as per DOM requirements.

V. Utilization Management

Review of Magnolia's Utilization Management (UM) Program include UM documents, medical necessity determination processes, pharmacy requirements, the Care Management Program, and a review of approval, denial, appeal, and care management files.

The Utilization Management Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services for members in Mississippi. Additionally, they outline the program's structure, lines of responsibility, and standards used for making UM determinations.

Service authorization requests are reviewed by appropriate staff using InterQual and other established criteria. Magnolia assesses consistency in criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers. Review of approval and denial files reflect consistent decision-making using approved criteria or professional clinical judgement.

Envolve Pharmacy Solutions is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services. Magnolia uses the most current version of the MS Division of Medicaid Universal Preferred Drug List (PDL), which is available on the website, to fulfill pharmacy requirements.

The Care Management Program and Population Health Management Program promote access and delivery of physical and behavioral health services to identified members. During the onsite teleconference, staff discussed the recent renaming and transitioning of the Medical Management Department to Population Health Management and Clinical Operations. Magnolia uses CM techniques to ensure comprehensive, coordinated care for

all members in various risk levels and follows a standard outreach process as it applies to continual care, transitional care, and discharge planning.

Magnolia has established policies defining processes for handling appeals of adverse benefit determinations. CCME identified documentation issues regarding appeals, such as use of outdated terminology for "adverse benefit determination" and an incomplete description of who can be a member's authorized representative. CCME's review of appeal files revealed appeals are processed with timely acknowledgement, resolution, and notification of resolution.

The UM Program is evaluated at least annually to assess its strengths and effectiveness. Overall, no major issues were identified. Minor documentation issues were noted with appeals definitions, and CCME offered recommendations to address them.

As noted in *Figure 6: Utilization Management Findings*, Magnolia received scores of "Met" for 98.1% of the standards, and "Partially Met" scores for 1.9% of the standards.

Figure 6: Utilization Management Findings

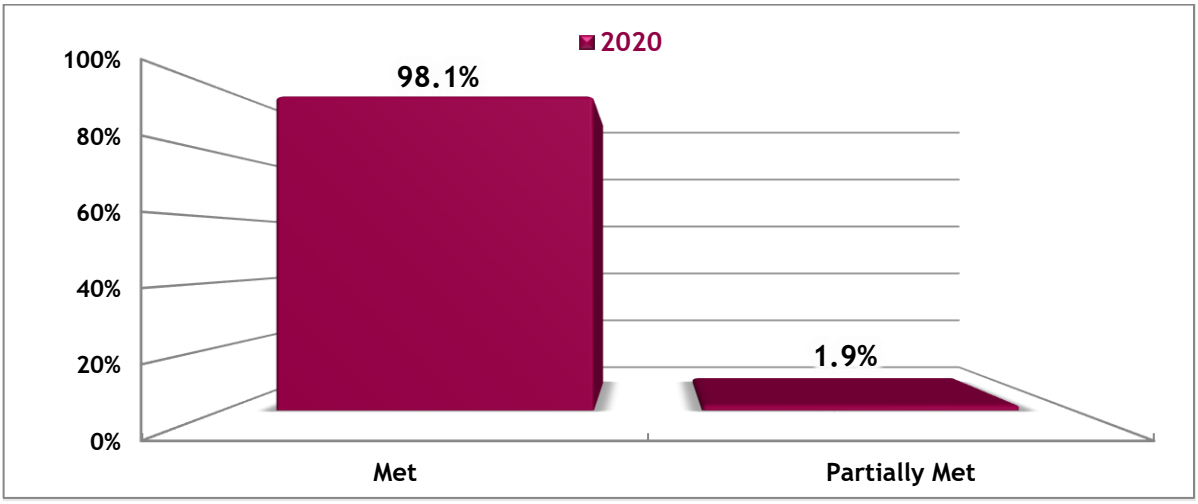


Table 12: Utilization Management

Section	Standard	CAN 2019 Review	CAN 2020 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Not Met	Partially Met
	The procedure for filing an appeal	Partially Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met

Section	Standard	CAN 2019 Review	CAN 2020 Review
Appeals	Other requirements as specified in the contract	Partially Met	Met
Transitional Care Management	The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020

Strengths

- Magnolia created a social determinants of health resource database to utilize when social determinants of health issues are identified with members.

Weaknesses

- The following issues are identified with appeals documentation:
  - The Utilization Management Program Description uses outdated terms such as "adverse medical necessity decision" and "adverse determination" instead of the correct term of "adverse benefit determination."
  - The Member Handbook and Provider Manual do not completely define who can be a member's authorized representative.

Corrective Actions

- Edit the Utilization Management Program Description to replace outdated terms for "adverse benefit determination." Refer to the *CAN Contract, Section 2 (A)*.
- Edit the Member Handbook and Provider Manual to clarify and describe who can act as a member's authorized representative.

VI. Delegation

CCME's EQR of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials.

Magnolia reported 19 current delegation agreements, as shown in *Table 13: Delegated Entities and Services*.

Table 13: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve Dental	Dental claims, network, utilization management, credentialing, and quality management

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

Magnolia retains accountability for each delegated service and monitors the performance of the delegated entity in accordance with Policy MS.QI.14, Oversight of Delegated Vendor Services and Policy CC.CRED.12, Oversight of Delegated Credentialing. A pre-delegation review is conducted to assess the entity's program, associated policies and procedures, staffing capabilities, and performance record prior to the entity performing the delegated activity. Annually, Magnolia conducts oversight monitoring for each delegated entity to determine whether the delegated activities are being carried out as

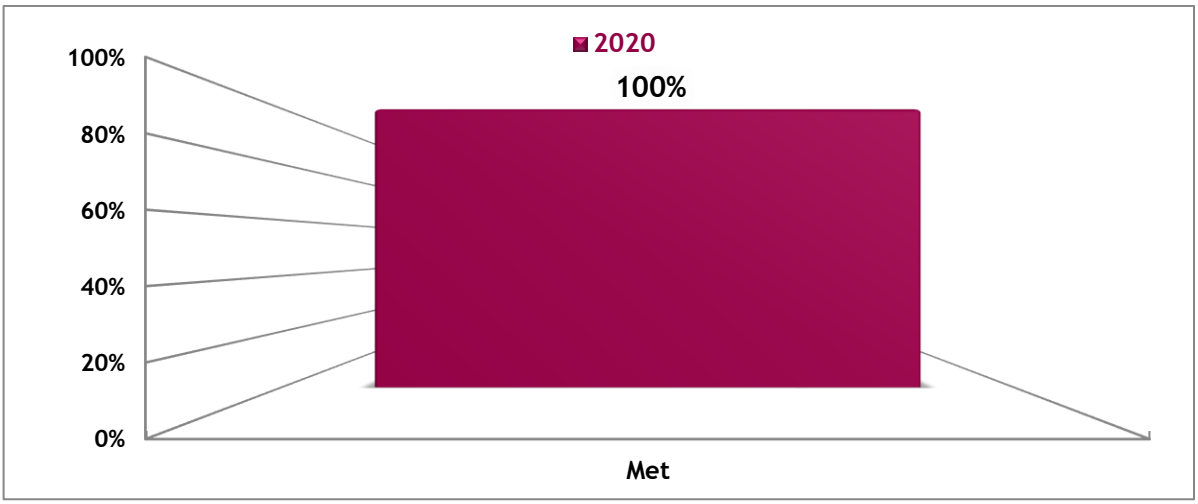
required. Magnolia provided a copy of the annual monitoring activities for each delegated entity. Deficiencies and applicable corrective actions were noted in the monitoring reports.

The monitoring tools for seven of the credentialing delegates noted the site visits for the primary care providers as not applicable. Per the *CAN Contract, Section E (3) (a), Provider Credentialing and Qualifications*, credentialing policies and procedures must meet Federal, State, and Division requirements and shall include a description of site assessment including the initial site assessment, prior to the completion of the initial credentialing process.

Also, Magnolia indicated that credentialing was included as a function delegated to Envolve Dental, Envolve Vision, Envolve Pharmacy Solutions and Medical Transportation Management. However, the annual monitoring did not include a review of the delegated credentialing.

As indicated in *Figure 7: Delegation Findings*, 100% of the standards in the Delegation section were scored as "Met."

Figure 7: Delegation Findings



Strengths

- Annual oversight monitoring for each delegated entity to determine whether the delegated activities are being carried out as required was conducted.

Weaknesses

- The monitoring tools for seven of the credentialing delegates noted the site visits for the primary care providers as not applicable.

- Credentialing was included as a function delegated to Envolve Dental, Envolve Vision, Envolve Pharmacy Solutions and Medical Transportation Management. However, the annual monitoring did not include a review of the delegated credentialing.

Recommendations

- Include in the delegation monitoring oversight a sample of credentialing and recredentialing files and ensure the site visit is included in the initial credentialing files for primary care providers.

ATTACHMENTS

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

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

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

July 2, 2020

Mr. Aaron Sisk
Plan President & CEO
Magnolia Health Plan
111 East Capitol Street, Suite 500
Jackson, MS 39201

Dear Mr. Wedin:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2020 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN Program (MSCAN) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME) and an onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The onsite visit will be conducted via teleconference on **October 7, 2020** through **October 8, 2020** for the MississippiCAN Program.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** list should be provided to CCME no later than **August 3, 2020**.

Please upload all the desk materials electronically to CCME through our secure file transfer website. The file transfer site can be found at: https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will simultaneously be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending until CCME grants you the appropriate security clearance.

We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site. We will also send written desk instructions on how to use the file transfer site. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support. Of course, additional information and technical assistance will be provided as needed.

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DOM, to describe the review process and answer any questions prior to the onsite visit is being offered as well.

Please contact me directly at 803-212-7586 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

External Quality Review 2020 for MississippiCAN

Materials Requested for Desk Review

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

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

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

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

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

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

Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information. (Note: this information will be requested quarterly.)

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

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

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

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs

for MSCAN. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

10. The Quality Improvement work plans for MSCAN for 2019 and 2020.

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

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

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

14. Membership lists and a committee matrix for all MSCAN committees including the professional specialty of any non-staff members. <u>Please indicate which members are voting members and include committee charters if available</u>.

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

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

17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews for MSCAN providers.

18. Provide reports for measuring provider adherence to medical record standards for 2019 and 2020.

19. A complete list of all MSCAN members enrolled in the Care Management program from June 2019 through June 2020. Please include open and closed files, the member's

name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

22. A report of findings from the most recent member and provider satisfaction surveys for the MSCAN program with a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and any other documentation of the requested scope of work.

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

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

25. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of June 2019 through June 2020.

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

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

28. Preventive health practice guidelines recommended by the CCO for use by practitioners for MSCAN members, 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.

29. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for MSCAN members, 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.

30. For the MSCAN program, a list of physicians currently available for utilization consultation/review and their specialty.

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

32. A sample provider contract for the MSCAN program.

33. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    h. A copy of the Information Security Plan & Security Risk Assessment.
    i. A copy of the claims processing monitoring reports covering the period of June 2019 through June 2020.

34. For the MSCAN program, 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.

35. Contracts for all delegated entities.

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

37. Please provider the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS 2020 (Measurement Year 2019) Roadmap (Record of Administration, Data Management and Processes) (Roadmap)	• Please submit the same Roadmap your CCO completed for the 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN.

Folder	Requested Document	Description
c.	HEDIS 2020 Final Audit Report (from Licensed Organization) for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that EQR reviewer may contact the vendor to review source code/process flow for measure production.
f.	List of measures rotated for HEDIS 2020 due to COVID-19 impact	Please submit a table/list of measures that were rotated for HEDIS 2020 due to COVID-19 impact.
g.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37g) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite visit.*
h.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37. h) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.*
i.	Reporting template populated with data for Non-HEDIS measure rates	CCME will provide the reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.

1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
2. HEDIS Certified Measures [SM] is a service mark of the NCQA.

38. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (including signed Ownership Disclosure Forms and provider office site visits as appropriate) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;

iv. Two network hospitals; and
v. One file for each additional type of facility in the network.

b. Recredentialing (including signed Ownership Disclosure Forms) files for:
   i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
   ii. Two OB/GYNs;
   iii. Two specialists;
   iv. Two network hospitals; and
   v. One file for each additional type of facility in the network.
c. Twenty-five medical necessity denial files for the MSCAN program made in the months of June 2019 through June 2020. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of June 2019 through June 2020, including any medical information and approval criteria used in the decision.
   Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

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

II. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied. (Please include QIC Meeting Minutes after April 2020.)
2. Compliance Program Description
3. All Provider Newsletters from 2020
4. Screen shots of Magnolia's Provider Analytic tool. Also, include an example of care gap reporting at the member level, quality measure results, and an example of a provider whose performance was identified as an outlier or out of range from his/her peers.
5. Copies of the following policies:
    a. MS.PRVR.09, Verification of Member Eligibility
    b. MS.CONT.01, Provider Network
    c. MS.PRVR.10, Evaluation of the Accessibility of Services
    d. CC.COMP.22, Policy and Procedure Documentation
6. Most recent evaluation of open/closed provider panels.
7. Provide a copy of a sample report generated to identify members needing follow-up care after an EPSDT screening. (This is referenced in policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Services.)
8. Results of the monitoring conducted to measure Provider performance against the clinical practice guidelines and any corrective actions taken for performance noted below the goal(s).
9. Documentation of the most recent usability testing of the web-based provider directory.
10. A policy that addresses provider medical record documentation requirements.
11. Documentation of provider medical record reviews conducted in 2019.

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

III. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation
- Member Satisfaction Survey Validation (Adult)
- Member Satisfaction Survey Validation (Child with CCC)
- Member Satisfaction Survey Validation (Child)
- HEDIS PM Validation
- CMS Adult Core Set Measures
- CMS Child Core Set Measures
- PIP Validation CAN
  - Asthma
  - Behavioral Health Readmissions
  - Sickle Cell Disease Outcomes
  - Improving Pregnancy Outcomes with Makena

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2019
Review Performed	2020

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. (updated based on October 2019 version of EQR protocol 6)

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

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**	Survey purpose documented in the report. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

Survey Element		Element Met / Not Met	Comments and Documentation
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

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 response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The total sample size was 2000 and 198 were ineligible. A total of 395 providers responded for a response rate of 6.6% for mail/internet surveys (n= 82 and n=37, respectively) and 28% for the phone (n=376) surveys. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Provider Satisfaction Report 2019 *Recommendation: Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the provider population on the satisfaction surveys.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Provider Satisfaction Report 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Provider Satisfaction Report 2019

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health**
Survey Validated	**CAHPS MEMBER SATISFACTION - ADULT**
Validation Period	2019
Review Performed	2020

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. (updated based on October 2019 version of EQR protocol 6)

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

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**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

Survey Element		Element Met / Not Met	Comments and Documentation
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

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 response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were used. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,350. The total completed surveys was 313 for a 23% response rate. This response rate is lower than the NCQA target rate of 40 and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019 *Recommendation: Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report - Adult 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report - Adult 2019

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2019
Review Performed	2020

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. (updated based on October 2019 version of EQR protocol 6)

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

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**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid.	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable.	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019

Survey Element		Element Met / Not Met	Comments and Documentation
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019

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 response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3,490 for the total sample. The total completed surveys was 545 for a 16% response rate. The sample size was 1,650 for the general population. The total completed surveys was 255 for a 16% response rate. These response rates are lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019 *Recommendation: Determine if there are any new barriers that occur for completion of surveys for the Child CCC member population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health**
Survey Validated	**CAHPS MEMBER SATISFACTION - CHILD**
Validation Period	2019
Review Performed	2020

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. (updated based on October 2019 version of EQR protocol 6)

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

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**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019

Survey Element		Element Met / Not Met	Comments and Documentation
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019

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 response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report - Child 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 2,310. The total completed surveys was 346 for a 15% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report - Child 2019 *Recommendation: Determine if there are any new barriers that occur for completion of surveys for the Child member population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report - Child 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report - Child 2019

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN AGE 18 AND OLDER (CDF – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	This hybrid measure was reported using only administrative methodology
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	This hybrid measure was reported using only administrative methodology

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ELECTIVE DELIVERY (PC-01)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CESAREAN BIRTH (PC02-CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTATIVE DENTAL SERVICES (PDENT -CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01 – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI05 - AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI08 - AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI15 – AD)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DENTALSEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL – CH)**
Reporting Year:	**2020**
Review Performed:	**10/7/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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**	

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**	
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**	

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**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Magnolia Health**
Name of PIP:	**ASTHMA**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	10.4% of Mississippi children ages 0-17 years and 7.5% of adults ages 18 and above currently have asthma.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one-year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and four remeasurement periods are documented.
7.4 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**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The goal is to increase the rate of members appropriately identified as having asthma and prescribed medication. The goal is 30.16% and although that has not been met, the most recent rate for 2019 was the highest rate at 25.57%.
9.2 Does the reported improvement in performance have "face" validity (i.e., Does the improvement in performance appear to be the result of the planned quality improvement intervention?)? **(5)**	**MET**	Improvement appears to be related to interventions that are impacting rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical tests were conducted to compare rates.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Hinds County has a high rate of readmissions.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement period 1 are reported.
7.4 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**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is to reduce the readmission rate to 6%. The annual report shows an increase from 7.98% to 13.05% for the first remeasurement period. *Recommendation: The current interventions may need to be revised for continued implementation in dealing with COVID-19. An analysis of most impactful interventions may need to be performed, and then re-focusing on those interventions until the rate decreases toward the goal rate.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement recorded.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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**
Name of PIP:	**SICKLE CELL DISEASE OUTCOMES (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	**In 2018, a low percentage of members were compliant with taking Hydroxyurea.**
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care and health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one-year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and one remeasurement period are documented.
7.4 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**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is to increase the rate of members who remain on the medication during the treatment period. The rate decreased slightly from baseline to remeasurement 1. *Recommendation: A barrier analysis was conducted, and interventions focused on member outreach, assistance with appointments, and education are currently active and should be continued. Discussion of any potential new interventions should be included in task force and work group meetings regarding PIPs.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	73
Project Possible Score	74
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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**
Name of PIP:	**IMPROVING PREGNANCY OUTCOMES WITH MAKENA (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	In 2018, Magnolia had 101 preterm births, with 34 eligible for Makena but not prescribed.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 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 changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one-year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and one remeasurement period are documented.
7.4 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**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is to increase the utilization of Makena and increase members that receive dose and deliver past 37 weeks. For utilization, the rate decreased from 66% to 59%. Benchmark is 79%. For delivery past 37 weeks, the rate also decreased from 59% to 27%. Benchmark is 73%. *Recommendations: Continue outreach interventions and develop any provider-based interventions that might improve rates. Quality Task Force should continue to determine if current interventions are effective and initiate new interventions if current ones are not effective.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	73
Project Possible Score	74
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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.*

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**Magnolia Health MS CAN**
Review Performed:	2020

I. ADMINISTRATION

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 members, both directly and indirectly.	X					CC.COMP.22, Policy Management provides processes and requirements for the development, review, approval, and maintenance of policies. All policies are reviewed and approved annually and as needed for changes in state or federal laws, regulations, or contractual obligations. Magnolia uses the RSA Archer® policy management system to manage policies and house policies for staff access. Staff are advised of new and revised policies through staff meetings and training sessions.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Aaron Sisk is Plan President & Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Sesha Mudunuri is Chief Operating Officer.
1.3 Chief Financial Officer;	X					Trip Peeples is Chief Financial Officer.
1.4 Chief Information Officer;	X					Mark Brooks is the Centene Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Cynthia Bruemleve is Manager, Claims & Configuration and serves as the Claims Administrator for Magnolia.
1.6 *Provider Services Manager;	X					Cynthia Douglas is Vice President, Network Development. The Senior Manager, Provider Relations is Diandra Lee, and the Senior Manager, Contracting & Network Development is Lalainya Williamson.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					Kennesha Higgins is Senior Manager, Customer Service.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					Tinisha Woodberry is Supervisor, Clinical Grievance & Appeals.
1.9 Utilization Management Coordinator;	X					Michael Adcock is the Vice President, Medical Management. Cherie Polk is Senior Director, Medical Management.
1.9.1 *Medical/Care Management Staff;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Quality Management Director;	X					Carrie Mitchell is Vice President, Quality Improvement. Jeff Martin is Director, Quality Improvement and Suzanne Lindley is Senior Manager, Quality Improvement.
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Rebecca Waterer, MD is Vice President, Medical Affairs/Pharmacy. Jeremy Erwin, MD is the Chief Medical Director. Leigh Campbell, MD and Bri May, MD are Medical Directors. Faiza Qureshi, MD is the Medical Director for behavioral health.
1.13 *Compliance Officer.	X					Will Simpson is Vice President, Compliance and serves as the Compliance Officer for Magnolia. Nicole Litton is Director of Compliance.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia has set goals for 99% of clean claims to be completed in 30 days, 99% in 60 days, and 100% within 90 days. Additionally, Information Systems Capabilities Assessment (ISCA) documentation states all claims processors are required to adhere to accuracy and timeliness standards. Claims processing statistics supplied for desk review show that Magnolia exceeds Mississippi's 30-day payment requirement (90%) by paying 100% of claims in 30 days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia begins processing the Enrollment 834 files when they are made available by the State, and the ISCA documentation notes that enrollment data is typically processed within 24 hours. Member ID numbers included in the 834 files are used to identify enrollees, and the organization notes that its systems are capable of tracking claims, encounters, and enrollees across multiple product lines. Finally, the organization's processing systems merge duplicate records that are detected while retaining the enrollee's membership history.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Magnolia uses NCQA certified software to calculate and generate HEDIS reports. The organization audits and tests the software annually by a certified HEDIS auditor. Additionally, the organization's HEDIS analyst verifies rate and population data monthly.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia has a detailed disaster recovery (DR) plan that is tested annually. The organization's most recent disaster recovery test demonstrated all systems could be successfully restored. As is the case with most thorough DR tests, Magnolia identified areas that could be revised to improve recovery times and the DR test results noted the work that would be performed to address those improvements.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					Magnolia's Compliance Program Description (Compliance Plan), found in Policy CC.COMP.100, covers processes and controls that make up the Compliance Program and provides guidance for ethical conduct that aligns with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Centene standards, values, and expectations as well as applicable laws, regulations, policies, and procedures. The Fraud, Waste and Abuse Plan (FWA Plan), found in Policy CC.COMP.16, describes processes to comply with applicable regulations and to prevent fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Centene Corporation Business Ethics and Code of Conduct: A Guide to Conduct in the Workplace (Code of Conduct) applies to all employees of Centene Corporation and subsidiaries.
2.2 Identification of the Compliance Officer;						Magnolia's Compliance Officer and Compliance Committee are responsible for implementation and ongoing monitoring of the Compliance Program. They report to the President/CEO and governing Board.
2.3 Information about the Compliance Committee;						Information about Magnolia's Compliance Committee is found in the Compliance Plan. Additionally, the Compliance Committee Charter states, "The Compliance Committee consists of a cross-functional team that is responsible to provide Magnolia with feedback and to make recommendations regarding health plan compliance issues. This Committee reports directly to the BOD."
2.4 Compliance training and education;						Information about Compliance training and education is included in the Compliance Plan. Employees are required to attend specific training during new hire orientation and annually thereafter. Topics include, but are not limited to, overviews of federal and state statutes, pertinent laws related to fraud and abuse, regulations, guidelines, Centene's policies, and ethics. A variety of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						training methods are used, such as in-services, online training, and newsletters to ensure employees understand the standards of conduct and procedures for alerting senior management to any problems and concerns.
2.5 Lines of communication;						Processes are in place to submit, record, and respond to compliance questions and reports of noncompliance. Confidentiality is maintained to the extent possible, anonymity is allowed, and there are assurances of non-retaliation against anyone who reports suspected misconduct or FWA. Methods to ask compliance questions and to report suspected FWA are publicized and disseminated through group and department meetings, email, mailings, awareness articles, posters displayed in common work areas, the website, etc. An Ethics & Compliance Helpline is available to all employees, and additional resources include access to the corporate Compliance Officer, the corporate President and CEO, and the Board of Directors.
2.6 Enforcement and accessibility;						The Code of Conduct states, “It is the policy of the Company to prevent the occurrence of unethical or unlawful behavior, to halt such behavior as soon as reasonably possible after its discovery, and to discipline directors, officers, or employees who violate the standards contained in the Code. This includes any individuals who fail to report a known violation.” The Code of Conduct further states that individuals who violate the Code of Conduct may be subject to disciplinary action up to and including termination, civil liability, criminal prosecution under applicable law, etc.
2.7 Internal monitoring and auditing;						Centene performs periodic compliance audits focusing on company programs or divisions, including external

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						relationships with third-party contractors. The Compliance Program also incorporates reviews at least annually of whether compliance elements have been satisfied to verify conformance by departments. If monitoring reveals that deviations were not detected in a timely manner due to program deficiencies, modifications are implemented. Monitoring may include, but is not limited to, unannounced site visits, staff interviews, questionnaires, medical and financial record reviews as well as reviews of other written materials and documentation, trend analyses, and longitudinal studies. Centene has established a Third Party Risk Management Program to promote communication and collaboration, and to ensure third party adherence to state, federal, and NCQA requirements.
2.8 Response to offenses and corrective action;						The Compliance Officer initiates prompt investigations of reported or suspected violations or noncompliance to determine if an actual violation has occurred and takes steps to correct the problem. These steps may include an immediate referral to criminal or civil law enforcement authorities, a corrective action plan, or a report to the state or federal authorities. Additional detail about responses to offenses and corrective action is found in the Compliance Plan.
2.9 Exclusion status monitoring.						Processes to conduct exclusion status monitoring for employees, vendors, and board members are described in Policy CC.COMP.36, Monthly Employee, Vendor, and Board Member Exclusion Screening. An exclusion screening vendor, OIG Compliance Now, conducts screenings on behalf of Centene and Magnolia. All health plan employees, vendors, and other subsidiary

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						temporary/contingent employees, consultants, contractors, and volunteers are screened monthly.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee Charter defines the committee's purpose, objectives, structure and operation, membership, decision authority, and meeting frequency. The committee meets quarterly and as needed, is chaired by the Compliance Officer, and reports directly to the Magnolia Board of Directors and the Corporate Compliance Committee. The quorum is established as 50% of voting members, and the attendance expectation is 75% of meetings. When comparing the membership of the committee documented on the Compliance Committee Charter against the most recent Compliance Committee minutes from June 18, 2020, there were discrepancies noted. The minutes appear to show all the members listed in the charter plus an additional 26 members. Also, it was impossible to tell on the minutes which attendees are committee members and which members have voting rights. During onsite discussion of these findings, Magnolia agreed that the minutes are not clearly formatted to indicate which attendees are committee members and which have voting rights. *Recommendation: Revise formatting for future Compliance Committee meeting minutes to clearly reflect members versus attendees, and to indicate who has voting rights.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Magnolia's FWA Plan, policies, and ISCA documentation confirm processes have been established to prevent and detect potential or suspected FWA, including the use of:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•pre-payment claims edits •pre- and post-payment audits of claim payments and related systems •safeguards against unnecessary or inappropriate use of services •monitoring for over- and under-utilization
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					A specialized triage team within the Special Investigations Unit (SIU) evaluates all referrals to the SIU and logs all FWA referrals with a summary of the allegation and relevant information. The case is then assigned to an investigator. During the investigation process, the SIU and health plan collaborate to ensure all actions are completed accurately and timely. The health plan Work Group reviews final SIU reports and makes decisions for action. Action may include: •Provider or member education when there is a billing error but no confirmed abuse or fraud. •Corrective action plan developed by CCO staff, often with the Chief Medical Director, to resolve the billing or service issues. •Federal/State referral when necessary based on regulations and/or the seriousness of the violation. •100% prepayment review to continually monitor the provider's billing to ensure compliance with any education resulting from an investigation.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes and requirements related to payment suspensions and recoupments are included in the FWA Plan and in its associated Mississippi – State Specific Guidelines attachment (Attachment M).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Policy MS.PHAR.15, Pharmacy Lock-In Program defines processes and requirements for the program, and includes all contractual requirements found in the *CAN Contract, Section 11 (F).*
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy CC.COMP.04, Confidentiality and Release of Protected Health Information indicates Centene and Magnolia comply with all applicable laws regarding use and disclosure of protected health information and confidential provider information. Protected health information may only be used or disclosed pursuant to the terms of a valid authorization for the purpose of treatment, payment, or healthcare operations. Policy CC.COMP.10, Annual Compliance Training confirms that initial training for newly hired employees includes the topics of privacy and confidentiality. The Notice of Privacy Practices and the Member Authorization to Disclose Health Information form are included in the Member Handbook. The Notice of Privacy Practices, Member Authorization to Disclose Health Information form, and Revocation of Authorization to Disclose Personal Health Information form are available on Magnolia's website. Onsite discussion confirmed all employees sign a confidentiality agreement during initial orientation/training, and annually thereafter. Board members and external providers of various committees also sign confidentiality agreements.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The Centene Corporation Credentialing Program Description (Credentialing Plan) provides an overview of credentialing processes. Detailed information is found in related credentialing and recredentialing policies.
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					Magnolia's Credentialing Committee uses a peer-review process to make recommendations regarding credentialing decisions. Committee membership includes network providers who provide advice and expertise for credentialing decisions, review credentials for providers who do not meet established thresholds, and ensure clean files are reviewed and approved by a medical director or designated physician. The local Medical Director has overall responsibility for the Credentialing Committee's activities. Voting members of the committee are the Medical Director and network physician attendees. The committee's quorum is defined as a minimum of 50% of voting members in attendance, and the attendance requirement is 75% of scheduled meetings. The Credentialing Committee meets monthly and reports to the QIC quarterly. CCME's review of committee minutes confirms the committee meets at the stated frequency. Based on documentation of attendance at meetings over the past year, it appears two network providers did not meet the attendance requirement. One attended only 66% of the meetings, and the other attended only 50%. This was discussed during the onsite, and Magnolia responded they would engage with the two providers to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						try to improve their attendance, and if necessary, replace the providers on the committee.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						Issues identified in the credentialing files are addressed in the standards below.
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant:	X					
3.1.4 Work history;	X					
3.1.5 Malpractice insurance coverage / claims history;	X					One initial credentialing file was missing verification of malpractice insurance coverage. *Recommendation: Ensure all credentialing files include a copy of the current malpractice insurance coverage verification document.*

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 the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
3.1.15 Ownership Disclosure form.		X				Three initial credentialing files were missing a copy of the Ownership Disclosure Form. An additional five files contained outdated Ownership Disclosure Forms with signatures dated up to four years prior to the credentialing decision. During onsite discussion, credentialing staff reported that at the time of credentialing, Ownership Disclosure Forms must have been signed within 12-14 months of the credentialing event. *Corrective Action: Ensure all credentialing files include an Ownership Disclosure Form and that signature dates are current.*
3.2 Site assessment.	X					Due to COVID-19, site visits are not currently being conducted. Magnolia reports that when restrictions are lifted, all site visits that were delayed will be completed.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					Issues identified in the recredentialing files are addressed in the standards below.
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 members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure form.		X				The Ownership Disclosure Forms in two recredentialing files were outdated, with signatures dates as old as four years prior to the credentialing decision date. *Corrective Action: Ensure all Ownership Disclosure Forms are current.*
4.3 Provider office site reassessment, when applicable.	X					
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy MS.PRVR.23, Provider Termination describes the processes followed when a provider is terminated for cause. The policy includes the requirements listed in the *CAN Contract, Section 7 (D) (3).* Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting describes actions that may be taken against a practitioner for quality issues (including suspension, restriction, or termination) and processes for a formal provider appeal process and reporting to appropriate authorities. The Quality Improvement and Credentialing programs monitor providers for quality and safety of their services, and the Credentialing Committee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determines, after investigation by the Medical Director, a peer review committee, or by the Credentialing Committee itself, if a provider's network participation should be suspended, restricted, or terminated. Procedures for identifying, monitoring, investigating, and analyzing potential or suspected quality of care incidents are addressed in Policy CC.QI.17, Potential Quality of Care Incidents. Policy CC.CRED.08, Practitioner Appeal Hearing Process addresses processes for provider appeals when the Credentialing Committee recommends termination, revocation, or suspension of network participation for reasons relating to the competence or professional conduct of the practitioner.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				Policy CC.CRED.09, Organizational Assessment and Reassessment defines processes for ensuring all institutional providers are accredited and/or licensed according to applicable state and federal regulations and applicable standards of accrediting bodies, such as the National Committee for Quality Assurance (NCQA). No issues were identified in the initial credentialing files for organizational providers. However, the following issues were noted in the organizational provider recredentialing files: •One provider's license was expired at the time of recredentialing. The license expired on March 31, 2020, and primary source verification and committee approval for this provider occurred on April 14, 2020. •Two files contained unsigned Ownership Disclosure Forms. *Corrective Action: Ensure all recredentialing files for organizational providers have evidence of current,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						unexpired licensure, and that all Ownership Disclosure Forms are signed.
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.01, PCP Member Panel Reports states the current PCP Panel/Patient List is available at any time to participating PCPs who are registered for the secure provider web portal. Magnolia makes the list available within five business days of receiving the monthly enrollment file. Providers who do not have access to the secure provider portal or who would like an additional copy of the PCP Panel/Patient List may contact Provider Relations to request a copy. Providers may also contact the Provider Services Call Center to verify member eligibility as well as their member panel.
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 states Magnolia ensures non-participating providers can verify member enrollment within five business days of the date Magnolia receives the Member Listing Report from DOM. Onsite discussion revealed non-participating providers can contact the call center to verify a member's enrollment and may also check DOM's Envision website.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Provider's limitations on panel size are monitored and tracked via quarterly geographic access reports that have a separate report of open/closed provider panels.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability defines mechanisms to monitor the type, number, and geographic distribution of PCPs. Practitioner type and availability is measured at least annually by the Provider Relations Department. Onsite discussion confirmed geographic access studies are conducted quarterly. Also considered are member satisfaction survey results, grievances, and complaints about provider availability. Geographic access reports reflect appropriate standards are used to measure access to PCPs. The MSCAN Quality Management Program Evaluation 2019 confirms 100% of members have appropriate access to PCPs.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability defines mechanisms to monitor the type, number, and geographic distribution of high-volume and high-impact specialty care providers. The policy states the goal for the percentage of members who have a specialty care provider within an acceptable distance is 95%. Practitioner type and availability is measured at least annually by the Provider Relations Department. Onsite discussion confirmed geographic access studies are conducted quarterly. Also considered are member satisfaction survey results and grievances/complaints about provider availability. Geographic access reports reflect appropriate standards are used to measure access to specialty care providers. The MSCAN Quality Management Program Evaluation 2019 confirms goals for the percentage of members with appropriate access to specialty care providers were met.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					Magnolia analyzes data regarding member cultural needs and preferences at least annually to determine whether the current provider network is meeting these needs. Member needs and preferences are assessed through CAHPS surveys, US Census data, a language line assessment, and member complaint/grievance data. Policy MS.QI.04, Evaluation of Practitioner Availability defines procedures to assess cultural needs and preferences. Interventions to address identified areas for improvement include: •Recruiting, contracting, and credentialing practitioners and providers who speak languages reflecting members' linguistic, cultural and/or ethnic needs and backgrounds. •Encouraging practitioners to complete cultural competency training courses based on the racial or ethnic composition of the member population. CCME noted the Provider Directory documents completed cultural competency courses.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy CC.PRVR.48, Evaluation of the Accessibility of Services describes processes to monitor member access to primary care, behavioral health, and specialty care services annually through CAHPS survey results, complaint/grievance/appeal data, and site specific surveys/audits conducted telephonically or onsite. If minimum compliance is not met, a written corrective action plan is implemented. The provider is allowed enough time to demonstrate a change as described in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the corrective action plan, and another audit is conducted to monitor for improvement. If minimum compliance is not met after the second audit, the Credentialing Committee, or other appropriate committee, recommends next steps for corrective action. The MSCAN Quality Management Program Evaluation 2019 states that during the second quarter of 2019, a telephone survey of 412 PCP offices (a total of 3,164 PCPs) was conducted. Additionally, a telephone survey was conducted after hours to gather data on after-hours access. Results of this monitoring were documented in the MSCAN Quality Management Program Evaluation 2019 and reflected several appointment goals were not met: •PCP routine appointments (via CAHPS question 6) •PCP urgent appointments (via CAHPS question 4) •Behavioral Health urgent appointments (via telephonic study) Additionally, the PCP after-hours care (via after hours call study) goal of 95% compliance was not met at 79% compliance. The documentation included in the MSCAN Quality Management Program Evaluation 2019 included identified barriers as well as interventions to address the barriers.
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy CC.PRVR.13, Provider Orientations describes the process for educating newly contracted providers about the health plan. Provider orientation is scheduled within 30 days of the contract execution date or the date the provider becomes participating in the network, whichever comes first, and a follow-up session is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						tentatively scheduled to provide an opportunity for provider questions. Core elements of provider orientation are listed in an attachment to the policy. In addition to the orientation, the Provider Manual is a thorough source of information for providers.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					Policy CC.PRVR.13, Provider Orientations, Attachment A – Provider Orientation Core Elements includes Case Management Programs. The Provider Manual provides detailed information about Care Management and its various programs.
2.2 Billing and reimbursement practices;	X					Policy CC.PRVR.13, Provider Orientations, Attachment A – Provider Orientation Core Elements includes a Claims Processing Overview covering filing limits, billing requirements, EDI billing requirements, clearinghouse information, methods to submit claims, claims address, claims submission and resubmission, and appeals. Information about billing and reimbursement practices is also found in the Provider Manual.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					Member benefits, including covered services, excluded services, and services provided under fee-for-service by DOM are covered in the Provider Manual. When reviewing benefit information in the Provider Manual, CCME noted a statement on page 29 (and also on page 20 of the Member Handbook) that for Plastic Surgeon services, "all services must be in an office setting." CCME requested an explanation of this statement, and Magnolia staff stated they would follow-up. However, no explanation or follow-up information was provided. The statement that all services by a plastic surgeon must be conducted in an office setting is either incorrect

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and/or confusing. The benefit grids in the Provider Manual and Member Handbook list covered services that could be provided by a plastic surgeon in either an outpatient or inpatient setting. *Recommendation: Correct or clarify the information regarding limitations on plastic surgeon services in the Provider Manual and Member Handbook.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					Information is included in orientation and is found in the Provider Manual and on Magnolia's website.
2.11 Prior authorization requirements including the definition of medically necessary;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with contract requirements.	X					Policy MS.PRVR.19, Provider Directory states, "The Plan will make available hard copy provider directories in the State Medicaid Regional offices, in the Plan's office, WIC offices, upon member request, and other areas as directed by the Division." Magnolia's web-based Provider Directory is searchable by many components, including but not limited to, name, specialty, languages spoken, and location. The Provider Directory data is updated nightly by refreshing from the Enterprise Data Warehouse (EDW) system. Printed directories are updated annually and if there are significant network changes. Policy MS.PRVR.19 states Magnolia performs usability testing of the web-based Provider Directory through its

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member Advisory Committee or by random survey on an ad hoc basis and after any upgrades to functionality or design that directly affect how members or providers use the site. Usability is evaluated in the following areas: font size, reading level, content organization, ease of navigation, and directories in language other than English (if applicable). Magnolia last conducted usability testing on the web-based provider directory in February 2020.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Policy MS.PRVR.14, Provider Visit Schedule indicates Magnolia establishes regular monthly meetings with VIP providers and with other providers as needed. Magnolia reported that due to restrictions related to COVID-19, processes have been adjusted to provide ongoing education to network providers through use of webinars, web-based conferences, virtual sessions, etc.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines describes processes for adopting and distributing preventive health guidelines. Magnolia adopts preventive health guidelines (PHGs) from recognized sources for the provision of preventive care services relevant to the member population. The guidelines are subjected to appropriate physician review and adoption through the QIC and are updated at least every two years and when there is new scientific evidence or change in national standards.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Guidelines are distributed to practitioners and upon request to members, potential members, and providers. New or updated guidelines are disseminated to providers via Magnolia's website within 60 days of adoption or revision. A list of adopted PHGs is maintained in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Manual with a notation that the links and/or full guidelines are available on the website or hard copy upon request. Additional mechanisms to distribute guidelines include, but are not limited to new practitioner orientation materials, newsletters, and special mailings.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines describes processes for adopting and distributing clinical practice guidelines (CPGs). Magnolia adopts CPGs from recognized sources for the provision of acute and chronic care services relevant to the member population as well as behavioral health services. The guidelines are subjected to appropriate physician review

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
developed in conjunction with pertinent network specialists.						and adoption through the QIC and are updated at least every two years and when there is new scientific evidence or change in national standards.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	X					Guidelines are distributed to practitioners and upon request to members, potential members, and providers. New or updated guidelines are disseminated to providers via Magnolia's website within 60 days of adoption or revision. The adopted CPGs are maintained on the Magnolia website and are discussed in the Provider Manual, with a notation that the links and/or full guidelines are available on the website or hard copy upon request. Additional mechanisms to distribute guidelines include, but are not limited to new practitioner orientation materials, newsletters, and special mailings. Magnolia's website includes a list of the adopted guidelines with a notation that due to inactive links, the URLs for the guidelines have been removed, and instruction to copy and paste or type the Guideline Title in the user's browser and search to access to the guidelines.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MS.QI.13, Medical Record Review, describes processes used to monitors providers' maintenance of medical records in a current, detailed and organized manner. The policy includes minimum documentation standards for provider medical records. The Provider Manual includes information about medical record-keeping practices and requirements, including required documentation components. The Medical Record Review Template is available on Magnolia's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						website and contains identical information as that presented in the Provider Manual.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					The 2020 MississippiCAN Quality Management Program Description states Magnolia monitors network practitioners for maintenance of medical records and that providers must meet specific requirements for medical record-keeping. Medical Record Reviews are conducted annually for a sample of providers to determine compliance to the documentation standards. Magnolia works with providers who score below the benchmark to develop an action plan for improvement. Medical record review results are reported to the QIC and shared with the Credentialing Department as needed for consideration at the time of recredentialing. Due to COVID-19, the 2020 Medical Record Review was delayed but resumed in August 2020, and results were reported to the QIC in October 2020.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems. Supporting documentation included the SPH Analytics Provider Satisfaction Report 2019 and the MSCAN Quality Management Program Evaluation 2019.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified. Results were presented to the QIC committee in the February 2020 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Member rights are listed in Policy MS.MBRS.25, Member Rights and Responsibilities, Member Handbook, Provider Manual, and the member website. Policy MS.CM.10, Advance Directives, describes processes for informing members about Advance Directives.
2. Member rights include, but are not limited to, the right:		X				See 2.2 for specific issues.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						Policy MS.MBRS.25, Member Rights and Responsibilities, does not include the member's right, "To privacy and confidentiality, both in their person and in their medical information." During the onsite teleconference Magnolia explained the policy was updated and that they would submit it. Upon review, CCME still could not identify that the requirement was included. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member rights as required in CAN Contract, Section 6 (J).*
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:		X				Member responsibilities are listed in Policy MS.MBRS.25, Member Rights and Responsibilities, the Member Handbook, Provider Manual, and the member website. See standard 3.5 for specific comments.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate 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 member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						Policy MS.MBRS.25, Member Rights and Responsibilities does not include the requirement that members have the responsibility to notify the Plan for changes in family size, address changes, or other health care coverage. During the onsite teleconference Magnolia explained the policy was updated and stated they would submit it. Upon review, CCME still could not identify that this requirement was included. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member responsibilities as required in the CAN Contract, Section 6 (J).*
III B. Member CCO Program Education						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					Policy MS.MBRS.01, New Member Packet/Member ID card, Policy MS.MBRS.02, and the Member Handbook, state members are provided, via priority or first-class mail, a New Member Packet within 14 days after Magnolia receives the member's enrollment data from MS DOM. It includes all contract required information such as the CAN ID card, Member Handbook, benefit booklet and instructions to access or request a Provider Directory from the website. See corresponding comments in standards 1.1 to 1.20.
1.1 Full disclosure of benefits and services included and excluded in coverage;						Benefit information is provided in the Member Handbook and easily located on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The Member Handbook provides instructions for and limitations on obtaining care from out-of-network providers. Members are informed they may have to cover the costs for unauthorized services from out-of-network providers, except in emergent situations.
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 Member Handbook and Magnolia's website provide clear and specific information instructing members on the appropriate level of care for a routine, urgent, or emergent healthcare need for medical, dental, and behavioral health services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List (PDL) and to find participating pharmacies, or to contact Member Services to obtain this information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Members who are pregnant, under 18 years of age, and of the Indian Race are exempt from copays. Contraceptives, vaccines, antiretroviral drugs, and hepatitis C drugs are exempt from copays. Effective January 1, 2020, Magnolia applied a $1.00 copay to certain brand name, OTC, narcotic, and benzodiazepine medications. These copays are capped monthly at $11.00 per household. Discussions during the onsite teleconference confirmed Magnolia received approval from DOM to implement this copay.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Magnolia notifies members of changes to the program no later than 30 calendar days prior to implementation, as described in Policy MS. MBRS.12, Member Notification of Plan Changes, and noted in the Member Handbook. Updates to the PDL are maintained by DOM, appropriately dated to indicate the effective date, and accessible on Magnolia's website.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						The Member Handbook provides contact information and descriptions for Member Services, the 24-Hour Nurse Advice Line, the secure member portal, and the MyMagnolia Mobile App. Members can communicate with Member Services staff, view their benefit summary, and change their PCP when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						logged into the secure portal. Through the mobile app, members can view their member ID Card, receive health service reminders, and quickly call their PCP with a speed-dial button.
1.13 A description of EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						The Member Handbook provides information on the requirements for disenrollment and instructs members to make requests directly to DOM, either in writing or by phone.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						The Member Handbook informs members to contact Member Services or use the Provider Directory to select a PCP and obtain information about the PCP. The website informs members how to obtain provider credentials.
1.17 Instructions for reporting suspected cases of fraud and abuse;						The FWA program is defined and described in the Member Handbook and the website. Instructions are provided for members to anonymously report FWA to Magnolia and DOM.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						Magnolia's Care Management Program is described in the Member Handbook and on the website. Members are instructed to contact Member Services for information on the various care management programs offered, such as Start Smart for Pregnancy, Weight Management, Asthma, or Behavioral Health. Members are advised their role is to be actively engaged and participate in the care management process by answering calls from the care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						manager, participating in the treatment plan, and attending provider appointments.
1.19 Information about advance directives;						The Member Handbook, page 78, and the website describe and define Advanced Directives. Members can complete the Mississippi Advance Health Care Directive Form located on the Mississippi State Department of Health's (MSDH) website.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Magnolia notifies members by mail of significant changes in benefits 30 days prior to the effective date, as described in Policy MS.MBRS.12, Member Notification of Plan Changes, and in the Member Handbook. The Eligibility Department sends written notice of any provider terminations within 15 days using state-approved Provider Termination letters, as indicated in Policy MS.MBRS.27, Member Advisory of Provider Termination.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy MS.COMM.01, Marketing: General Guidelines for Marketing Activities and Policy MS.MBRS.06, Member Materials Readability and Translation describe and outline processes Magnolia uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Member materials use a minimum 12-point font and items requiring large print are printed in 18-point font. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Interpreter and translation services are provided at no cost to non-English speaking members, members who have limited English proficiency, and for members who are deaf or hearing impaired as described in the Member Handbook, Policy MS.MBRS.03, Impaired/Language-Specific Interpreter Services, and Policy MS.MBRS.06, Member Materials Readability and Translation. Additionally, Magnolia's documents, the website, and member materials include Relay 711 for members with hearing and speech limitations.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.		X				Policies MS.MBRS.10, Member Service Calls/Hotline and MS.PRVR.03, Toll-free Provider Telephone Hotline state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line has nurses available 24 hours a day, 7 days a week, including holidays. Magnolia ensures members have access to a toll-free number, an automated voice system, or a live person to address questions or concerns. CCME discussed the Provider Manual incorrectly lists hours of operation from 8:00 am – 5:00 pm; the correct hours are from 7:30 am to 5:30 pm. This was a recommendation during the 2019 EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Correct the Provider Manual to reflect the Provider Services operating hours are 7:30 am to 5:30 pm CST, as required by the CAN Contract, Section 7 (H) (I).
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Training logs confirm Call Center staff receive training at least quarterly, as required. The Call Center staff have appropriate call scripts and work processes to assist members and providers, such as a script for Member Returning Calls, Handling BH Crisis Calls, Provider Services Escalation, and Pharmacy Calls.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Magnolia monitors and evaluates member and provider Call Center agents for the quality of incoming and outgoing calls as outlined in Policy MS.PRVR.24, Member & Provider Call Audit and Quality Criteria and Protocol. The MSCAN 2019 Quality Management Program Evaluation (page 64) indicates Magnolia monitors and evaluates Call Center Performance monthly; however, the corresponding data table reports quarterly performance metrics. During the onsite teleconference, staff confirmed metrics are monitored monthly and provided detailed monthly tracking and monitoring data for the Member Call Center, Provider Call Center, and Nurse Line.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Members can access the website, the MyMagnolia Mobile App, and Member Handbook for information on scheduled preventive health services, available CM programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services. Additionally, Magnolia sends targeted mailers, such as EPSDT brochures and member newsletters, and make calls to eligible members reminding them of screenings and well visits. Magnolia's Disease Management Vendor is Envolve People Care Disease Management, which provides Low to Moderate levels of care management for health coaching.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					The MyMagnolia Mobile App and Member Handbook inform members about the Start Smart for Your Baby® (SSFB) Program. Policy SSFB.01, Start Smart for Your Baby® Program Overview, states, "The program consists of identifying pregnant members; stratifying them by risk level and impactability; providing care management, care coordination, disease management and intervention as appropriate; and health education for all enrolled pregnant members. SSFB provides participants with the education and tools to reduce their risk of adverse pregnancy outcomes." Additionally, Magnolia tracks timeliness of prenatal care by HEDIS monitoring of pregnant members, and participation in SSFB program as reported in the 2019 Quality Management Program Evaluation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					Magnolia ensures the provision of screening, preventive, and medically necessary diagnostic and treatment services for members through the month of their 21st birthday, as stated in Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service and Policy MS.QI.20.01, EPSDT Notification System. Policies describe processes and methods for notification, tracking, and follow-up of the EPSDT program and address barriers of low utilization by creating interventions to encourage members to use the services. Magnolia implemented the CentAccount Program that rewards members for healthy behaviors such as well child visits and immunizations.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. Magnolia contracts with SPH Analytics, a certified CAHPS Survey vendor, to conduct the Adult and Child Surveys. The actual sample sizes were adequate and met the NCQA minimum sample size and number of valid surveys (at least 411), but the response rates were below the NCQA target of 40%. Generalizability of the survey results is difficult to discern due to low response rate for the following surveys: •Adult Survey—response rate of 23% •Child Survey—response rate of 15%

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Children with Chronic Conditions (CCC) Survey—response rate of 16% for total sample and 16% for general population *Recommendation: Determine if there are any new barriers to completion of surveys for the Adult, Child, and Child CCC populations. Continue to work with SPH Analytics to improve response rates.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the member satisfaction survey to identify quality problems. The Program Evaluation contained an analysis of the 2019 response rates for each of the three surveys, as well as comparative rates year over year.
3. The CCO reports results of the member satisfaction survey to providers.	X					The CCO reports the results of the member satisfaction survey to providers, as evidenced by the Winter Newsletter and CAHPS Survey Overview for Providers.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The CCO reports to the appropriate committee results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee. The April 2020 minutes contained discussion of CAHPS results from 2019.
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					
1.1 Definition of a grievance and who may file a grievance;	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, the Member Handbook, and the Provider Manual correctly define the term “grievance.”

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing and handling a grievance;	X					The procedure for filing a grievance is correctly described in Policy MS.MBRS.07, Member Grievance and Complaints Process, the Member Handbook, the Provider Manual, and website. Magnolia provides instructions, including mailing address, fax numbers, and phone numbers for grievances to be filed either orally or in writing. Grievances will be acknowledged in writing within 5 calendar days. However, the Work Process, MS.HIM.11, Complaint and Grievance Process incorrectly states that grievance acknowledgements will occur within 10 calendar days. The Member Handbook, Provider Manual, and the website include that members must give written permission for someone else to file a grievance on their behalf, and members are instructed to request a form from Member Services or access a form from the website. However, Magnolia does not give the name of the required form. Onsite discussions confirmed it is the Authorized Representative Form. *Recommendation: In the Member Handbook, Provider Manual, and website, specify the Authorized Representative Form is required for providers or representatives to file a grievance on the member's behalf. Correct the Work Process, MS.HIM.11, Complaint and Grievance Process document to indicate grievances will be acknowledged within 5 calendar days as noted in the CAN Contract, Section 6 (K).*
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
or a physician designee as part of the resolution process;						
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.		X				Policy MS.MBRS.07, Member Grievance and Complaints Process, indicates grievance records are retained for a minimum of 10 years; however, it does not specify that grievance records will be retained "during the entire term of the Contract and for a period of 10 years thereafter," as noted in the *CAN Contract, Section 11 (A).* *Corrective Action: Edit Policy MS.MBRS.07, Member Grievance and Complaints Process, to include the complete grievance requirement from the CAN Contract, Section 11(A).*
2. The CCO applies the grievance policy and procedure as formulated.	X					Review of grievance files reflect timely acknowledgement, determination, and notification of determination.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Magnolia tracks, trends, and analyzes grievances for medical and behavioral health services, and reports results to the QIC quarterly, as noted in Policy MS.MBRS.07, Member Grievance and Complaints Process. The QIC reviews the grievance information to identify and address trends. QIC Meeting Minutes on April 30, 2020 confirm presentation and discussion of grievance reports. The goal for Grievances is 3 or less complaints per 1,000 members. In 2019 grievance goals for BH were met and goals for medical services were not.
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					Policy MS.ELIG.03, PPCP Selection and Change, describes Member Services staff assist members with PCP change requests for any reason including dissatisfaction.
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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Magnolia's Quality Improvement (QI) Program operates under a plan of continuous improvement. The 2020 MississippiCAN Quality Management Program Description includes the program's structure, accountabilities, scope, goals, and available resources. The program description is reviewed and updated at least annually.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The scope of the QI program is addressed on pages one and two of the QI program description and includes monitoring health care disparities for flu and primary care visits.
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					Data analysis is conducted using various data sources such as medical, pharmacy, dental, and vision encounter data to identify patterns of potential over- and under-utilization.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous	X					Magnolia's quality work plan defines the activities to be completed throughout the year. The work plan is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).						developed annually and is based on the Quality Program Evaluation for the previous year. The work plan is updated frequently to document progress towards meeting the established goals.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) performs oversight of all quality activities and is responsible for reviewing and monitoring all clinical, physical, and behavioral health quality and service functions. Other committees involved in the quality improvement activities include the Performance Improvement Team and the Quality Task Force.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership for the QIC includes Magnolia's senior leadership, department directors and other health plan staff. Meetings are chaired by the Chief Medical Director. The committee charter indicates the membership includes a minimum of two network providers. One of the two physicians should be a behavioral health provider. The committee's participant roster indicates there are five participating providers with specialties including pediatrics, family medicine, psychiatry, and a nurse practitioner. A minimum of five members, including three plan staff and two external physicians, must be present for a quorum.
3. The QI Committee meets at regular intervals.	X					The QIC meets at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions.
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The Performance Measure validation found that Magnolia was fully compliant with all information system standards and determined that the health plan submitted valid and reportable rates for all HEDIS measures in scope of the audit. There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Magnolia followed the measure specifications and produced reportable rates for all measures in the scope of the validation. Magnolia did not report two Core Set measures. The two measures were Elective Delivery (PC-01) and Cesarean Birth (PC-02 CH). The rates were provided by DOM. Details of the validation activities and recommendations for the Performance Measures may be found in *Attachment 3, CCME EQR Validation Worksheets.* *Recommendation: Work proactively with DOM for clarification on core set measures that are required to be reported.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					Magnolia submitted four performance improvement projects for validation. Topics for these projects included: Asthma, Behavioral Health Readmission, Improved Pregnancy Outcomes with Makena, and Sickle Cell Disease Outcomes. A performance improvement project regarding Adult COPD, as required by DOM was not submitted. However, the HEDIS measure, Medication Management for People with Asthma (MMA), used as the study indicator for the Asthma PIP was retired. Magnolia has closed this PIP and will implement a new Adult and Child Respiratory Disease

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PIP. Magnolia indicated the new PIP will include Child Asthma and Adult COPD as required by DOM. *Recommendation: Initiate a PIP focused on Respiratory Illness Management specific to the Child Asthma and Adult COPD population, as per DOM requirements.*
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					Projects were validated using the updated CMS Protocol for Validating Performance Improvement Projects (Protocol 1, October 2019). All projects received scores in the "High Confidence Range," although three of the four PIPs did not show improvement in the indicator rates. Details of the validation activities for the PIPs and specific outcomes are found in *Attachment 3, CCME EQR Validation Worksheets.* *Recommendation: Monitor the ongoing interventions and consider revising interventions as needed for PIPs not showing improvements in the indicator rates.*
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					Magnolia's providers have access to their performance data through the Secure Provider Portal. The Provider Analytic tools features care gaps, readmission data, cost utilization and performance measure results.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines indicates Magnolia, on an annual basis, measures Provider performance against at least two of the clinical guidelines. The policy also indicates Magnolia provides DOM the results of the study as well as a summary of any corrective actions taken to ensure future compliance with the guidelines. Magnolia chose the guidelines for diabetes care, prenatal care, ADHD,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and depression for monitoring, and provided the report of the annual monitoring. There were three measures that did not meet the goal. During the onsite discussion staff indicated the health plan was working to implement interventions to improve the rates and new interventions would be implemented in 2021.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						Policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Services and policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System outlines Magnolia's process for monitoring EPSDT services.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					Per policy MS.QI.20, Early and Periodic Screening, Diagnostic and Treatment Periodic (EPSDT) Services, Magnolia's EPSDT Coordinator will monitor claims to identify members with any abnormal finding on an EPSDT screening. If there is no evidence that treatment was sought, the EPSDT Coordinator will contact the provider and member to assist in arranging an appointment for follow-up. Magnolia provided a copy of the tracking reports for monitoring members identified as having an abnormal finding on an EPSDT screening. The tracking reports did not include the CPT and ICD-10 codes to identify the abnormal finding and the need for follow-up as mentioned in policy MS.QI.20. *Recommendation: Update the tracking report to identify members needing follow-up care after an EPSDT screening and include the CPT and ICD 10 codes and the dates or notes regarding the contact made.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Magnolia provided their MSCAN Quality Management Program Evaluation 2019 for review. The annual Quality Improvement Program Evaluation provides a summary of all completed and ongoing activities of the previous year. Barriers, interventions, and recommendations for 2020 were included for each activity. During the previous EQR, several recommendations were provided regarding the program evaluation and it appears Magnolia implemented those recommendations.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Magnolia's Utilization Management (UM) Program Description outlines the goals, scope, and staff roles for physical health, BH, and pharmaceutical services for members in Mississippi. Several policies describe UM processes and requirements.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The roles of the Chief Medical Director and other Medical Directors are described in the 2020 Utilization Management Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, and participating in plan committees. Behavioral health practitioners assist with oversight of BH UM activities. Medical Directors are licensed to practice medicine in the state of Mississippi. The Vice President of Medical Management (VPMM) is responsible for the daily management of the UM activities. The Pharmacy Director reports to the VPMM, oversees pharmacy services with the Pharmacy Benefit Manager, PerformRx, and participates on the Pharmacy and Therapeutics (P&T) Committee.
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					Magnolia evaluates the Utilization Program annually to assess its strengths, weaknesses, and determine improvement opportunities. The program evaluation is submitted to the QIC and Board of Directors (BOD) for approval annually. During the onsite teleconference, staff confirmed the 2019 Utilization Management Program Evaluation was approved in September 2020.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					Policy MS.UM.02, Clinical Decision Criteria and Application and the Utilization Management Program Description, explains Magnolia uses clinical policies, InterQual Level of Care and Care Planning Criteria, and regulatory guidelines according to an established hierarchy.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The Utilization Management Program Description, Policy MS.UM.02, Clinical Decision Criteria, and Policy MS.UM.02.01, Medical Necessity Review, describe and outline processes used to make UM determinations. Review of UM approval files reflect consistent decision-making utilizing standards such as InterQual, evidenced base criteria, and relevant medical information.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Approval files reflect individual member circumstances are taken into consideration and show clinical staff appropriately consulting with the Medical Director.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Magnolia conducts annual inter-rater reliability testing (IRR) for clinical staff reviewers, physicians, non-physicians, and BH clinicians as defined in Policy CC.UM.02.05, Interrater Reliability. Discussions during the onsite teleconference confirmed nurse and BH reviewers, as well as physician reviewers, achieved passing scores after remedial training was completed.
5. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Policy MS.PHAR.09, Pharmacy Program states Envolve Pharmacy Solutions is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Magnolia, including but limited to the Universal PDL, prior authorizations, and pharmacy network management. A link to access the most current version of Universal PDL is posted on Magnolia's website and takes the user directly to DOM's website where the PDL is available in a searchable, electronic format.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					The Pharmacy Program Description indicates the pharmacy prior authorization (PA) process is conducted according to state, federal, and regulatory requirements. PA requests are determined within 24 hours and a 72-hour (3-day) supply of medication will be approved, in emergent situations, while the prior authorization request is pending.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The Utilization Management Program Description and Policy MS.UM.12, Emergency Services, correctly describe Magnolia's process for providing emergency and post-stabilization care.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Magnolia ensures UM decisions are rendered by appropriate staff, as described in Policy MS.UM.02.01, Medical Necessity Review and Policy CC.UM.04, Appropriate UM Professionals. A Level I review is conducted by a Mississippi licensed nurse or Referral Specialist, and a Mississippi-licensed physician or other appropriate healthcare practitioner conducts Level II medical necessity reviews resulting in adverse benefit

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determinations. The list of UM Physician reviewers shows a diversity of clinical specialties. Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists. UM decisions related to BH, dental, or pharmacy are made by respective licensed staff.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with Policy MS.UM.05, Timeliness of UM Decisions and Notifications, the UM Program Description, and contractual requirements. Additional information was appropriately requested, from the member or provider, to assist in decision-making. Pharmacy timeframes are determined within 24 hours.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files reflect review by appropriate medical professionals when UM clinical staff cannot approve requests that do not meet medical necessity criteria.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files reveal denial decisions are made according to the processes described in Policy UCSMM.06.16, Initial Review Timeframes. Denial notifications are appropriately rendered via mail, fax, or telephone.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse	X					Magnolia has several policies that outline appeals processes, such as Policy MS.UM.08, Appeal of UM Decisions and Policy MS.UM.01, Utilization Management Program Description. Additionally, information is provided

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
benefit determination by the CCO in a manner consistent with contract requirements, including:						in the Provider Manual, Member Handbook, and the member tab of the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				The terms "appeal" and "adverse benefit determination," as well as who can file an appeal, are defined in Policy MS.UM.08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, and the Provider Manual. The following documentation issues were identified: •The Utilization Management Program Description has outdated terms such as "adverse medical necessity decision" and "adverse determination" instead of the correct term of "adverse benefit determination." •The Member Handbook (page 71) provides examples of people who can file an appeal, but it does not specify these are people who can be the member's authorized representative. •The Provider Manual states that the member's authorized representative can file an appeal, but it does not describe who can be an authorized representative. The website adequately describes a member's authorized representative. *Corrective Action: Edit the Utilization Management Program Description to replace outdated terms for "adverse benefit determination." Refer to the CAN Contract, Section 2 (A). Edit the Member Handbook and Provider Manual to clarify and describe who can act as a member's authorized representative.*
1.2 The procedure for filing an appeal;	X					The procedure for filing an appeal is correctly documented in the Policy MS.UM.08, Appeal of UM Decisions, Member Handbook, Provider Manual, and website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Requirements for timely resolution of standard and expedited appeals are correctly documented in Policy MS.UM.08, Appeal of UM Decisions, the Member Handbook, the Provider Manual, and on Magnolia's website.
1.6 Written notice of the appeal resolution as required by the contract;	X					The written notice of the appeal resolution contains all contractual requirements.
1.7 Other requirements as specified in the contract.	X					Magnolia correctly describe other appeal requirements in Policy MS.UM.08, Appeal of UM Decisions and the Member Handbook.
2. The CCO applies the appeal policies and procedures as formulated.	X					Review of appeal files reflected timely acknowledgement, resolution, and notification of appeal determination.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MS.UM.08, Appeal of UM Decisions explains appeals are tracked, trended, analyzed, and reported quarterly to the QIC. QIC meeting meetings reflected detailed discussions and reporting of medical, BH, and pharmaceutical appeals results. The 2019 Utilization Management Program Evaluation reports that of 408 total appeals, 61% were overturned, and the highest number of appeals were in the pharmacy and radiology categories.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Magnolia has an established Care Management Program and Population Health Management Program to ensure and promote access and delivery of care management services for all members. During the onsite teleconference, Magnolia staff discussed the recent renaming and transitioning of the Medical Management Department to Population Health Management and Clinical Operations.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The CM Program Description and policies, such as Policy CC.CM.06, Predictive Modeling Methodology, describe methods for how eligible members are identified and referred into case management. In addition to referral guidelines and results from predictive modeling, Magnolia uses claims, health risk assessment results, medical records, and utilization management data to identify members who can benefit from case management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.4 Member's current treatment provider and treatment plan, if available.	X					Magnolia staff explained that CM staff send letters to the provider requesting a treatment plan when a new member is brought into the program.
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriate for the member's health condition.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Guidelines for outreach are noted in policies such as, but not limited to, MS.CM.01, Care Management Program and Program Description, MS.UM.24, Continuity and Coordination of Services, and MS.UM.24.04, Post Discharge Member Outreach. Magnolia uses CM techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process, as it applies to continual care, transitional care, and discharge planning.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
risk level and the specific services required by the contract.						
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MS.UM.24, Continuity and Coordination of Services and the CM Program Description state Magnolia will transfer the member's care management history, six months of claims history, and other pertinent information when a member disenrolls.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					The Care Management Program and Program Description and Policy MS.CM.99, Transitional Care Management Process describe the Transitional Care Management Program and outline processes and requirements for managing transitions of care across healthcare settings. Additionally, Policy MS.PHAR.09, Pharmacy Program, states Magnolia provides new members with continuity of their current medications until the provider can transition the member to formulary medications.
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Policy MS.CM.99, Transitional Care Management Process describes Magnolia's process for monitoring new members, members transferring from another health plan, when discharged from a clinic or inpatient setting, including a psychiatric residential treatment facility

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(PRTF), and terminated providers. Policy MS.UM.24, Continuity and Coordination of Services and the Care Management Program Description provides additional information.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					
4. The CCO meets other Transition of Care requirements.	X					Policy MS.CM.99, Transitional Care Management Process, and Policy MS.UM.24, Continuity and Coordination of Services correctly documents how Magnolia meets other Transition of Care requirements, such as approving provider visits for up to 90 days after a member leaves the network.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					During the onsite teleconference staff confirmed the 2019 UM Program Evaluation was reviewed and approved in September 2020.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION						
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 has delegation agreements with the following entities: •Envolve Dental—Dental claims, network, utilization management, credentialing, and quality management •Medical Transportation Management, Inc. (CAN Only)—Non-emergency transportation claims, network, utilization management, and quality management •National Imaging Associates, Inc. (NIA)—Radiology utilization management •EPC-NurseWise—Nurse call center •EPC-Nurtur—Disease management •Envolve Vision—Vision services claims, network, utilization management, credentialing, and quality management •Envolve Pharmacy Solutions—Pharmacy claims, network, utilization management, credentialing •Hattiesburg Clinic, PA—Credentialing •LSU Healthcare Network (New Orleans)—Credentialing •North Mississippi Medical Clinic/North MS Healthlink—Credentialing •Rush Health Systems—Credentialing •Ochsner Clinic Foundation—Credentialing •St. Judes Research Hospital—Credentialing •Baptist Memorial Health Care-Baptist Health Services Group—Credentialing •Magnolia Regional Medical Center—Credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Mississippi Physicians Care Network—Credentialing •Mississippi Health Partners—Credentialing •University of Mississippi Medical Center—Credentialing •Memorial Hospital at Gulfport—Credentialing
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					Magnolia retains accountability for each delegated service and monitors the performance of the delegated entity in accordance with Policy MS.QI.14, Oversight of Delegated Vendor Services and Policy CC.CRED.12, Oversight of Delegated Credentialing. A pre-delegation review is conducted to assess the entity's program, associated policies and procedures, staffing capabilities, and performance record prior to the entity performing the delegated activity. Annually, Magnolia conducts oversight monitoring for each delegated entity to determine whether the delegated activities are being carried out as required. Magnolia provided a copy of the annual monitoring activities for each delegated entity. Deficiencies and applicable corrective actions were noted in the monitoring reports. The monitoring tools for seven of the credentialing delegates noted the site visits for the primary care providers as not applicable. Per the *CAN Contract, Section E (3) (a),* credentialing policies and procedures must meet Federal, State, and Division requirements and shall include a description of site assessment including the initial site assessment, prior to the completion of the initial credentialing process. Also, Magnolia indicated that credentialing was included as a function delegated to Envolve Dental, Envolve Vision, Envolve Pharmacy Solutions and Medical Transportation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Management. However, the annual monitoring did not include a review of the delegated credentialing. *Recommendation: Include in the delegation monitoring oversight a sample of credentialing and recredentialing files and ensure the site visit is included in the initial credentialing files for primary care providers.*