#563

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

Follow-Up Review: Progress Report on Evaluability of the Mississippi Coordinated Access Network

In January 2011, the Mississippi Division of Medicaid (DOM) implemented the Mississippi Coordinated Access Network (MSCAN), a managed care program. *Managed care* encompasses a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care, primarily through increased care coordination. Two managed care organizations, UnitedHealthcare and Magnolia, have contracted with the DOM to deliver managed care services until December 31, 2013.

The state law authorizing DOM to implement managed care also required PEER to conduct a comprehensive performance evaluation of MSCAN by December 15, 2011, and the Committee issued *An Evaluability Assessment of the Mississippi Coordinated Access Network* on November 15, 2011. In that report, PEER identified the critical elements of an accountability structure that should be in place in order to evaluate the MSCAN program in comparison to its three primary goals (i. e., cost savings, quality of care, and access to care). PEER determined that MSCAN did not have all components in place to calculate the program's actual cost savings, nor did it have extensive access measures or clearly defined outcome measures and performance targets for quality of care.

Since PEER's initial evaluability assessment, the Division of Medicaid has completed the State Quality Assessment and Improvement Strategy, required by federal regulations, and has contracted for an external quality review. Also, the managed care organizations have administered an experience of care survey to enrollees and have provided the results to DOM. However, the division has still not established health-related outcome measures for each of its selected health focus categories, which prevents DOM or a third party from objectively evaluating the actual impact that services provided have had on the health of the selected populations.

The Division of Medicaid plans to expand the MSCAN program on December 1, 2012, prior to completion of the federally mandated external quality review for year one of the MSCAN program. Thus the division is expanding MSCAN without first determining whether the program is achieving measurable improvements in the health of MSCAN enrollees.

October 16, 2012

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms, with one Senator and one Representative appointed from each of the U. S. Congressional Districts and three at-large members appointed from each house. Committee officers are elected by the membership, with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(Website) http://www.peer.state.ms.us

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
GARY JACKSON
Chair
KELVIN E. BUTLER
VIDET CARMICHAEL
NANCY ADAMS COLLINS
THOMAS GOLLOTT
SAMPSON JACKSON II
PERRY LEE

REPRESENTATIVES
RAY ROGERS
Vice Chair
MARGARET ELLIS ROGERS
Secretary
KIMBERLY CAMPBELL BUCK
BECKY CURRIE
DAVID GIBBS
STEVE HORNE
JESSICA SIBLEY UPSHAW

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

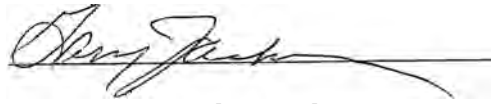
www.peer.state.ms.us

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201

October 16, 2012

Honorable Phil Bryant, Governor
Honorable Tate Reeves, Lieutenant Governor
Honorable Philip Gunn, Speaker of the House
Members of the Mississippi State Legislature

On October 16, 2012, the PEER Committee authorized release of the report entitled **Follow-Up Review: Progress Report on Evaluability of the Mississippi Coordinated Access Network**.



Senator Gary Jackson, Chair

This report does not recommend increased funding or additional staff.

Table of Contents

Follow-Up Review: Progress Report on Evaluability of the Mississippi Coordinated Access Network

Executive Summary

Introduction

Problem Statement

During its 2009 Second Extraordinary Session, the Mississippi Legislature passed House Bill 71 (now codified as MISS. CODE ANN. Section 43-13-117 [1972]), which contained several provisions designed to control Medicaid costs, including a provision authorizing the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010.

The DOM selected two providers to implement the Mississippi Coordinated Access Network (MSCAN) and entered into contracts with Magnolia and UnitedHealthcare to provide these services. On January 1, 2011, the division implemented MSCAN, with the goals of improving access to and quality of care and reducing state expenditures for Medicaid.

The bill included a mandate for the PEER Committee to conduct a comprehensive performance evaluation of the program by December 15, 2011. Early in the fieldwork for that review, PEER determined that the program was still not fully operational in terms of a functioning performance accountability structure and refocused the review from an evaluation of actual performance to an evaluability assessment of whether the DOM was collecting information to allow a comprehensive performance by a date certain in the future. In PEER's report #555, *An Evaluability Assessment of the Mississippi Coordinated Access Network* (November 15, 2011), PEER identified critical elements that the DOM needed to have in place and operable in order to conduct a comprehensive performance evaluation of MSCAN (see pages vi-vii of this summary). Appendix A, page 19 of the report, contains an executive summary of Report #555, including a brief description of the concept of managed care for delivery of Medicaid services.

After PEER issued that report, the PEER Committee voted on May 15, 2012, to conduct this follow-up review to determine what progress has been made since PEER's

initial evaluability assessment in establishing a framework for MSCAN that would allow the Division of Medicaid or a third party such as PEER to perform a comprehensive performance evaluation.

Scope and Purpose

PEER sought to address the following objectives during the course of this review:

- identify short and long-term performance measures in place for holding the MSCAN program accountable for the quality of healthcare services provided and assess the adequacy of these measures, by managed care provider (including the validity and reliability of the measures);
- determine whether additional performance measures are necessary in order to allow for a comprehensive performance evaluation of service quality to be completed in the future (MSCAN Program Year 2013); and,
- determine whether comparable data is available to assess the quality of care being provided to fee-for-service (FFS) Medicaid beneficiaries in comparison to the same populations covered by MSCAN.

While the initial evaluability assessment of the MSCAN program noted opportunities for improvement and steps necessary for a future comprehensive evaluation in the areas of access, quality, and cost efficiencies and effectiveness, this MSCAN review primarily focuses on the program's quality of healthcare services.

Summary of Conclusions from PEER's Initial Evaluability Assessment of MSCAN

As noted previously, the Division of Medicaid and the MSCAN managed care organizations (Magnolia and UnitedHealthcare) are responsible for assuring that Mississippi's Medicaid managed care program fulfills the goals of the program, which are:

- to improve access to needed medical services;
- to improve the quality of care received; and,
- to reduce state Medicaid costs.

In its initial evaluability assessment, PEER identified the critical elements of an accountability structure that should be in place in order to evaluate the MSCAN program in comparison to its three primary goals:

- operational definitions of the key variables of interest (i. e., access, quality, and cost of care);
- performance goals and objectives (both long-term and short-term) for access, quality, and cost; and,
- comprehensive, valid, accurate, and reliable performance data (including baseline data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program or other relevant standard.

Also, PEER identified steps needed to prepare MSCAN for future evaluations:

- complete the State Quality Assessment and Improvement Strategy and submit it to the Centers for Medicare and Medicaid Services;
- select target levels of service or outcomes for the Healthcare Effectiveness Data and Information Set quality measures utilized for MSCAN and establish time frames for achieving expected outcomes;
- review the results of the Consumer Assessment of Healthcare Providers and Systems survey administered by Magnolia and UnitedHealthcare to MSCAN enrollees regarding their experience of care;
- enter into a contract with an external third party organization for the External Quality Review of medical decisions and quality of care; and,
- analyze its data collection and reporting systems to identify potential data elements that could be utilized to compare quality and access of services of MSCAN enrollees with those same eligibility categories in the FFS system, as long as program enrollment is voluntary.

Additional detail to support these conclusions is available in Appendix A, page 19 of the report, which is an executive summary of PEER's initial evaluability assessment, or in Report #555 at **www.peer.state.ms.us**.

Status of Evaluability of the MSCAN Program

Since PEER's initial evaluability assessment, the Division of Medicaid has completed the State Quality Assessment and Improvement Strategy and has contracted for an external quality review. Also, the managed care organizations have administered an experience of care survey to enrollees and have provided the results to DOM. However, the division has still not established health-related outcome measures for each of its selected health focus categories, which prevents DOM or a third party from objectively evaluating the actual impact that services provided have had on the health of the selected populations.

Steps Taken to Improve the Evaluability of MSCAN

Completion of State Quality Assessment and Improvement Strategy

As noted by PEER in its first evaluability assessment of MSCAN, the Centers for Medicare and Medicaid Services requires that the Division of Medicaid develop a State Quality Assessment and Improvement Strategy that incorporates goals and objectives for MSCAN and standards for quality measurement and improvement. The Division of Medicaid submitted the draft of its State Quality Assessment and Improvement Strategy to CMS in November 2011 and CMS approved it in January 2012.

Contract Entered into for External Quality Review

As noted by PEER in its first evaluability assessment of MSCAN, the Centers for Medicare and Medicaid Services requires that every state that enters into a contract for a comprehensive Medicaid managed care program obtain an independent, external review of the quality of service by a third party. The Division of Medicaid has contracted with the Carolinas Center for Medical Excellence for such a review, with the final report for the MSCAN 2011 program year due on May 17, 2013.

Completion of Consumers' Experience of Care Survey

As noted by PEER in its first evaluability assessment of MSCAN, the Division of Medicaid requires that both managed care organizations administer an experience of care survey to MSCAN enrollees and report the results to DOM annually. Both Magnolia and UnitedHealthcare elected to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure patient satisfaction. However, because the division did not conduct exit surveys for those enrollees who opted out of the program during the first open disenrollment period, the survey results provide only a partial depiction of

MSCAN enrollee satisfaction and the division has no documented insight into enrollees' reasons for opting out.

Action Still Needed to Improve the Evaluability of MSCAN: Need for Health-Related Outcome Measures

DOM currently has outcome measures for only one of its four health focus areas (diabetes). The division still must implement health-related outcomes for its three remaining health focus areas (obesity, asthma, and congestive heart failure). While output measures and target service levels ensure that DOM can monitor what services are being provided to MSCAN enrollees, the lack of health-related outcome measures prevents DOM or a third party from objectively evaluating the actual impact that MSCAN has on the quality of health of the selected populations.

Medicaid Management Information System Does Not Allow for a Direct Comparison of MSCAN to FFS Medicaid

Although the collection and reporting capabilities of the Medicaid Management Information System allow the Division of Medicaid to compare selected outpatient services of the MSCAN and fee-for-service Medicaid populations based on administrative claims data, the system can provide only limited data for prescriptions and inpatient hospital services. Thus the DOM can make only limited quality and access comparisons between the MSCAN enrollees and fee-for-service Medicaid categories of eligibility for the types of outpatient services provided by each program. Without the ability to compare directly the healthcare services provided to the respective populations, neither the Division of Medicaid nor a third party can perform a comprehensive program evaluation to determine how the MSCAN program is performing in comparison to fee-for-service Medicaid.

Program Expansion Without Validation of Performance Measures

Without first determining whether the program is achieving measurable improvements in the health of enrollees or validating the performance measures reported by the managed care organizations, the Division of Medicaid plans to expand the MSCAN program on December 1, 2012, prior to completion of the federally mandated external quality review for year one of the MSCAN program.

Recommendations

1. The Division of Medicaid should establish health-related outcome measures for all of the targeted health categories selected for MSCAN based on the existing Healthcare Effectiveness Data and Information Set and DOM performance measures. Health-related outcome measures would allow DOM or a third party to evaluate objectively the actual impact that MSCAN services have on the health of the selected populations.

2. The Division of Medicaid should develop and implement an exit survey process for those MSCAN enrollees who opt out of the program to return to fee-for-service Medicaid as long as there are optional populations participating in the MSCAN program. Furthermore, DOM should consider developing a process to identify MSCAN enrollees who are in the program but not actively utilizing MSCAN services to address potential barriers for program participation, since the state pays the managed care organizations a per member per month capitation based on enrollment.

3. The Division of Medicaid should reconsider its decision to expand the MSCAN program on December 1, 2012.

4. The Division of Medicaid should compare outpatient services provided for the same categories of eligibility and demographic groups based on their four quality focus areas for the MSCAN and FFS populations during the timeframe that the MSCAN program remains optional. This comparison should provide DOM with insight into any trends of services provided to the two populations. DOM should also compare these services for those enrollees who transitioned from fee-for-service Medicaid to MSCAN and then opted out of the MSCAN program to return to fee-for-service Medicaid.

For More Information or Clarification, Contact:

PEER Committee
P.O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
http://www.peer.state.ms.us

Senator Gary Jackson, Chair
Weir, MS

Representative Ray Rogers, Vice Chair
Pearl, MS

Representative Margaret Rogers, Secretary
New Albany, MS

Follow-Up Review: Progress Report on Evaluability of the Mississippi Coordinated Access Network

Introduction

Authority

The PEER Committee conducted a follow-up review of the Mississippi Coordinated Access Network (MSCAN), the state's Medicaid managed care program, to determine what additional progress has been made in establishing a framework that would allow a comprehensive performance evaluation as required by MISS. CODE ANN. Section 43-13-117 (1972).

PEER conducted the review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-51 et seq. (1972).

Problem Statement

During its 2009 Second Extraordinary Session, the Mississippi Legislature passed House Bill 71 (now codified as MISS. CODE ANN. Section 43-13-117 [1972]), which contained several provisions designed to control Medicaid costs, including a provision authorizing the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010.

The DOM selected two providers to implement the Mississippi Coordinated Access Network (MSCAN) and entered into contracts with Magnolia and UnitedHealthcare to provide these services. On January 1, 2011, the division implemented MSCAN, with the goals of improving access to and quality of care and reducing state expenditures for Medicaid.

The bill included a mandate for the PEER Committee to conduct a comprehensive performance evaluation of the program by December 15, 2011. Early in the fieldwork for that review, PEER determined that the program was still not fully operational in terms of a functioning performance accountability structure and refocused the review from an evaluation of actual performance to an evaluability assessment of whether the DOM was collecting information to allow a comprehensive performance by a

date certain in the future. In PEER's report #555, *An Evaluability Assessment of the Mississippi Coordinated Access Network* (November 15, 2011), PEER identified critical elements that the DOM needed to have in place and operable in order to conduct a comprehensive performance evaluation of MSCAN (see page 4). Appendix A, page 19, contains an executive summary of Report #555, including a brief description of the concept of managed care for delivery of Medicaid services.

After PEER issued that report, the PEER Committee voted on May 15, 2012, to conduct this follow-up review to determine what progress has been made since PEER's initial evaluability assessment in establishing a framework for MSCAN that would allow the Division of Medicaid or a third party such as PEER to perform a comprehensive performance evaluation.

Scope and Purpose

PEER sought to address the following objectives during the course of this review:

- identify short- and long-term performance measures in place for holding the MSCAN program accountable for the quality of healthcare services provided and assess the adequacy of these measures, by managed care provider (including the validity and reliability of the measures);
- determine whether additional performance measures are necessary in order to allow for a comprehensive performance evaluation of service quality to be completed in the future (MSCAN Program Year 2013); and,
- determine whether comparable data is available to assess the quality of care being provided to fee-for-service (FFS) Medicaid beneficiaries in comparison to the same populations covered by MSCAN.

While the initial evaluability assessment of the MSCAN program noted opportunities for improvement and steps necessary for a future comprehensive evaluation in the areas of access, quality, and cost efficiencies and effectiveness, this MSCAN review primarily focuses on the program's quality of healthcare services.

Method

In conducting this review, PEER:

- reviewed applicable state and federal laws;

- interviewed personnel and examined records of the Office of the Governor, Division of Medicaid;
- reviewed the MSCAN State Quality Assessment and Improvement Strategy, including Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- reviewed the results for the initial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; and,
- reviewed data reports from the Medicaid Management and Information System (MMIS) for a sample of MSCAN enrollees based on outpatient services, inpatient services, and prescriptions.

Summary of Conclusions from PEER's Initial Evaluability Assessment of MSCAN

As noted previously, the Division of Medicaid and the MSCAN managed care organizations (Magnolia and UnitedHealthcare) are responsible for assuring that Mississippi's Medicaid managed care program fulfills the goals of the program, which are:

- to improve access to needed medical services;
- to improve the quality of care received; and,
- to reduce state Medicaid costs.

In its initial evaluability assessment, PEER identified the critical elements of an accountability structure that should be in place in order to evaluate the MSCAN program in comparison to its primary goals:

- *operational definitions of the key variables of interest* (i.e., access, quality, and cost of care);
- *performance goals and objectives* (both long-term and short-term) for access, quality, and cost; and,
- *comprehensive, valid, accurate, and reliable performance data* (including baseline data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program or other relevant standard.

Also, PEER identified steps needed to prepare MSCAN for future evaluations:

- complete the State Quality Assessment and Improvement Strategy and submit it to CMS;
- select target levels of service or outcomes for the HEDIS quality measures utilized for MSCAN and establish time frames for achieving expected outcomes;
- review the results of the CAHPS survey administered by Magnolia and UnitedHealthcare to MSCAN enrollees regarding their experience of care;
- enter into a contract with an external third party organization for the External Quality Review of medical decisions and quality of care; and,

- analyze its data collection and reporting systems to identify potential data elements that could be utilized to compare quality and access of services of MSCAN enrollees with those same eligibility categories in the FFS system, as long as program enrollment is voluntary.

Additional detail to support these conclusions is available in Appendix A, page 19, which is an executive summary of PEER's initial evaluability assessment, or in Report #555 at **www.peer.state.ms.us**.

Status of Evaluability of the MSCAN Program

For the purpose of this follow-up review, PEER utilized critical elements and action steps noted on pages 4 and 5 of this report as focal points to determine what progress DOM has made since the initial MSCAN evaluability assessment in regard to quality, data collection, and reporting. This chapter will discuss DOM's progress based on each of the action steps previously noted and will address the following question:

- *What progress has the Division of Medicaid made since PEER's original evaluability assessment in ensuring the evaluability of the quality of the MSCAN program?*

Since PEER's initial evaluability assessment, the Division of Medicaid has completed the State Quality Assessment and Improvement Strategy and has contracted for an external quality review. Also, the managed care organizations have administered an experience of care survey to enrollees and have provided the results to DOM. However, the division still has not established health-related outcome measures for each of its selected health focus categories, which prevents DOM or a third party from objectively evaluating the actual impact that services provided have had on the health of the selected populations.

The following sections briefly describe DOM's progress and areas of improvement for the evaluability of the impact on quality of healthcare through the MSCAN program.

Steps Taken to Improve the Evaluability of MSCAN

Completion of State Quality Assessment and Improvement Strategy

As noted by PEER in its first evaluability assessment of MSCAN, the Centers for Medicare and Medicaid Services requires that the Division of Medicaid develop a State Quality Assessment and Improvement Strategy that incorporates goals and objectives for MSCAN and standards for quality measurement and improvement. The Division of Medicaid submitted the draft of its State Quality Assessment and Improvement Strategy to CMS in November 2011 and CMS approved it in January 2012.

As noted by PEER in its first evaluability assessment, the federal Centers for Medicare and Medicaid Services (CMS) requires that states with Medicaid managed care contracts develop a State Quality Assessment and Improvement Strategy that shows how the managed care program will measure and report on quality and access performance measures. This strategy must address how the state will:

- assess the quality of care delivered through the managed care organization (MCO) contract(s); and,

- improve the quality of care delivered through the managed care organization contract(s), based on the above assessment.

According to CMS, MSCAN should report the following in this strategy:

- a description of the goals and objectives of the state's managed care program, including priorities and strategic partnerships; and,

- a summary description of the state standards for quality measurement and improvement with reference as applicable to details included in the managed care organization contract.

The Division of Medicaid submitted the draft of the MSCAN State Quality Assessment and Improvement Strategy to CMS in November 2011. CMS approved the MSCAN strategy in January 2012.

The shared goal of DOM and the managed care organizations noted in the MSCAN strategy was "to improve health outcomes for MSCAN beneficiaries." The MSCAN strategy also provides operational definitions for quality and target levels of service through fourteen performance measures (see Appendix B on page 25 for a list of these measures) and provides a description of other quality-related focus areas and action steps (i. e., a joint emergency room diversion plan for Magnolia and UnitedHealthcare).

Contract Entered into for External Quality Review

As noted by PEER in its first evaluability assessment of MSCAN, the Centers for Medicare and Medicaid Services requires that every state that enters into a contract for a comprehensive Medicaid managed care program obtain an independent, external review by a third party of the program's quality of service. The Division of Medicaid has contracted with the Carolinas Center for Medical Excellence for such a review, with the final report for the MSCAN 2011 program year due on May 17, 2013.

As noted by PEER in its first evaluability assessment, the federal Centers for Medicare and Medicaid Services requires that each state Medicaid managed care program be evaluated by an external quality review organization (EQRO) on an annual basis to determine the quality of services furnished by the program.

On January 27, 2012, the Division of Medicaid issued a request for proposals (RFP) for an EQRO. Subsequently, DOM entered into a contract with the Carolinas Center for Medical Excellence for June 1, 2012, through May 31, 2014. According to the request for proposals for the EQRO, the

following were the primary objectives for the review process:

- conduct annual reviews of the MCOs;
- assure quality of the data collected from the MCOs;
- achieve measurable improvements in the health status of the MSCAN enrollees; and,
- assure that MSCAN enrollees have access to and the availability of an adequate provider network.

In addition, CMS mandates five activities that the EQRO contractor should perform:

- validate performance improvement projects required by the state;
- validate performance measures reported during the preceding twelve months;
- review the data management processes of the MCOs;
- evaluate HEDIS and DOM performance measures; and,
- verify performance measures to confirm that the reported results are based on accurate source information.

Upon completion of the review, the EQRO must electronically submit a detailed technical report to DOM describing the manner in which the data from all activities conducted was aggregated and analyzed and the conclusions drawn as to the quality of, timeliness of, and access to care furnished by each MCO. The completed external quality report for the first MSCAN program year is to be provided to DOM on May 17, 2013.

Completion of Consumers' Experience of Care Survey

As PEER noted in its first evaluability assessment of MSCAN, the Division of Medicaid requires that both managed care organizations administer an experience of care survey to MSCAN enrollees and report the results to DOM annually. Both Magnolia and UnitedHealthcare elected to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure patient satisfaction. However, because the division did not conduct exit surveys for those enrollees who opted out of the program during the first open disenrollment period, the survey results provide only a partial depiction of MSCAN enrollee satisfaction and the division has no documented insight into their reasons for opting out.

As PEER noted in its first evaluability assessment, the Division of Medicaid required that both Magnolia and UnitedHealthcare administer an experience of care survey to their respective MSCAN enrollees and report the results to DOM annually in order to measure subjectively the quality of healthcare provided through MSCAN. Both MCOs elected to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure

experience of care per contractual requirements and to seek accreditation from the National Committee for Quality Assurance (NCQA). Both managed care organizations began administering the survey to their enrollees in August 2011 and prepared a summary of the survey results in March 2012. Upon completion of the survey summary reports, the results were then provided to the Division of Medicaid.

However, PEER notes that a comprehensive evaluation on the experience of care provided through the MSCAN program should encompass both the experience of care for those who actively received services as well as those who did not actively participate in the program, such as the use of an exit survey when an enrollee opts out of the program. The lack of an exit survey process results in only a partial depiction of the enrollee satisfaction with the quality of the MSCAN program. While CAHPS captures subjective feedback from actively participating enrollees, DOM does not have any documented insight into the reasons for the initial MSCAN enrollees who elected to opt out of the MSCAN program during the first open enrollment (and disenrollment) period in order to return to fee-for-service (FFS) Medicaid.

Milliman, Inc., an independent actuarial and consulting firm retained by the DOM to establish the capitation rate for the MSCAN program, noted the enrollment changes in the MSCAN program from October 2011 through January 2012 within its MSCAN Capitation Risk Adjustment Report provided to DOM in March 2012. According to this report, Magnolia experienced a decrease in MSCAN membership by approximately 3.6% and UnitedHealthcare experienced a decrease in membership by approximately 10.5%. Milliman noted that this change was largely driven by the open enrollment period for the MSCAN program at the end of 2011, but that these numbers also include normal monthly membership changes. Without an exit survey of the enrollees who returned to FFS Medicaid, the DOM does not have documented feedback that could lead to improvements in the MSCAN program that could encourage enrollees to participate and seek services.

Action Still Needed to Improve the Evaluability of MSCAN

Need for Health-Related Outcome Measures

DOM currently has outcome measures for only one of its four health focus areas (diabetes). The division still must implement health-related outcomes for its three remaining health focus areas (obesity, asthma, and congestive heart failure). While output measures and target service levels ensure that DOM can monitor what services are being provided to MSCAN enrollees, the lack of health-related outcome measures prevents DOM or a third party

from objectively evaluating the actual impact that MSCAN has on the quality of health of the selected populations.

One key component of the State Quality Assessment and Improvement Strategy is how the managed care program will measure and report on quality and access. As noted in PEER Report #555, the Division of Medicaid noted that it would utilize the Healthcare Effectiveness Data and Information Set[1] (HEDIS) as its operational definitions for quality of the MSCAN program, but did not have target levels of service or benchmarks in place at that time.

Since PEER's initial evaluability assessment of MSCAN, the Division of Medicaid has established target levels of service and benchmarks through fourteen performance measures provided within the MSCAN quality strategy (see Appendix B on page 25 for a list of these performance measures). The measures were based on the four health category focus areas--obesity, asthma, diabetes, and congestive heart failure--as well as measures for hemophilia and Early and Periodic Screening Diagnosis and Treatment (EPSDT) services. These performance measures consisted of both HEDIS measures and DOM-specified target goals. The HEDIS measures utilize goals based on HEDIS 2010 benchmarks for the 50th percentile.[2]

While these performance measures established within the MSCAN quality strategy are important in determining to what extent managed care participants are receiving quality services (i. e., output measures), not all of the measures selected by DOM provide actual health-related outcome measures to determine the impact of the MSCAN program on improving the health status of the participants. For example, one of the HEDIS performance measures listed within the state quality strategy for targeting obesity is as follows:

Health Target Area	Performance Measure	HEDIS 2010 Benchmark
Obesity	Percentage of members who had an outpatient visit and their body mass index (BMI) documented during the measurement period	35.28

SOURCE: MSCAN State Quality Assessment and Improvement Strategy.

[1] The *Healthcare Effectiveness Data and Information Set* (HEDIS) is a widely used set of performance measures in the managed care industry developed and maintained by the National Committee for Quality Assurance. HEDIS is a tool used by more than ninety percent of America's health plans to measure performance on important dimensions of care and service.

[2] HEDIS 2010 benchmarks represent Calendar Year 2009 performance reported by Medicaid health plans to the National Committee for Quality Assurance in 2010. The 50th percentile benchmarks are an indicator that half of the health plans performed above the benchmark rates and half had rates below the benchmark rates.

An *output* measure typically focuses on a process or a task that can be documented and reported quantitatively based on completion of the process or task. An *outcome* measure focuses on the impact or change that results from a program and its output measures. Outcomes are generally documented through evaluative actions taken after a specified interval or timeframe and are reported either quantitatively, qualitatively, or by a combination of the two. The HEDIS performance measure provided above in regard to obesity is a clear example of an output measure because it documents the number of MSCAN enrollees who receive a specific service (a BMI assessment).

This measure alone does not provide a way for DOM to determine the impact of providing BMI assessments to MSCAN enrollees on their health outcomes. While it is important to ensure that MSCAN enrollees are receiving necessary healthcare services, it is also important to evaluate the impact of these services on improving the quality of health of the enrollees. For example, one possible health-related outcome based on the number of enrollees receiving BMI assessments would be to measure the percentage of these MSCAN enrollees that went from an overweight or obese status category to a normal weight status category based on national weight status categories provided by the Centers for Disease Control and Prevention (CDC).

While the majority of the performance measures listed within the MSCAN quality strategy only represented target service levels through output measures, potential outcome measures were in place for childhood immunizations and for the health target area of diabetes. For example, one of the HEDIS performance measures listed within the MSCAN quality strategy for targeting diabetes is as follows:

Health Target Area	Performance Measure	HEDIS 2010 Benchmark
Diabetes	Percentage of members with HbA1c results less than or equal to 8.0 percent	46.55

SOURCE: MSCAN State Quality Assessment and Improvement Strategy.

DOM has output measures in place for the number of MSCAN enrollees who are diagnosed with diabetes and receive screenings, but also has a health-related outcome measure in place based on how many enrollees are controlling their blood sugar at acceptable levels defined by the HEDIS measure.

Without health-related quality outcome measures for at least the four targeted health categories selected by DOM for MSCAN, neither DOM nor a third party can objectively

evaluate the actual impact that services provided through MSCAN have on the health status of the selected populations.

The Medicaid Management Information System Does Not Allow for a Direct Comparison of MSCAN to FFS Medicaid

Although the collection and reporting capabilities of the Medicaid Management Information System (MMIS) allow the Division of Medicaid to compare selected outpatient services of the MSCAN and fee-for-service Medicaid (FFS) populations based on administrative claims data, the system can provide only limited data for prescriptions and inpatient hospital services. Thus the DOM can make only limited quality and access comparisons between the MSCAN enrollees and FFS categories of eligibility for the types of outpatient services provided by each program. Without the ability to compare directly the healthcare services provided to the respective populations, neither the Division of Medicaid nor a third party can perform a comprehensive program evaluation to determine how the MSCAN program is performing in comparison to FFS Medicaid.

The Medicaid Management Information System (MMIS), which is contractually managed and maintained by Xerox, is the primary data system used by DOM in collecting and reporting both MSCAN and FFS claim and encounter data.

As noted on page 4, one critical element the Division of Medicaid should have in place and operable in order to conduct a comprehensive performance evaluation is:

> *. . .comprehensive, valid, accurate, and reliable performance data (including baseline data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program or other relevant standard.*

This data collection and reporting element is necessary because in measuring the actual impact of the MSCAN program in relation to its goals regarding access, quality, and cost savings, such a system would ensure that the results presented are as accurate as possible and would allow DOM to make well-informed decisions on how the program is performing.

PEER requested sample reports from the Division of Medicaid to see the capabilities of its data system as well as what data elements were in place that could allow a comparison of the access and quality of the MSCAN program to the same populations who remained in or opted out to return to FFS Medicaid. According to sample

MMIS reports provided by DOM staff, the data system has the ability to search and provide reports for outpatient, inpatient, and prescription claims. These reports may be generated based on numerous search criteria such as Medicaid category of eligibility, age range, primary health diagnosis, or county of service.

The DOM data reports for outpatient services, inpatient services, and prescriptions are primarily focused on the cost of the managed care program, using administrative claims as the primary data source. Outpatient services are billed by line-item services on the claim submissions, listing specific services received by the sample population. Regarding inpatient hospital services, the current Medicaid FFS system only reimburses providers on a fee per inpatient day method and therefore only a list of generic revenue description categories may be obtained, with no specific breakout of services provided regardless of the sample population.

However, DOM staff noted that effective October 2012, inpatient claims will shift from a fee per inpatient day method to an All-Patient Refined-Diagnosis Related Groups (APR-DRG) payment method, which will require inpatient services to provide the diagnosis-related service on the claim form instead of a generic revenue description. Regarding prescription data reports, the costs associated with the claims are provided, but the system does not readily provide or break out a description of the specific medication provided without extensive record review.

Furthermore, Division of Medicaid staff noted that they attempted to establish a HEDIS baseline for their fee-for-service data collected through MMIS with the goal of directly comparing the quality of services for those categories of eligibility that opted out of the MSCAN program to remain in FFS Medicaid versus those same categories that remained enrolled in MSCAN. However, DOM staff noted that the HEDIS baseline for the FFS data attempt was unsuccessful. DOM staff attributed this to the primary issue that FFS has traditionally not utilized HEDIS or other quality measures and therefore the MMIS system does not capture all of the data elements required by the National Committee of Quality Assurance's HEDIS formulas in calculating a baseline or does not collect and report the data in the same format. The lack of a HEDIS baseline inhibits DOM from making a direct quality comparison to the FFS population based on the quality performance measures used for the MSCAN program.

Based on the sample reports provided, the MMIS system has the potential to compare outpatient services between the MSCAN and FFS populations during the timeframe the MSCAN program remains optional for similar categories of eligibility. However, reports for inpatient services (not covered under MSCAN/only provided through FFS) only

list a generic revenue description category and do not provide a breakout of services provided regardless of the population that would allow a comparison of services between the two populations. Regarding prescription data reports, the costs associated with the claims are provided, but the system does not readily provide or break out a description of the specific medication provided without extensive record review.

The Division of Medicaid should be able to make limited quality and access comparisons between the MSCAN enrollees and FFS categories of eligibility on the types of outpatient services provided by each respective program. This would at least allow DOM to identify trends in utilization of outpatient services based on Medicaid category of eligibility and primary diagnosis between the two populations to see if the services provided are similar and what services may be more or less prevalent in one population versus the other. For example, if a particular outpatient service was provided far more often within either the MSCAN or the FFS population, the Division of Medicaid could identify this service and compare it to denied claims or prior authorization requests to determine whether quality or access was actually limited or enhanced by participation in the respective Medicaid program.

DOM also noted within its MSCAN State Quality Assessment and Improvement Strategy that it plans to overhaul the current MMIS data system and have a new system in place within the next three years. While the DOM might have missed the opportunity to develop and implement a data collection and reporting system that allows for a direct comparison between MSCAN and the FFS Medicaid populations based on the existing data systems, it should consider that the new MMIS data system should have the ability to collect data at the service level for all service types for any future managed care programs or pilot programs on the horizon. This is especially important because Medicaid categories of eligibility selected by DOM to participate in the MSCAN program will be subject to mandatory enrollment effective December 1, 2012, with the MSCAN expansion (see discussion on page 15). With mandatory enrollment into the MSCAN program, DOM no longer has a comparison group within FFS Medicaid against which to measure program performance.

MSCAN Program Expansion Plans

During the 2012 Regular Session, the Mississippi Legislature passed House Bill 421 (now codified as MISS. CODE ANN. Section 43-13-117 [1972]), which altered the initial creation language authorizing the Division of Medicaid to create and implement the MSCAN program. House Bill 421, effective July 1, 2012, stated the following in regard to the MSCAN program:

> *Managed care programs, coordinated care programs, coordinated care organization programs, health maintenance organization programs, patient-centered medical home programs, accountable care organization programs, or any combination of the above programs or other similar programs implemented by the division* [Division of Medicaid] *under this section shall be limited to a maximum of forty-five percent (45%) of all Medicaid beneficiaries, and the division is authorized to enroll categories of beneficiaries in such program(s) as long as the forty-five percent (45%) limitation is not exceeded in the aggregate.*

House Bill 421 not only authorized the expansion of the MSCAN program beyond the original fifteen percent population cap, but also repealed the provision that required MSCAN-eligible populations to remain optional in managed care enrollment. It also allows for provision of mental and behavioral health services by not explicitly carving them out of the program (as was done the first program year).

Program Expansion Without Validation of Performance Measures

Without first determining whether the program is achieving measurable improvements in the health of enrollees or validating the performance measures reported by the managed care organizations, the Division of Medicaid plans to expand the MSCAN program on December 1, 2012, prior to completion of the federally mandated external quality review for year one of the MSCAN program.

While House Bill 421 gives the Division of Medicaid the authority to expand MSCAN enrollment, it does not mandate that the managed care program be expanded by any specific date nor does it require that enrollment into the program be mandatory. In addition, according to DOM staff, no changes were made to the original contracts between DOM and Magnolia and UnitedHealthcare

regarding the MSCAN program expansion plans. Therefore, DOM can establish its own timeframe on how and when to expand the MSCAN program.

DOM plans to enroll approximately twenty-five percent of the state Medicaid population into the MSCAN program effective December 1, 2012. Enrollment of the selected categories of eligibility will now be mandatory (except for several federally excluded sub-populations primarily involving children under nineteen years of age).[3] Appendix C, page 28, shows the eligibility categories and whether they will have mandatory or optional enrollment as of December 1, 2012. Appendix D, page 29, provides definitions of the categories of eligibility.

The Supplemental Security Income (SSI), working disabled, and breast and cervical cancer categories were included in the original implementation of the MSCAN program, with optional enrollment. Enrollment for these categories will now be mandatory effective December 1, 2012. New mandatory eligibility categories effective December 1, 2012, are pregnant women and infants, Temporary Assistance for Needy Families (TANF), and children from zero to one year old. According to DOM staff, the Centers for Medicare and Medicaid Services requires that any state operating a managed care program via state plan amendment (such as MSCAN) must maintain optional enrollment in the program for children with special needs up to age nineteen years old.

Based on the current DOM timeline, the MSCAN program will expand to approximately twenty-five percent of the state Medicaid population on December 1, 2012, prior to completion of the federally required external quality review for the first MSCAN program year (see page 7). Thus the division is expanding the MSCAN program before the EQRO can validate the quality performance measures, validate the source data used by the managed care organizations, and ultimately determine whether the program has achieved measurable improvements in the health status of MSCAN enrollees.

[3] Beginning December 1, 2012, all Medicaid categories of eligibility selected by DOM to participate in the MSCAN program will be enrolled in either Magnolia or UnitedHealthcare. The MSCAN program will no longer offer an annual open enrollment period for MSCAN enrollees to opt out of the managed care program and return to FFS Medicaid unless the enrollee is within one of the optional populations as required by federal law (see Appendix C, page 28). In addition, the contractual terms between DOM and the managed care organizations state the following are terms for automatic disenrollment: enrollee no longer resides in the state of Mississippi; enrollee is deceased; or no longer qualifies for medical assistance under one of the MSCAN Medicaid eligibility categories. A MSCAN enrollee may also request disenrollment from the program if the managed care organization does not, because of moral or religious objections, cover the service the enrollee seeks or if neither plan can provide all related services necessary for the enrollee's health care needs.

Recommendations

1. The Division of Medicaid should establish health-related outcome measures for all of the targeted health categories selected for MSCAN based on the existing HEDIS and DOM performance measures. Health-related outcome measures would allow DOM or a third party to evaluate objectively the actual impact that MSCAN services have on the health of the selected populations.
2. The Division of Medicaid should develop and implement an exit survey process for those MSCAN enrollees who opt out of the program to return to FFS Medicaid as long as there are optional populations participating in the MSCAN program. Furthermore, DOM should consider developing a process to identify MSCAN enrollees who are in the program but not actively utilizing MSCAN services to address potential barriers for program participation, since the state pays the managed care organizations a per member per month capitation based on enrollment.
3. The Division of Medicaid should reconsider its decision to expand the MSCAN program on December 1, 2012.
4. The Division of Medicaid should compare outpatient services provided for the same categories of eligibility and demographic groups based on their four quality focus areas for the MSCAN and FFS populations during the timeframe that the MSCAN program remains optional. This comparison should provide DOM with insight into any trends of services provided to the two populations. DOM should also compare these services for those enrollees who transitioned from FFS to MSCAN and then opted out of the MSCAN program to return to FFS.

Appendix A: Executive Summary of PEER Report #555, *An Evaluability Assessment of the Mississippi Coordinated Access Network* (November 15, 2011)

Introduction

Statutory Mandate

During its 2009 Second Extraordinary Session, the Mississippi Legislature passed House Bill 71 (now codified as MISS. CODE ANN. Section 43-13-117 [1972]), which contained several provisions designed to control Medicaid costs, including a provision authorizing the Division of Medicaid (DOM) to implement a managed care program on or after January 1, 2010. The bill included a mandate for the PEER Committee to conduct a comprehensive performance evaluation of the program by December 15, 2011.

Problem Statement

For PEER to conduct a comprehensive performance evaluation of the Mississippi Coordinated Access Network (MSCAN) program by the legislatively mandated deadline, the following information would need to be available to serve as the basis for the evaluation:

- *operational (i. e., measurable) definitions of the key components* of the evaluation, as established in state law--i. e., quality of care to the beneficiaries, access to care by the beneficiaries, and cost savings to the Division of Medicaid;
- *program performance goals and objectives* for each of the key program evaluation components, both long-term and short-term; and,
- *comprehensive, valid, accurate and reliable performance data* (including benchmark data) collected over a period of at least one year from full implementation of the program, measuring the program's success in achieving its goals and objectives, and ideally measuring the success of the Medicaid managed care program relative to the Medicaid fee-for-service program.

Early in this review, PEER determined that while the Division of Medicaid was statutorily authorized to implement managed care on or after January 1, 2010, MSCAN was not implemented until January 1, 2011, and is

still not fully operational in terms of a functioning performance accountability structure.

As a result, PEER refocused this review from an evaluation of actual performance to an evaluability assessment of whether the Division of Medicaid is collecting adequate information to allow a comprehensive performance evaluation by a date certain in the future. PEER cautions that such a performance evaluation should take place before the Legislature considers any changes to the Medicaid managed care program in Mississippi.

Background: Managed Care and Delivery of Medicaid Services

Medicaid has traditionally been provided in a fee-for-service delivery system. Fee-for-service is a method for the administration of the Medicaid program whereby provider participation is open to all providers that meet state requirements. Under a fee-for-service system, providers are reimbursed for each unit of service delivered.

A growing concern is that the traditional fee-for-service system has the potential for Medicaid providers to provide many services as an economic incentive, which may contribute to rising Medicaid costs. As a result of this concern, many states have shifted from the traditional fee-for-service system to a managed care system for their respective Medicaid programs to reduce and stabilize costs and gain greater budget control.

Managed care is a term used to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care, primarily through increased care coordination. The primary method for paying Medicaid managed care programs is through capitation, whereby the state agency pays a managed care organization a per member per month payment based on program enrollment.

The Division of Medicaid's Implementation of the Mississippi Coordinated Access Network

The Division of Medicaid selected two providers to implement MSCAN and entered into contracts with Magnolia and UnitedHealthcare to provide these services until December 31, 2013. On January 1, 2011, the division implemented MSCAN, with the goals of improving access to and quality of care and reducing state expenditures for Medicaid. As of September 2011, the program had complied with all state-mandated requirements and most federal requirements. According to the division's staff, the program is in the process of complying with the remaining

federal requirements or will have complied upon completion of the first full program year.

The contracts between the Division of Medicaid and the managed care organizations established reporting requirements, including periodic reporting of financial, quality, and access data. As of September 2011, both managed care organizations (MCOs) had complied with all contractual reporting requirements to date. However, the MCOs cannot fulfill some of the contractual reporting requirements until completion of the first MSCAN program year.

MSCAN's Cost Savings: Performance Measures, Impact, and Evaluability

The Division of Medicaid considers its capitation rates (which are designed to ensure a ten percent net savings to the state) and savings guarantee program (a financial incentive to the MCOs to save at least ten percent on inpatient hospital services) to be its cost savings performance measures.

PEER could not calculate documented cost savings of MSCAN to date because of delays in financial reporting by the managed care organizations. This was compounded by delays in submitting encounter and claims data to the DOM data system because of coding errors. However, Milliman (the actuarial firm that DOM retained to calculate capitation rates to be paid to the MCOs) is scheduled to review actual MSCAN expenditures in comparison to capitation rates and inpatient hospital cost targets upon completion of the first complete program year of MSCAN.

MSCAN's actuarially sound capitation rate was calculated taking into account a ten percent net savings to the state for MSCAN enrollees. However, due to limited program data during its implementation, actual cost savings to date cannot be calculated until completion of the Milliman capitation rate and inpatient cost targets analysis. This analysis will occur once the first MSCAN program year has been completed.

MSCAN's Quality of Care: Performance Measures, Impact, and Evaluability

According to the Division of Medicaid, it will utilize the primary quality tools (such as the Healthcare Effectiveness Data and Information Set [HEDIS] measures) commonly used by other states that have entered into a comprehensive MCO arrangement for Medicaid managed care. However, the DOM did not establish clearly defined objectives with associated timeframes or target levels of performance for the program prior to its implementation. Also, the State Quality Assessment and Improvement

Strategy, required by federal regulation, should incorporate goals and objectives for MSCAN and the state standards for quality measurement and improvement.

The Division of Medicaid has not completed the State Quality Assessment and Improvement Strategy, which should contain outcome measures for quality. Also, although both Magnolia and UnitedHealthcare have general measures that they plan to use to assess quality of care for MSCAN's enrollees, neither has data regarding whether the program has improved the quality of care for MSCAN enrollees to date compared to the quality of care received by those eligible populations who did not enroll in MSCAN.

Operational definitions of the MSCAN quality requirements are in place based on the sources of general measures that the Division of Medicaid will utilize in monitoring the quality of program providers' service structures. However, PEER cannot perform a comprehensive review of how MSCAN has impacted quality due to a lack of clearly defined outcome measures and performance targets.

MSCAN's Access to Care: Performance Measures, Impact, and Evaluability

The Division of Medicaid has several operational definitions for and performance goals for MSCAN access measures. The division noted that the primary access measure that will be utilized for MSCAN is to ensure that enrollees travel no more than sixty minutes or sixty miles in rural regions and thirty minutes or thirty miles in urban regions for access to primary care. The division also established timeframe requirements for MSCAN enrollees to receive services for urgent care, routine care, and wellness care. Both Magnolia and UnitedHealthcare measure access through the number and types of network providers and the ratio of providers by type to enrollees.

Both managed care organizations produce GeoAccess maps that may be utilized to measure access in terms of distance and time of travel for their respective MSCAN enrollees, but these maps do not necessarily reflect enrollees' actual utilization of active providers in the program. Furthermore, no other extensive access measures are readily available on how MSCAN might improve access to care in comparison to those eligible beneficiaries who did not enroll in MSCAN. Therefore, PEER cannot conduct a comprehensive review of how MSCAN has impacted access to date.

PEER determined that operational definitions, access standards, and service requirements for a managed care program are in place for MSCAN. However, adequate performance data is missing on these and other indicators to allow evaluators to draw conclusions on whether

managed care has improved enrollees' access beyond the access available to those in the fee-for-service Medicaid system.

Steps to Ensure Future Evaluability of MSCAN

Mississippi should take the lessons learned from implementation of MSCAN and focus on the steps needed next to prepare the program for future evaluability.

As noted in this report, several key reports and a full year of MSCAN program data should be available in early 2012. At that point, the Division of Medicaid should ensure that it takes the actions listed on pages 52-53 of the report [Report #555] to facilitate future evaluability of MSCAN's cost savings, quality of care, and access to care.

Recommendations

1. The Legislature should require the PEER Committee to monitor and evaluate the continued implementation of MSCAN by using a tiered evaluation approach.

   a. At the midpoint of the 2012 MSCAN program year, PEER should evaluate the State Quality Assessment and Improvement Strategy that DOM will provide to CMS in early 2012 to ensure that operational definitions as well as performance goals, objectives, and outcome measures are in place.

      This review should include, but not be limited to, a review of specific outcome measures developed by the DOM such as specific HEDIS measure targets, a review of the Milliman follow-up capitation rate and inpatient cost target analysis, and a review of the analysis performed by the External Quality Review Organization upon its completion.

      PEER should also compare these measures to those of other states who have similar Medicaid managed care structures and target populations.

   b. At the midpoint of the 2013 MSCAN program year, PEER should perform a follow-up evaluation of MSCAN. This evaluation should compare how MSCAN performed during its second full program year in comparison to the baseline data established in the initial program implementation year regarding specific quality and access outcome measures, as well as documented cost savings.

2. The Division of Medicaid should amend the initial MSCAN contracts with Magnolia and UnitedHealthcare through the addition of a renewal option for one

additional year (through December 31, 2014) instead of utilizing another request for proposals process in 2013. This would allow PEER to perform a more comprehensive evaluation for MSCAN (see Recommendation 1) while ensuring that the Legislature has sufficient time to review the findings and allow a decision to continue or repeal the managed care program during the 2014 regular legislative session. Also, this one-year renewal option would allow for a more continuous system of care and would be less likely to disrupt or require transition for a new contracting process.

3. The Division of Medicaid should analyze its data collection and reporting systems to identify potential data elements that could be utilized to compare quality and access of services of MSCAN enrollees with those same eligibility categories in the FFS system, as long as program enrollment is voluntary. Potential measures could include, but would not be limited to, the use of enhanced benefits of MSCAN, such as unlimited office visits, the number of preventable inpatient hospitalizations and hospital readmissions, EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screenings, and the number of active specialists participating in MSCAN versus fee-for-service Medicaid.

Appendix B: MSCAN Performance Measures

DOM Performance Measure		Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark[4]
Effectiveness of Care Measures			
1.	BMI for adults *Percentage of members who had an outpatient visit and their body mass index (BMI) documented during the measurement period*	Adult BMI Assessment (ABA)	35.28 percent
2.	BMI, weight assessment for nutrition, and physical activity counseling for children and adolescents *Percentage of members who had an outpatient visit with a primary care physician or obstetrician/gynecologist and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year (BMI Percentile Total)*	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI percentile (Total)*	29.44 percent
		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition (Total)*	46.23 percent
		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity (Total)*	35.58 percent
3.	Use of appropriate medications for people with asthma *Percentage of members age 5-11 and 12-50 who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year*	Use of Appropriate Medications for People with Asthma - Total (ASM)	88.57 percent

[4] HEDIS 2010 benchmarks represent Calendar Year 2009 performance reported by Medicaid health plans to NCQA in 2010. The 50th percentile benchmarks are an indicator that half of the health plans performed above the benchmark rates and half had rates below the benchmark rates.

DOM Performance Measure		Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark[4]
4.	Asthma education and counseling *Percentage of members with asthma who received education/counseling (e.g., mailings, pamphlets)*	N/A – see monthly Management Report	DOM Target: 85 to 90 percent
5.	Lead Screening for Children *Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday*	Lead Screening in Children (LSC)	71.62 percent
6.	Childhood Immunizations *Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday*	Childhood Immunization Status – Combo 2 (CIS) *Note: The HEDIS measure calculates a rate for each vaccine and nine separate combination rates. This sample HEDIS measure uses Combo 2, which is a combination of vaccines.*	76.64 percent (HEDIS) DOM Contract Requirement: Immunization rate of 90 percent[5]
7.	Nephropathy screening *Percentage of members with diabetes who received a nephropathy screening test*	Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	77.70 percent
8.	Cholesterol screening for diabetics *Percentage of members with diabetes who received an LDL-C screening test*	Comprehensive Diabetes Care (CDC) - LDL Screening	75.36 percent
9.	Cholesterol control for diabetics *Percentage of members 18 through 75 years of age with diabetes mellitus (Type 1 and Type 2) whose most recent low-density lipoprotein cholesterol (LDL-C) level is less than 100 mg/dL*	Comprehensive Diabetes Care (CDC) - LDL Poor Control (<100 mg/dL)	33.57 percent
10.	Blood sugar poorly controlled in people with diabetes	Comprehensive Diabetes Care (CDC) -	43.23 percent

[5] Penalties apply for renewal contract periods only. Achievement of less than 85 percent screening and 90 percent immunization rate will require a refund of $100 per enrollee for all enrollees under age twelve months. Also see Performance Measure for EPSDT screenings.

DOM Performance Measure		Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark[4]
	Percentage of members with HbA1c results greater than or equal to 9.0 percent	HbA1c Poor Control (>9.0 percent) *Note: Lower rates are desired for this measure.*	
11.	Blood sugar well controlled in people with diabetes *Percentage of members with HbA1c results less than or equal to 8.0 percent*	Comprehensive Diabetes Care (CDC) – HbA1c Good Control (<8.0 percent)	46.55 percent
12.	Ace inhibitor therapy *Percentage of members 18 and older on persistent medications (ACE inhibitors) for at least 180 days who received at least one annual monitoring*	Annual Monitoring for Patients on Persistent Medications (MPM)	84.10 percent
13.	Hemophilia *Percentage of members being treated for hemophilia who received at least an annual monitoring*	N/A – see monthly Management Report	DOM Target: 85 – 90 percent
14.	EPSDT Screening *Percentage of children age one or younger who received a Periodic Health Screening Assessment*	Quarterly 416 Report	DOM Target: Screening rate of 85 percent. For a child enrolled from birth through 12 months, EPSDT periodicity schedule dictates six (6) screens[6]

SOURCE: 2011 MSCAN State Quality Assessment and Improvement Strategy.

[6] Penalties apply for renewal contract periods only. Achievement of less than 85 percent screening and 90 percent immunization rate will require a refund of $100 per enrollee for all enrollees under age twelve months. Also see Performance Measure for Childhood Immunizations.

Appendix C: MSCAN Enrollment Categories of Eligibility, Both Mandatory and Optional, as of December 1, 2012

Category of Eligibility[1]	Age (years)[2]	Mandatory Enrollment	Optional Enrollment
Supplemental Security Income (SSI)	0 up to 19		X
Supplemental Security Income (SSI)	19 up to 65	X	
Working Disabled	19 up to 65	X	
Disabled Child Living at Home	0 up to 19		X
Breast and Cervical Cancer	19 up to 65	X	
Department of Human Services Foster Care Children	0 up to 19		X
Department of Human Services Foster Care Children (Adoption Assistance)	0 up to 19		X
Pregnant Women and Infants	0 up to 1 and 8 up to 65	X	
Family/Children – Temporary Assistance for Needy Families (TANF)	0 up to 1 and 19 up to 65	X	
Children	0 up to 1	X	

Note: Based on the categories of eligibility for MSCAN, total enrollment in the MSCAN program may not exceed forty-five percent of the total state Medicaid population.

[1]For definitions of the categories of eligibility, refer to Appendix D, page 29.

[2]A person who qualifies for one of the selected eligibility categories is MSCAN-eligible through the last day of his or her birthday month up to the age specified within this appendix. For example, a child is MSCAN-eligible through the last day of the month the child turns one year old.

SOURCE: Mississippi DOM staff.

Appendix D: Medicaid Categories of Eligibility Definitions

The Medicaid categories of eligibility that DOM selected to participate in MSCAN are:

- *individuals receiving Supplemental Security Income* (SSI)--Administered by the federal Social Security Administration, SSI provides monthly benefits to people with limited income and resources who are disabled, blind, or age sixty-five or older. Blind or disabled children and adults may receive SSI benefits. For the purposes of MSCAN eligibility, the Division of Medicaid has included the SSI Medicaid beneficiaries up to age sixty-five, because after that age the individual would become eligible for Medicare, which is excluded from MSCAN.
- *working disabled*--Medicaid beneficiaries ages nineteen up to age sixty-five and disabled, but work and have earnings under 250% of the federal poverty level.
- *disabled children living at home*--Medicaid beneficiaries who are disabled and are up to the age of nineteen based on income under 300% of the SSI limit (excluding parental income and resources) and who meet an institutional level of care requirement.
- *breast and cervical cancer*--female Medicaid beneficiaries from age nineteen up to age sixty-five with no other insurance and income under 250% of the federal poverty level who have been screened and diagnosed with breast or cervical cancer and are enrolled in the Centers for Disease Control and Prevention screening program that is administered through the state Department of Health.
- *Department of Human Services foster care and adoption assistance*--Medicaid beneficiaries up to age nineteen in the custody of the Mississippi Department of Human Services and in a licensed foster home or receiving adoption assistance.
- *pregnant women and infants*--pregnant women ages eight up to sixty-five and children up to age one whose family income does not exceed 185% of the federal poverty level.
- *family and children receiving Temporary Assistance for Needy Families (TANF)*--children up to age one and low-income families ages nineteen up to sixty-five with children under age eighteen. Children must be deprived of the support of one or both parents due to

incapacity, death, or continued absences or under/unemployment.

- *children*--children up to age one whose family income does not exceed 133% of the federal poverty level.

SOURCE: PEER Report #555; Mississippi Division of Medicaid staff.

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

September 27, 2012

Dr. Max K. Arinder, Executive Director
Joint Committee on Performance Evaluation and
Expenditure Review
Post Office Box 1204
Jackson, MS 39215-1204

Dear Dr. Arinder:

Staff of the Division of Medicaid (DOM) has reviewed the draft of the PEER Report entitled *Follow-Up Review: Progress Report on Evaluability of the Mississippi Coordinated Access Network.* We do not agree with many of the statements and conclusions in the report, however, we do appreciate the external review by PEER staff. We offer the following comments in response to your draft.

In response to PEER's recommendations:

1. **The Division of Medicaid should establish health-related outcome measures for all of the targeted health categories selected for MSCAN based on the existing HEDIS and DOM performance measures. Health-related outcome measures would allow DOM or a third party to evaluate objectively the actual impact that MSCAN services have on the health of the selected populations.**

Prior to the implementation of the MSCAN program, extensive research was done to determine what other states were doing to measure health outcomes in their managed care populations. It was determined that the HEDIS performance targets that were integrated into the MSCAN program are the most commonly used targets. The Division believes that coupling the HEDIS outcome measures with the CAHPS survey results in a reliable picture of the care provided under the MSCAN program. While setting specific health related outcomes is an admirable goal, the Division does not feel it is feasible at this time for two reasons. First, the MSCAN program has been in operation for less than two years. This period of time is not enough time to demonstrate any valid health outcomes. Secondly, specific health outcomes require individual medical record reviews of each beneficiary. The Division does not have the resources to conduct the reviews necessary to demonstrate the proposed health outcomes.

2. **Division of Medicaid should develop and implement an exit survey process for those MSCAN enrollees who opt out of the program to return to FFS Medicaid as long as there are optional populations participating in the MSCAN program. Furthermore, DOM should consider developing a process to identify MSCAN enrollees who are in the program but not actively utilizing MSCAN services to address potential barriers for program participation, since the state pays the managed care organizations a per member per month capitation based on enrollment.**

The Division of Medicaid agrees that an exit interview would be helpful for future program development. Although the Division does not currently have a formal exit interview process in place, the current disenrollment form does ask the beneficiary why they are disenrolling. These forms are all logged and used internally. The majority of beneficiaries state that they are disenrolling because their healthcare provider told them not to participate in MSCAN. As with any new program, a change in culture is required, and the Division is working towards educating providers so that they better understand the MSCAN program and the benefits this program offers their Medicaid patients.

Through a procurement to be released this fiscal year, the Division intends to retain an enrollment broker for the MSCAN program. Among other responsibilities, exit interviews of disenrolling beneficiaries will be conducted by this contractor. The results of these interviews will be used by the Division for program development and shared with the plans to provide them feedback on their services.

The Division disagrees with the implication that a beneficiary who is not utilizing services is encountering barriers to that service. The Division has worked tirelessly to ensure that all beneficiaries of the program have sufficient access to all covered services and that there are processes in place for those who do encounter barriers to report those for DOM intervention. Both Managed Care Organizations (MCOs) employ case management systems to ensure beneficiaries have access to needed services for their particular health status. This is just one of the benefits for beneficiaries enrolled in the MSCAN program that is not available to beneficiaries under the FFS program. There are countless beneficiaries throughout both the MSCAN and FFS programs that do not utilize services, not because they can't, but because they choose not to. The Division will continue to ensure provider networks and access are maintained at adequate levels, as well as promote the numerous services offered by the Medicaid program; however, the Division cannot guarantee that every beneficiary will choose to receive benefits or services.

3. **The Division of Medicaid should reconsider its decision to expand the MSCAN program on December 1, 2012.**

The Division of Medicaid does not agree with this recommendation. Medicaid and the Managed Care Organizations (MCOs) have been diligently working towards expansion. To delay expansion now would be detrimental to the state and the MCOs. Significant resources have been put into the expansion by the Division and the MCOs including: Statewide provider and beneficiary workshops, mailings to all affected beneficiaries outlining program changes, extensive systems modifications, and execution of contracts for actuarial services needed for rate development. Additionally, projected savings for the expansion population were built into the budget presented to LBO on September 20, 2012. Delaying the expansion would squander the resources already invested in the program and force the Division to request additional budget authority. It is also important to note that the Division's current plan for expansion is in full compliance with State and Federal law. For these reasons, Medicaid will move forward with the December 1, 2012 expansion date.

4. **The Division of Medicaid should compare outpatient services provided for the same categories of eligibility and demographic groups based on their four quality focus areas for the MSCAN and FFS populations during the timeframe that the MSCAN program remains optional. This comparison should provide DOM with insight into any trends of services provided to the two populations. DOM should also compare these services for those enrollees who transitioned from FFS to MSCAN and then opted out of the MSCAN program to return to FFS.**

The Division understands and agrees that MSCAN encounter data should be used for analytical purposes including service utilization, access evaluation, continuity of care, and cost effectiveness of the program, and intends to develop processes to properly evaluate the data. Although the Division has the ability to compare historical FFS claims data to MSCAN encounter data, it does not believe the comparison is a relevant one. This type of comparison does not take into account the additional services offered by the MCOs, including case managers, which often result in a beneficiary seeking fewer services. Additionally, the MCOs do not set the same service limits as FFS Medicaid.

Again, we appreciate the external review conducted by PEER. If you have any questions, please do not hesitate to contact my office.

Sincerely,

David J. Dzielak, Ph.D.
Executive Director

PEER Committee Staff

Max Arinder, Executive Director
James Barber, Deputy Director
Ted Booth, General Counsel

Evaluation
David Pray, Division Manager
Linda Triplett, Division Manager
Kim Cummins
Matthew Dry
Brian Dickerson
Lonnie Edgar
Barbara Hamilton
Matthew Holmes
Kevin Mayes
Angela Norwood
Jennifer Sebren
Julie Winkeljohn

Editing and Records
Ava Welborn, Chief Editor/Archivist and Executive Assistant
Tracy Bobo

Administration
Rosana Slawson
Gale Taylor

Information Technology
Larry Landrum, Systems Analyst

Corrections Audit
Louwill Davis, Corrections Auditor