



March 11th, 2020

External Quality Review:
MCNA Dental
Report of Findings
2018 - 2019

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**External Quality Review Organization:
MCNA Dental
Annual Review and Summary
2018 - 2019**

Table of Contents

External Quality Review Summary	5
Review of Quality Standards	7
Performance Improvement Project	11
• Increasing the Rate of Enrollees Accessing Preventive Dental Services	
Information Systems Capabilities Assessment	15
Performance Measures	21
• Annual Dental Visit	
Attachments	
Attachment 1 – BBA Compliance Tool	27
Attachment 2 - Performance Improvement Project Validation Worksheet	45
Attachment 3 – Performance Measure Validation Worksheet	51

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External Quality Review Summary

In accordance with the United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) rule, Telligen, Inc. conducts onsite evaluations of Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) under contract with the Idaho Department of Health and Welfare (IDHW). The purpose of the evaluation is to assure that each contracted entity is providing quality services for its Medicaid members in accordance with the CMS Protocols. The CMS 42 CFR §433 and §438; Medicaid Program, External Quality Review (EQR) of Medicaid Managed Care Organizations rule specifies the requirements for evaluation of Medicaid managed care programs.

In 2011, MCNA Insurance Company began providing Dental Health Medicaid benefits to eligible enrollees statewide through MCNA Dental. This is the first year that IDHW has requested an EQR of MCNA Dental. This technical report involves MCNA Dental's (MCNA) performance as evaluated during desk reviews of MCNA's policies and procedures and a review conducted on March 11, 2020 via WebEx.

During the time of this review (July 1, 2018 through June 30, 2019) MCNA reported having 335,191 Medicaid enrollees in Idaho. MCNA was the only dental health provider under contract during the review period in the State of Idaho to provide Medicaid dental health services. Therefore, this report will not include comparative analysis with any other plan's performance.

The Telligen External Quality Review (EQR) Evaluation Team (the Team) includes Telligen staff with extensive managed care experience and the Security Administrator. Team members are experienced in managed care peer-to-peer review, quality improvement principles, and outcomes measurement. The Team is supported by an independent writer with many years of experience in EQR analysis and validation. This writer analyzed the findings and wrote an independent summary of those findings.

MCNA participants in the on-site review included:

MCNA Dental

Sharon Turner, Executive Vice President
Rene Canales, VP of Network Development and Provider Engagement
DeDe Davis, VP of Dental Management and Quality Improvement
Colleen Grace, Associate Vice President of Operations
Daniel Salama, Chief Information Officer/Chief Information Security Officer
Jeanette Logan, Client Services Senior Manager
Mayre Thompson, Chief Compliance and Privacy Officer
Jonathan Raof, VP Data Analytics
Kendra Aracena, Quality Improvement Manager
Nelsigleny Lopez, Manager of Clinical Analytics
Kevin Hollins, Director of Call Center Operations
Marianna Chiyuto, Manager Grievances and Appeals
Dustin Brookshire, Director of Compliance
Shannon Hays, Regional Provider Relations Manager
Caitlin Lacy, Provider Relations Supervisor

Telligen, Inc.

Jennifer Bly, RN, Quality Improvement Manager
Brandi Lister, Information Security, GRC Analyst
Amy McCurry Schwartz, EQRO Consultant

This EQR technical report analyzes and aggregates data from three mandatory EQR activities as described below:

CMS regulations require an annual review of Performance Improvement Projects and Performance Measures, and a Compliance review every three years. The regulations also require an annual follow-up review of any identified Quality Standards that did not meet expectations during the prior evaluation period. This is a full compliance review year. The IDHW also requires an annual Information Systems Capabilities Assessment (ISCA).

1) Validating Compliance with Managed Care Regulations.¹

The Team conducted an evaluation of compliance with Quality Standards addressing access to care, structure and operations, and quality management and improvement per 42 CFR §438.

2) Validating Performance Improvement Projects²

MCNA conducted one Performance Improvements Project (PIP) during the 12 months preceding the audit, as required in 42 CFR 438.20 (b)(1). The PIP was then validated by the Team:

- Increasing the Rate of Enrollees Accessing Preventive Dental Services

3) Validating Performance Measures³

One Performance Measures (PM) that was underway the preceding 12 months was validated by the Team as required by 42 CFR 438.20(b)(2). This PM was:

- Annual Dental Visit

and

4) Information Systems Capabilities Assessment (ISCA)⁴

The ISCA is the evaluation of MCNA's information systems by the Team. This evaluation is intended to assess the strength of those systems and their capability to accurately and reliably produce performance measure data and reports, as well as manage the care of enrollees.

The Team used review procedures for the ISCA that were based on the CMS protocol for this activity. For each ISCA review area, reviewers used the information collected from MCNA in the ISCA data collection tool, and responses to interview questions to rate MCNA's performance in five review areas.

To clearly report findings, technical methods of data collection, description of the data, conclusions, and recommendations for improvement will be discussed separately for the requirements pertaining to Quality Standards as well as PIPs, PMs, and the ISCA.

¹ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, D.C.: Author.

² Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September, 2012. Washington, D.C.: Author.

³ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the PAHP: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, D.C.: Author.

⁴ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Appendix V: Information Systems Capabilities Assessment – Activity Required for Multiple Protocols, Version 2.0, September, 2012. Washington, D.C.: Author.

Compliance

Review of Quality Standards

Technical Methods of Data Collection and Analysis:

As this is MCNA's first EQR, it is subject to a full compliance audit. The content of this 2018-19 audit will include a review of the Quality Standards: Enrollee Rights and Protections; Access and Availability; Structure and Operations; and Measurement and Improvement Standards, as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Review of Grievance and Appeals files
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol EQR Protocol I: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR) (Compliance Protocol). See Attachment I. Utilizing this tool, MCNA was evaluated on the timeliness, access, and quality of care provided. This report incorporates a discussion of Plan strengths and areas for improvement with recommendations to enhance overall performance and compliance with standards.

The Telligen rating scale is as follows:

P = Proficient

Documentation supports that all components were implemented, reviewed, revised, and/or further developed and PAHP staff provided responses to reviewers that are consistent with the standard and with the documentation.

D = Developing

All documentation listed under a component was present, however PAHP staff are unable to consistently articulate evidence of compliance, or PAHP staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.

N = No Documentation

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation.

A summary of compliance with all evaluated Quality Standards is included in Table I.

Table I. Compliance Ratings

Measure	<u>2018-2019</u> <u>Rate</u>
<i>Enrollee Rights and Protections</i>	Proficient
<i>Access and Availability</i>	Proficient
<i>Coordination and Continuity of Care</i>	Proficient
<i>Coverage and Authorization of Services</i>	Proficient
<i>Provider Selection</i>	Proficient
<i>Grievance System</i>	Proficient
<i>Sub-Contractual Relationships and Delegations</i>	Proficient
<i>Enrollment and Disenrollment</i>	n/a
<i>Practice Guidelines</i>	Proficient
<i>Quality Assessment and Performance Improvement Program</i>	Developing
<i>Health Information Systems</i>	Proficient
Overall Rating	Developing

Description of the Data:

The review of Quality Standards was completed using Attachment I, BBA Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

The areas of Access and Availability, Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Rights and Protections, Provider Selection, Grievance System, Sub-Contractual Relationships and Delegations, Practice Guidelines, and Health Information Systems were found to meet all required standards.

Quality Assessment and Performance Improvement Program

The category of Quality Assessment and Performance Improvement Program addresses 10 standards. For the 2018 - 2019 review year, MCNA was rated as proficient in seven standards and developing in three standards.

The standard that received the rating of developing pertained to MCNA's Performance Improvement Projects. More details regarding the specifics of MCNA's performance on these standards can be found in the Performance Improvement Projects and ISCA sections of this report.

Enrollment and Disenrollment

The five standards under Enrollment and Disenrollment are rated as "not applicable". This function has been retained by IDHW.

Overall Evaluation and Recommendations for Improvement

This plan is committed to providing a high level of care to its members. MCNA has a commitment to timeliness, access and quality of care.

Timeliness

MCNA provides newsletters twice annually to members and providers. Members are also able to access MCNA's website to obtain additional information in real time.

Access To Care

Neither the Team nor MCNA have identified any areas of concern regarding access in their network, but MCNA continues to monitor the network for access issues and reports performance on many indicators, including appointment wait times and access.

Quality of Care

The quality of care provided by MCNA's contracted providers is assured by MCNA's compliance with the standards of review set forth in the areas of Quality Assessment. All MCNA providers are credentialed and monitored according to required policies and procedures.

All levels of evaluation during this review show that MCNA is committed to their members as the users of its services.

Recommendations for Improvement:

1. The EQRO recommends that MCNA make every effort to ensure all performance improvement projects meet the standards of the CMS Protocol 3 "Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQRO)".
2. The EQRO recommends ongoing evaluation of projects that can be fostered into performance improvement projects.
3. The EQRO recommends that MCNA continue to place emphasis on the grievances and appeals process, so that they may maintain the gains they have seen in this area.

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Performance Improvement Projects

MCNA, under the direction of IDHW, has compiled one Performance Improvement Project (PIP) which will be discussed during this review.

- Increasing the Rate of Enrollees Accessing Preventive Dental Services

Technical Methods of Data Collection:

The technical methods of data collection and analysis incorporated by MCNA are developed internally. These methods incorporate information from existing Plan reporting programs and databases. Utilizing the Performance Improvement Project Validation Worksheet (Attachment 2), analysis of internal processes utilized to document and interpret data results was completed by the Team. Finally, an interpretation of the interventions and ensuing improvements was incorporated as a measure of the effectiveness of the improvement process.

The reviewers incorporated document review, interview, and observation techniques to fully evaluate the components of each Performance Improvement Project. All evaluation was calculated utilizing the CMS Final Protocol, Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review.

The rating scale reflecting compliance with standards is as follows:

P = Proficient

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

D = Developing

Documentation supports some but not all components were present.

N = No Documentation

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation.

A summary of compliance with all evaluated Performance Improvement Projects is included in Table 2.

Table 2 - Performance Improvement Project Ratings

Step	Increasing the Rate of Enrollees Accessing Preventive Dental Services
Step 1: Selected Study Topics	Proficient
Step 2: Study Questions	Proficient
Step 3: Study Indicators	Proficient
Step 4: Study Populations	Proficient
Step 5: Sampling Methods	N/A
Step 6: Data Collection Procedures	Proficient
Step 7: Improvement Strategies	Developing
Step 8: Analysis and Interpretation of Study Results	Proficient
Step 9: Validity of Improvement	Proficient
Step 10: Sustained Improvement	N/A
Overall Rating	Developing

Increasing the Rate of Enrollees Accessing Preventive Dental Services

Description of the Data:

MCNA utilized many methods of data collection for this PIP. These data collection methods include:

- Administrative data derived from claims/encounters (inpatient and outpatient)
- Monthly Care Gaps from MCNA's Dental Trac software

This PIP focused on increasing the number of MCNA enrollees who access at least one preventive dental service during the measurement year. This PIP coincides with MCNA's Performance Measure and the Healthcare Effectiveness Data and Information Set (HEDIS) measure of Annual Dental Visit (ADV). ADV that is used to evaluate patient access to dental services.

MCNA states that the baseline measurement period for this PIP was October 1, 2017 – September 30, 2018. Therefore, the first re-measurement period would be October 1, 2018 – September 30, 2019. The second re-measurement period will be October 1, 2019 – September 30, 2020.

MCNA selected two measurements/indicators for this study.

Study Measurement #1: The study measurement was “the number of Idaho Medicaid enrollees ages 1-20 who received at least one preventive dental service during the measurement year”. The goal for this study measurement was to increase two percentage points over the baseline for each remeasurement period.

Study Measurement #2: The study measurement was “the number of Idaho Medicaid enrollees ages 21 and over who received at least one preventive dental service during the measurement year”. The goal for this study measurement was to increase two percentage points over the baseline for each remeasurement period.

The Team's evaluation processes incorporated a review of study documentation regarding decision-making processes, identification of interventions, and anticipated change or hypothesis. Results were evaluated for statistical significance and compared to the defined goals for the study year.

Conclusions:

MCNA selected this PIP due to the proven effectiveness of preventive dental services improving member outcomes. By improving the number of members who have an annual dental visit, it has been shown that the occurrence of dental disease decreases, and member outcomes improve.

The study question is: “Will targeted interventions increase the percentage of eligible enrollees ages 1 to 20 and 21 and over accessing at least one preventive dental service during the measurement year?”

MCNA has implemented four interventions:

- **Care Gap Reminders:** This intervention is carried out by Member Services Representatives (MSR). When a member calls in for any reason, the MSR will look for care gaps in the member's claim history. When it is found that the member does not have an annual dental visit, the MSR will assist them in scheduling that visit.
- **Targeted Outreach Events:** This intervention targets members identified at outreach events. The intervention is designed to contact any MCNA member that comes to an outreach event if they have not completed a preventive service visit within 60 days of attendance at the event.

- Preventive Service Reminders: Members receive a text message to remind them if they have not received a preventive service. Then it is determined if members who received the text message received a preventive service within 30, 60, or 90 days of the text message.
- Provider Practice Site Performance Summary: Providers who have low numbers of members receiving preventive dental services are monitored and coached by provider relations as needed.

MCNA did not meet its goals for improvement over baseline for Study Measurement #1 during the first re-measurement period. MCNA did see improvement from 52.10% to 53.36%, but did not improve by two percentage points. For Study Measurement #2, MCNA did improve from 10.79% to 13.27%, meeting their goal. However, both of these improvements proved to be statistically significant and can therefore be attributed to the interventions that MCNA implemented. MCNA was advised to continue to report and analyze data on a minimum of a quarterly basis, to allow for corrections during the life of the PIP.

Strengths:

- 1) MCNA's rationale for choosing this PIP is clearly documented.
- 2) MCNA's use of HEDIS proven measures to show quality improvement.
- 3) MCNA's write up of the PIP was well documented and easily understood.

Areas for Improvement:

- 1) The EQRO recommends continuing a minimum data analysis cycle of quarterly going forward. This would allow MCNA to identify any trends and make corrections as needed in a timely manner.
- 2) The EQRO would like to see MCNA develop another PIP for validation. Some guidance from IDHW on a topic area or concentration for an additional PIP would be welcomed by MCNA.

Overall Evaluation and Recommendations for Improvement

Access to Care

MCNA was clearly focused on the access to services delivered to the population in the Preventive Services Dental. This PIP is a project that should ensure members receive access to appointments.

Quality of Care

The link that preventive dental services has to quality of health is provide by MCNA and is a focus of this PIP. Improving the Quality of Care for members and improving member outcomes is a focus for MCNA.

Recommendations:

- 1) Continue to utilize the CMS Protocol, Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), to understand all project requirements.
- 2) Request technical assistance, as needed, when developing PIPs or implementing new interventions.
- 3) Continue to focus PIPs on member outcomes, PIPs should have the end goal of improving the health of members.
- 4) Consider expanding PIPs and developing an additional PIP for next year's review.

MCNA is an organization with a commitment to excellence for their members; this is a significant strength. It is the opinion of this Team that the Increasing the Rate of Enrollees Accessing Preventive Dental Services PIP warrants a rating of Developing.

Information Systems Capabilities Assessment (ISCA)

Objectives

Telligen examined MCNA's information systems and data processing and reporting procedures to determine the extent to which those systems and procedures support the production of valid and reliable State performance measures and the capacity to manage care of enrollees.

Methodology

The ISCA procedures are based on the CMS protocol Appendix V⁵, as adapted for MCNA. For each ISCA review area, reviewers used the information collected in the ISCA data collection tool, responses to interview questions, and results of the security walkthroughs to rate the PAHP's performance for seven review areas. Scores are based on the following: fully meeting, partially meeting or not meeting standards.

The ISCA review process consists of four activities:

Activity 1: Standard information about the PAHP's information systems is collected. The PAHP completed the ISCA data collection tool before the onsite review.

Activity 2: The completed ISCA data collection tools and accompanying documents are reviewed. Submitted ISCA tools are thoroughly reviewed. Follow-up is conducted as needed.

Activity 3: Onsite visits and walkthroughs with the PAHP are conducted. Data center security walkthroughs are conducted. In-depth interviews with knowledgeable PAHP staff are conducted. Additional documents are requested if needed, based upon interviews and walkthroughs completed at the PAHP.

Activity 4: Analysis of the findings from the PAHP's information systems onsite review. In this phase, the material and findings from the first three phases are reviewed. The PAHP-specific ISCA evaluation report is then finalized.

The following sections discuss the specific criteria for assessing compliance in each of the five ISCA review areas.

Section A: Information Systems

Section B: Hardware Systems

Section C: Information Security

Section D: Data Acquisition Capabilities

Section E: Provider Data

⁵ Ibid.

Scoring

All evaluation was calculated against the CMS Final Protocol, Validation of Performance Measures Reported by the PAHP: A Mandatory Protocol for External Quality Review (EQR). The rating scale reflecting compliance with standards was as follows:

M = Met

MCNA's measurement and reporting was fully compliant with State specifications.

PM= Partially Met

Substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

NM = Not Met

MCNA's measurement and reporting process was not compliant with State specifications.

NV = 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.

n/a = Not Applicable

Measure was not reported because PAHP did not have any Medicaid enrollees that qualified for the denominator.

Table 3. ISCA scoring

ISCA Section	Description	Score
A. Information Systems	This section assesses the PAHP's information systems for collecting, storing, analyzing and reporting medical, member, provider and vendor data.	Met
B. Hardware Systems	This section assesses the PAHP's hardware systems and network infrastructure.	Met
C. Information Security	This section assesses the security of the PAHP's information systems.	Met
D. Data Acquisition Capabilities	This section assesses the PAHP's ability to capture and report accurate medical services data and the PAHP's ability to capture and report accurate Medicaid enrollment data.	Met
E. Provider Data	This section assesses the PAHP's ability to capture and report accurate provider information.	Met

Summary of ISCA Review

Telligen examined MCNA's documentation of their information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable State performance measures and the capacity to manage care of enrollees.

The determination of Medicaid eligibility, initial assessment and enrollment is handled by IDHW.

Information Systems

This section assesses MCNA's information systems for collecting, storing, analyzing and reporting medical data by member, provider and vendor. Information systems that facilitate valid and reliable performance measurement have the following characteristics:

- flexible data structures
- no degradation of processing with increased data volume
- adequate programming staff
- reasonable processing and coding time
- ease of interoperability with other database systems
- data security via user authentication and permission levels
- data locking capability
- proactive response to changes in encounter and enrollment criteria
- adherence to the Federally required format for electronic submission of claims/encounter data.

Strengths, areas for improvement, and recommendations are based on the MCNA ISCA submission, onsite interviews, and facility review.

Strengths:

1. MCNA utilizes McAfee Endpoint protection for their workstation endpoint security. McAfee uses FIPS 140-2 approved algorithms such as Triple DES, AES, SHA-1, HMAC-SHA-1 and RNG.
2. MCNA safeguards for ePHI\ellHI by standards that are comparable to those imposed by state regulatory agencies by 42 CFR Part 431, Subpart F (2005, as amended) and state regulations
3. MCNA users will be disconnected from the network after 30 mins of inactivity.
4. All confidential data stored, used or transmitted over MCNA's network such as email, shared files of file transfers must be encrypted with cryptographic keys using a minimum 128-bit encryption.

Areas for Improvement:

None Identified

Recommendations:

None Identified

Hardware Systems

This section assesses MCNA's hardware systems and network infrastructure. Appropriate protocol for sustaining quality hardware systems include:

- Infrastructural support that includes maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff and a secure computing environment.
- Redundancy or duplication of critical components of a hardware system with the intention of increasing reliability of the system, usually in the case of a backup or fail-safe.

Strengths, areas for improvement, and recommendations are based on the MCNA ISCA submission, 2019 findings validation, and interviews.

Strengths

1. All confidential data that is stored on computed devices or transmitted over MCNA's network is encrypted using at a minimum 128-bit encryption.
2. MCNA uses cryptographic keys to secure stored confidential data.
3. They also perform full disk encryption of all their computers prior to assigning the computer to an employee.
4. When accessing MCNA's network over VPN they utilize a 256-bit SSL encryption.
5. For contingency planning they follow recommendations from NIST, including but not limited to Develop the contingency policy objective statement, conduct BIA, conduct testing and training and review/maintenance of the plan.
6. MCNA tests their contingency plan for DRBCP annually and determines if additional training or plan modifications need to occur at that time.

Areas for Improvement

None Identified.

Recommendations

MCNA has a robust DRBCP plan but should consider adding additional sections for pandemic planning as well.

Information Security

This section assesses the security of the PAHP's information systems. Appropriate practices for securing data include:

- Maintaining a well-run security management program that includes IT governance, risk assessment, policy development, policy dissemination and monitoring.
- Protecting computer systems and terminals from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.
- Securing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.

- Utilizing a comprehensive backup plan that includes scheduling, rotation, verification, retention and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
- Verifying integrity of backups periodically by performing a “restore” and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite, climate-controlled facility.
- Ensuring databases and database updates include transaction management, commits and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- Employing formal controls in the form of batch control sheets or assignment of a batch control number to ensure a full accounting of all claims received.

Strengths, areas for improvement, and recommendations are based on the MCNA ISCA submission, 2019 findings validation, and interviews.

Strengths:

1. MCNA has professional security staff that utilizes video surveillance and state-of-the-art intrusion detection systems.
2. They at a minimum require annual security and privacy training. Additional training maybe assigned throughout the year based on their phishing campaign results.
3. MCNA does not allow the use of any portable mediums such as CD or USB to physically transfer ePHI.
4. MCNA also has completed many SOC 2 audits with the most recent one being a SOC 2 Type 2.
5. All MCNA computer devices that are connected to the MCNA network have anti-virus software installed. It is configured in such a way that the virus definition files are current, routinely and automatically updated, and the anti-virus software is actively running.
6. MCNA utilizes a patch management software that audits all network computers monthly to determine what security patches need installed and installs them if missing.

Areas for Improvement:

None identified.

Recommendations:

None identified.

Data Acquisition Capabilities

This section assesses the PAHP’s ability to capture and report accurate medical services and Medicaid enrollment data. To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data. Timely and accurate eligibility

data are paramount in providing high-quality care and for monitoring services reported in utilization reports.

Strengths, areas for improvement, and recommendations are based on the MCNA ISCA submission, 2019 findings validation, and interviews.

Strengths:

1. All of MCNA's member level transactions are submitted in real time.
2. MCNA uses DentalTrac™'s extensive validation routines and inherent design and core system for monitoring the required level of coding detail.
3. This system also uses business validation logic and system edits which ensures all names, identifiers, date, code sets, addresses and other identifiable information meet all levels of SNIP Level 7 compliance.
4. If data merges are necessary, their EDI transactions go through an extensive validation process before data is put into production systems. This EDI module applies hundreds of data validation steps and business rules to verify and validate the completeness and accuracy of the data.
5. All data sources are managed by MCNA's proprietary MIS known as DentalTrac™. These data scopes include claims data, prior authorization data, eligibility data, provider data, ACD call center performance data, satisfaction survey data, accessibility survey data, grievances and appeals data and returned mail data.
6. MCNA performs two types of Post Adjudication audits to ensure performance standards are being met. The first type is a plan audit and the second is a claim examiner audit. These results are broken down into two categories Procedural and financial.

Areas for Improvement:

None identified.

Recommendations:

None Identified.

Provider Data

This section assesses MCNA's ability to capture and report accurate provider information. MCOs need to ensure accuracy in capturing, rendering provider type as well as provider service location. MCOs also need to be able to uniquely identify each provider. MCOs must also present accurate provider information within the MCNA provider directory.

Strengths:

1. Providers are uniquely identified by provider IDs for each provider.
2. Provider information is received by the provider configuration team. That team performs first level validation to ensure completeness of the data.
3. The credentialing system then performs primary source verifications while the credentialing team verifies other data elements required to deem a provider record verified and credentialed.

Areas for Improvement:

None observed.

Performance Measures

As a part of the EQR evaluation, MCNA reported the results of one Performance Measure (PM) for this evaluation period. The PM was:

Annual Dental Visit

Technical Methods of Data Collection:

The PM is an administrative indicator utilized by MCNA to evaluate performance. The technical methods of data collection and analysis incorporated by MCNA are internally defined utilizing available State and Plan data. Utilizing the PM Validation Worksheet (Attachment 3), a subsequent analysis of internal processes utilized to document and interpret data results was completed by the Team. The Team incorporated document review and interview techniques to fully evaluate the identified components of the PM.

The measure was derived from several sources, including claims/encounter systems and enrollment/eligibility system.

All evaluation was calculated against the CMS Final Protocol, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR). The rating scale reflecting compliance with standards was as follows:

M = Met

MCNA's measurement and reporting was fully compliant with State specifications.

PM = Partially Met

Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

NM = Not Met

MCNA's measurement and reporting process was not compliant with State specifications.

NV = 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.

n/a = Not Applicable

Measure was not reported because MCO did not have any Medicaid enrollees that qualified for the denominator.

A summary of compliance for the evaluated PM is included in Table 4.

Table 4: Performance Measure Compliance Rating Summary Table

Step	Annual Dental Visit
Documentation	Fully Compliant
Denominator: Data Source	Fully Compliant
Denominator: Calculation	Fully Compliant
Numerator: Data Source	Fully Compliant
Numerator: Calculation	Fully Compliant
Numerator: Integration	Fully Compliant
Numerator: Validation	Fully Compliant
Sampling: Unbiased	n/a
Sampling: Methodologies	n/a
Reporting	Fully Compliant
<u>Overall Compliance Rating*</u>	Fully Compliant

*The overall rating is one of the following:

FC = Fully Compliant (Measure was fully compliant with State Specifications.)

SC = Substantially Compliant (Measure was substantially compliant with State Specifications.)

NV = 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.)

Annual Dental Visit

Description of Data:

MCNA utilized data obtained from claims and encounter databases to access the number of Medicaid members ages 2-20 years of age who had at least one dental visit during the measurement year. This performance measure provides an analysis of access and availability of care. The study denominator includes all MCNA members ages 2-20 who were continuously enrolled during the measurement year. The time-period reported during this review was HEDIS 2019 which encompasses January 2018 – December 2018.

The measure evaluated was the percentage of the eligible population who received a dental visit from a dental practitioner during the measurement year.

Conclusions:

The results for the measurement period were 66.39%. This was an increase from the HEDIS 2018 rate of 65.25% and the HEDIS 2017 rate of 61.98%.

Evaluation of the Study and Recommendations for Improvement:

This Performance Measure is a measure of the access and availability of dental visits.

Based on documentation supplied by MCNA and on the Team's ISCA review, the process used to collect, integrate and report this measure meets all standards. During the review, the Team and MCNA discussed the possibility of new Performance Measures to be reviewed in the coming year.

The following discussion of evaluation and recommendations will clarify target areas for improvement.

Strengths:

1. MCNA clearly defined the measurement period adding consistency in data measurement.
2. MCNA identified a performance measure that impact their day to day operations.

Areas for Improvement:

1. The narrative supplied to the Team for review did not contain a description of the data source or calculation of the Denominator.

Recommendations:

1. Continue to request technical assistance from the EQRO to enhance understanding of PM requirements and steps.
2. Work with IDHW to propose new Performance Measures for the coming year.
3. Provide a narrative explanation of the Performance Measure that can be read prior to the on-site review.
4. If MCNA wishes to further improve this PM, they should consider constructing a Performance Improvement Project around this measurement that would include documented interventions and outcome goals.

Overall Evaluation and Recommendations for Improvement

Dental caries (cavities) is one of the most common, preventable childhood diseases.⁶ Regular dental visits provide access to cleaning, early diagnosis, treatment and education about caring for teeth to prevent problems. Approximately 25% of our nation's children have multiple cavities. Oral health is essential to overall health. Dental diseases have negative effect on quality of life in childhood and in older age.⁷ Annual dental visits and oral care throughout childhood and adolescence can significantly reduce the risks of developing oral disease.⁸

There was evidence of understanding of the PMs as data measurement studies or projects.

Access to Care

MCNA placed a great deal of emphasis on their enrollees' access to care. MCNA's focus on ensuring that members received an annual preventive dental visit should improve other outcomes as well.

Quality of Care

MCNA was fully committed to their members' quality of care. In addition, to the Annual Dental Visit PM that was validated in this report, MCNA submits the following Performance Measures to IDHW:

Telephone Access/Call Center Operations

Telephone Access – Provider Hotline

Member Satisfaction Surveys

Member Verbal Complaints

Member Grievances

Member Appeals

Provider Appeals

Provider Complaints and Satisfaction

Claims

Utilization Management

Sentinel Events/Consumer Safety

Credentialing

Network Operations/GeoAccess

Human Resources File Audits

IT Data Integrity Audit

Each of these PMs contained a quality of care element. MCNA was committed to ensuring quality care was received by their members and they have used the data available to them to make informed policy and practice decisions that will further impact members' quality of care in the future.

It is the opinion of the Team that, the study presented for review during this measurement year be considered: Fully Compliant.

⁶ US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. 2000. "Oral health in America; A report of the Surgeon General." Rockville, MD. National Institutes of Health, National Institute of Dental and Craniofacial Research. 33-59.

⁷ "Dental Diseases and Organ Health Factsheet, 2003." http://www.who.int/oral_health/publications/en/orh_fact_sheet.pdf

⁸ CDC, National Center for Health Statistics. "Trends in Oral Health Status: United States 1988-1994 and 1999-2004."

ATTACHMENTS

Attachment 1

BBA Compliance Audit Tool 2018 -19 Compliance Review

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		438.10(f)(6) The State, its contracted representative, or MCNA must provide the following information to all enrollees:	
A-29	438.10(f)(6)(i)	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For Plans this includes, at a minimum, information on primary care physicians, specialists, and hospitals. <i>(related to 438.10(e)(2)(ii)(D) for State above)</i>	P
A-30	438.10(f)(6)(ii)	Any restrictions on the enrollee's freedom of choice among network providers.	P
A-31	438.10(f)(6)(iii)	Enrollee rights and protections, as specified in § 438.100. (following pages)	P
A-32	438.10(f)(6)(iv)	Information on grievance and fair hearing procedures, and for Plan enrollees, the information specified in § 438.10(g)(1), <i>and for PAHP enrollees, the information specified in § 438.10(h)(1).</i>	P
A-33	438.10(f)(6)(v)	The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	P
A-34	438.10(f)(6)(vi)	Procedures for obtaining benefits, including authorization requirements.	P
A-35	438.10(f)(6)(vii)	The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of- network providers.	P
A-36	438.10(f)(6)(viii)	The extent to which, and how, after-hours and emergency coverage are provided, including: (A) What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in § 438.114(a). <i>(attached for reference)</i>	P
A-37	438.10(f)(6)(viii) (B)	The fact that prior authorization is not required for emergency services.	P
A-38	438.10(f)(6)(viii) (C)	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	P
A-39	438.10(f)(6)(viii) (D)	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.	P
A-40	438.10(f)(6)(viii) (E)	The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.	P
A-41	438.10(f)(6)(ix)	The post-stabilization care services rules set forth at § 422.113(c) of this chapter.	P
A-42	438.10(f)(6)(x)	Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	P
A-43	438.10(f)(6)(xi)	Cost sharing, if any.	P
A-44	438.10(f)(6)(xii)	How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that MCNA does not cover because of moral or religious objections, MCNA need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		438.10(g) <i>Specific information requirements for enrollees of Plans.</i> In addition to the requirements in § 438.10(f), the State, its contracted representative, or MCNA must provide the following information to their enrollees: 438.10(g)(1)(i)(A) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§ 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:	
A-45	438.10(g)(1)(i)(A)	For State fair hearing— (A) The right to hearing;	P
A-46	438.10(g)(1)(i)(B)	The method for obtaining a hearing;	P
A-47	438.10(g)(1)(i)(C)	The rules that govern representation at the hearing.	P
A-48	438.10(g)(1)(ii)	The right to file grievances and appeals.	P
A-49	438.10(g)(1)(iii)	The requirements and timeframes for filing a grievance or appeal.	P
A-50	438.10(g)(1)(iv)	The availability of assistance in the filing process.	P
A-51	438.10(g)(1)(v)	The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.	P
		438.10(g)(1)(vi) The fact that, when requested by the enrollee—	
A-52	438.10(g)(1)(vi)(A)	Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and	P
A-53	438.10(g)(1)(vi)(B)	The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.	P
A-54	438.10(g)(1)(vii)	Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.	P
A-55	438.10(g)(2)	Advance directives, as set forth in § 438.6(i)(2). (<i>adults only</i>)	P
		438.10(g)(3) Additional information that is available upon request, including the following:	
A-56	438.10(g)(3)(i)	Information on the structure and operation of MCNA.	P
A-57	438.10(g)(3)(ii)	Physician incentive plans as set forth in § 438.6(h) of this chapter.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		438.10(h) <i>Specific information for PAHPs.</i> The State, its contracted representative, or the PAHP must provide the following information to their enrollees: 438.10(h)(1) The right to a State fair hearing, including the following:	
A-58	438.10(h)(1)(i)	The right to a hearing.	P
A-59	438.10(h)(1)(ii)	The method for obtaining a hearing.	P
A-60	438.10(h)(1)(iii)	The rules that govern representation.	P
A-61	438.10(h)(2)	Advance directives, as set forth in § 438.6(i)(2), to the extent that the PAHP includes any of the providers listed in § 489.102(a) of this chapter. <i>438.6(i)(2): All PAHP contracts must provide for compliance with the requirements of § 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in § 489.102(a) of this chapter.</i>	P
A-62	438.10(h)(3)	Upon request, physician incentive plans as set forth in § 438.6(h).	P
		438.10(i) <i>Special rules: States with mandatory enrollment under State plan authority—(1) Basic rule.</i> If the State plan provides for mandatory enrollment under § 438.50, the State or its contracted representative must provide information on Plans (as specified in paragraph (i)(3) of this section), either directly or through MCNA. (2) <i>When and how the information must be furnished.</i> The information must be furnished as follows:	
*A-64	438.10(i)(2)(ii)	For enrollees, annually and upon request.	n/a
		438.10(i)(3) <i>Required information.</i> Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting Plan in the potential enrollees and enrollee's service area:	
*A-66	438.10(i)(3)(iv)	To the extent available, quality and performance indicators, including enrollee satisfaction.	n/a
A-67	438.100(b)(2)(ii)	Be treated with respect and with due consideration for his or her dignity and privacy.	P
A-68	438.100(b)(2)(iii)	Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(f)(6)(xii).] Include requirements of §438.102 (next page)	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		<p>438.102 Provider-enrollee communications.</p> <p>(a) <i>General rules.</i></p> <p>(1) A Plan may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:</p> <p>(i) The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.</p> <p>(ii) Any information the enrollee needs in order to decide among all relevant treatment options.</p> <p>(iii) The risks, benefits, and consequences of treatment or non-treatment.</p> <p>(iv) The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.</p> <p>(2) Subject to the information requirements of paragraph (b) of this section, a Plan that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if MCNA objects to the service on moral or religious grounds.</p> <p>(b) <i>Information requirements: Plan responsibility.</i></p> <p>(1) A Plan that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows:</p> <p>(i) To the State—</p> <p>(A) With its application for a Medicaid contract; and</p> <p>(B) Whenever it adopts the policy during the term of the contract.</p> <p>(ii) Consistent with the provisions of § 438.10—</p> <p>(A) To potential enrollees, before and during enrollment; and</p> <p>(B) To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle MCNA to the option provided in paragraph (a)(2) of this section, the overriding rule in § 438.10(f)(4) requires the State, its contracted representative, or Plan to furnish the information at least 30 days before the effective date of the policy.)</p> <p>(2) As specified in § 438.10, paragraphs (e) and (f), the information that Plans must furnish to enrollees and potential enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section.</p> <p>(c) <i>Information requirements: State responsibility.</i> For each service excluded by a Plan under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in § 438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).</p> <p>(d) <i>Sanction.</i> A Plan that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.</p>	
A-69	438.100(b)(2)(iv)	Participate in decisions regarding his or her health care, including the right to refuse treatment.	P
A-70	438.100(b)(2)(v)	Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	P
A-71	438.100(b)(2)(vi)	If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.	P
A-72	438.100(b)(3)	An enrollee of a Plan (consistent with the scope of the PAHP’s contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.	P
Findings:			

B. Subpart C Regulations: Access Standards - §438.206 Availability of services.			
Tool	CFR		Score*
	§438.206(a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of Plans. (b) <i>Delivery network.</i> The State must ensure, through its contracts, that each Plan consistent with the scope of MCNA’s contracted services, meets the following requirements:		
*B-1	438.206(1)	Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each Plan must consider the following:	P
B-2	438.206(1)(i)	The anticipated Medicaid enrollment.	P
B-3	438.206(1)(ii)	The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular Plan.	P
B-4	438.206(1)(iii)	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.	P
B-5	438.206(1)(iv)	The numbers of network providers who are not accepting new Medicaid patients.	P
B-6	438.206(1)(v)	The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.	P
B-7	438.206(2)	Provides female enrollees with direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the enrollee’s designated source of primary care if that source is not a women’s health specialist.	P
B-8	438.206(3)	Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	P
B-9	438.206(4)	If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, MCNA must adequately and timely cover these services out of network for the enrollee, for as long as MCNA is unable to provide them.	P
B-10	438.206(5)	Requires out-of-network providers to coordinate with MCNA with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	P
B-11	438.206(6)	Demonstrates that its providers are credentialed as required by § 438.214.	P
	438.206(c)(1) <i>Timely access.</i> Each Plan must do the following:		
B-13	438.206(c)(1)(i)	Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.	P
B-14	438.206(c)(1)(ii)	Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.	P
B-15	438.206(c)(1)(iii)	Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	P
B-16	438.206(c)(1)(iv)	Establish mechanisms to ensure compliance by providers.	P
B-17	438.206(c)(1)(v)	Monitor providers regularly to determine compliance.	P
B-18	438.206(c)(1)(vi)	Take corrective action if there is a failure to comply.	P
B-19	438.206(c)(2)	<i>Cultural considerations.</i> Each Plan participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	P
Findings:			

C. Subpart C Regulations: Access Standards- §438.208 Coordination and continuity of care.			
Tool	CFR		Score*
	§438.208(a) <i>Basic requirement</i> —(1) <i>General rule.</i> Except as specified in paragraphs (a)(2) and (a)(3) of this section, the State must ensure through its contracts, that each Plan complies with the requirements of this section. 438.208(a)(2) <i>PIHP and PAHP exception.</i> For PIHPs and PAHPs, the State determines, based on the scope of the entity’s services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to— <i>PIHP and PAHP exception.</i> For PIHPs and PAHPs, the State determines, based on the scope of the entity’s services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to—		
C-1	438.208(a)(2)(i)	Meet the primary care requirement of paragraph (b)(1) of this section; and	P
C-2	438.208(a)(2)(ii)	Implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.	P
C-3	438.208(a)(3)(i)	<i>Exception for Plans that serve dually eligible enrollees.</i> (i) For each Plan that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent MCNA must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals	P
C-4	438.208(a)(3)(ii)	The State bases its determination on the services it requires MCNA to furnish to dually eligible enrollees.	P
		438.208(b) <i>Primary care and coordination of health care services for all Plan enrollees.</i> Each Plan must implement procedures to deliver primary care to and coordinate health care service for all Plan enrollees. These procedures must meet State requirements and must do the following:	
C-5	438.208(b)(1)	Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.	P
C-6	438.208(b)(2)	Coordinate the services MCNA furnishes to the enrollee with the services the enrollee receives from any other Plan.	P
C-7	438.208(b)(3)	Share with other Plans serving the enrollee with special health care needs the results of its identification and assessment of that enrollee’s needs to prevent duplication of those activities.	P
C-8	438.208(b)(4)	Ensure that in the process of coordinating care, each enrollee’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	P
		438.208(c)(1) <i>Additional services for enrollees with special health care needs</i> —(1) <i>Identification.</i> The State must implement mechanisms to identify persons with special health care needs to Plans, as those persons are defined by the State. These identification mechanisms—	
C-11	438.208(c)(3)(i)	<i>Treatment plans.</i> If the State requires Plans to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be— (i) Developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; <i>(not required by State)</i>	P
C-12	438.208(c)(3)(ii)	Approved by MCNA in a timely manner, if this approval is required by MCNA; and	P
C-13	438.208(c)(3)(iii)	In accord with any applicable State quality assurance and utilization review standards.	P
C-14	438.208(c)(4)	<i>Direct access to specialists.</i> For enrollees with special health care needs determined through an assessment by appropriate health care professionals [consistent with §438.208(c)(2)] to need a course of treatment or regular care monitoring, each Plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs.	P
Findings:			

D. Subpart C Regulations: Access Standards- §438.210 Coverage and authorization of services.			Score*
Tool	CFR		
D-1	438.210(b)	<i>Authorization of services.</i> For the processing of requests for initial and continuing authorizations of services, each contract must require— (including 438.114 emergency and post-stabilization services) (1) That MCNA and its subcontractors have in place, and follow, written policies and procedures. 438.210(b)(2) That MCNA—	
D-2	438.210(b)(2)(i)	Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and	P
D-3	438.210(b)(2)(ii)	Consult with the requesting provider when appropriate.	P
D-4	438.210(b)(3)	That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.	P
*D-5	438.210(c)	<i>Notice of adverse action.</i> Each contract must provide for MCNA to notify the requesting provider, and give the enrollee written notice of any decision by MCNA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For Plans, the notice must meet the requirements of § 438.404, except that the notice to the provider need not be in writing. 438.210(d) <i>Timeframe for decisions.</i> Each Plan contract must provide for the following decisions and notices:	P
*D-6	438.210(d)(1)	<i>Standard authorization decisions.</i> For standard authorization decisions, provide notice as expeditiously as the enrollee’s health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—	P
D-7	438.210(d)(1)(i)	The enrollee, or the provider, requests extension; or	P
D-8	438.210(d)(1)(ii)	MCNA justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee’s interest.	P
D-9	438.210(d)(2)(i)	(2) <i>Expedited authorization decisions.</i> (i) For cases in which a provider indicates, or MCNA determines, that following the standard timeframe could seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function, MCNA must make an expedited authorization decision and provide notice as expeditiously as the enrollee’s health condition requires and no later than 3 working days after receipt of the request for service.	P
D-10	438.210(d)(2)(ii)	(ii) MCNA may extend the 3 working day time period by up to 14 calendar days if the enrollee requests an extension, or if MCNA justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee’s interest.	P
Findings: D-6: NCQA requirement is 15 days – EQRO must ensure 14-day timeframe is followed.			

E. Subpart C Regulations: Structure and Operation Standards- §438.214 Provider selection.			
Tool	CFR		Score*
E-2	438.214(b)(2)	Each Plan must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with MCNA.	P
E-3	438.214(c)	<i>Nondiscrimination.</i> Plan provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P
E-4	438.214(d)	<i>Excluded providers.</i> Plans may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	P
E-5	438.214(e)	<i>State requirements.</i> Each Plan must comply with any additional requirements established by the State. (n/a)	n/a
Findings:			

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems.			Score*
Tool	CFR		
		<p>Subpart F: Grievance System. § 438.400(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.</p> <p>(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.</p> <p>(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of MCNA.</p> <p>(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.</p> <p>(b) <i>Definitions.</i> As used in this subpart, the following terms have the indicated meanings:</p> <p><i>Action</i> means— In the case of a Plan—</p> <p>(1) The denial or limited authorization of a requested service, including the type or level of service;</p> <p>(2) The reduction, suspension, or termination of a previously authorized service;</p> <p>(3) The denial, in whole or in part, of payment for a service;</p> <p>(4) The failure to provide services in a timely manner, as defined by the State;</p> <p>(5) The failure of a Plan to act within the timeframes provided in § 438.408(b); or</p> <p>(6) For a resident of a rural area with only one Plan, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.</p> <p><i>Appeal</i> means a request for review of an action, as "action" is defined in this section.</p> <p><i>Grievance</i> means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at MCNA level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)</p>	
G-2	438.402	§ 438.402 General requirements. (a) <i>The grievance system.</i> Each Plan must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.	P
G-3	438.402(b)(1)(i)	<i>Filing requirements—</i> (1) <i>Authority to file.</i> (i) An enrollee may file a grievance and a Plan level appeal, and may request a State fair hearing.	P
G-4	438.402(b)(1)(ii)	A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.	P
*G-5	438.402(b)(2)(i)	<i>Timing.</i> The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on MCNA's notice of action. Within that timeframe— The enrollee or the provider may file an appeal; and	P
G-6	438.402(b)(2)(ii)	In a State that does not require exhaustion of Plan level appeals, the enrollee may request a State fair hearing.	P
*G-7	438.402(b)(3)(i)	<i>Procedures.</i> (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with MCNA.	P
G-8	438.402(b)(3)(ii)	The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.	P
G-9	438.404(a)	§ 438.404 Notice of action. (a) <i>Language and format requirements.</i> The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.	P
G-10	438.404(b)(1)	<i>Content of notice.</i> The notice must explain the following: (1) The action MCNA or its contractor has taken or intends to take.	P
G-11	438.404(b)(2)	The reasons for the action.	P
G-12	438.404(b)(3)	The enrollee's or the provider's right to file a Plan appeal.	P
*G-13	438.404(b)(4)	If the State does not require the enrollee to exhaust MCNA level appeal procedures, the enrollee's right to request a State fair hearing. (<i>required</i>)	P
G-14	438.404(b)(5)	The procedures for exercising the rights specified in this paragraph.	P
G-15	438.404(b)(6)	The circumstances under which expedited resolution is available and how to request it.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			Score*
Tool	CFR		
G-16	438.404(b)(7)	The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.	P
G-17	438.404(c)(1)	<i>Timing of notice.</i> MCNA must mail the notice within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter. (10 days before action)	P
G-18	438.404(c)(2)	For denial of payment, at the time of any action affecting the claim.	P
G-19	438.404(c)(3)	For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1). (within 14 days)	P
G-20	438.404(c)(4)(i)	If MCNA extends the timeframe in accordance with § 438.210(d)(1), it must— (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and	P
G-21	438.404(c)(4)(ii)	Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	P
G-22	438.404(c)(5)	For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.	P
G-23	438.404(c)(6)	For expedited service authorization decisions, within the timeframes specified in § 438.210(d). (3 days)	P
		§ 438.406 Handling of grievances and appeals. (a) <i>General requirements.</i> In handling grievances and appeals, Plans must meet the following requirements:	
G-24	438.406(a)(1)	Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	P
G-25	438.406(a)(2)	Acknowledge receipt of each grievance and appeal.	P
G-26	438.406(a)(3)(i)	Ensure that the individuals who make decisions on grievances and appeals are individuals—(i) Who were not involved in any previous level of review or decision-making; and	P
G-27	438.406(a)(3)(ii)	(Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues.	P
G-28	438.406(b)(1)	<i>Special requirements for appeals.</i> The process for appeals must: (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.	P
G-29	438.406(b)(2)	Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (MCNA must inform the enrollee of the limited time available for this in the case of expedited resolution.)	P
G-30	438.406(b)(3)	Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.	P
G-31	438.406(b)(4)(i)	Include, as parties to the appeal— The enrollee and his or her representative; (ii) or the legal representative of a deceased enrollee's estate.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			Score*
Tool	CFR		
		§ 438.408 Resolution and notification: Grievances and appeals. (a) <i>Basic rule.</i> MCNA must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.	
G-32	438.408(b)(1)	<i>Specific timeframes—(1) Standard disposition of grievances.</i> For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day MCNA receives the grievance.	P
G-33	438.408(b)(2)	<i>Standard resolution of appeals.</i> For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day MCNA receives the appeal. This timeframe may be extended under paragraph (c) of this section.	P
G-34	438.408(b)(3)	<i>Expedited resolution of appeals.</i> For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after MCNA receives the appeal. This timeframe may be extended under paragraph (c) of this section.	P
G-35	438.408(c)(1)(i)	<i>Extension of timeframes—(1)</i> MCNA may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—(i) The enrollee requests the extension; Or	P
G-36	438.408(c)(1)(ii)	MCNA shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.	P
G-37	438.408(c)(2)	<i>Requirements following extension.</i> If MCNA extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.	P
G-39	438.408(d)(2)(i)	<i>Appeals.</i> (i) For all appeals, MCNA must provide written notice of disposition.	P
G-40	438.408(d)(2)(ii)	For notice of an expedited resolution, MCNA must also make reasonable efforts to provide oral notice.	P
G-41	438.408(e)(1)	<i>Content of notice of appeal resolution.</i> The written notice of the resolution must include the following: (1) The results of the resolution process and the date it was completed.	P
G-42	438.408(e)(2)(i)	For appeals not resolved wholly in favor of the enrollees—(i) The right to request a State fair hearing, and how to do so;	P
G-43	438.408(e)(2)(ii)	The right to request to receive benefits while the hearing is pending, and how to make the request; and	P
G-44	438.408(e)(2)(iii)	That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds MCNA's action.	P
G-46	438.408(f)(1)(ii)	If the State <u>does not require exhaustion</u> of MCNA level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on MCNA's notice of action. <i>(required)</i>	P
G-48	438.410	§ 438.410 Expedited resolution of appeals. (a) <i>General rule.</i> Each Plan must establish and maintain an expedited review process for appeals, when MCNA determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.	P
G-49	438.410(b)	<i>Punitive action.</i> MCNA must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	P
G-50	438.410(c)(1)	<i>Action following denial of a request for expedited resolution.</i> If MCNA denies a request for expedited resolution of an appeal, it must—(1) Transfer the appeal to the timeframe for standard resolution in accordance with § 438.408(b)(2);	P
G-51	438.410(c)(2)	Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			Score*
Tool	CFR		
G-52	438.414	§ 438.414 Information about the grievance system to providers and subcontractors. MCNA must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.	P
G-53	438.416	§ 438.416 Recordkeeping and reporting requirements. The State must require Plans to maintain records of grievances and appeals and must review the information as part of the State quality strategy.	P
G-54	438.420	§ 438.420 Continuation of benefits while MCNA appeal and the State fair hearing are pending. (a) Terminology. As used in this section, “timely” filing means filing on or before the later of the following: (1) Within ten days of MCNA mailing the notice of action. (2) The intended effective date of MCNA’s proposed action.	P
G-55	438.420(b)	Continuation of benefits. MCNA must continue the enrollee’s benefits if— (1) The enrollee or the provider files the appeal timely; (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) The services were ordered by an authorized provider; (4) The original period covered by the original authorization has not expired; and (5) The enrollee requests extension of benefits.	P
G-56	438.420(c)	Duration of continued or reinstated benefits. If, at the enrollee’s request, MCNA continues or reinstates the enrollee’s benefits while the appeal is pending, the benefits must be continued until one of following occurs: (1) The enrollee withdraws the appeal. (2) Ten days pass after MCNA mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10- day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. (3) A State fair hearing Office issues a hearing decision adverse to the enrollee. (4) The time period or service limits of a previously authorized service has been met.	P
G-57	438.420(d)	Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds MCNA’s action, MCNA may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter.	P
G-58	438.424	§ 438.424 Effectuation of reversed appeal resolutions. (a) Services not furnished while the appeal is pending. If MCNA or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, MCNA must authorize or provide the disputed services promptly, and as expeditiously as the enrollee’s health condition requires.	P
G-59	438.424(b)	Services furnished while the appeal is pending. If MCNA, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, MCNA or the State must pay for those services, in accordance with State policy and regulations.	P
Findings:			

H. Subpart C: Structure and Operation Standards - §438.230 Sub contractual relationships and delegation.			
Tool	CFR		Score
H-2	438.230(b)(1)	<i>Specific conditions.</i> (1) Before any delegation, each Plan evaluates the prospective subcontractor’s ability to perform the activities to be delegated.	P
H-3	438.230(b)(2)(i)	There is a written agreement that—(i) Specifies the activities and report responsibilities delegated to the subcontractor; and	P
H-4	438.230(b)(2)(i)	Provides for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate.	P
H-5	438.230(b)(3)	MCNA monitors the subcontractor’s performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State PAHP laws and regulations.	P
H-6	438.230(b)(4)	If any Plan identifies deficiencies or areas for improvement, MCNA and the subcontractor take corrective action.	P
Findings:			

I. Subpart C: Measurement and Improvement Standards - §438.236 Practice guidelines			
Tool	CFR		Score
		438.236(a) <i>Basic rule: The state must ensure through its contracts that each Plan meets the requirements of this section. Each Plan adopts practice guidelines that meet the following requirements:</i>	
I-1	438.236(b)(1)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	P
I-2	438.236(b)(2)	Consider the needs of MCNA's enrollees.	P
I-3	438.236(b)(3)	Are adopted in consultation with contracting health care professionals.	P
I-4	438.236(b)(4)	Are reviewed and updated periodically, as appropriate.	P
I-5	438.236(c)	MCNA disseminates the guidelines to all affected providers, and upon request, to enrollees and potential enrollees.	P
I-8	438.236(d)	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	P
<p>Findings: I-4: NCQA prescribes updating the guidelines at least every two years. I-8: EQRO must determine whether enrollee education is consistent with the guidelines.</p>			

J. Subpart C: Measurement and Improvement Standards - §438.240 Quality assessment and performance improvement program.			Score
Tool	CFR		
		438.240(b) <i>Basic elements of Plan quality assessment and performance improvement programs.</i> At a minimum, the State must require that each Plan comply with the following requirements:	
J-3	438.240(b)(1)	Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.	D
J-4	438.240(b)(2)	Submit performance measurement data as described in paragraph (c) of this section.	P
J-5	438.240(b)(3)	Have in effect mechanisms to detect both underutilization and overutilization of services.	P
J-6	438.240(b)(4)	Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	P
*J-7	438.240(c)(1)	<i>Performance measurement.</i> Annually each Plan must—(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of § 438.204(c) and § 438.240(a)(2); (2) Submit to the State, data specified by the State, that enables the State to measure MCNA’s performance; or (3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.	P
J-8	438.240(d)(1)(i)	<i>Performance improvement projects.</i> (1) Plans must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: (i) Measurement of performance using objective quality indicators.	P
J-9	438.240(d)(1)(ii)	Implementation of system interventions to achieve improvement in quality.	D
J-10	438.240(d)(1)(iii)	Evaluation of the effectiveness of the interventions.	P
J-11	438.240(d)(1)(iv)	Planning and initiation of activities for increasing or sustaining improvement.	D
J-12	438.240(d)(2)	Each Plan must report the status and results of each project to the State as requested, including those that incorporate the requirements of § 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.	P
J-15	438.240(e)(2)	The State may require that a Plan have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. (n/a with EQR)	n/a
Findings: J-3 PIPs submitted by MCNA require modifications in interventions and design. J-9 & J-10			

K. Subpart C: Measurement and Improvement Standards - §438.242 Health information systems.			Score
Tool	CFR		
K-1	438.242(a)	<i>General rule.</i> The State must ensure, through its contracts, that each Plan maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. (b) <i>Basic elements of a health information system.</i> The State must require, at a minimum, that each Plan comply with the following:	
K-2	438.242(b)(1)	(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.	P
K-3	438.242(b)(2)(i)	Ensure that data received from providers is accurate and complete by—(i) Verifying the accuracy and timeliness of reported data;	P
K-4	438.242(b)(2)(ii)	Screening the data for completeness, logic, and consistency; and	P
K-5	438.242(b)(2)(iii)	Collecting service information in standardized formats to the extent feasible and appropriate.	P
K-6	438.242(b)(3)	Make all collected data available to the State and upon request to CMS, as required in this subpart.	P
Findings: K-3 MCNA is not currently calculating defect rates for programs.			

***Individual Component Scoring:** (scoring present on each line of the administrative tool)

P = Proficient - Documentation supports that component was implemented, reviewed, revised, and/or further developed.

D = Developing - Documentation supports some but not full compliance was present.

N = No Documentation - No documentation was found to substantiate component compliance.

n/a = Not Applicable - Component is not applicable to the focus of the evaluation.

Attachment 2

PIP Audit Tool

- Increasing the rate of enrollees accessing preventive dental services

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

Demographic Information

Plan Name or ID: MCNA Idaho
Name of PIP: Appointment Reminder Program
Dates in Study Period: 07/01/2018 to 06/30/2019

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)

Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	P	
1.2. Did MCNA’s PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	P	
1.3. Did MCNA’s PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	P	

Step 2: REVIEW THE STUDY QUESTION(S)

2.1 Was/were the study question(s) stated clearly in writing?	P	
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Step 3: REVIEW SELECTED STUDY INDICATOR(S)

3.1 Did the study use objective, clearly defined, measurable indicators?	P	
3.2 Did the indicators measure changes in health status, functional status or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	P	

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did MCNA clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	P	All Medicaid enrollees are included.
4.2 If MCNA studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	P	
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (overestimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	n/a	
5.2 Did MCNA employ valid sampling techniques that protected against bias? Specify the type of sampling or census used:	n/a	
5.3 Did the sample contain a sufficient number of enrollees?	n/a	
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	P	
6.2 Did the study design clearly specify the sources of data?	P	
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?	P	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	P	
6.5 Did the study design prospectively specify a data analysis plan?	P	

Component/Standard	Score	Comments
Step 6: REVIEW DATA COLLECTION PROCEDURES (continued)		
6.6 Were qualified staff and personnel used to collect the data?	P	
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	D	Although the intervention proved somewhat successful, MCNA did not reach their stated goals for improvement.
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	P	The baseline was presented, and one remeasurement quarter.
8.2 Did MCNA present numerical PIP results and findings accurately and clearly?	P	The baseline was presented and one remeasurement quarter.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	P	There was improvement seen between the baseline and remeasurement period and statistical significance was shown. MCNA did give an explanation for not meeting the goal on one of the measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	P	An additional intervention was presented for re-measurement period 2.
*Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	P	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	P	
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of MCNA quality improvement intervention?	P	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	P	

Step 10: ASSESS SUSTAINED IMPROVEMENT

10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	n/a	
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ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL) Score

I. Were the initial study findings verified upon repeat measurement?	n/a	
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**ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:
SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.**

MCNA presented a well thought out PIP.

- Check one:
- High confidence in reported Plan PIP results
 - Confidence in reported Plan PIP results
 - Low confidence in reported Plan PIP results
 - Reported Plan PIP results not credible
- No results reported.

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Attachment 3

PM Audit Tool

Annual Dental Visit

Performance Measure Validation Worksheet

Performance Measure to be Validated: Clinical Appointment Wait Times

Methodology for Calculating Measure: Administrative Medical Record Review Hybrid

Scoring: MET: MCNA’s measurement and reporting process was fully compliant with State specifications.
 NOT MET: MCNA’s measurement and reporting process was not compliant with State specifications. (This designation should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include explanation of the deviation in the comments section.)
 n/a: The audit element was not applicable to MCNA's measurement and reporting process.

Audit Element	Specifications	Score	Comments
DENOMINATOR			
1. Population	• Medicaid population appropriately segregated from commercial/Medicare.	Met	Only Medicaid enrollees ages 0-20 are eligible
	• Population defined as effective Medicaid enrollment as of ____	Met	
	• Dual Medicaid and Medicare beneficiaries are included.	n/a	
2. Geographic Area	• Includes only those Medicaid enrollees served in MCNA’s reporting area.	Met	
3. Age & Sex	• No specifications, all included	Met	
4. Enrollment Calculation	• Were members of Plan on ____	Met	
	• Were continuously enrolled from <u>01/2018 to 12/31/2018</u> with one break per year of up to 45 days allowed.	Met	

Audit Element	Specifications	Score	Comments
DENOMINATOR (continued)			
4. Enrollment Calculation (continued)	<ul style="list-style-type: none"> Switches between populations (Medicare, Medicaid, and commercial) were not counted as breaks. 	n/a	
5. Data Quality	<ul style="list-style-type: none"> Based on the IS assessment findings, are any of the data sources for this denominator inaccurate? 	Met	
6. Proper Exclusion Methodology in Administrative Data (If no exclusions were taken, score as n/a)	<ul style="list-style-type: none"> Only members with contraindications or data errors were excluded. 	n/a	
	<ul style="list-style-type: none"> Contraindication exclusions were performed according to current State specifications. 	n/a	
	<ul style="list-style-type: none"> Only the codes listed in specifications as defined by State were counted as contraindications. 	n/a	
NUMERATOR			
7. Administrative Data: Claims	<ul style="list-style-type: none"> Standard codes listed in State specifications or properly mapped internally developed codes were used. (Intended to reference appropriate specifications as defined by State.) 	Met	Only D codes were counted as visits
	<ul style="list-style-type: none"> Members were counted only once. 	Met	
8. Medical Record Review Documentation Standards	<ul style="list-style-type: none"> Record abstraction tool required notation of the date that the element was performed. 	n/a	
	<ul style="list-style-type: none"> Record abstraction tool required notation of the element result or finding. 	n/a	

Audit Element	Specifications	Score	Comments
NUMERATOR (continued)			
9. Time Period	<ul style="list-style-type: none"> Element performed on or between __ & __. 	Met	
10. Data Quality	<ul style="list-style-type: none"> Properly identified enrollees. 	Met	
	<ul style="list-style-type: none"> Based on the IS assessment findings, were any of the data sources used for this numerator inaccurate? 	Met	
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13)			
11. Unbiased Sample	<ul style="list-style-type: none"> As specified in State specifications, systematic sampling method was utilized. 	n/a	
12. Sample Size	<ul style="list-style-type: none"> After exclusions, sample size is equal to <ol style="list-style-type: none"> n/a the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or the total population. 	n/a	

Audit Element	Specifications	Score	Comments
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13) (continued)			
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, score as n/a)	<ul style="list-style-type: none"> Only excluded members for whom medical record review revealed <ol style="list-style-type: none"> contraindications that correspond to the codes listed in appropriate specifications as defined by State, or data errors. 	n/a	
	<ul style="list-style-type: none"> Substitutions were made for properly excluded records and the percentage of substituted records was documented. 	n/a	
ADDITIONAL QUESTIONS			
Were members excluded for contraindications found in the administrative data?			n/a
Were members excluded for contraindications found during the medical record review?			n/a
Were internally developed codes used?			n/a

VALIDATION FINDING	
<p>The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be “NOT MET.” Consequently, it is possible that an error for a single audit element may result in a designation of “NV” because the impact of the error biased the reported performance measure by more than “x” percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and, thus, the measure could be given a designation of “SC.” The following is a list of the validation findings and their corresponding definitions:</p>	
FC = Fully Compliant	Measure was fully compliant with State specifications.
SC = Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
NV = 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.
n/a = Not Applicable	Measure was not reported because PAHP/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Performance Measure Designation:

FC

This Performance Measure was a measure of Annual Dental Visits for members ages 0-20 by MCNA.