Mississippi External Quality Review

ANNUAL COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR 2021 - 2022

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Prepared on behalf of the Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCO) evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the Mississippi Division of Medicaid (DOM) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all Coordinated Care Organizations (CCO) participating in the MississippiCAN (CAN) and Mississippi CHIP (CHIP) Medicaid Managed Care Programs. The CCOs include:

- UnitedHealthcare Community Plan – Mississippi (United)
- Magnolia Health Plan (Magnolia)
- Molina Healthcare of Mississippi (Molina)

The goals and objectives of the review were to:

- Determine if the CCOs are in compliance with service delivery as mandated in Federal Regulations and in the Coordinated Care Organization (CCO) contracts with DOM.
- Assessed the degree to which the health plans implemented actions to address deficiencies identified during the previous EQR and provide feedback for potential areas of continued improvement.

The purpose of the EQRs was to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and quality of health care services. This was accomplished by conducting the following activities for the CAN and CHIP programs: validation of performance improvement projects, performance measures, and surveys; assessment of compliance with state and federal regulations; and access studies for each health plan. CCME also conducted a Behavioral Health Member Satisfaction Survey for each of the CCOs. This Annual Technical Report is a compilation of the activities conducted during the 2021-2022 review cycle for each CCO's CAN and CHIP Programs.

Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements are related to:

- Availability of Services (*§ 438.206, § 457.1230*)

- Assurances of Adequate Capacity and Services (*§ 438.207, § 457.1230*)
- Coordination and Continuity of Care (*§ 438.208, § 457.1230*)
- Coverage and Authorization of Services (*§ 438.210, § 457.1230, § 457.1228*)
- Provider Selection (*§ 438.214, § 457.1233*)
- Confidentiality (*§ 438.224*)
- Grievance and Appeal Systems (*§ 438.228, § 457.1260*)
- Subcontractual Relationships and Delegation (*§ 438.230, § 457.1233*)
- Practice Guidelines (*§ 438.236, § 457.1233*)
- Health Information Systems (*§ 438.242, § 457.1233*)
- Quality Assessment and Performance Improvement Program (§ 438.330, § 457.1240)

To assess the health plan's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas:

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation

The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

Administration

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

Magnolia, Molina, and United have policies and procedures in place to guide daily business operations and to ensure quality services. Each CCO has a policy management policy and/or a policy committee tasked with overseeing policy and procedure development, annual review, revisions, and approval. Health plan staff can access policies and procedures via electronic storage and/or internal shared drives.

Based on review of each CCO's Organizational Chart, staffing appears to be sufficient to ensure functions and services required by the State of Mississippi are conducted.

Each CCO has a Compliance Plan describing methods to detect and respond to alleged or suspected Fraud, Waste, and Abuse (FWA). Compliance and FWA training is mandatory for all staff at the time of employment and annually, thereafter. Lines of communication are clear for reporting instances of suspected FWA and other compliance violations.

A Code of Conduct was submitted for review by each health plan, which applies to employees, affiliates, and subsidiaries as a requirement of compliance training. Each CCO's Compliance Officer is clearly identified. The Compliance Officers collaborate with the plan Compliance Committees and are responsible for oversight of training, auditing, analysis, investigations, and reporting related to compliance and FWA.

Policies and procedures are in place outlining each plan's commitment to ensuring the confidential handling of information related to members, employees, providers, and contractors.

Information Systems Capabilities Assessment

Review and assessment of each CCO's Information Systems Capabilities Assessment documentation and related policies and procedures indicated each organization's information systems infrastructure was capable of meeting contractual requirements. It was noted that timeliness requirements for clean claims payment were exceeded by each of the CCOs. The 2021 EQRs found that infrastructure is assessed and managed in accordance with policies that prioritize data security and system resilience. Disaster Recovery plans are tested and updated yearly to identify risks and protect system data.

Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

CCO processes and requirements for practitioner and organizational provider credentialing and recredentialing are documented in credentialing plans, program descriptions, policies, and procedures. United and Molina policies did not address processes for collecting fingerprints for high-risk CHIP providers. Molina's policies indicated the CCO conducts site assessments prior to completing initial credentialing process for all practitioners, it was determined during the onsite that Molina had not implemented a process for site visits. For Molina, both issues were repeat findings from the 2020 EQR.

Issues identified through review of initial credentialing and recredentialing files were related to failure to collect collaborative agreements for nurse practitioners (United and Magnolia), verification of CLIA certificates for organizational providers (United), queries of the MS DOM Sanctioned Provider List (United), and failure to collect fingerprints for high-risk CHIP providers (Molina). United and Molina were noted to have repeat findings from the 2020 EQR. Magnolia corrected all deficiencies noted in the 2020 EQR.

Committees that make credentialing and recredentialing determinations meet at specified intervals and are chaired by the health plans' Chief Medical Officer or Medical

Director. Membership of the committees includes a variety of network practitioners. Each CCO has documented the requirements for a quorum and expectations for member attendance. For Magnolia, three members did not meet the attendance expectation.

The plans use appropriate parameters to measure member access to PCPs, specialists, and hospitals. Routine Geo Access mapping is conducted, and additional factors are considered when evaluating network adequacy, including member satisfaction with practitioner access and availability, complaint and grievance data, etc. The CCOs work to address any identified network gaps. Policies define appointment access standards for PCPs and specialists, as well as processes for evaluating provider compliance with those standards. Molina's policy did not include the appointment access timeframe for urgent care providers and the frequency of conducting appointment access audits. To ensure the provider networks can meet the needs of members with special needs and foreign language or cultural requirements, the CCOs routinely assess the needs of their membership populations, provide cultural competency training and resources to network providers, monitor member satisfaction with the network, etc.

The CCOs conduct initial provider education within 30 days of a provider's effective date for network participation. Established processes are followed for ongoing provider education regarding changes and/or additions to programs, member benefits, standards, policies, and procedures. Most provider education sessions are conducted virtually due to the Covid 19 pandemic. Provider Manuals and plan websites are comprehensive resources for providers; however, issues were noted related to lack of documentation of all appointment access standards, medical record retention timeframes, and restrictions on a PCP's ability to request reassignment of a member to another PCP. Also, United's CAN and CHIP Provider Manuals had minor discrepancies and errors related to Well-Child Care and Peer Support Services.

Provider Directories are available on the health plans' websites and in print version upon request. Provider Directories for United and Molina were missing some required elements, such as hours of operation and ability to accommodate physical disabilities.

The plans follow appropriate processes for adoption, review, and revision of preventive health and clinical practice guidelines. The guidelines are evidence based, adopted from nationally recognized sources, and relevant to the membership populations. Providers are informed of the guidelines through orientation and ongoing education, newsletters, Provider Manuals, etc. The guidelines are available on plan websites.

Policies and procedures define provider medical record documentation standards and processes for assessing provider compliance with the standards. Issues noted with the policies included missing information, including the timeframe for conducting follow-up

medical record audits for providers who do not pass the initial audit (United) and lack of detailed information about the medical record audit process (Molina).

Provider Satisfaction Survey

CCME conducted a validation review of the provider satisfaction surveys using the protocol developed by CMS titled, *Protocol 6: Administration or Validation of Quality of Care Surveys*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. Due to low provider response rates, the provider satisfaction survey findings have limitations and issues with generalization of the results. United's response rate was 1.9%, while Magnolia's was 9.2% and Molina's response rate was 6.6% for mail/internet survey responses and 6.8% for phone survey responses. CCME encouraged the CCOs to take action to improve survey response rates, such as increasing email quality and survey advertisement, analyzing barriers to gathering survey responses, and addressing any identified barriers, etc.

Member Services

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Magnolia, United, and Molina detail member rights and responsibilities in plan policies, Member Handbooks, Provider Manuals, and on plan websites. Rights and responsibilities, along with member ID Cards, benefit coverage and limitations, and 24-hour access to care information are included in new member materials. Each CCO has policies and procedures in place to ensure members are provided with new member packets within 14 days of receipt of the member's enrollment data from DOM. Each plan makes the Provider Directory available to members on the plan website, and printed copies are provided upon request.

Members are provided with contact information for the Member Services call centers and 24-hour nurse advice lines through member materials and the plans' websites. Call center representative training is conducted to prepare staff for the management of urgent, emergent, and routine communication with members. Performance monitoring of call center activity occurs as required with data analyzed and reported to the appropriate committees.

Policies and procedures detail processes related to member enrollment, disenrollment, and re-enrollment. Preventive Health and Chronic Disease Management Education policies are in place, and onsite discussion included this year's annual initiatives and steps taken to educate and provide resource information to assist members.

Grievances

Each health plan has policies and procedures in place outlining the definition of a grievance as well as who can file a grievance and procedures for filing a grievance.

Timeliness, categorization, monitoring, and analysis of grievances are outlined in policies, the Member Handbooks, Provider Manuals, and on websites. Of the grievance files reviewed, no issues were found regarding the timely resolution or acknowledgment and resolution letters to members.

Member Satisfaction Survey

The CCOs conducted Adult, Child and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Using the protocol developed by CMS titled, *Protocol 6: Administration or Validation of Quality of Care Surveys*, CCME validated to ensure that the results of the surveys were reliable and valid. The results of the validation found the generalizability of the survey results was difficult to discern due to low response rates. The CCO's were advised to work with their survey vendors on strategies to increase the response rates.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

The Quality Improvement (QI) section of the EQR of the Mississippi health plans included review of the programs' structures, work plans, program evaluations, performance measure validation, and performance improvement project validation.

The health plans' program descriptions explain each programs' structure, accountabilities, scope, goals, and needed resources. The health plans' Cultural Competency Programs/Plans are described in QI program descriptions and provide a summary of the plan to address healthcare disparities through tools and needed trainings.

To direct the planned activities, each health plan developed an annual work plan which included areas to be studied, follow-up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). Activities for the CAN and CHIP lines of business, where applicable, were clearly delineated in the work plans. Last year, there were several errors noted in Molina's work plan. These errors were addressed in their corrective action plan and the changes were implemented.

Each plan has established a committee charged with oversight of the QI programs. The committees review data received from the QI activities to ensure performance meets standards and make recommendations as needed. Membership for the quality committees included the health plan's senior leadership, department directors and managers, and other plan staff. Network providers of varying specialties are included as voting members.

DOM requires the health plans to track provider compliance with EPSDT services provided to the Medicaid population and the Well Baby and Well Child services provided to the CHIP population. DOM further requires the health plans to track any abnormal diagnoses, treatments and or referrals provided to members. All plans have policies and procedures for tracking EPSTD services and Well Baby and Well Child services as applicable. Molina's process indicated once the member is identified, follow-up is provided to determine if the member received a referral, received treatment, missed any follow-up appointments, and/or needed assistance with securing an appointment with an appropriate specialist. To address an identified deficiency from the 2020 EQR, a tracking report template was developed. However, this tracking report template was not implemented.

Each plan evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors and to various Quality Improvement Committees. Each plan provided copies of the Annual Evaluations for review. Molina's Quality Improvement Program 2020 Annual Evaluation did not include the results and analysis of the availability of practitioners, accessibility of services, continuity and coordination of medical care, provider directory analysis, results of delegation oversight, and credentialing activities. The performance improvement projects were included in the executive summary; however, the information was incomplete. There was no mention of the barriers and interventions to address the barriers. Most of the target rates were listed as "TBD." These were the same or similar errors found during the previous (2020) EQR.

Performance Measures Validation

Health plans are required to have an ongoing improvement program and to report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. DOM also requires the CCOs to report the Adult and Child Core Set measures. To evaluate the accuracy of the performance measures (PMs) reported, CCME contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA certified HEDIS Compliance Organization. Following the CMS Protocol, Aqurate conducted a validation review of the PMs identified by DOM to evaluate the accuracy of the rates as reported by the health plans for the CAN and CHIP populations.

To ensure HEDIS rates were accurate and reliable, DOM also required each CCO to undergo an NCQA HEDIS Compliance Audit. The three CCOs contracted with an NCQA-licensed organization to conduct the HEDIS audits. Aqurate reviewed each CCO's final audit reports, information systems capabilities assessments, and the Interactive Data Submission System files approved by the CCOs' NCQA licensed organization. Aqurate found that the CCOs' information systems and processes were compliant with the applicable information system standards and HEDIS reporting requirements.

All relevant HEDIS performance measures for the CAN and CHIP populations were compared for the current review year (MY 2020) to the previous year (MY 2019). Since MY 2020 was the first year that Molina reported rates, there was no comparison made between MY 2019 and MY 2020 for Molina for some measure rates. There were only a few measures that showed a substantial improvement of more than 10 percentage points year over year. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have a substantial increase or decrease in rate.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	54.02%	45.04%	54.39%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Statin Adherence 80% - 40-75 years (Female)	52.73%	49.32%	NA
Statin Therapy for Patients with Diabetes (spd)			
Statin Adherence 80%	51.43%	50.65%	77.05%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	42.73%	42.1%	55.84%
Substantial Decrease in Rate (>10% decrease)			
Adult BMI Assessment (aba)	47.10%	40.58%	49.56%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
Counseling for Nutrition	55.96%	46.96%	40.63%
Counseling for Physical Activity	51.82%	40.63%	35.52%
Immunizations for Adolescents (ima)			
Tdap/Td	80.05%	79.32%	58.64%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	47.30%	50.00%	36.59%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	28.51%	30.14%	25.65%
Blood Glucose and Cholesterol Testing (1-11)	18.21%	19.9%	8.38%
Blood Glucose Testing (12-17)	39.27%	41.84%	37.59%
Blood Glucose Testing (Total)	34.87%	36.85%	32.77%
Annual Dental Visit (adv)			
2-3 Years	41.78%	41.82%	35.57%
4-6 Years	60.11%	61.08%	50.05%
7-10 Years	62.81%	62.82%	53.45%

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates
11-14 Years	61.8%	61.27%	50.16%
Total	57.52%	57.72%	48.14%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	62.50%	67.35%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	65.97%	72.06%	60.42%
Total: Initiation of AOD Treatment: 13-17 Years	62.56%	69.66%	55.56%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	58.44%	64.21%	49.00%

The CHIP HEDIS rates were also compared. *Table 2: CHIP HEDIS Measures with Substantial* Change *in Rates* highlights the HEDIS measures with a substantial decrease in rate from 2019 to 2020. There were no measures noted with a substantial increase.

United CHIP rates fell by 10 percentage points or more for the Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure for the Glucose Testing (12-17) and Glucose Testing (Total) Activity indicators and the Annual Dental Visits Measure. While Molina CHIP did not have any MY 2019 data to compare against, their ADV measure rates were as low as the United CHIP rates for ADV.

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates
Substantial Decrease in Rate (>10% decrease)		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)		
Blood Glucose Testing (12-17)	36.47%	48.65%
Blood Glucose Testing (Total)	34.36%	39.68%
Annual Dental Visit (adv)		
2-3 Years	45.15%	41.74%
4-6 Years	64.54%	60.08%
7-10 Years	70.36%	65.22%
11-14 Years	66.76%	61.25%
15-18 Years	59.17%	51.96%
19-20 Years	44.52%	38.60%
Total	63.37%	58.00%

The HEDIS and non-HEDIS measure rates for the CAN and CHIP populations reported by the health plans and the statewide averages are listed in the Quality Improvement section of this report.

Performance Improvement Project Validation

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

Each health plan is required to submit performance improvement projects to CCME for review annually. CCME validates and scores the submitted project documents using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Twenty-three projects were validated for the three health plans. Results of the validation and project status for each CAN project are displayed in *Table 3: Results of the Validation of CAN PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

Table 3: Results of the Validation of CAN PIPs

Project	Validation Score	Project Status
United CAN PIPs		
Behavioral Health Readmissions	79/80=99% High Confidence in Reported Results	The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest readmission rate from 19.2% to 17.7% and the enrollment indicator had a decline from 46% to 38%. Individual facility rates were reported as well for each of the five facilities.
Improved Pregnancy Outcomes	74/75=99% High Confidence in Reported Results	The Improved Pregnancy Outcomes PIP goal is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment. The baseline rate was 92.21% and the remeasurement #1 rate was 91.48%. This rate reflects a decline in the prenatal care visit rate, although it was above the DOM goal rate of 90.1%.

Project	Validation Score	Project Status
Sickle Cell Disease Outcomes	80/80=100% High Confidence in Reported Results	The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28% and declined to 26.43% in 2020. This is improvement as a lower rate is better.
Respiratory Illness: COPD/Asthma	80/80=100% High Confidence in Reported Results	The Respiratory Illness PIP examines the COPD exacerbations and pharmacotherapy management HEDIS rate and the AMR measure assessing controller medication to total medication ratio HEDIS rate. The bronchodilators baseline rate was 74.96% which improved to 75.13% although it was still below the goal rate of 84.71%. The corticosteroids baseline rate was 42.24% which improved to 54.02% at remeasurement one, but still below the goal rate of 71.05%. The AMR goal rate was 71.28% and the baseline was 70.70% with an improvement of remeasurement one of 74.08%.
Magnolia CAN PIPs		
Behavioral Health Readmissions	73/74=99% High Confidence in Reported Results	The Behavioral Health Readmissions PIP aimed at reducing the 30-day psychiatric readmission rates in Hinds County, Brentwood, and MS State Hospital. For this validation, the PIP showed a substantial increase in the readmission rate (2020 annual rate) to 27.69% from the previous year's rate of 13.05%. Magnolia felt the increase was due to a decrease in the total number of admissions and unable to contact members. Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Behavioral Health Care Management Team to provide education and support services to promote adherence to treatment plans, assist with scheduling appointments, and enrolling the member in the care management program. The Clinical Provider Trainer will continue to conduct both telephonic and face-to-face visits with all Hinds County Behavioral Health facilities to provide education and resources to aide in the discharge planning process, address any barriers identified in the discharge planning process, and assist with resolving any other identified issues.
Reducing Preterm Births	72/72=100% High Confidence in Reported Results	The Reducing Preterm Births PIP is a newly initiated PIP with baseline data only. The goal for this PIP is to reduce the preterm birth rate by interventions

Project	Validation Score	Project Status
		directed at members with hypertension or pre-eclampsia. The baseline rate was 13.4% with a benchmark of 11.4%.
Sickle Cell Disease Outcomes	73/74= 99% High Confidence in Reported Results	The goal of the Sickle Cell Disease Outcomes PIP is to increase the compliance rate of Hydroxyurea for members who are prescribed to take the medication. Magnolia did not meet the goal that 47% of members with a diagnosis of Sickle Cell Disease who were dispensed a prescription for Hydroxyurea and remained on the medication during the treatment period. Results were recorded at 35.5% in 2019, 34.7% in 2020, and 20.6% in 2021.
Asthma/COPD	73/74= 99% High Confidence in Reported Results	The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and who had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year. This indicator uses the HEDIS measure, Asthma Medication Ratio (AMR). A decrease in percentile range was noted from baseline (71.15%) to remeasurement period 1 (70.24%) with a goal of 76.86%. For the adult population, this PIP measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. This indicator uses the HEDIS measure, Use of Spirometry testing in the Assessment, and Diagnosis of COPD (SPR). A decrease in percentile range was noted from baseline (28.38%) to remeasurement period 1 (26.49%) with a goal of 36.82%.
Molina CAN PIPs		
Behavioral Health Readmissions	73/74=99% High Confidence in Reported Results	The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions The Behavioral Health Readmissions for Hinds County showed an increase in readmissions from the overall 2020 rate of 23.8% to Q1 2021 at 27.7%. Enrollment in high-risk case management for unique readmitted patients is reported to be 100%.

Project	Validation Score	Project Status
Asthma Medication Ratio	73/74=99% High Confidence in Reported Results	The aim for the Asthma PIP is to increase the compliance rate for members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The rate reduced from 66% to 60.8% in Q2 2021, with a goal of 71%.
Pharmacotherapy Management of COPD Exacerbation (PCE)	80/80=100% High Confidence in Reported Results	The COPD PIP focuses on improving the rate of COPD members who are dispensed a systemic corticosteroid within 14 days of an acute event. The PCE measure is used and both rates improved to above goal rate. For systemic corticosteroid, the rate improved from 40% to 69.4% with a goal of 67%. The bronchodilator rate improved from 80% to 83.3% with a goal of 81.8%.
Follow-up 7 and 30 Days After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	Measures the percentage of behavioral health discharges for which the member received follow-up within 7 days and 30 days of discharge. The 7-day rate improved from 8.1% in Q1 to 26.3% in Q2. The goal is 28%. For 30-day follow up, the rate also improved from 16.9% in Q1 to 46% in Q2 with a goal of 50%.
Prenatal and Postpartum Care	80/80=100% High Confidence in Reported Results	The aim of the Prenatal and Postpartum Care PIP is to improve the percentage of deliveries that receive a prenatal care visit as a member of Molina in the first trimester. And improve the percentage of deliveries that had a postpartum visit on or between 21-56 days of delivery. Both measures improved but are not yet at the goal rate. For prenatal care, the rate improved from 89.67% to 90.3% with a goal of 93.6%. The postpartum rate improved from 30.8% to 35% with a goal of 74.3%.
Sickle Cell Disease	80/80=100% High Confidence in Reported Results	The aim for the Sickle Cell Disease PIP is to increase the rate of case management services for members with Sickle Cell Disease (SCD). The rate improved from 49% to 5.7% in Q2 2021.
Obesity	73/74=99% High Confidence in Reported Results	The Obesity PIP focuses on the child population. The BMI percentile, Nutrition, and Counseling HEDIS rates are utilized. The rates did not show improvement from Q1 to Q2. For BMI Percentile, the rate went from 12.6% to 12.5%, with a goal of 61.3%. The nutrition rate went from 11.5% to 7.3% with a goal of 52.3%. The counseling rate declined from 8.4% to 5.4% with a goal of 57.4%.

Results of the validation and project status for each CHIP project are displayed in *Table 4: Results of the Validation* of *CHIP PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

Table 4: Results of the Validation of CHIP PIPs

Project	Validation Score	Project Status
United CHIP		
Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	73/73/=100% Hight Confidence in Reported Results	The Adolescent Well Child Visits (AWC)/Child and Adolescent Well Care Visits (WCV) PIP goal is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year. The AWC measure was retired and replaced with the WCV measures. This measure looks at the percentage of members completing at least one comprehensive wellness visit during the calendar year. For this review only the baseline rates were provided for the 12–17-year-olds. The baseline rate for 2020 was 36.37% and the baseline rate for 18–21-year-olds was 19.64%.
Follow Up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	The goal for the Follow-Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7-day and 30-day follow-up visits. For this review period the PIP documentation report showed that the 30-day follow up rate improved from 61.39% to 64.55% which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.15% to 37.27% in 2020, then improved to 39.31% for MY 2020/RY2021. The goal rate for United is 30.07% which is above the goal rate but below the NCQA rate of 46.22%.
Reducing Adolescent and Childhood Obesity	94/95 = 99% High Confidence in Reported Results	The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity. All rates declined from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate. Measure one declined slightly from 64.96% to 64.23%, but it is above United's goal of 33.17%; and below the NCQA rate of 80.5%. Measure two declined from 55.96% in reporting year (RY) 2019 to 52.07% in RY2020. United's goal for measure two is 42.34%, so that goal has been exceeded; the NCQA goal is 71.55% which was not exceeded. Measure three declined slightly from 50.12% in RY2020 to 49.15% in RY2021. United's goal for measure three is 34.25%, so

Project	Validation Score	Project Status
		the current rate exceeded the United goal rate, but it below the NCQA goal of 66.79%.
Getting Needed Care CAHPS	94/95=99% High Confidence in Reported Results	For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019 and then it reduced again slightly to 82.3%. This is below the NCQA 50th percentile rate and the United goal of 91.19%.
Molina CHIP PIPs		
Adolescent Well Care/Well Child	72/72=100% High Confidence in Reported Results	The aim for the Well Care/Well Child PIP is to increase the number of CHIP members who receive at least 6 or more well care/well child visits during the first 0-15 months of life. The baseline rate for this PIP was 42.59% with a goal of 55.79%.
Asthma Medication Ratio (AMR)	72/72=100% High Confidence in Reported Results	The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. The baseline rates for Q1 2021 are presented in the documentation. For the AMR PIP, the baseline rate was presented at 84.5% with a goal of 71.28%, so the HEDIS measure is above goal at baseline.
Obesity- Ages 3 to 19	72/72=100% High Confidence in Reported Results	The Obesity PIP's aim is to increase the percentage of CHIP member who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. For the Obesity PIP, the rates for all three components were 0%. The BMI percentile goal is 61.31%; the Nutrition goal rate is 52.31%; and the physical activity counseling goal is 57.42%.
Follow-up After Hospitalization for Mental Illness (FUH)- Ages 6 to 19	72/72=100% High Confidence in Reported Results	The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate was 14.29% at baseline with a goal of 50%. The 7-day baseline rate was 7.14% with a goal of 28.3%.

Utilization Management

42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

United, Molina, and Magnolia have appropriate program descriptions, policies, and procedures that define and describe how utilization management (UM) services are operationalized and provided to CAN and CHIP members. The purpose, goals, objectives,

and staff roles for physical and behavioral health services are outlined. The program descriptions further explain collaboration and relationships between each UM Program and other programs within the health plan.

Policies and procedures provide guidance to staff on handling service authorizations. Appropriate reviewers conduct service authorization reviews using InterQual, MCG criteria, or other established criteria. Review of approval and denial files confirmed the plans met criteria and timeframe requirements, appropriate processes are followed, and no major issues were identified.

The CAN and CHIP Care Management (CM) program descriptions and policies appropriately document care management processes and services provided. The plans incorporate Population Health Management activities to identify and provide physical and behavioral health services to select populations and to address issues related to social determinants of health. United's Care Management Program has been updated with a new Care Management (CM) model and a revised 2021 United Healthcare C&S Care Model Program Description. CCME could not identify documentation of Molina's processes for addressing continuity of care when a CAN or CHIP member disenrolls from the health plan. CM files indicate care gaps are identified and addressed consistently and services are provided for various risk levels.

Appeals

The health plans have established policies for appeals of adverse benefit determinations. Review of documentation in policies and member notices revealed incorrect and/or missing information about appeals processes and requirements. CCME's review of appeal files revealed only isolated issues and, overall, appeals are handled correctly.

Each health plan tracks, monitors, and analyzes specific UM metrics and conducts an evaluation of their respective CAN and CHIP UM Programs to determine effectiveness and identify opportunities to improve quality of care and service.

Overall, documentation weaknesses were identified for the UM Program. Areas of strength include, but are not limited to, appeal files that were well organized and included all pertinent information, Adverse Benefit Determination notices including information written in Spanish directly within the body of the letter (United), conducting a COVID-19 project that includes outreach to all members (Magnolia), and the hiring of a full-time nurse auditor to enhance year-round interrater reliability activities (Molina).

Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

Each of the CCO's has policies and procedures that document processes for delegation of services and activities, including general delegation requirements, performance monitoring, annual oversight, and corrective action and/or termination of delegation agreements.

Pre-delegation assessments are conducted to ensure potential delegates can perform the activities to be delegated in compliance with standards and applicable contractual and regulatory requirements. Upon approval of the delegation, delegation agreements are executed to specify the activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.

CCME reviewed plan documentation of pre-delegation assessments and annual oversight conducted for the delegated entities. For United and Magnolia, no issues were identified from review of delegate oversight documentation. Molina's Credentialing Delegation Requirements policy did not address site visits for providers credentialed by delegated credentialing entities and collection of fingerprints for CHIP providers designated as high risk by DOM. File review worksheets for credentialing delegates did not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for high-risk CHIP providers. These were both repeat findings from the previous EQR.

Optional EQR Activities

The Mississippi Division of Medicaid has requested that CCME conduct the optional EQR activities of Provider Access Study and Provider Directory Validations and a Behavioral Health Member Satisfaction Survey for each of the CCOs.

Provider Access Study and Provider Directory Validation

CCME conducted a validation of network access/availability and provider directory accuracy for each of the CCOs. The objectives were to determine if provider contact information was accurate and to assess appointment availability. The methodology involved two phases: (1) a telephonic survey to determine if CCO-provided PCP information was accurate with regard to telephone, address, accepting the CCO, and accepting new Medicaid patients. Appointment availability for urgent and routine care was also evaluated. (2) Verification of the accuracy of provider directory-listed address, phone number, and panel status against access-study confirmed PCP contact information. See *Section G, Provider Access Study and Provider Directory Validation*.

Behavioral Health Member Satisfaction Survey

CCME contracted with DataStat, Inc. an NCQA Certified CAHPS Survey Vendor to conduct an Experience of Care and Behavioral Health Outcomes (ECHO) Survey, developed by the Agency for Healthcare Research and Quality (AHRQ), to learn about the experiences of adult and child members who have received counseling or treatment from CAN and CHIP providers. The survey addresses key topics such as access to counseling and treatment, provider communication, plan information, and overall rating of counseling and treatment received. For MississippiCAN, attempts were made to survey 3,549 enrollee households, and for Mississippi CHIP, attempts were made to survey 2,366 enrollee households. The surveys for both MississippiCAN and Mississippi CHIP were conducted by mail during the period from October 26, 2021, through February 16, 2022, using a standardized survey procedure and questionnaire. See *Section H, Behavioral Health Member Satisfaction Survey*.

Corrective Action Plans and Recommendations from Previous EQR

For a health plan not meeting requirements, CCME requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected. During the 2021 EQR, CCME assessed the degree to which the health plan implemented the actions to address deficiencies identified during the 2020 EQR.

United and Molina had deficiencies from the previous EQR for which the CAP was not implemented. These were related to credentialing policies and processes (Molina), credentialing file review (United and Molina), EPSDT/Well-Baby and Well-Child follow-up (Molina), and incomplete Quality Improvement Program Evaluation (Molina).

Conclusions

For the 2021 EQRs overall, the CCOs met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*.

Table 5: Compliance Results for Part 438 Subpart D and QAPI Standards - United and Molina provides an overall snapshot of United's and Molina's CAN and CHIP compliance scores specific to each of the 11 Subpart D and QAPI standards.

Table 5: Compliance Results for Part 438 Subpart D and QAPI Standards - United and Molina

Category	Report Section	Total Number of Standards	United CAN and CHIP		Molina CAN and CHIP	
			Number of Standards Scored as "Met"	2021 Overall Score	Number of Standards Scored as "Met"	2021 Overall Score
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)	Provider Services, Section II. B	18	18	100%	18	100%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	36	36	100%	34	94.4%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	28	28	100%	28	100%
Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	77	71	92.2%	73	94.8%
Confidentiality *(§ 438.224)*	Administration, Section I. E	2	2	100%	2	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Section V. C	40	37	92.5%	39	97.5%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	4	4	100%	2	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	20	20	100%	20	100%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	8	8	100%	8	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	38	38	100%	34	89.5%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

For United:

- Provider Selection standards that were not scored as "Met" were due to identified issues with credentialing and recredentialing and lack of a process for collecting fingerprints for CHIP providers designated as high-risk by DOM.
- Grievance and Appeal Systems standards not scored as "Met" were due to not following policy guidelines for appeal processing and appeal resolution letter templates that did not include complete information regarding continuation of benefits.

For Molina:

- Coordination and Continuity of Care standards not scored as "Met" were due to identified issues with processes for addressing continuity of care when a member disenrolls from the health plan.
- Provider Selection standards not scored as "Met" were because processes for conducting site visits for initial provider credentialing and collecting fingerprints for CHIP providers designated as high-risk by DOM were not established.
- Grievance and Appeal Systems standards not scored as "Met" were due to issues identified in CHIP appeal policy omitting information about the process for CHIP members to request an Independent External Review.
- Sub contractual Relationships and Delegation standards not scored as "Met" were due to identified issues with audit tools and delegation oversight regarding credentialing site visits and collection of fingerprints for CHIP providers designated as high risk by DOM.
- Quality Assessment and Performance Improvement Program standards not scored as "Met" were due to identified issues with tracking provider/member compliance with treatments or referrals needed for abnormal conditions identified through the EPSDT/Well-Baby and Well-Child services and incomplete information in the Quality Improvement Program Evaluation.

Table 6: Compliance Results for Part 438 Subpart D and QAPI Standards – Magnolia provides an overall snapshot of Magnolia's compliance scores for CAN specific to each of the 11 Subpart D and QAPI standards.

Table 6: Compliance Results for Part 438 Subpart D and QAPI Standards--Magnolia

Category	Report Section	Total Number of Standards	Magnolia CAN	
			Number of Standards Scored as "Met"	2021 Overall Score
Availability of Services *(§ 438.206, § 457.1230)* Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	9	9	100%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	18	18	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	38	37	97%
Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Section V. C	20	20	100%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	11	11	100%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	18	18	100%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

As noted in the table above, Magnolia received scores of "Met" all standards except for one standard in the Provider Selection area. This was due to an identified issue with collection of complete collaborative agreements between nurse practitioners and supervising/collaborating physicians.

The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2021 EQRs.

Figure 1: Percentage of Met Standards

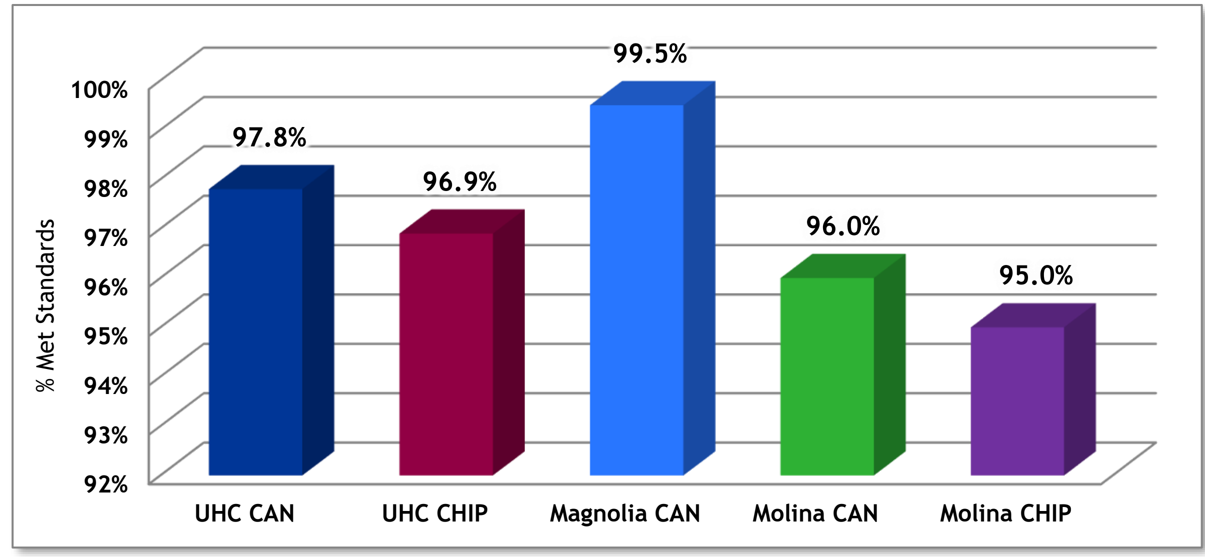

Table 7: 2021 Scoring Overview—CAN, provides a comparison overview of the scoring for the six areas reviewed for the CCOs participating in the CAN Program.

Table 7: 2021 Overall Scoring—CAN

	Met	Partially Met	Not Met	Not Evaluated/ Not Applicable	Total Standards	*Percentage Met Scores
Administration						
United	31	0	0	0	31	100%
Magnolia	31	0	0	0	31	100%
Molina	31	0	0	0	31	100%
Provider Services						
United	80	4	0	0	84	95.2%
Magnolia	83	1	0	0	84	98.8%
Molina	81	2	1	0	84	96.4%
Member Services						
United	33	0	0	0	33	100%

	Met	Partially Met	Not Met	Not Evaluated/ Not Applicable	Total Standards	*Percentage Met Scores
Magnolia	33	0	0	0	33	100%
Molina	33	0	0	0	33	100%
Quality Improvement						
United	19	0	0	0	19	100%
Magnolia	19	0	0	0	19	100%
Molina	17	2	0	0	19	89.5%
Utilization						
United	51	1	0	0	52	98.2%
Magnolia	55	0	0	0	55	100%
Molina	53	2	0	0	55	96.4%
Delegation						
United	2	0	0	0	2	100%
Magnolia	2	0	0	0	2	100%
Molina	1	0	1	0	2	50%
Totals						
United	**219**	**5**	**0**	**0**	**224**	**97.8%**
Magnolia	**223**	**1**	**0**	**0**	**224**	**99.5**
Molina	**216**	**6**	**2**	**0**	**224**	**96%**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Table 8: 2021 Scoring Overview—CHIP, provides a comparison overview of the scoring for each of the six areas reviewed for the CCOs participating in the CHIP Program.

Table 8: 2021 Overall Scoring—CHIP

	Met	Partially Met	Not Met	Not Evaluated/ Not Applicable	Total Standards	*Percentage Met Scores
Administration						
United	31	0	0	0	31	100%
Molina	31	0	0	0	31	100%
Provider Services						
United	78	4	0	1	83	94%
Molina	78	3	1	0	82	95.1%
Member Services						
United	33	0	0	0	33	100%
Molina	29	0	0	0	29	100%
Quality Improvement						
United	19	0	0	0	19	100%
Molina	17	2	0	0	19	89.5%
Utilization						
United	53	2	0	0	55	96.4%
Molina	52	3	0	0	55	94.5%
Delegation						
United	2	0	0	0	2	100%
Molina	1	0	1	0	2	50%
Totals						
United	**216**	**6**	**0**	**1**	**223**	**96.9%**
Molina	**208**	**8**	**2**	**0**	**218**	**95%**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Overall Recommendations

The Mississippi Division of Medicaid (DOM) requirement that CCOs must achieve NCQA accreditation, as well as its stipulations regarding the number and priority-based topic choices for performance improvement projects that plans must conduct, indicate that

the State is committed to a higher level of quality monitoring and accountability for its health plans. CCME recommends that DOM continue to use measures from the annual network adequacy reviews, HEDIS audits, and performance improvement project validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its health plans. The 2020 - 2021 EQR assessment results, including the identification of health plan strengths, weaknesses, and recommendations, attest to the positive impact of DOM's strategy in monitoring plan compliance, improving quality of care, and aligning healthcare goals with priority topics. The Quality Strategy outlined several DOM goals and standards that align with CMS priority areas. Based on these goals and standards, CCME developed recommendations to allow CCOs to fulfill the goals of the Quality Strategy. Subsequent recommendations will center around the updated Comprehensive Quality Strategy released in September 2021.

Table 9: DOM Quality Strategy Goals displays the recommendations for each goal.

Table 9: DOM Quality Strategy Goals

DOM Quality Strategy Goal	Recommendation
Improve access to necessary medical services	•Determine additional processes regarding updates to provider directory information that would benefit access for members. •Consider assessing additional indicators of member access regarding cultural competencies and *Americans with Disabilities Act* (*ADA*) regulations.
Improve quality of care and population health	•Continue to monitor Core Quality Measures, HEDIS measures, and state-specific performance measures related to priority topics. •Continue to monitor contract specific measures regarding care management responsibilities, drug utilization, health information system, member services call center, and others. •Continue to monitor clinical practice guidelines and revise as needed based on scientific and medical evidence.
Improve efficiencies and cost effectiveness	•Continue to monitor claims and encounter data to determine best utilization of services for optimal quality of care. •Maintain transition of care processes to ensure efficient care and continued access for beneficiaries.

Assessment of Strengths and Weaknesses

The results of 2021 EQR activities demonstrate that the coordinated care organizations are well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for members.

The following tables provide an overview of strengths, weaknesses, and recommendations related to quality, timeliness, and access to care identified after the annual reviews of the Coordinated Care Organizations.

Table 10: Evaluation of Quality

Strengths Related to Quality
• Staffing is sufficient to conduct all required functions and activities. Key personnel positions are filled. • The CCOs' management information systems are sufficient to ensure all contractual requirements are met. • Clearly defined access management policies are in place to bolster the organizations' security plans. • Processes and methods for reporting potential and actual fraud, waste, and abuse are found in the CCOs' member handbooks, provider manuals, on plan websites, in newsletters, etc. • Credentialing committees make credentialing determinations using a peer review process with network provider participation. • The CCOs provide initial and ongoing education to ensure providers have the necessary information to understand the CCO's processes and requirements, CAN and CHIP program requirements, etc. • Provider education is conducted through a variety of forums, including virtually. • The CCOs adopt preventive health guidelines from nationally-recognized sources that are evidence based and appropriate to the member population. The adopted preventive health guidelines include the required topics. • The CCOs adopt clinical practice guidelines from nationally recognized sources that are evidence based and appropriate to the member population. Physician input is considered in the review and adoption of clinical practice guidelines. • Health plan policies define standards for acceptable documentation in member medical records maintained by providers. • Plans used credible, independent vendors to conduct satisfaction surveys. • Analysis of findings and domains of focus for action-steps were documented for all plans. • Policies and other documentation appropriately define member rights and responsibilities. Members are informed of their rights and responsibilities through various avenues such as member handbooks, websites, etc. • Call center staff receive training about various topics to ensure they are prepared to handle a variety of member calls. • Call quality and call center metrics are monitored and reported to appropriate committees. • Plans used NCQA-accredited, independent vendors to conduct member satisfaction surveys • Analysis of findings and plans to address opportunities for improvement in composite domains were documented for all plans.

Strengths Related to Quality
• Information to guide members about grievance filing processes and requirements is included in member handbooks and on plan websites. • The health plans have QI program descriptions that described the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually. • United and Magnolia tracks EPSTD services and monitors claims to identify members with abnormal findings and assists with follow-up as needed. • The CCOs were fully compliant with all information systems standards and HEDIS determination standards for the CAN and CHIP HEDIS performance measures. • Based on Aqurate's validation of performance measure rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. • All plans submitted appropriate documentation for the performance improvement projects. • Topics selected for the performance improvement projects aligned with DOM's quality strategy. • Each plan ensures that network practitioners can provide input in UM activities, such as appeals, grievances, and UM guidelines and criteria through committee participation. • Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used. • The CCOs assess the consistency of criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers. • Appeal files submitted for review were well organized and included pertinent information. • Magnolia is conducting a COVID-19 project that includes outreach and education to all plan members. • Pre-delegation assessments are conducted, and appropriate written delegation agreements are in place for all delegated entities.

Weaknesses Related to Quality	Recommendations Related to Quality
• Credentialing processes do no address requirements for site visits at initial credentialing.	• Develop and implement a process for conducting site visits for providers to comply with requirements of the *CAN Contract, Section 7 (E) (3)* and the *CHIP Contract, Section 7 (E) 3.*
• Credentialing processes do not address collection of fingerprints for providers designated as high-risk by DOM.	• Develop and implement a process for collecting fingerprints for all CHIP providers designated as high risk by DOM at initial credentialing. The process must be detailed in a policy and evidence of fingerprint collection must be included in applicable provider credentialing files. Refer to the CHIP Contract, Section 7 (E) 6.

Weaknesses Related to Quality	Recommendations Related to Quality
• Some credentialing and recredentialing files did not include evidence of collecting collaborative agreements for nurse practitioners.	• Ensure credentialing and recredentialing files include all required elements.
• Provider Manuals were missing information about the timeframe for provider medical record retention and restrictions on a PCP's ability to request reassignment of a member to another PCP.	• Ensure Provider Manuals include all necessary information for providers to understand health plan requirements and provider responsibilities.
• CCO policies do not provide complete information about processes for medical record review audits.	• Ensure policies include complete information about medical review audit processes, such as frequency of conducting assessments, the department/staff who will staff conduct the audits, score thresholds, processes and timeframes for follow-up reviews when scores do not meet the expected thresholds, etc.
• Response rates for provider satisfaction surveys were low across all plans, impacting the reliability and generalizability of the results.	• Generate new methods to advertise the provider satisfaction survey to increase response rates. • Evaluate and conduct analysis to determine barriers impacting the response rates.
• Member satisfaction survey response rates were below the target rate of 40% for all plans.	• Generate new methods to advertise the provider satisfaction survey to increase response rates. • Evaluate and conduct analysis to determine barriers impacting the response rates.
• Some grievance resolutions letters did not contain language consistent with the reading level requirements for member materials.	• Ensure grievance resolution letters are written in appropriate language to ensure member understanding of the information presented.
• While the CCOs have sufficient systems and processes in place, the rates reported for the Adult and Child Core Set measures indicate that the CCOs need to improve monitoring for gaps in data and monitor for effective utilization of services to improve performance.	• CCOs should pay special attention to supplemental data accuracy as well as opportunities to leverage more supplemental data to calculate HEDIS as well as non-HEDIS rates.
• Source code review and/or primary source verification revealed inconsistencies in measure rate reporting for some measures amongst the CCOs.	• Continue working toward improvement of non-HEDIS measure rates and ensure that all available data sources are explored to calculate non-HEDIS rates.
• All CCOs did not report at least one or more HEDIS and/or Adult and Child Core Set measures that were required for reporting by DOM for MY 2020.	• CCOs should work with DOM to obtain CMS Adult and Child Core set measure interpretation/clarification to ensure accuracy of rate reporting.
• When year-over-year trending was available, the outcomes of care declined for several performance improvement projects.	• In efforts to improve outcomes of care, plans should determine if there are additional barriers to improving rates that are relevant for providers and/or members for each PIP. Interventions to address additional barriers identified should be developed and implemented.

Weaknesses Related to Quality	Recommendations Related to Quality
	• When possible, changes in rates should be assessed in association with each intervention individually to determine which interventions are most effective to improve processes of care.
• United and Molina demonstrated areas of weakness in documentation of appeal processes and requirements in policies, websites, etc.	• Ensure documentation of appeal processes and requirements is complete and correct in policies, on websites, etc.
• Plan documentation was noted with Incorrect or missing information related to case management continuity of care and transitional care processes.	• Edit policies to include care management processes for: addressing continuity of care when a member disenrolls from a health plan according to requirements in the CAN Contract, Section 9 (A) (4) and CHIP Contract, Section 8 (A) (3). • Ensure policies address transitional care management requirements for notifying providers within 14 days of a member's discharge. Refer to the CAN Contract, Section (9) (B)(1.d).
• Monitoring tools do not include all required elements or incorrectly indicate elements are not applicable.	• The plans should ensure delegation monitoring tools include all required elements and accurately reflect contractual requirements.
• Monitoring documentation does not indicate all delegated activities are included in the monitoring and oversight conducted.	• The plans should ensure monitoring is conducted for all activities delegated to each entity.

Table 11: Evaluation of Timeliness

Strengths Related to Timeliness
• The CCOs review policies annually using established policy management processes. • The health plans provide initial and ongoing member education via welcome calls, new member materials, member handbooks, websites, and newsletters to ensure members understand their benefits, processes for obtaining care, etc. • Grievance file review found acknowledgement and resolution timeliness requirements were followed. • Service Authorization requests are completed within timeframe requirements according to policy guidelines and CAN and CHIP contract requirements.

Weaknesses Related to Timeliness	Recommendations Related to Timeliness
• Policies have incorrect or omitted information related to extensions of urgent prior authorization requests and requirements for requesting approval for extensions from DOM.	• Ensure policies include complete and correct information regarding extensions of urgent prior authorization requests and requirements to request approval of extensions from DOM. Refer to the *CAN Contract, Section 5 (J) (6)* and *CHIP Contract, Section 5 (I)(4)*.

Weaknesses Related to Timeliness	Recommendations Related to Timeliness
• Documentation in CAN and CHIP appeal files reflected United did not consistently follow the United appeal policy requirement that the appeal timeframe starts the day United receives the verbal or written request.	• Ensure staff are following guidelines for appeal start times documented in policies.

Table 12: Evaluation of Access to Care

Strengths Related to Access to Care
• Processes are in place to ensure providers are notified of the member assigned to their panels and to ensure out of network providers can verify member enrollment. • The CCOs routinely assess the adequacy of provider networks and the ability of the networks to meet members' language and cultural needs. • Appropriate parameters are used to assess geographic access to providers. • Efforts are made to close network gaps when identified. • Information about preventive health guidelines and recommendations is provided to members via member handbooks, health plan websites, newsletters, etc. Members may request printed copies of preventive health and clinical practice guidelines.

Weaknesses Related to Access to Care	Recommendations Related to Access to Care
• United's CHIP Provider Manual did not include the timeframe for appointments after discharge from an acute psychiatric hospital.	• Ensure Provider Manuals include all necessary information for providers to understand health plan requirements and provider responsibilities.
• Molina's printed Provider Directories did not include indicators of providers' abilities to accommodate members with physical disabilities.	• Ensure Provider Directories include all required elements.

BACKGROUND

As detailed in the *Executive Summary*, CCME, as the EQRO, conducts an EQR of the each CCO participating in the MississippiCAN (CAN) and Mississippi CHIP (CHIP) Medicaid Managed Care Programs on behalf of the Division of Medicaid. Federal regulations require that EQRs include three mandatory activities: validation of performance improvement projects, validation of performance measures, and an evaluation of compliance with state and federal regulations for each health plan.

In addition to the mandatory activities, CCME validates consumer and provider surveys conducted by the CCOs, conducts provider access studies and directory validation, and conducts a behavioral health member satisfaction survey.

After completing the annual review of the required EQR activities for each health plan, CCME submits a detailed technical report to DOM and the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addressed the corrective actions from the previous year's review, if applicable. Annually, CCME prepares an annual comprehensive technical report for the State which is a compilation of the individual annual review findings. The comprehensive technical report for contract year 2021 through 2022 contains data regarding results of the EQRs conducted for the CAN and CHIP programs for United and Molina and the CAN program for Magnolia.

The report also includes findings of provider access studies and directory validations as well as the behavioral health member satisfaction survey conducted during this reporting period.

METHODOLOGY

The process used by CCME for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plan's office. During this contract year, all onsite visits were conducted virtually due to the COVID-19 pandemic. After completing each annual review, CCME submits a detailed technical report to DOM and to the health plan (covered in the preceding section titled, Background). For a health plan not meeting requirements, CCME requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. CCME also provides technical assistance to each health plan until all deficiencies are corrected. Following the initial acceptance of the CAP items, quarterly CAP reviews are completed to evaluate whether the health plan has fully implemented the corrective action items.

The following table displays the dates of the EQRs conducted for each health plan.

Table 13: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Report Submitted
UnitedHealthcare CAN United Healthcare CHIP	7/6/21	10/4/21 – 10/5/21	11/16/21
Magnolia Health Plan CAN	7/6/21	10/18/21 – 10/19/21	11/30/21
Molina Healthcare CAN Molina Healthcare CHIP	7/6/21	11/1/21 – 11/2/21	12/14/21

FINDINGS

The plans were evaluated using the standards developed by CCME and summarized in the tables for each of the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an up arrow (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score from the previous review.

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

During the 2021 EQRs, findings indicated that Magnolia, Molina, and United have policies and procedures in place to guide the operation of daily business activities. Each CCO has a policy management policy and/or a policy committee tasked with the oversight of policy and procedure development, annual review, revision, and approval. Magnolia outlines their approach to policy development in Policy CC.COMP.22, Policy Management. United's approach is outlined in Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures. Molina has formed a Policy Committee responsible for policy development, review, and updates as needed. Policies are made available to staff via electronic storage and/or internal shared drives.

Operational relationships among staff are clearly outlined in each plan's Organizational Chart. A review of the Organizational Charts found that staffing appears to be sufficient to ensure functions and services required by the State of Mississippi are conducted.

Compliance Plans describing methods to detect and respond to suspected or actual Fraud, Waste, and Abuse (FWA) were in place for each of the CCOs. Compliance and FWA training are required for new employees and annually, thereafter. Lines of communication are clear for reporting instances of suspected FWA or violations. The CCOs' Compliance Officers were clearly identified. The Compliance Officers collaborate with the plan Compliance Committees and are responsible for oversight of training, auditing, analysis, investigations, and reporting related to compliance and FWA. A Code of Conduct, which applies to employees, affiliates, and subsidiaries, was submitted for review by each health plan.

A review of Compliance Committee minutes and charters concluded that oversight is provided in accordance with contract standards. The Compliance Officer is clearly identified by each CCO and oversees the Compliance Committee, responsible for training, auditing, analysis, investigations, and reporting, as appropriate. Policies and procedures are in place outlining each plan's commitment to ensuring the confidential handling of protected health information related to members, employees, providers, and contractors.

Information Systems Capabilities Assessment

Review and assessment of each CCO's Information Systems Capabilities Assessment documentation and related policies and procedures indicated each organization's information systems infrastructure was capable of meeting contractual requirements. It was noted that timelines were exceeded for State requirements specific to clean claims for each of the CCOs. The 2021 EQRs found that infrastructure is assessed and managed in accordance with policies that prioritize data security and system resilience. Disaster Recovery plans are tested and updated yearly to identify risks and protect system data.

An overview of the scores for the Administration section is illustrated in *Table 14: Administration Comparative Data.*

Table 14: Administration Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
General Approach to Policies and Procedures						
The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Met	Met	Met	**Strength:** ▶ The CCOs review policies annually using established policy management processes.
Organizational Chart / Staffing						
The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: Chief Executive Officer	Met	Met	Met	Met	Met	**Strength:** ▶ Staffing is sufficient to conduct all required functions and activities. Key personnel positions are filled.
Chief Operating Officer	Met	Met	Met	Met	Met	
Chief Financial Officer	Met	Met	Met	Met	Met	
Chief Information Officer	Met	Met	Met	Met	Met	
Information Systems personnel	Met	Met	Met	Met	Met	
Claims Administrator	Met	Met	Met	Met	Met	
Provider Services Manager	Met	Met	Met	Met	Met	
Provider credentialing and education	Met	Met	Met	Met	Met	
Member Services Manager	Met	Met	Met	Met	Met	
Member services and education	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
CAN: Complaint/Grievance Coordinator CHIP: Grievance and Appeals Coordinator	Met	Met	Met	Met	Met	
Utilization Management Coordinator	Met	Met	Met	Met	Met	
Medical/Care Management Staff	Met	Met	Met	Met	Met	
Quality Management Director	Met	Met	Met	Met	Met	
CAN: Marketing, member communication, and/or public relations staff CHIP: Marketing and/or Public Relations	Met	Met	Met	Met	Met	
Medical Director	Met	Met	Met	Met	Met	
Compliance Officer	Met	Met	Met	Met	Met	
Operational relationships of CCO staff are clearly delineated	Met	Met	Met	Met	Met	
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
The CCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met	**Strengths:** ▶ The CCOs' management information systems are sufficient to ensure all contractual requirements are met. ▶ Clearly defined access management policies are in place to bolster the organizations' security plans.
The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met	
The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met	Met	Met	Met	
Compliance/Program Integrity						
The CCO has a Compliance Plan to guard against fraud, waste and abuse	Met	Met	Met	Met	Met	**Strength:** ▶ Processes and methods for reporting potential and actual fraud, waste, and abuse are found in the CCOs' member handbooks, provider manuals, on plan websites, in newsletters, etc.
The Compliance Plan and/or policies and procedures address requirements	Met	Met	Met	Met	Met	
The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Met	Met	Met	Met	
The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met	Met	
The CCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met	
The CCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met	Met	
The CCO implements and maintains a Pharmacy Lock-In Program	Met	Met	Met	Met	Met	
Confidentiality *42 CFR § 438.224*						
The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met	

B. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Reviews of Provider Services encompass credentialing and recredentialing, network adequacy and availability, provider education, preventive health and clinical practice guidelines, practitioner medical records, and provider satisfaction surveys.

Provider Credentialing and Selection

42 CFR § 438.214, 42 CFR § 457.1233(a)

The CCOs document processes and requirements for practitioner and organizational provider credentialing and recredentialing in credentialing plans, program descriptions, and policies and procedures. United's and Molina's policies did not address processes for collecting fingerprints for CHIP providers designated as high-risk by DOM, as required by the *CHIP Contract, Section 7 (E) 6*. Although Molina's policies indicated initial site assessments are conducted prior to completing the initial credentialing process for all practitioners, it was determined during the onsite that Molina had not implemented a process for site visits. For Molina, both of these issues were repeat findings from the 2020 EQR. See *Table 15: Previous Provider Credentialing and Selection CAP Items—Molina*.

Table 15: Previous Provider Credentialing and Selection CAP Items—Molina

Standard	EQR Comments
II. A. Credentialing and Recredentialing (CHIP)	
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	Processes and requirements for credentialing and recredentialing health care providers are found in the Credentialing Program Policy (Policy CR 01), the Assessment of Organizational Providers Policy (Policy CR 02), and in Mississippi-specific addenda to the policies. None of the documents address the requirement from the *CHIP Contract, Section 7 (E) (6)*, which states, "Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk Provider and any person with a 5 percent or more direct or indirect ownership interest in the Provider, as those terms are defined in 455.101." Onsite discussion confirmed that Molina is not obtaining fingerprints from CHIP providers identified as high-risk by DOM. *Corrective Action Plan: Develop and implement a process to obtain fingerprints from identified high-risk CHIP providers. The process must be documented in the appropriate credentialing policies.*
Molina's Response: Molina has updated our credentialing policies and procedures to include information for site fingerprinting (CR-02- Addendum B uploaded to portal.) It includes detailed information that addresses how site visits will be conducted. These visits will begin once the public health emergency is over. Molina is in	

Standard	EQR Comments
the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. Our ETA around this process is July 1, 2021. **Update (5-25-2021):** The process for collecting fingerprints or the location for maintaining such information has not be developed or determined yet, but Molina can provide an update once the process is finalized. After several internal meetings where the complexities of this requirement was discussed, Molina has decided to focus on identifying and contracting with a vendor to meet this requirement. Molina reached out to DOM about Molina engaging Gainwell to perform related credentialing functions to meet this requirement, and DOM was supportive of this idea. Molina has reached out to Gainwell and is working to set up a meeting between the parties to further discuss. **Molina Comments – June 16th, 2021:** Molina met with Gainwell Technologies on June 8, 2021 to discuss performing of this function as a delegated service. Molina will have a follow up meeting with Gainwell to inform them that the site visit and fingerprinting requirement is retroactive for all applicable Molina providers. Molina will continue to work on and develop a site visit and fingerprinting process that will address how and where related information will be maintained. We are targeting having a vendor in place and an established process for how fingerprints will be collected and where the information will be stored by no later than August 1, 2021.	

All the CCOs have committees that are tasked with making credentialing and recredentialing determinations. The committees meet at specified intervals and are chaired by the health plans' Chief Medical Officer or Medical Director. Committee membership includes network practitioners with a variety of specialties. Committee charters specify the quorum for meetings and attendance expectations of voting members. Review of committee minutes revealed that for Magnolia, three members did not meet the attendance expectation.

For each CCO, a sample of practitioner and organizational provider initial credentialing and recredentialing files was reviewed. For practitioners, an issue identified during these reviews was failure to collect the complete collaborative agreement between nurse practitioners and their supervising physicians (United and Magnolia). The CCOs were not conducting site visits due to the restrictions from the Covid 19 pandemic.

For organizational providers, issues were noted regarding verification of Clinical Laboratory Improvement Amendments (CLIA) certificates and queries of the MS DOM Sanctioned Provider List (United). The finding regarding queries of the MS DOM Sanctioned Provider List was a repeat finding for United. See *Table 16: Previous Provider Credentialing and Selection CAP Items—United*. For Molina, a repeat finding was failure to collect fingerprints for high-risk CHIP providers. See *Table 17: Previous Provider Credentialing and Selection CAP Items—Molina*.

Table 16: Previous Provider Credentialing and Selection CAP Items—United

Standard	EQR Comments
II. A. Credentialing and Recredentialing – CAN and CHIP	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	File review findings for CAN and CHIP organizational providers include: •All initial credentialing files for organizational providers contained evidence that the MS DOM Sanctioned Provider List was checked, but for three of the files, the date the MS DOM Sanctioned Provider List was updated was not captured on the document included in the file. During onsite discussion, United staff stated they would follow-up with CCME, but no additional information was provided. •All recredentialing files for organizational providers contained screenshots of the SAM query; however, four of the screenshots did not display the date the query was conducted. •Three recredentialing files for organizational providers included screenshots of the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) query; however, the screenshots did not display the date the query was conducted. •One recredentialing file for an organizational provider did not contain evidence of the query of the OIG LEIE. *Corrective Action: Ensure the date the MS DOM Sanctioned Provider List was updated is included on screenshots captured as evidence of query. Ensure primary source verification of the SAM includes the date the query was conducted. Ensure primary source verification of the OIG LEIE is included in all files and that it includes the date the query was conducted.*
United's Response: United enabled document printing properties for each credentialing processor to capture the date the query was conducted. Staff have been educated and shown how to automatically populate the source document date. United will capture screen shots of the date and time stamp on the computer screen for evidence.	

Table 17: Previous Provider Credentialing and Selection CAP Items—Molina

Standard	EQR Comments
II. A. Credentialing and Recredentialing (CAN and CHIP)	
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies. 3.2 Site assessment.	CCME understands that due to Covid-19, restrictions are in place that prevent provider office site visits from being conducted as part of initial credentialing. However, of 14 initial credentialing files reviewed, 10 were from 2018 and 2019, prior to Covid-19. These 10 files contained no evidence of a site visit being conducted, and onsite discussion confirmed Molina has not been conducting site visits as a part of initial credentialing. However, Policy CR 01, Credentialing Program Policy, Addendum B states, "Molina will conduct an initial site assessment prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the provider office visit." Requirements for site visits are specified in the *CAN Contract, Section 7 (E). Requirements for site visits are specified in the CHIP Contract, Section 7 (E).* *Corrective Action: Develop and implement a process to conduct site visits for initial credentialing to begin when Covid-19 restrictions are lifted.*
Molina's Response: Molina has updated our credentialing policies and procedures to include information for site visits CR-01-Addendum B (document uploaded to portal.) It includes detailed information that addresses how site visits will be conducted. These visits will begin once the public health emergency is over. Molina is in the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. Our ETA around this process is July 1, 2021.	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	Of 11 initial organizational provider credentialing files reviewed, six are considered high-risk by DOM for the purposes of fingerprinting requirements. None of the files included fingerprints. *Corrective Action: Ensure credentialing files for CHIP providers considered by DOM to be high risk include submitted fingerprints.*
Molina Response: Molina has updated our credentialing policies and procedures (CR-02- Addendum B uploaded to portal) to include information for site fingerprinting. It includes detailed information that addresses how site visits will be conducted. These visits will begin once the public health emergency is over. Molina is in the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. Our ETA around this process is July 1, 2021.	

Magnolia corrected all deficiencies noted in the 2020 EQR. See *Table 18: Previous Provider Credentialing and Selection CAP Items – Magnolia*.

Table 18: Previous Provider Credentialing and Selection CAP Items - Magnolia

Standard	EQR Comments
II A. Credentialing and Recredentialing	
3.1 Verification of information on the applicant, including: 3.1.15 Ownership Disclosure form.	Three initial credentialing files were missing a copy of the Ownership Disclosure Form. An additional five files contained outdated Ownership Disclosure Forms with signatures dated up to four years prior to the credentialing decision. During onsite discussion, credentialing staff reported that at the time of credentialing, Ownership Disclosure Forms must have been signed within 12-14 months of the credentialing event. *Corrective Action: Ensure all credentialing files include an Ownership Disclosure Form and that signature dates are current.*
Magnolia's response: Health Plan team will ensure that all enrollments, including those submitted via roster include an Ownership and Disclosure form with current signature dates. Staff have received refresher training and the Credentialing application checklist has been updated to reflect that the Ownership and disclosure form must be signed within 12-14 months.	
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies. 4.2.14 Ownership Disclosure form.	The Ownership Disclosure Forms in two recredentialing files were outdated, with signatures dates as old as four years prior to the credentialing decision date. *Corrective Action: Ensure all Ownership Disclosure Forms are current.*
Magnolia's response: The Re-credentialing team will ensure that all Ownership and Disclosure forms are current. Team will receive a refresher training regarding these items to be completed no later than February 15, 2020.	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	Policy CC.CRED.09, Organizational Assessment and Reassessment defines processes for ensuring all institutional providers are accredited and/or licensed according to applicable state and federal regulations and applicable standards of accrediting bodies, such as the National Committee for Quality Assurance (NCQA). The following issues were noted in the organizational provider recredentialing files: •One provider's license was expired at the time of recredentialing. The license expired on March 31, 2020, and primary source verification and committee approval for this provider occurred on April 14, 2020. •Two files contained unsigned Ownership Disclosure Forms. *Corrective Action: Ensure all recredentialing files for organizational providers have evidence of current, unexpired licensure, and that all Ownership Disclosure Forms are signed.*
Magnolia's response: Organizational Re-credentialing Team will ensure that all re-credentialing files for organizational providers have evidence of current, unexpired licensure, and that all Disclosure of Ownership forms are signed. Team will receive a refresher training regarding these items to be completed no later than February 15, 2020.	

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

The CCOs' policies address notifying primary care providers (PCPs) of the members assigned and processes for out-of-network providers to verify member enrollment. The plans use appropriate parameters to measure member access to PCPs, specialists, and hospitals. Geo Access mapping is conducted routinely, and the plans consider other factors in assessing the adequacy of their networks, including member satisfaction with practitioner access and availability, complaint and grievance data, etc. When network gaps are identified, the plans implement action plans to address identified issues.

United corrected a deficiency noted in the 2020 EQR related to incorrect parameters for measuring geographic access to rural emergency medicine providers See *Table 19: Previous Availability of Services CAP Items—United*.

Table 19: Previous Availability of Services CAP Items—United

Standard	EQR Comments
II B. Adequacy of the Provider Network - CAN	
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	Policy PS3, Geographic Access Standards, defines the specialist geographic access standards for United's provider network. The most recent Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CAN Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural. *Corrective Action: Ensure Geo access reports are run using the contractually-required standard for Emergency Care Providers.*
United's Response: The Geographic Access Report was updated to run the contractually required standard for Emergency Care Providers (see pages 3 and 5). Supporting Documentation: CAN 02_Attachment 1_UHC CAP_MSCAN GEO Access Reports	
II B. Adequacy of the Provider Network - CHIP	
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	Policy PS3, Geographic Access Standards, defines the specialist geographic access standards for United's provider network. The most recent Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CHIP Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural. *Corrective Action: Ensure Geo access reports are run using the contractually-required standard for Emergency Care Providers.*
United's Response: The Geographic Access Report was updated to run using the contractually required standard for Emergency Care Providers (see pages 3 and 5). Supporting Documentation: •CHIP 12_Attachment 1_UHC CAP_CHIP GEO Access Report	

Health plan policies define standards for PCP and specialist appointment access; however, Molina's policy did not include the appointment access timeframe for urgent care providers and the frequency of conducting appointment access audits. Network providers are educated about appointment access standards via provider education session, Provider Manuals, etc. Processes to evaluate provider compliance to the appointment access standards include "secret shopper" call studies and monitoring of member satisfaction survey results, grievances and appeals about appointment access, etc. Processes are in place to notify providers of identified deficiencies and to work with the providers to improve compliance rates.

Molina corrected deficiencies related to appointment access that were identified in the 2020 EQR. See *Table 20: Previous Network Adequacy CAP Items—Molina* for the 2020 findings and Molina's response.

Table 20: Previous Network Adequacy CAP Items--Molina

Standard	EQR Comments
II B. Adequacy of the Provider Network (CAN)	
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	The *CAN Contract, Section 7 (B) (2)* stipulates that follow-up appointments should be scheduled within 7 days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavior Health 1st Quarter 2020 MSCAN indicates that the standard was measured using a 14-calendar day parameter. *Corrective Action: Review and revise the process for measuring follow-up appointments after discharge from an acute psychiatric hospital to reflect the required 7-day appointment timeframe as required by the CAN Contract, Section 7 (B) (2).*
Molina's Response: Per the email sent from Jeremy Ketchum to Wendy Johnson on April 15, 2020, Molina Healthcare disagrees with the finding. The data for the Q1 Behavioral Health Availability Report is reported on a DOM issued template. The fields were pre-populated by DOM. Molina agrees the 14-calendar day language is non-compliant with the contract language. However, we are not at liberty to alter DOM templates for reporting. DOM issued a new reporting manual and updated this report in July of 2020. However, in the new template this is still being measured at 14 calendar days. Molina has since reported this discrepancy to DOM, and they have updated the template to correct the reporting template deficiency going forward.	
II B. Adequacy of the Provider Network (CHIP)	
2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Evidence was found that accessibility standards are being measured and, except for the requirement for appointments after discharge from an acute psychiatric hospital, appear to be met. The *CHIP Contract, Section 7 (B) (2)* stipulates that follow-up appointments should be scheduled within 7 days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability

Standard	EQR Comments
	Report Behavior Health 1st Quarter 2020 CHIP indicates that the standard was measured using a 14-calendar day parameter. *Corrective Action: Review and revise the process for measuring follow-up appointments after discharge from an acute psychiatric hospital to reflect the required seven-day appointment timeframe, as required by the CHIP Contract, Section 7 (B) (2).*
Molina's Response: This is the same response as number two for the MSCAN finding. However, the email sent from Jeremy Ketchum only addressed the finding for MSCAN and not CHIP. We will work with the Division of Medicaid to have the CHIP template updated as well. Molina agrees the 14-calendar day language is non-compliant with the contract language. However, we are not at liberty to alter DOM templates for reporting. For this reason, Molina disagrees with this finding.	

To ensure the provider networks can meet the needs of members with special needs and foreign language or cultural requirements, the CCOs routinely assess the needs of their membership populations, provide cultural competency training and/or resources to network providers, monitor member satisfaction with the network, etc.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for initial and ongoing provider education are documented in CCO policies. All of the plans conduct initial provider orientation within 30 days of a provider's effective date for network participation. The CCOs have established processes for providing ongoing education to providers regarding changes and/or additions to programs, practices, member benefits, standards, policies, and procedures. The plans reported that most provider education sessions continue to be conducted virtually due to continuing restrictions from the Covid 19 pandemic.

Provider Manuals and plan websites are rich resources for providers. United's CHIP Provider Manual documented appointment access standards for behavioral health providers but did not include the requirement that appointments after discharge from an acute psychiatric hospital are required within seven days. Also, United's CAN and CHIP Provider Manuals did not include the required timeframe for provider medical record retention. Magnolia's CAN Provider Manual did not address restrictions on a PCP's ability to request reassignment of a member to another PCP.

During the 2019 and 2020 EQRs, a significant number of errors and discrepancies in member benefit information were noted in United's CAN and CHIP Provider Manuals. The 2020 EQR revealed the previously noted issues were corrected. See *Table 21: Previous Provider Education CAP Items—United* for details on the issues noted in the 2020 EQR and United's response to those items. The current EQR revealed only minor discrepancies and

errors in United's Provider Manuals related to Well-Child Care and Peer Support Services that resulted in a recommendation being offered.

Table 21: Previous Provider Education CAP Items—United

Standard	EQR Comments
II C. Provider Education - CAN	
2.3 Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CAN Provider Manual and CAN Member Handbook. When comparing the CAN Provider Manual and CAN Member Handbook information for the current EQR, CCME again noted numerous discrepancies, including: •The CAN Provider Manual states there is a limit of 25 home health services visits per calendar year for adults. The CAN Member Handbook states the limit is 36 visits per calendar year for adults. •The CAN Provider Manual says prior authorization is required for hospice. The CAN Member Handbook states no prior authorization is required. •The CAN Provider Manual states medical supplies are covered but lists limitations and states prior authorization is required to exceed those limitations. The CAN Member Handbook states medical supplies are covered with no prior authorization required. •The CAN Provider Manual states non-emergency transportation services are covered but lists limitations and states to call Member Services to arrange. The CAN Member Handbook does not include limitations and states to call MTM to arrange. •The CAN Provider Manual states prior authorization is required for outpatient PT/OT/ST when provided by home health agencies. The CAN Member Handbook states prior authorization is required. •The CAN Provider Manual states human solid organ (heart, lung, liver, kidney) or bone marrow/stem cell transplants are covered with prior authorization. It does not include cornea transplant, which is included in the CAN Member Handbook. •The CAN Provider Manual lists skilled nursing facility coverage and requirements in the benefits grid. There is no information related to coverage for skilled nursing facilities in the CAN Member Handbook. •The CAN Provider Manual includes Physician Services for Long-Term Care Visits in the benefits grid, but the CAN Member Handbook does not. •The CAN Provider Manual lists Skilled Nursing Services along with Private Duty Nursing Services in the benefit grid but the CAN Member Handbook does not include Skilled Nursing Services.

Standard	EQR Comments
	Corrective Action: Update the 2020 CAN Provider Manual and/or the CAN Member Handbook to ensure correct and consistent information about member benefits is included in both.

United's Initial Response 1/19/21:
•The CAN Provider Manual, CAN Member Handbook and CAN Member Benefit Grid were updated to include the requirements as outlined. Going forward, documents will be reviewed on a quarterly basis to ensure consistency.

•The CAN Provider Manual was updated to accurately represent 36 visits per calendar year for home health services (see page 13), remove nursing facility benefits as they are administered through the Division of Medicaid, and remove physician services for long-term care visits as they are administered through the Division of Medicaid.

•The CAN Member Handbook was updated to match the language in the CAN Provider Manual for hospice (see page 37), medical supplies (see page 38), non-emergency transportation services (see page 3), and outpatient PT/OT/ST (see page 39).

•The CAN Provider Manual and the CAN Member Handbook were updated to remove the notes for transplant services and update the information for skilled nursing services.

Supporting Documentation:
CAN 03_05_Attachment 1_UHC CAP_MS Provider Manual_MSCAN_DRAFT
CAN 03_Attachment 2_UHC CAP_CAN Member Handbook_DRAFT
CAN 03_Attachment 3_UHC CAP_Member Benefit Grid

United's Revised Response 2/8/21:

•United updated the Member Benefit Grid to account for CCME comments, which is included in the CAN Member Handbook (pages 35-36) and will be inserted into the CAN Provider Manual (pages 12-16).

•There are no limitations for hospice services, therefore that language was removed in both the CAN Member Handbook and CAN Provider Manual.
•United updated the CAN Member Handbook (page 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the same language for medical supplies.
•United updated the CAN Member Handbook (pages 14-15; 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the same language for non-emergency transportation.
•United updated the CAN Member Handbook (page 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the same language for outpatient PT/OT/ST.
•United updated the CAN Member Handbook (page 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the limitations for transplant services.
•United updated the Member Benefit Grid which will be inserted into the CAN Provider Manual, to remove nursing facility benefits.
•United updated the Member Benefit Grid which will be inserted into the CAN Provider Manual, to remove physician services for long-term care visits.
•United updated the Member Benefit Grid which will be inserted into the CAN Provider Manual, to remove skilled nursing services.

Supporting Documentation:
CAN 03_Attachment 1_UHC CAP_Updated Member Benefit Grid
CAN 03_Attachment 2_UHC CAP_Member Handbook_UPDATED
CAN 03_Attachment 3_UHC CAP_MS CAN Provider Manual_UPDATED

II C. Provider Education - CHIP

<table>
<tr><th>Standard</th><th>EQR Comments</th></tr>
<tr><td>2.3 Initial provider education includes: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;</td><td>During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CHIP Provider Manual and Member Handbook.

When comparing the CHIP Provider Manual and Member Handbook information for the current EQR, CCME again noted numerous discrepancies, including:
•The CHIP Provider Manual does not include Parenting Education as a benefit, but the CHIP Member Handbook does.
•For Prosthetic/Orthotic Devices, the CHIP Provider Manual does not include the coverage restrictions for orthotic shoes that are included in the CHIP Member Handbook.
•For Speech Therapy, the CHIP Provider Manual does not include the restrictions on maintenance speech therapy that are found in the CHIP Member Handbook.

Corrective Action: Update the CHIP Provider Manual and/or the CHIP Member Handbook to ensure correct and consistent information about member benefits is included in both.</td></tr>
<tr><td colspan="2">United’s Initial Response 1/19/21:
The CAN Provider Manual, CAN Member Handbook and CAN Member Benefit Grid were updated to include the requirements as outlined. Going forward, documents will be reviewed on a quarterly basis to ensure consistency. The CHIP Member Handbook was updated to match the CHIP Provider Manual for parenting education, prosthetic/orthotic devices. The CHIP Provider Manual was updated to match the CHIP Member Handbook for speech therapy. Supporting Documentation:
CHIP 13_14_16_Attachment 1_UHC CAP_MS Provider Manual_CHIP_ DRAFT
CHIP 13_Attachment 2_UHC CAP_CHIP Member Handbook_DRAFT
CHIP 13_Attachment 3_UHC CAP_Member Benefit Grid

United’s Revised Response 2/8/21:
United updated the Member Benefit Grid to account for CCME comments, which is included in the CHIP Member Handbook (see pages 29-30) and will be inserted into the CHIP Provider Manual (see pages 7-9). United updated the CHIP Member Handbook (see page 29) and the Member Benefit Grid which will be inserted into the CHIP Provider Manual, to reflect Parenting Education. United updated the CHIP Member Handbook (see page 30) and the Member Benefit Grid which will be inserted into the CHIP Provider Manual, to reflect maintenance speech therapy. Supporting Documentation:
CHIP 13_Attachment 1_UHC CAP_Updated Member Benefit Grid
CHIP 13_Attachment 2_UHC CAP_Member Handbook_UPDATED
CHIP 13_Attachment 3_UHC CAP_CHIP Provider Manual_UPDATED</td></tr>
<tr><td>2.7 Initial provider education includes: Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;</td><td>The PCP Responsibilities section of the CHIP Provider Manual does not clearly state the responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule. Refer to CHIP Contract Section 7 (H) 2 (m).

Corrective Action: Revise the CHIP Provider Manual to include the PCP’s responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule.</td></tr>
</table>

Standard	EQR Comments
United's Response: The CHIP Provider Manual was updated to include the PCP's responsibility to follow up as required. Supporting Documentation: CHIP 13_14_16_Attachment 1_UHC_CAP_ MS Provider Manual_CHIP_DRAFT	

The health plans maintain Provider Directories that are available on their websites and in print version upon request. For United, some provider entries in the printed and online provider directories for CAN and CHIP do not include hours of operation. Molina's print version of the Provider Directory did not include an indicator of providers' abilities to accommodate people with physical disabilities.

All of the CCO's have established processes for review and adoption of preventive health and clinical practice guidelines. The guidelines are evidence-based, adopted from nationally recognized sources, and are relevant to the CCOs' membership. The guidelines are approved by health plan quality committees and other applicable committees, through which external physician input is received, and are reviewed at least annually and as needed for significant new scientific evidence or changes in national standards. Network providers are informed of the guidelines through provider orientation and education, newsletters, Provider Manuals, etc. The guidelines are available on plan websites and in printed form upon request.

Policies and procedures define provider medical record documentation standards, and the CCOs assess provider compliance to the documentation standards annually through medical record documentation audits. For United, the Ambulatory Medical Record Review Process policy and associated attachments describe the medical record review process and actions taken when a provider does not achieve a passing score, including a follow-up audit. The policy did not clearly relay the timeframe for conducting the follow-up medical record audit. Molina's Standards of Medical Record Documentation policy did not provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc. Onsite discussion did not provide clear information about the medical record review process. Additional information was requested to be submitted after the completion of the onsite but no additional information was provided. For Magnolia, no issues were identified.

Provider Satisfaction Survey

CCME conducted a validation review of the provider satisfaction surveys using the protocol developed by CMS titled, *Protocol 6: Administration or Validation of Quality of Care Surveys*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. *Table 22* provides an overview of the provider survey validation results.

Table 22: Provider Satisfaction Survey Validation Results

Plan	Section	Reason	Recommendation
United	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 1.9% with 57 providers completing the survey out of the 2,958. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution.	Work on action plan steps as per the report including increasing email quality and survey advertisement to improve response rates.
Magnolia	Do the survey findings have any limitations or problems with generalization of the results?	The total sample size was 2000 and 183 responded for a 9.2% response rate. This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.1% (51 out of 282).	Analysis of barriers to gathering survey responses should be considered and any methods to address response barriers implemented. This will ensure a greater representation of the provider PCP, Specialist, and Behavioral Health population on the satisfaction surveys.
Molina	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,500. SPH Analytics collected 129 surveys (44 mail, 45 Internet, and 40 phone) from the eligible provider population from September to October 2020. The mail/internet survey response rate is 6.6%, and the phone survey response rate is 6.8%. The rate in the previous survey was 15.6%.	Generate new initiatives to advertise survey and gather more responses for providers.

Table 23: Provider Services Comparative Data, illustrates the scoring for each standard reviewed during the 2021 EQR as well as strengths, weaknesses, and recommendations.

Table 23: Provider Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met ↓	Met	Not Met ↓	Not Met ↓	**Strength:** ▶ Credentialing committees make credentialing determinations using a peer review process with network provider participation. **Weaknesses:** ▶ Credentialing processes do no address requirements for site visits at initial credentialing. ▶ Credentialing processes do not address collection of fingerprints for providers designated as high-risk by DOM. ▶ Some credentialing and recredentialing files did not include evidence of collecting collaborative agreements for nurse practitioners. **Recommendations:** • Develop and implement a process for conducting site visits for providers to comply with requirements of the *CAN*
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO	Met	Met	Met	Met	Met	
The credentialing process includes all elements required by the contract and by the CCO's internal policies	Partially Met ↓	Met	Partially Met ↓	Met	Met	
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met	
Valid DEA certificate and/or CDS Certificate	Met	Met	Met	Met	Met	
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met	
Work history	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Malpractice insurance coverage/claims history	Met	Met	Met	Met	Met	*Contract, Section 7 (E) (3)* and the *CHIP Contract, Section 7 (E) 3.* • Develop and implement a process for collecting fingerprints for all CHIP providers designated as high risk by DOM at initial credentialing. The process must be detailed in a policy and evidence of fingerprint collection must be included in applicable provider credentialing files. Refer to the *CHIP Contract, Section 7 (E) 6.* • Ensure credentialing and recredentialing files include all required elements.
Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Met	Met	Met	Met	
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	
Query of the System for Award Management (SAM)	Met	Met	Met	Met	Met	
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List	Met	Met	Met	Met	Met	
Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met	Met	Met	Met	Met	
Query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met	Met	
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	
CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	Met	Met	Met	Met	Met	
Fingerprints, when applicable.	N/A	N/A	N/A	N/A	N/A	
Site assessment	Met	Met	Met	Met ↑	Met ↑	
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met	
Recredentialing processes include all elements required by the contract and by the CCO’s internal policies	Partially Met ↓	Met	Met	Met	Met	
Recredentialing every three years	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met	
Valid DEA certificate and/or CDS Certificate;	Met	Met	Met	Met	Met	
Board certification if claimed by the applicant	Met	Met	Met	Met	Met	
Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met	
Practitioner attestation statement	Met	Met	Met	Met	Met	
Re-query the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	
Re-query the System for Award Management (SAM)	Met	Met	Met	Met	Met	
Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List	Met	Met	Met	Met	Met	
Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	Met	Met	Met	Met	Met	
Re-query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met	Met	
Re-query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	Met	Met	Met	Met	Met	
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	
Provider office site reassessment, when applicable	Met	Met	Met	Met	Met	
Review of practitioner profiling activities	Met	Met	Met	Met	Met	
The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues	Met	Met	Met	Met	Met	
Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met	Met ↑	Met	Partially Met ↑	
Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.10 (h), 42 CFR § 457.1230(a)*						
The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met	Met	Met	Met	**Strengths:** ▶ Processes are in place to ensure providers are notified of the member assigned to their panels and to ensure out-of-network providers can verify member enrollment. ▶ The CCOs routinely assess the adequacy of provider networks and
The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met	Met	Met	Met	
The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties	Met	Met	Met	Met	Met	the ability of the networks to meet members' language and cultural needs. ▶ Appropriate parameters are used to assess geographic access to providers. ▶ Efforts are made to close network gaps when identified.
Members have access to specialty consultation from network providers located within the contract specified geographic access standards	Met ↑	Met ↑	Met	Met	Met	
The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met	Met	Met	Met	
Providers are available who can serve members with special needs, foreign language/cultural requirements, complex medical needs, and accessibility considerations	Met	Met	Met	Met	Met	
The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met	
The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met	Met	Met ↑	Met ↑	
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
The CCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met	Met	**Strengths:**

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Initial provider education includes: A description of the Care Management system and protocols	Met	Met	Met	Met	Met	▶ The CCOs provide initial and ongoing education to ensure providers have the necessary information to understand the CCO's processes and requirements, CAN and CHIP program requirements, etc. ▶ Provider education is conducted through a variety of forums, including virtually. **Weaknesses:** ▶ United's CHIP Provider Manual did not include the timeframe for appointments after discharge from an acute psychiatric hospital. ▶ Provider Manuals were missing information about the timeframe for provider medical record retention and restrictions on a PCP's ability to request reassignment of a member to another PCP. ▶ Molina's printed Provider Directories did not include indicators of providers' abilities to accommodate members with physical disabilities.
Billing and reimbursement practices	Met	Met	Met	Met	Met	
CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	Met ↑	Met ↑	Met	Met	Met	
Procedure for referral to a specialist including standing referrals and specialists as PCPs	Met	Met	Met	Met	Met	
Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Partially Met ↓	Met	Met	Met	
CAN: Recommended standards of care including EPSDT screening requirements and services CHIP: Recommended standards of care including Well-Baby and Well-Child screenings and services	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
CAN: Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services CHIP: Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services	Met	Met ↑	Met	Met	Met	**Recommendations:** • Ensure Provider Manuals include all necessary information for providers to understand health plan requirements and provider responsibilities. • Ensure Provider Directories include all required elements.
Medical record handling, availability, retention, and confidentiality	Partially Met ↓	Partially Met ↓	Met	Met	Met	
Provider and member complaint, grievance, and appeal procedures including provider disputes	Met	Met	Met	Met	Met	
Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Met	Met	Met	Met	Met	
Prior authorization requirements including the definition of medically necessary	Met	Met	Met	Met	Met	
A description of the role of a PCP and the reassignment of a member to another PCP	Met	Met	Met	Met	Met	
The process for communicating the provider's limitations on panel size to the CCO	Met	Met	Met	Met	Met	
Medical record documentation requirements	Met	Met	Met	Met	Met	
Information regarding available translation services and how to access those services	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Provider performance expectations including quality and utilization management criteria and processes	Met	Met	Met	Met	Met	
A description of the provider web portal	Met	Met	Met	Met	Met	
A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Met	Met	Met	Met	Met	
The CCO regularly maintains and makes available a Provider Directory that that includes all required elements	Met	Met	Met	Partially Met ↓	Partially Met ↓	
The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures	Met	Met	Met	Met	Met	
Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Met	Met	Met	**Strengths:** ▶ The CCOs adopt preventive health guidelines from nationally recognized sources that are evidence based and appropriate to the member population. The adopted preventive
The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: CAN: Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services CHIP: Pediatric and Adolescent preventive care with a focus on Well-Baby and Well-Child services	Met	Met	Met	Met	Met	health guidelines include the required topics.
Recommended childhood immunizations	Met	Met	Met	Met	Met	
Pregnancy care	Met	Met	Met	Met	Met	
Adult screening recommendations at specified intervals	Met	N/A	Met	Met	N/A	
Elderly screening recommendations at specified intervals	Met	N/A	Met	Met	N/A	
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met	
Behavioral health	Met	Met	Met	Met	Met	
Clinical Practice Guidelines for Disease and Chronic Illness Management *42 CFR § 438.236, 42 CFR § 457.1233(a)*						

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met	**Strength:** ▶ The CCOs adopt clinical practice guidelines from nationally recognized sources that are evidence-based and appropriate to the member population. Physician input is considered in the review and adoption of clinical practice guidelines.
The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers	Met	Met	Met	Met	Met	
Practitioner Medical Records						
The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians	Met	Met	Met	Met	Met	**Strength:** ▶ Health plan policies define standards for acceptable documentation in

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers	Met	Met	Met	Partially Met ↓	Partially Met ↓	member medical records maintained by providers. **Weaknesses:** ▶ CCO policies do not provide complete information about processes for medical record review audits. **Recommendations:** • Ensure policies include complete information about medical review audit processes, such as frequency of conducting assessments, the department/staff who will staff conduct the audits, score thresholds, processes and timeframes for follow-up reviews when scores do not meet the expected thresholds, etc.
Provider Satisfaction Survey						
A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met	Met	**Strengths:** ▶ Plans used credible, independent vendors to conduct satisfaction surveys.
The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified	Met	Met	Met	Met	Met	▶ Analysis of findings and domains of focus for action-steps were documented for all plans. **Weakness:** ▶ Provider satisfaction survey response rates were low across all plans, impacting the reliability and generalizability of the results. **Recommendations:** • Generate new methods to advertise the provider satisfaction survey to increase response rates. • Evaluate and conduct analysis to determine barriers impacting the response rates.

C. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

The 2021 EQR found that all CCOs have policies in place outlining member rights and responsibilities. Member rights and responsibilities are also noted in collateral plan documents and resources, to include Member Handbooks, Provider Manuals, and websites.

During the 2020 EQR, Magnolia's Policy MS.MBRS.25, Member Rights and Responsibilities, did not include the member's right, "To privacy and confidentiality, both in their person and in their medical information" or the requirement that members have the responsibility to notify the Plan for changes in family size, address changes, or other health care coverage. Magnolia's response to the Corrective Action Plan is referenced in *Table 24: Previous Member Rights and Responsibilities CAP Items - Magnolia*. Magnolia Policy MS.MBRS.25, Member Rights and Responsibilities edits were made to reflect all contract-specific rights and responsibilities for the 2021 EQR.

Table 24: Previous Member Rights and Responsibilities CAP Items - Magnolia

Standard	EQR Comments
III A. Member Rights and Responsibilities	
2. Member rights include, but are not limited to, the right: 2.2 To privacy and confidentiality, both in their person and in their medical information;	Policy MS.MBRS.25, Member Rights and Responsibilities, does not include the member's right, "To privacy and confidentiality, both in their person and in their medical information." During the onsite teleconference, Magnolia explained the policy was updated and that they would submit it. Upon review, CCME still could not identify that the requirement was included. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member rights as required in CAN Contract, Section 6 (J).*
Magnolia's response: Policy updated to include: To privacy and confidentiality, both in their person and in their medical information	
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.	Policy MS.MBRS.25, Member Rights and Responsibilities, does not include the requirement that members have the responsibility to notify the Plan for changes in family size, address changes, or other health care coverage. During the onsite teleconference Magnolia explained the policy was updated and stated they would submit it. Upon review, CCME still could not identify that this requirement was included. *Corrective Action: Edit Policy MS.MBRS.25, Member Rights and Responsibilities, to include all member responsibilities as required in the CAN Contract, Section 6 (J).*

Standard	EQR Comments
Magnolia's response: Policy updated	

Policy information was found for each CCO detailing processes for ensuring that new member materials arrive timely. New Member Packets, Member ID cards, service coverage, and benefit limitations are provided within 14 days of the receipt of member enrollment data from DOM.

During the 2020 United EQR, CCME could not identify documentation of the requirement for member materials to have a minimum 12-point font for regular print items and 18-point font for large print items. The previous findings and plan response may be found in *Table 25: Previous Member CCO Program Education CAP Items--United*. United corrected Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension, and Policy MBR1b2, Notification of Oral Interpretation Services indicating that printed written materials use a minimum 12-point font and items requiring large print are completed in 18-point font.

Table 25: Previous Member CCO Program Education CAP Items--United

Standard	EQR Comments
III B. Member CCO Program Education - CAN and CHIP	
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension and Policy MBR1b2, Notification of Oral Interpretation Services, describe and outline the processes United uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. CCME could not identify documentation of the requirement for member materials to have a minimum 12-point font for regular print items and 18-point font for large print items. During the onsite teleconference, United staff explained this requirement in documented in Policy MBR11a, Marketing Material. Upon review CCME still could not identify documentation of this requirement. This requirement was discussed during the 2019 EQR and a recommendation was made to address it. *Corrective Action Plan: Document the requirement to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font.*

Standard	EQR Comments
United's Response: UHC's Member Materials Policy was updated to document the requirement to print written material using the correct font size. Supporting Documentation: •CAN 04_Attachment 1_UHC CAP_Member Materials Policy •CHIP 15_Attachment 1_UHC CAP_Member Materials Policy	

Two of three health plans provided details about Advanced Directives in member materials. The United EQR found that information is provided in the Member Handbook on the definition and types of advanced directives. However, the 2021 CAN and CHIP Provider Manuals did not include information about Advance Directives and associated forms.

Magnolia ensures that members are provided with a toll-free access number, an automated voice system, or a live person to address questions or concerns. Policy MS.MBRS.10, Member Service Calls/Hotline, and MS.PRVR.03, Toll-free Provider Telephone Hotline, state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line is available 24 hours a day, seven days a week, including holidays. Call Center hours of operation are consistently identified on the Magnolia website, in the Member Handbook, and in the Provider Manual.

The 2020 EQR for United found issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services Call Centers. *Table 26: Previous Call Center CAP Items--United* details the findings, the Corrective Action Plan, and the plan's response. The 2021 EQR found that United had made the needed corrections to the CAN Member Handbook, CAN Care Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services call centers.

Table 26: Previous Call Center CAP Items—United

Standard	EQR Comments
III C. Call Center – CAN	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	During the onsite teleconference, CCME discussed the following documentation issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services Call Centers: •The Member Services toll-free telephone number on the member website is not the same number that is listed in the CAN Member Handbook (1-877-743-8731) and in other materials. The CAN

<table>
<tr><th>Standard</th><th>EQR Comments</th></tr>
<tr><td></td><td>Contract, Section 6 (A) requires states that, “Members will be provided with one (1) toll free number, and the Contractor’s automated system and call center staff will route calls as required to meet Members’ needs.”
•The Member Services hours in the Wellness Mailer are not consistent with hours in the Member Handbook on page 13.
•The Provider Services hours on the CAN website are not consistent with operating hours in the CAN Member Handbook on page 13.
•The Provider Services hours on page 5 of the CAN Care Provider Manual are not correct.
•The Provider Services number in the Provider Manual (877-743-8734) is different than the number listed in the Spring 2020 Practice Matters newsletter (800-557-9933).
Corrective Action Plan: Edit the CAN Member Handbook, CAN Care Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services call centers as required in the CAN Contract, Section 6 (A) and Section 7 (H) (1), and ensure consistent documentation of such across the respective areas.</td></tr>
<tr><td colspan="2">United’s Response: Updates were made to the Wellness Mailer and CAN Provider Manual as required by the contract to ensure consistent documentation.
Supporting Documentation:
•CAN 03_05_Attachment 1_UHC CAP_MS Care Provider Manual_MS CAN_DRAFT
•CAN_05_Attachment 2_UHC CAP_Wellness Mailer
•The Member Services toll-free telephone number is correct in the CAN Member handbook, CAN Provider Manual and other materials. UHC tracks calls generated from the website via a different phone number that is currently routed to member services. This website enhancement helps the health plan better support its Medicaid members.
•The hours on the Wellness Mailer have been updated to match the Member Handbook.
•The operating hours for member services listed on the website are consistent with the CAN Member Handbook on page 13. The Provider Services hours are not listed on the member services website.
•The CAN Provider Manual was updated with correct hours of service (see page 8).</td></tr>
<tr><td colspan="2">III C. Call Center – CHIP</td></tr>
<tr><td>1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.</td><td>United maintains a Member Services Call Center, Provider Services Call Center, and 24-Hour NurseLine. In addition, members can access a 24-hour behavioral health hotline staffed with mental health professionals and TTY 711 relay is communicated in several areas.
During the onsite teleconference, CCME discussed the following documentation issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services:
•The CHIP website, under the “See more benefits and features” section, informs members they can call Member Services and the</td></tr>
</table>

Standard	EQR Comments
	NurseLine, however it does not provide the telephone number to call. • The Member Services hours of operation listed in the CHIP Member Handbook are not consistent with the hours listed on the CHIP website. •The tollfree number for Provider Services is correctly listed on page 6 in the CHIP Care Provider Manual, but incorrectly on page 20 as 888-980-8728. •The CHIP Care Provider Manual does not have hours of operation for Provider Services Call Center listed. *Corrective Action Plan: Edit the CAN Member Handbook, CAN Care Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services call centers as required in CAN Contract, Section 6 (A) and Section 7 (H) (1) and ensure consistent documentation of such across the respective areas.*
United's Response: Updates were made to the CHIP Website and CHIP Provider Manual as required by the contract to ensure consistent documentation. Supporting Documentation: •CHIP 13_14_16_Attachment 1_UHC CAP_MS CARE Provider Manual_CHIP_DRAFT •CHIP 16_Attachment 2_UHC CAP_Website Changes •The CHIP website was updated to include the correct telephone number as required. •The CHIP website was updated to include the correct hours as required. •The section on page 20 of the CHIP Care Provider Manual lists the number 888-980-8728, which is for contacting the UHC Utilization Management Team. Therefore, no update is required. •The CHIP Care Provider Manual was updated to include hours of operation for the Provider Services Call Center.	

The 2020 EQR for Magnolia found the Provider Manual did not reflect the correct Provider Services operating hours as 7:30 am to 5:30 pm CST. *Table 27: Previous Call Center CAP Items—Magnolia* details the findings, the Corrective Action Plan, and the plan's response. The 2021 EQR found that Magnolia corrected the hours of operations in the Provider Manual per the *CAN Contract*.

Table 27: Previous Call Center CAP Items—Magnolia

Standard	EQR Comments
III C. Call Center	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	Policies MS.MBRS.10, Member Service Calls/Hotline and MS.PRVR.03, Toll-free Provider Telephone Hotline state Magnolia maintains a toll-free Member Services and Provider Services call center as required. The 24-Hour Nurse Advice Line has nurses available 24 hours a day, 7 days a week, including holidays.

Standard	EQR Comments
	Magnolia ensures members have access to a toll-free number, an automated voice system, or a live person to address questions or concerns. CCME discussed the Provider Manual incorrectly lists hours of operation from 8:00 am – 5:00 pm; the correct hours are from 7:30 am to 5:30 pm. This was a Recommendation during the 2019 EQR. *Corrective Action: Correct the Provider Manual to reflect the Provider Services operating hours are 7:30 am to 5:30 pm CT, as required by the CAN Contract, Section 7 (H) (I).*
Magnolia's response: Updated Draft Provider Manual submitted. Page 9 - Provider Services Call Center Hours of Operation - updated to 7:30 – 5:30 CST.	

Each CCO has policies and procedures for Call Center training, monitoring, analysis, and reporting of communication for provider and member services staff to improve the quality of call handling. Call Center agents have appropriate work processes and call scripts to assist members and providers, such as scripts for Member Returning Calls, Handling Behavioral Health Crisis Calls, Provider Services Escalation, and Pharmacy Calls. Training is mandated upon hire and as needed throughout the year. Incoming and outgoing call activity is audited and monitored, and recorded calls are used as training tools for quality improvement efforts.

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Grievance terminology is defined and filing processes are outlined in policies, Member Handbooks, Provider Manuals, and on CCOs' websites. Grievances are acknowledged in writing within five calendar days. Information for filing by an authorized representative was referenced in plan policies.

The 2020 United EQR found that processes for filing a grievance were not found on the non-secure area of the CAN website. Also, incomplete information about grievance record retention requirements were noted in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and the timeframe for acknowledging grievances was incorrect in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy. Each of the above detailed issues were corrected by United and reviewed in the 2021 EQR. The findings, Corrective Action Plan, and the plan response is outlined in *Table 28* below.

Table 28: Previous Grievances CAP Items—United

<table>
<tr><th>Standard</th><th>EQR Comments</th></tr>
<tr><td colspan="2">III G. Grievances – CAN</td></tr>
<tr><td>The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:

1.2 The procedure for filing and handling a grievance;</td><td>CCME did not identify grievance procedures and instructions on the CAN website. During the onsite teleconference, United staff confirmed that grievance information is located on the Member Portal and not on the public website. However, the CAN Contract, Section 6 (H) requires the plan to provide specific up-to-date grievance information on a non-secure section of the website.

The CAN Member Handbook and CAN Care Provider Manual correctly state grievances will be acknowledged in writing within 5 calendar days; however, the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) indicates acknowledgement in 10 calendar days.

Corrective Action Plan: Include information on grievance procedures on the non-secured section of the CAN website, as required in the CAN Contract, Section 6 (H). Correct the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) to indicate that grievances will be acknowledged in 5 calendar days.</td></tr>
<tr><td colspan="2">United's Response: UHC created a new link on the non-secure section of the website. UHC will review the non-secure section of the A&G website on a biannual basis, to ensure grievance procedures align with the contract.
https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN Appeals_Grievance.pdf
The UHC A&G Policy (POL2015-01) contains the grievance acknowledgement of 5 calendar days (see page 18).
Supporting Documentation:
• CAN 06_Attachment 1_UHC CAP_ Web A&G
• CAN 06_Attachment 2_UHC CAP_ MS A&G Policy POL2015-01</td></tr>
<tr><td>1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.</td><td>The POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, indicates grievance records are retained for a minimum of 10 years, however it does not specify that grievance records will be retained, "during the entire term of this Contract and for a period of 10 years thereafter," as required by the CAN Contract Section 11 (A).

Corrective Action Plan: Edit the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy to include the complete grievance requirement in the CAN Contract, Section 11(A).</td></tr>
<tr><td colspan="2">United's Response: UHC's A&G Policy (POL2015-01) was revised to include the complete grievance requirement as stated in the CAN Contract.
Supporting Documentation:
•CAN 07_Attachment 1_UHC CAP_MS A&G Policy POL2015-01_DRAFT</td></tr>
<tr><td colspan="2">III G. Grievances – CHIP</td></tr>
</table>

<table>
<tr><th>Standard</th><th>EQR Comments</th></tr>
<tr><td>The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:

1.2 The procedure for filing and handling a grievance;</td><td>The procedure for filing a grievance is correctly described in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, and CHIP Care Provider Manual. CCME did not identify grievance procedures or instructions on the CHIP website. During the onsite teleconference, United staff confirmed that grievance information is located on the Member Portal and not on the public website. However, the CHIP Contract, Section 6 (H) requires the plan to provide specific up-to-date grievance information on a non-secure section of the website.

The CHIP Member Handbook and CHIP Care Provider Manual correctly state grievances will be acknowledged in writing within 5 calendar days; however, the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) indicates 10 calendar days.

Corrective Action Plan: Include information on grievance procedures on the non-secured section of the CHIP website, as required in the CHIP Contract, Section 6 (H). Correct the Member Appeal, State Fair Hearing, External Appeal, and Grievance Policy (POL2015-01) to indicate that grievances will be acknowledged in 10 calendar days.</td></tr>
<tr><td colspan="2">United's Response: UHC created a new link on the non-secure section of the website. UHC will review the non-secure section of the A&G website on a biannual basis, to ensure grievance procedures align with the contract.

https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN-Appeals_Grievance.pdf
The UHC A&G Policy (POL2015-01) contains the grievance acknowledgement of 5 calendar days (see page 18).
Supporting Documentation:
•CHIP 17_Attachment 1_UHC CAP_ Web A&G
•CHIP 17_Attachment 2_UHC CAP_ MS A&G Policy POL2015-01</td></tr>
<tr><td>1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;</td><td>The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy indicates grievance records are retained for a minimum of 10 years; however, it does not specify that grievance records will be retained "during the entire term of this Contract and for a period of 10 years thereafter," as required by the CHIP Contract, Section 11 (A).

Corrective Action Plan: Edit the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy to include the complete grievance requirement in the CHIP Contract, Section 11 (A).</td></tr>
<tr><td colspan="2">United's Response: UHC's A&G Policy (POL2015-01) was revised to include the complete grievance requirement as stated in the CHIP Contract.
Supporting Documentation:
•CHIP 18_Attachment 1_UHC CAP_MS A&G Policy POL2015-01_DRAFT</td></tr>
</table>

The 2020 EQR found that Magnolia's policy MS.MBRS.07, Member Grievance and Complaints Process, indicated grievance records are retained for a minimum of 10 years; however, it did not specify that grievance records will be retained "during the entire term of the Contract and for a period of 10 years thereafter." Magnolia made the appropriate edits to Policy MS.MBRS.07, Member Grievance and Complaints Process, as reviewed in the 2021 EQR. Magnolia's response to the Corrective Action Plan is provided in *Table 29* below.

Table 29: Previous Grievances CAP Items—Magnolia

Standard	EQR Comments
III G. Grievances	
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	Policy MS.MBRS.07, Member Grievance and Complaints Process, indicates grievance records are retained for a minimum of 10 years; however, it does not specify that grievance records will be retained "during the entire term of the Contract and for a period of 10 years thereafter," as noted in the CAN Contract, Section 11 (A). *Corrective Action: Edit Policy MS.MBRS.07, Member Grievance and Complaints Process, to include the complete grievance requirement from the CAN Contract, Section 11(A).*
Magnolia's response: Policy updated	

Of the randomly selected grievance files submitted during the 2021 EQR by Molina, United, and Magnolia, there were no identified patterns of noncompliance with the receipt, acknowledgement, investigation, and resolution notifications.

Member Satisfaction Survey

As contractually-required, the health plans conducted the Adult, Child and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Using the protocol developed by CMS titled, *Protocol 6: Administration or Validation of Quality of Care Surveys*, CCME validated to ensure that the results of the surveys were reliable and valid. The results of the validation found the generalizability of the survey results was difficult to discern due to low response rates. The CCO's were advised to work with their survey vendors on strategies to increase the response rates.

Table 30: Results of the Validation of CCO Member Satisfaction Surveys

CAHPS Survey Version	Section	Reason	Recommendation
United			
Adult	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 14.7% - 237 completed surveys out of the sample of 1614. This is the same as the previous year. There were 234 completed in 2020.	Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts); oversample of 20% is still not impacting the response rate.
Child with Chronic Conditions	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rates for general population and total population. The response rate was 10.8% (214 surveys out of 1,973 sample size). The previous rate for 2020 was 12.7%, so the response rate has declined from last year's survey.	Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts). The response rate has declined the past 3 years from 17.2% in 2019, to 12.7% in 2020, to 10.8% in 2021.
Magnolia			
Adult	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,342 and the total completed surveys was 214 (15.9%). This is a decline from the 2020 rate of 20.3%. This response rate is lower than the NCQA target rate of 40%.	Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.
Child	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 2310 and the total completed surveys was 216 for a 9.4% response rate. This response rate is lower than the NCQA target rate of 40%.	Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.
Child with Chronic Conditions	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3,490 for the total sample. The total completed surveys was 355 for a 10.2% response rate. The sample size was 1,650 for the general population. The total completed surveys was 161 for a 9.8% response rate. These response rates are lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.	Continue to work with SPH Analytics to improve response rates. Determine if there are other innovative ways to advertise surveys and increase response rates.

CAHPS Survey Version	Section	Reason	Recommendation
Molina			
Adult	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 10.3% which is lower than the average response rate of 15.5%. The total completed survey was 136, sample size was 1,318.	Initiate new interventions to attempt an increase in response rates.
Child	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 10.2% which is lower than the average response rate of 12.6%. The total completed survey was 166, sample size was 1,630.	Initiate new interventions to attempt an increase in response rates.

During the 2020 EQR for Molina, issues were found with the analysis of the Member Satisfaction Surveys to identify potential areas of quality improvement and that some network providers were not submitted for review. These issues are outlined in the table below along with the Corrective Action Plan and the CCO's response.

Table 31: Previous Member Satisfaction Survey CAP Items—Molina

Standard	EQR Comments
III F. Member Satisfaction Survey (CAN)	
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	Molina submitted no evidence that results of the member satisfaction survey were analyzed to identify potential quality problems. *Corrective Action: Ensure member satisfaction survey results are reviewed/analyzed by the appropriate committee to identify potential quality problems.*
Molina's Response: Upon receipt of the member satisfaction survey, Quality Improvement conducts a root cause analysis w/key driver diagram on the survey results to identify internal/external barriers, potential quality issues, and opportunities for improvement, specifically on survey questions that were below the recommended benchmarks. (CAHPS Key Driver Diagram uploaded to portal.) Also, results of the analysis were shared with applicable departments for collaboration and implementation of interventions focused to increase future survey ratings. However, we agree that the results were not reviewed by the Molina QIC or other committees. Beginning Quarter 3, the 2021 Members Satisfaction Survey and successive surveys will be analyzed using the root cause analysis w/key driver diagram. Quality Improvement will ensure that results of the analysis will be presented to the QIC and the newly established Molina Member and Provider Satisfaction Committee (this committed kicked off in Q1 2021) for feedback and collaboration on identified interventions that will be implemented.	

<table>
<tr><th>Standard</th><th>EQR Comments</th></tr>
<tr><td>3. The CCO reports results of the member satisfaction survey to providers.</td><td>Documentation of survey results reported to network providers was not submitted for review.
Corrective Action: Report the results of the member satisfaction surveys to network providers.</td></tr>
<tr><td colspan="2">Molina's Response: The Member Satisfaction/CAHPS survey was distributed to all Molina internal departments during 3rd Quarter 2020.
During 1st Quarter 2021, Molina has developed a new Member and Provider Satisfaction Committee that will review and make recommendations regarding the Member Satisfaction Survey ongoing. The committee is led by Network Management, Provider Services, and Member Services. The committee has representatives from various Molina departments, including Quality Improvement. The committee's charter has been approved and will be sent to the QIC for approval. Outlined in the committee's responsibilities is to ensure that member satisfaction survey results be disseminated to Molina internal departments and network providers. The committee will also collaborate with Molina Communications Department on appropriate, DOM approved dissemination efforts. Beginning in Quarter 3- 2021, the Member and Provider Satisfaction Committee will ensure survey results are reported to all Molina departments and network providers.
Additionally, survey results will be provided to our network providers during monthly meetings for discussion with specific areas of concern and focus. Information about the survey results will be listed in the News section of our website for providers to view and receive as education. Additional details regarding specific questions from the survey will be provided upon request.</td></tr>
<tr><td>4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.</td><td>Documentation that Molina reported results of the member satisfaction surveys and the impact of measures taken to address any quality problems identified to the QIC, was not submitted for review.
Corrective Action: Report the results of the member satisfaction surveys to the QIC.</td></tr>
<tr><td colspan="2">Molina's Response: Going forward, the Members Satisfaction Surveys will be analyzed using the root cause analysis w/key driver diagram. Quality Improvement will ensure that results of the surveys will be presented to the QIC and the newly established Molina Member and Provider Satisfaction Committee for feedback and collaboration of identified interventions that will need to be implemented.
Subsequently, the Member Satisfaction survey results will be presented to the Molina Board of Directors.</td></tr>
</table>

Table 32: Member Services Comparative Data, illustrates the scoring for each standard reviewed during the 2021 EQR as well as strengths, weaknesses, and recommendations.

Table 32: Member Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = Quality ▶ = Timeliness ▶ = Access to Care
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met	Met	**Strength:** ▶ Policies and other documentation appropriately define member rights and responsibilities. Members are informed of their rights and responsibilities through various avenues such as member handbooks, websites, etc.
All member rights included	Met	Met	Met ↑	Met	Met	
All member responsibilities included	Met	Met	Met ↑	Met	Met	
Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled	Met	Met	Met	Met	Met	**Strength:** ▶ The health plans provide initial and ongoing member education via welcome calls, new member materials, member handbooks, websites, and newsletters to ensure members understand their benefits, processes for obtaining care, etc.
Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Met	Met	Met	Met	
Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent	Met ↑	Met ↑	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
non-English languages as required by the contract						
The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages	Met	Met	Met	Met	Met	
Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed	Met	Met	Met	Met	Met	
CAN: Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members	Met	N/A	Met	Met	N/A	
Call Center						
The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Met ↑	Met ↑	Met ↑	Met	Met	**Strengths:** ▶ Call center staff receive training about various topics to ensure they are prepared to handle a variety of member calls. ▶ Call quality and call center metrics are monitored and reported to appropriate committees.
Call Center scripts are in-place and staff receive training as required by the contract	Met	Met	Met	Met	Met	
Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Member Enrollment and Disenrollment *42 CFR § 438.56*						
The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met	Met	Met	
Member disenrollment is conducted in a manner consistent with contract requirements	Met	Met	Met	Met	Met	
Preventive Health and Chronic Disease Management Education						
The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits	Met	Met	Met	Met	Met	**Strength:** ▶ Information about preventive health guidelines and recommendations is provided to members via member handbooks, health plan websites, newsletters, etc. Members may request printed copies of preventive health and clinical practice guidelines.
The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
CAN: The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits CHIP: The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met	
The CCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met	
Member Satisfaction Survey						
The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met	Not Evaluated	**Strengths:** ▶ Plans used NCQA-accredited, independent vendors to conduct member satisfaction surveys ▶ Analysis of findings and plans to address opportunities for improvement in composite domains were documented for all plans. **Weakness:** ▶ Member satisfaction survey response rates were below the target rate of 40% for all plans.
The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Met ↑	Not Evaluated	
The CCO reports results of the member satisfaction survey to providers	Met	Met	Met	Met ↑	Not Evaluated	
The CCO reports results of the member satisfaction survey and the impact of measures	Met	Met	Met	Met ↑	Not Evaluated	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
taken to address any quality problems that were identified to the appropriate committee						**Recommendations:** • Generate new methods to advertise the provider satisfaction survey to increase response rates. • Evaluate and conduct analysis to determine barriers impacting the response rates.
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to	Met	Met	Met	Met	Met	**Strengths:** ▶ Information to guide members about grievance filing processes and requirements is included in member handbooks and on plan websites. ▶ Grievance file review found acknowledgement and resolution timeliness requirements were followed. **Weaknesses:** ▶ Some grievance resolutions letters did not contain language consistent with the reading level requirements for member materials. **Recommendations:** • Ensure grievance resolution letters are written in appropriate language to
Definition of a grievance and who may file a grievance	Met	Met	Met	Met	Met	
The procedure for filing and handling a grievance	Met ↑	Met ↑	Met	Met	Met	
Timeliness guidelines for resolution of grievances as specified in the contract	Met	Met	Met	Met	Met	
Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met ↑	Met ↑	Met ↑	Met	Met	ensure member understanding of the information presented.
The CCO applies the grievance policy and procedure as formulated	Met	Met	Met	Met	Met	
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee	Met	Met	Met	Met	Met	
Grievances are managed in accordance with CCO confidentiality policies and procedures	Met	Met	Met	Met	Met	
Practitioner Changes						
The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction	Met	Met	Met	Met	Met	
Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee	Met	Met	Met	Met	Met	

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

Medicaid Managed Care Organizations are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the Mississippi health plans included review of the programs' structures, work plans, program evaluations, performance measure validation, and performance improvement project validation.

The health plans' program descriptions explain each programs' structure, scope, goals, accountabilities, and needed resources. The health plans Cultural Competency Programs/Plans are described in the QI program descriptions and provide a summary of plans to address healthcare disparities through tools and needed trainings. The QI Program Descriptions are reviewed and modified as needed on an ongoing basis and formally at least yearly. Providers and members are informed about QI activities through each health plan's website.

To direct the planned activities, each health plan developed an annual work plan which included areas to be studied, follow-up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). Activities for the CAN and CHIP lines of business, where applicable, were clearly delineated in the work plans.

Last year, there were several errors noted in Molina's work plan. These errors were addressed in their corrective action plan and the changes implemented. *Table 33: Previous Quality Improvement Program CAP – Molina* provides details of the deficiencies identified in the work plan and Molina's response to, or resolution for, those deficiencies.

Table 33: Previous Quality Improvement Program CAP -- Molina

Standard	EQR Comments
IV A. Quality Improvement (QI) Program CAN and CHIP	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	There were errors or missing information noted in the 3rd quarter 2020 work plan. These included: •Section 2.0, Patient Safety Initiatives—the objective states "Identify a process to receive, track, investigate, validate, and manage Potential Quality of Care Issues." This was an activity completed in 2019 even though listed as ongoing for 2020. •Section 5, Availability of Practitioners—the goals are not documented for the ratio of PCPs to members and the Ratio of High-Volume Specialist and High-Volume Behavioral Health

Standard	EQR Comments
	Providers to members. Also, the goal for the percentage of members with one open Behavioral Health provider is missing. •<u>Section 5</u>, Availability of Practitioners—the standards for measuring the percentage of adults and children that have access to a PCP is incorrect. The *CAN Contract, Section 7 (B), Provider Network Requirements* lists the standard for adult and pediatric members as two PCPs within 15 miles for urban and two PCPs within 30 miles for rural. •<u>Section 5</u>, Availability of Practitioners—the standards for measuring the percentage of members with one open specialist and the percentage of members with one open Behavioral Health specialist does not include the time requirements (30 minutes) for urban providers and does not include the requirements for rural providers. The *CAN Contract, Section 7 (B)* lists the requirements as one specialist and one Behavioral Health specialist within 30 minutes or 30 miles for urban and within 60 minutes or 60 miles for rural providers. •<u>Section 6.0</u>, Accessibility of Services—the standard for measuring a regular and routine PCP appointment is listed as 90% within six weeks. The *CAN Contract, Section 7 (B), Provider Network Requirements* lists the standard as not to exceed 30 calendar days for a PCP Well Visit and not to exceed seven calendar days for a PCP Routine Sick Visit. •<u>Section 7.0</u> Accessibility of Services: Behavioral Health—the standard used to measure urgent care for Behavioral Health is listed as within 48 hours. However, the *CAN Contract, Section 7 (B)* lists this requirement as not to exceed 24 hours. Also, the post discharge follow-up (not to exceed seven calendar days) is not included. •<u>Section 9.0</u>, Continuity and Coordination of Medical Care—the timeframe for notifying members of the termination of a PCP is listed as within 30 days of termination date or within 30 days of notification. However, the *CAN Contract, Section 7 (D), Provider Termination, Number 4, Member Notification*, states the Contractor shall send a written notice within 15 calendar days of notice or issuance of termination of a Provider to Members who received primary care from the Provider. *Corrective Action: Correct the errors identified in the 2020 QI Work Plan.*
Molina's Response: Section 2.0, Patient Safety Initiatives-The identification of a process to receive, track, investigate, validate, and manage Potential Quality of Care issues was completed in 2019. This process was documented in our QI-008 Potential Quality of Care Serious Reportable Adverse Events Policy and Procedure that was submitted during the audit. The QI Work Plan has been updated to reflect the changes to the wording of the objective for Section 2.0. •Section 5: Network Management and Operations is collaborating internally to develop provider to member ratio goals for PCPs, High Volume Specialists and Behavioral Health providers. Applicable goals, compliance	

Standard	EQR Comments
percentages and summaries will be documented in written format in future quarterly QI workplan updates rather than attaching visual geographic analysis reports. Applicable slides have been updated to reflect the following goals: Goal (Met = 100%; Partially Met = equal to or greater than 90%; Not Met = less than 90%). The QI workplan has been updated to remove the reference to the incorrect standard. •Section 5: The QI workplan has been updated to remove the reference to the incorrect standard. Access standard compliance percentages and other summaries will be documented in written format in future quarterly QI workplan updates rather than attaching visual geographic analysis reports. •Section 6.0, Accessibility of Services-The QI Work Plan has been updated to reflect the CAN Contract guidelines for regular and routine PCP appointment not to exceed 30 calendar days for a PCP Well Visit and not to exceed 7 calendar days for a PCP Routine Sick Visit. The QI Work Plan has been updated to reflect the goal of 90% for all PCP appointment scheduling timeframes. •Section 7.0, Accessibility of Services: Behavioral Health-The QI Work Plan has been updated to reflect the CAN Contract guidelines for urgent care for behavioral health not to exceed 24 hours and BH post discharge follow-up not to exceed 7 calendar days. •Section 7.0, Accessibility of Services-Behavioral Health-The QI Work Plan has been updated to reflect the goal of 90% for all BH appointment scheduling timeframes. Section 9.0, Continuity and Coordination of Medical Care - **Molina Comments-June 16, 2021:** Applicable slides have been updated to include the correct standard from Molina's contract with DOM. Related slides from the QI workplan have been updated and are being provided with Molina's response. Due to the updates, the QI Work Plan will be presented for review and approval during the 2nd Quarter 2021 QIC meeting. Upon approval, the revised QI Work Plan will be used for submission of quarterly and annual DOM reports.	

A committee charged with oversight of the QI programs was established for each plan. The committees review data received from the QI activities to ensure performance meets standards and make recommendations as needed. Membership for the quality committees included the health plans' senior leadership, department directors and managers, and other plan staff. Network providers of varying specialties are included as voting members.

DOM requires the health plans to track provider compliance with EPSDT services provided to the Medicaid population and the Well Baby and Well Child services provided to the CHIP population. DOM further requires the health plans to track any abnormal diagnosis, treatments and or referrals provided to members. All of the plans have policies and procedures for tracking EPSTD services, and Well-Baby and Well-Child services as applicable.

For United and Magnolia, members identified with abnormal conditions receive additional outreach and referrals, if needed. Molina's process indicated once the member is identified, follow-up is provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments, and/or needed assistance with securing an appointment with an appropriate specialist. A draft tracking report template was developed; however, this tracking report template was not

implemented. *Table 34: Previous Provider Participation* in *QI Activities CAP Items - Molina* provides an overview of the deficiency and corrective actions.

Table 34: Previous Provider Participation in QI Activities CAP Items--Molina

Standard	EQR Comments
IV E. Provider Participation in Quality Improvement Activities (CAN)	
4. The CCO tracks provider compliance with EPSDT service provision requirements for: 4.3 Diagnosis and/or treatment for children.	Per Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, Molina has a tracking system that tracks at a minimum, initial visits for newborns, EPSDT screenings and reporting of all screening results, and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the EPSDT service and did not include or indicate members who received additional treatments or referrals as required by the *CAN Contract, Section 5 (D)*. *Corrective Action Plan: The EPSDT tracking report should include the date the EPSDT service was provided, ICD 10 or CPT codes for the diagnosis, treatment and/or referrals for any suspected problem identified during the EPSDT screening as required by the CAN Contract, Section 5 (D).*
Molina's Response: Quality Improvement is currently collaborating with Provider Services, Network Management, and Claims to establish a monthly EPSDT tracking report that includes dates of service, newborn visits and EPSDT screenings, and screening results and treatment and referrals. Members who receive an abnormal finding during their EPSDT screening will be identified via claims data and ICD 10/z codes. Once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments and/or need assistance with securing an appointment with the appropriate specialist. (Please see draft template-EPSDT-Well Baby Well Child Tracking Report uploaded to portal).	
IV E. Provider Participation in Quality Improvement Activities (CHIP)	
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: 4.3 Diagnosis and/or treatment for children.	Per Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, Molina has a tracking system that tracks at a minimum, initial visits for newborns, Well-Baby and Well-Child screenings and reporting of all screening results and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the Well-Baby and Well-Child service and did not include or indicate members who received additional treatments or referrals as required by the *CHIP Contract, Section 5 (D)*. *Corrective Action Plan: The Well Baby and Well Child Services tracking report should include the date the service was provided, ICD 10 or CPT codes for the diagnosis, treatment and/or referrals for any suspected problem identified during the Well Baby and/or*

Standard	EQR Comments
	Well Child Services screening as required by the CHIP Contract, Section 5 (D).
Molina's Response: Quality Improvement is currently collaborating with Provider Services, Network Management, and Claims to establish a monthly Well-Baby Well-Child tracking report that includes dates of service, newborn visits and Well-Baby/Well-Child screenings, and screening results and treatment and referrals. Members who receive an abnormal finding during their Well-Baby/Well-Child screening will be identified via claims data and ICD 10/z codes. Once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments and/or need assistance with securing an appointment with the appropriate specialist. (See Example Template_EPSDT_Well Baby Well Child Tracking Report uploaded to portal).	

Each plan evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors and to various Quality Improvement Committees. Each CCO provided copies of the Annual Evaluations for review. Molina provided the Quality Improvement Program 2020 Annual Evaluation. This evaluation included an executive summary that provided a brief overview of the evaluation and areas of focus and/or recommendations for the next year (2021). It also included several appendices that covered the results of the CLAS analysis, population assessment, quality performance measures report, potential quality of care issues, and the member and provider experience report. Areas not included in the evaluation were the results and analysis of the availability of practitioners, accessibility of services, continuity and coordination of medical care, provider directory analysis, results of delegation oversight, and credentialing activities. The performance improvement projects were included in the executive summary, however; the information was incomplete. There was no mention of the barriers and interventions to address the barriers. Most of the target rates were listed as "TBD." These were the same or similar errors found during the 2020 EQR. Molina addressed these errors and indicated the 2021 QI Program Evaluation was expected to be completed by Q1 or Q2 2022 and the evaluation will include all required elements outlined in the contract. See *Table 35: Previous Annual Evaluation of the QI Program CAP Items—Molina.*

Table 35: Previous Annual Evaluation of the QI Program CAP Items—Molina

Standard	EQR Comments
IV F. Annual Evaluation of the Quality Improvement Program (CAN)	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	Per the *CAN Contract, Section 10 (D) and Exhibit G*, the annual performance evaluation of the QI program includes: a description of completed and ongoing QI activities including Case Management effectiveness evaluation, identified issues, including tracking of

Standard	EQR Comments
	issues over time, trending of measures to assess performance in quality of clinical care and quality of service to Members, and an analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care and quality of service to members, and overall effectiveness of the QI program. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight. *Corrective Action: The Quality Improvement Evaluation must meet all the requirements contained in the CAN Contract, Section 10 (D) and Exhibit G. Specifically, a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.*
Molina's Response: To comply with requirements of Section 10 (D) and Exhibit G, per the CAN Contract, Molina will ensure the 2021 QI Program Evaluation (reported in 1st Quarter 2022) and subsequent annual evaluations include the following components: a description of completed and ongoing Molina QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program. Molina is currently collecting data sets from multiple sources to obtain information for the QI Evaluation program. Moreover, we are collaborating with our corporate counter parts to discuss data set collection for compliance requirements.	
IV F. Annual Evaluation of the Quality Improvement Program (CAN)	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually	The Quality Improvement Program 2019 Annual Evaluation, Executive Summary and three Appendices (Appendix A – Member and Provider Experience Report, Appendix B – CLAS Analysis Report and Appendix C – Population Health Assessment) was provided for review. Per Molina staff this program evaluation included CHIP. The *CHIP Contract, Section 10 (D) and Exhibit G*, requires the annual performance evaluation of the QI program to include a description of completed and ongoing QI activities including Case Management effectiveness evaluation, identified issues, including tracking of issues over time, trending of measures to assess performance in quality of clinical care and quality of service to Members, and an analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care and quality of service to members, and overall effectiveness of the QI program. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight. *Corrective Action: The Quality Improvement Evaluation must meet all the requirements contained in the CHIP Contract, Section 10 (D)*

Standard	EQR Comments
	and Exhibit G. Specifically, a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.
Molina's Response: To comply with requirements of Section 10 (D) and Exhibit G, per the CHIP Contract, Molina will ensure the 2021 QI Program Evaluation (reported in 1st Quarter 2022) and subsequent annual evaluations include the following components: a description of completed and ongoing Molina QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program. Molina is currently collecting data sets from multiple sources to obtain information for the QI Evaluation program. Moreover, we are collaborating with our corporate counter parts to discuss data set collection for compliance requirements.	

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Health plans are required to have an ongoing improvement program and to report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. DOM has selected a set of performance measures (PMs) to evaluate the quality of care and services delivered by the plans to their members. To evaluate the accuracy of the PMs reported, CCME contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA-certified HEDIS Compliance Organization, to conduct a validation review. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS® measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2020 through December 31, 2020.

HEDIS® Measure Overview for CAN Programs

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

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

data reviewed included data integration, data control, and documentation of PM calculations. The following are some of the main steps conducted during the validation process:

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by the CCOs, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined the data integration processes were acceptable.

Data Control—Organizational infrastructure must support all necessary information systems. Its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated the CCOs' data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by each CCO. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmaps, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation was acceptable.

The CCOs rates based on audit reports for the most recent review year are reported in *Table 36: HEDIS® Performance Measure Data for CAN Programs*. The statewide average is calculated as the average of the health plan rates and shown in the last column of the table. Rates highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicated a substantial decrease in the rate of more than 10 percent.

Table 36: HEDIS® Performance Measure Data for CAN Programs

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
Effectiveness of Care: Prevention and Screening				
Adult BMI Assessment (aba)	47.10%	40.58%	49.56%	43.64%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)				
BMI Percentile	68.61%	53.53%	49.15%	57.10%

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
Counseling for Nutrition	55.96%	46.96%	40.63%	47.85%
Counseling for Physical Activity	51.82%	40.63%	35.52%	42.66%
Childhood Immunization Status (cis)				
DTaP	81.27%	71.53%	59.12%	70.64%
IPV	95.38%	90.02%	79.81%	88.40%
MMR	93.92%	89.29%	77.37%	86.86%
HiB	90.02%	85.89%	73.48%	83.13%
Hepatitis B	96.11%	86.62%	79.32%	87.35%
VZV	93.19%	88.81%	76.89%	86.29%
Pneumococcal Conjugate	82.24%	73.97%	57.18%	71.13%
Hepatitis A	81.75%	81.02%	69.83%	77.53%
Rotavirus	82.48%	75.91%	60.58%	72.99%
Influenza	34.06%	31.14%	26.76%	30.66%
Combination #2	79.08%	67.88%	55.72%	67.56%
Combination #3	76.4%	65.21%	51.58%	64.40%
Combination #4	68.61%	61.31%	48.66%	59.53%
Combination #5	70.56%	58.88%	42.58%	57.34%
Combination #6	30.41%	26.52%	21.17%	26.03%
Combination #7	63.75%	55.47%	40.15%	53.12%
Combination #8	28.95%	26.03%	20.68%	25.22%
Combination #9	27.74%	24.57%	17.76%	23.36%
Combination #10	26.28%	24.09%	17.27%	22.55%
Immunizations for Adolescents (ima)				
Meningococcal	61.56%	59.37%	45.74%	55.56%
Tdap/Td	80.05%	79.32%	58.64%	72.67%
HPV	25.79%	25.79%	11.92%	21.17%
Combination #1	61.56%	58.88%	43.55%	54.66%
Combination #2	24.82%	24.82%	10.22%	19.95%
Lead Screening in Children (lsc)	74.21%	72.71%	66.67%	72.47%
Breast Cancer Screening (bcs)	45.54%	53.86%	36.36%	50.43%
Cervical Cancer Screening (ccs)	50.85%	57.18%	47.93%	51.99%
Chlamydia Screening in Women (chl)				
16-20 Years	45.72%	47.2%	48.26%	46.71%
21-24 Years	58.9%	60.75%	63.2%	60.70%
Total	47.78%	49.23%	53.13%	49.17%
Effectiveness of Care: Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis (cwp)				

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
Appropriate Testing for Pharyngitis (3-17)	75.62%	75.36%	76.98%	75.66%
Appropriate Testing for Pharyngitis (18-64)	61.47%	61.36%	66.42%	62.19%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	73.89%	73.64%	75.29%	73.95%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	25.68%	26.49%	NA	26.17%*
Pharmacotherapy Management of COPD Exacerbation (pce)				
Systemic Corticosteroid	54.02%	45.04%	54.39%	49.01%
Bronchodilator	75.13%	77.56%	80.7%	77.04%
Asthma Medication Ratio (amr)				
5-11 Years	82.00%	81.52%	75.53%	81.45%
12-18 Years	74.79%	70.24%	54.55%	71.75%
19-50 Years	52.36%	55.41%	NA	54.17%*
51-64 Years	51.16%	45.90%	NA	47.58%*
Total	74.08%	71.09%	62.89%	72.03%
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (cbp)	50.61%	45.74%	47.2%	4.16%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.92%	60%	NA	68.35%*
Statin Therapy for Patients with Cardiovascular Disease (spc)				
Received Statin Therapy - 21-75 years (Male)	73.25%	72.68%	NA	72.92%*
Statin Adherence 80% - 21-75 years (Male)	61.43%	57.18%	NA	59.02%*
Received Statin Therapy - 40-75 years (Female)	73.73%	71.52%	NA	72.35%*
Statin Adherence 80% - 40-75 years (Female)	52.73%	49.32%	NA	50.63%*
Received Statin Therapy - Total	73.48%	72.05%	78.95%	72.75%
Statin Adherence 80% - Total	57.22%	52.97%	86.67%	55.38%
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (cdc)				
Hemoglobin A1c (HbA1c) Testing	81.27%	87.59%	82%	83.62%
HbA1c Poor Control (>9.0%)	51.82%	55.96%	55.96%	54.58%
HbA1c Control (<8.0%)	37.47%	38.2%	36.25%	37.31%
Eye Exam (Retinal) Performed	57.91%	65.94%	49.15%	57.66%
Blood Pressure Control (<140/90 mm Hg)	53.77%	53.28%	51.82%	52.96%
Statin Therapy for Patients with Diabetes (spd)				
Received Statin Therapy	57.83%	59.43%	52.14%	58.65%
Statin Adherence 80%	51.43%	50.65%	77.05%	51.41%
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (amm)				

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
Effective Acute Phase Treatment	46.77%	46.04%	74.76%	49.11%
Effective Continuation Phase Treatment	30.43%	28.51%	58.89%	32.23%
Follow-Up Care for Children Prescribed ADHD Medication (add)				
Initiation Phase	55.63%	59.25%	52.05%	57.29%
Continuation and Maintenance (C&M) Phase	73.18%	72.68%	60.66%	72.19%
Follow-Up After Hospitalization for Mental Illness (fuh)				
6-17 years - 30-Day Follow-Up	60.20%	64.72%	62.50%	62.71%
6-17 years - 7-Day Follow-Up	35.88%	41.20%	35.12%	38.42%
18-64 years - 30-Day Follow-Up	56.72%	59.05%	45.52%	55.91%
18-64 years - 7-Day Follow-Up	33.73%	34.60%	24.55%	32.60%
65+ years - 30-Day Follow-Up	NA	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	NA
30-Day Follow-Up	58.61%	62.24%	53.37%	59.59%
7-Day Follow-Up	34.90%	38.33%	29.44%	35.76%
Follow-Up After Emergency Department Visit for Mental Illness (fum)				
6-17 years - 30-Day Follow-Up	47.30%	50.00%	36.59%	47.18%
6-17 years - 7-Day Follow-Up	32.43%	31.76%	24.39%	31.16%
18-64 years - 30-Day Follow-Up	37.41%	43.99%	25.24%	38.58%
18-64 years - 7-Day Follow-Up	22.73%	24.68%	16.5%	22.70%
65+ years - 30-Day Follow-Up	NA	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	NA
Total - 30-Day Follow-Up	40.69%	45.91%	28.47%	41.32%
Total- 7-Day Follow-Up	25.98%	26.94%	18.75%	25.41%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)				
30-Day Follow-Up: 13-17 Years	2.94%	3.13%	NA	3.03%*
7-Day Follow-Up: 13-17 Years	2.94%	3.13%	NA	3.03%*
30-Day Follow-Up: 18+ Years	5.96%	5.67%	6.00%	5.85%
7-Day Follow-Up: 18+ Years	3.64%	3.55%	3.00%	3.51%
30-Day Follow-Up: Total	5.65%	5.41%	5.45%	5.53%
7-Day Follow-Up: Total	3.57%	3.50%	2.73%	3.42%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	66.52%	66.18%	71.19%	66.78%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	63.61%	69.76%	49.12%	66.05%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	77.78%	73.17%	NA	75.58%*
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	59.45%	57.84%	59.25%	58.59%

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)				
Blood Glucose Testing (1-11)	28.51%	30.14%	25.65%	29.14%
Cholesterol Testing (1-11)	21.27%	23.67%	13.09%	21.86%
Blood Glucose and Cholesterol Testing (1-11)	18.21%	19.9%	8.38%	18.29%
Blood Glucose Testing (12-17)	39.27%	41.84%	37.59%	40.44%
Cholesterol Testing (12-17)	23.73%	28.01%	25.53%	26.08%
Blood Glucose and Cholesterol Testing (12-17)	21.62%	24.91%	21.99%	23.34%
Blood Glucose Testing (Total)	34.87%	36.85%	32.77%	35.72%
Cholesterol Testing (Total)	22.73%	26.16%	20.51%	24.32%
Blood Glucose and Cholesterol Testing (Total)	20.23%	22.77%	16.49%	21.23%
Effectiveness of Care: Overuse/Appropriateness				
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.47%	NR	1.21%	1.42%**
Appropriate Treatment for Upper Respiratory Infection (uri)				
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	71.17%	70.98%	77.08%	71.96%
Appropriate Treatment for Upper Respiratory Infection (18-64)	55.84%	55.77%	54.81%	55.68%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	69.35%	69.00%	74.74%	69.97%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	44.14%	43.65%	59.10%	46.69%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	36.48%	35.97%	33.24%	35.83%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	42.73%	42.1%	55.84%	44.71%
Use of Imaging Studies for Low Back Pain (lbp)	71.78%	72.59%	71.96%	72.20%
Use of Opioids at High Dosage (hdo)	0.98%	1.18%	4.76%	1.50%
Use of Opioids from Multiple Providers (uop)				
Multiple Prescribers	15.58%	13%	18.1%	14.79%
Multiple Pharmacies	2.41%	1.92%	3.82%	2.37%
Multiple Prescribers and Multiple Pharmacies	1.44%	0.93%	2.80%	1.39%
Risk of Continued Opioid Use (cou)				
18-64 years - >=15 Days covered	4.69%	2.93%	11.52%	4.82%
18-64 years - >=31 Days covered	3.47%	1.89%	4.43%	2.86%
65+ years - >=15 Days covered	NA	NA	NA	NA

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
65+ years - >=31 Days covered	NA	NA	NA	NA
Total - >=15 Days covered	4.68%	2.95%	11.52%	4.83%
Total - >=31 Days covered	3.46%	1.9%	4.43%	2.86%
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (aap)				
20-44 Years	83.74%	84.87%	83.06%	84.16%
45-64 Years	88.95%	91.10%	85.38%	89.81%
65+ Years	79.17%	80.18%	NA	79.78%*
Total	85.79%	87.46%	83.59%	86.34%
Annual Dental Visit (adv)				
2-3 Years	41.78%	41.82%	35.57%	41.11%
4-6 Years	60.11%	61.08%	50.05%	58.99%
7-10 Years	62.81%	62.82%	53.45%	61.53%
11-14 Years	61.8%	61.27%	50.16%	60.17%
15-18 Years	54.72%	55.3%	44.37%	53.86%
19-20 Years	39.58%	36.67%	31.3%	37.12%
Total	57.52%	57.72%	48.14%	56.43%
Initiation and Engagement of AOD Dependence Treatment (iet)				
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	62.50%	67.35%	NA	65.35%*
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%	2.04%	NA	2.04%*
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	65.97%	72.06%	60.42%	68.52%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.71%	8.1%	2.08%	6.17%
Total: Initiation of AOD Treatment: 13-17 Years	62.56%	69.66%	55.56%	65.41%
Total: Engagement of AOD Treatment: 13-17 Years	4.27%	7.87%	1.85%	5.83%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	40.08%	42.09%	51.16%	42.36%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	5.16%	4.27%	2.79%	4.46%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	29.76%	29.25%	47.15%	31.12%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	11.90%	10.49%	22.76%	12.24%

Measure/Data Element	United HEDIS MY 2020 CAN Rates	Magnolia HEDIS MY 2020 CAN Rates	Molina HEDIS MY 2020 CAN Rates	Statewide Average
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	41.65%	40.5%	43.79%	41.44%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.91%	5.25%	4.97%	5.07%
Total: Initiation of AOD Treatment: 18+ Years	37.56%	37.84%	44.66%	38.61%
Total: Engagement of AOD Treatment: 18+ Years	6.95%	6.25%	7.44%	6.70%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.24%	43.55%	51.98%	43.61%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.90%	4.14%	2.64%	4.27%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	30.32%	29.32%	46.4%	31.34%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	11.73%	10.46%	22.40%	12.12%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	44.84%	45.27%	45.42%	45.11%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.88%	5.68%	4.68%	5.22%
Total: Initiation of AOD Treatment: Total	39.65%	40.93%	45.43%	40.97%
Total: Engagement of AOD Treatment: Total	6.73%	6.41%	7.05%	6.62%
Prenatal and Postpartum Care (ppc)				
Timeliness of Prenatal Care	91.48%	92.21%	95.38%	17.05%
Postpartum Care	72.51%	74.45%	66.42%	13.03%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)				
1-11 years	58.44%	64.21%	49.00%	60.61%
12-17 years	64.71%	67.40%	63.28%	65.95%
Total	62.20%	66.02%	57.02%	63.71%
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
First 15 Months	51.30%	51.78%	50.09%	51.10%
15 Months-30 Months	65.25%	66.67%	51.23%	65.82%
3-11 Years	38.60%	41.16%	33.71%	39.08%
12-17 Years	32.61%	35.62%	28.33%	33.54%
18-21 Years	17.24%	20.05%	14.73%	18.24%
Total	34.83%	37.65%	30.78%	35.61%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.
*: This statewide average includes CCO rates with small denominators.
**: This statewide average was calculated with data from only two CCOs.

United, Magnolia and Molina (for select measures) had data for comparison year over year between MY 2019 and MY 2020 for the CAN population. Because MY 2020 was the first

year that Molina reported rates, many measures that required more than one year of data for the CAN population, there was no comparison made between MY 2019 and MY 2020 for some measure rates. For United and Molina, there were only a few measures that showed a substantial improvement of more than 10 percentage points year over year.

United CAN improved by 10 percentage points or more for the Pharmacotherapy Management of COPD Exacerbation (PCE) measure for the Systemic Corticosteroid indicator, the Statin Therapy for Patients with Cardiovascular Disease (SPC) measure for the Statin Adherence 80% - 40-75 years (Female) indicator, and the Statin Therapy for Patients with Diabetes (SPD) measure for the Statin Adherence 80% indicator. Molina CAN showed improvement of 10 percentage points or more for the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) measure for the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total) indicator.

Magnolia CAN did not show improvement of 10 percentage points or more for any measures.

The Adult BMI Assessment (ABA) measure rates fell by 10 percentage points or more for both United CAN and Magnolia CAN between MY 2019 and MY 2020. While Molina CAN did not have rates from MY 2019 to compare against, the Molina CAN ABA measure rate was similar to the rates reported by United CAN and Magnolia CAN. This reduction in rate can be attributed to the change in reporting methodology from hybrid to administrative. While NCQA retired the ABA hybrid measure for MY 2020 reporting, DOM has continued to require the reporting of this measure using administrative data.

United CAN, Magnolia CAN, and Molina CAN all reported a decline of 10 percentage points or more for the Annual Dental Visit (ADV) measure for the 2 – 14 Years age group as well as the Total.

United CAN rates fell by 10 percentage points or more for the Initiation and Engagement of AOD Dependence Treatment (IET) measure for the Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years indicator.

Magnolia CAN did not show a 10 percentage point or more decline for any measures besides the ABA and ADV measures.

Molina CAN rates fell by 10 percentage points or more for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure for the Counseling for Nutrition and Counseling for Physical Activity indicators, Immunizations for Adolescents (IMA) measure for the Tdap/Td indicator, Follow-Up After Emergency Department Visit for Mental Illness (FUM) for the 6-17 years - 30-Day Follow-Up indicator, Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

measure for all the Blood Glucose Testing indicators, the Initiation and Engagement of AOD Dependence Treatment (IET) measure for the Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years and Total: Initiation of AOD Treatment: 13-17 Years indicators, and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) measure 1-11 years indicator.

HEDIS® Measure Overview for CHIP Programs

MY 2020 was the first year for Molina CHIP to report data for the CHIP population. Since Molina started receiving enrollment for the CHIP population in late 2019, there were no measure rates available for measures that needed more than one year of continuous enrollment for MY 2020 reporting. Many of the statewide average rates for the CHIP population are therefore calculated with data from only one CHIP CCO. Additionally, there were no rates available for comparison between MY 2019 and MY 2020 for Molina CHIP rates. *Table 37: HEDIS® Performance Measure Data for CHIP Program* provides an overview of the rates reported for United and Molina. The statewide average is calculated as the average of the health plan rates and shown in the last column of the table. Rates highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease in the rate of more than 10 percent.

Table 37: HEDIS® Performance Measure Data for CHIP Programs

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates	Statewide Average
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	64.23%	49.64%	56.93%
Counseling for Nutrition	52.07%	40.88%	46.47%
Counseling for Physical Activity	49.15%	37.71%	43.43%
Childhood Immunization Status (cis)			
DTaP	85.89%	68.35%	81.02%
IPV	96.11%	82.28%	92.27%
MMR	94.40%	85.44%	91.92%
HiB	92.94%	81.01%	89.63%
Hepatitis B	97.08%	76.58%	91.39%
VZV	93.67%	81.01%	90.16%
Pneumococcal Conjugate	90.51%	72.15%	85.41%
Hepatitis A	82.24%	81.65%	82.07%
Rotavirus	86.37%	70.89%	82.07%

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates	Statewide Average
Influenza	43.07%	29.11%	39.19%
Combination #2	85.16%	59.49%	78.03%
Combination #3	84.43%	58.86%	77.33%
Combination #4	74.70%	53.16%	68.72%
Combination #5	77.13%	53.16%	70.47%
Combination #6	40.88%	20.89%	35.33%
Combination #7	68.86%	49.37%	63.44%
Combination #8	38.44%	19.62%	33.22%
Combination #9	38.44%	18.99%	33.04%
Combination #10	36.50%	18.35%	31.46%
Immunizations for Adolescents (ima)			
Meningococcal	60.83%	42.54%	53.61%
Tdap/Td	83.94%	61.57%	75.11%
HPV	22.38%	14.18%	19.15%
Combination #1	60.34%	41.04%	52.72%
Combination #2	21.17%	13.81%	18.26%
Lead Screening in Children (lsc)	68.13%	77.85%	70.83%
Breast Cancer Screening in Children (bcs)	NA	NA	NA
Chlamydia Screening in Women (chl)			
16-20 Years	37.92%	37.99%	37.94%
21-24 Years	NA	NA	NA
Total	37.92%	37.99%	37.94%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	77.80%	79.16%	78.10%
18-64 years	71.12%	76.92%	72.12%
65+ years	NA	NA	NA
Total	77.55%	79.10%	77.89%
Asthma Medication Ratio (amr)			
5-11 Years	83.50%	NA	83.50%*
12-18 Years	75.11%	NA	75.11%*
19-50 Years	NA	NA	NA
51-64 Years	NA	NA	NA
Total	79.21%	NA	79.21%*
Effectiveness of Care: Cardiovascular Conditions			

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates	Statewide Average
Controlling High Blood Pressure (cbp)	NA	NA	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	NA	NA	NA
Effective Continuation Phase Treatment	NA	NA	NA
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	46.44%	NA	46.44%*
Continuation and Maintenance (C&M) Phase	66.22%	NA	66.22%*
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	67.52%	51.11%	61.54%
6-17 years - 7-Day Follow-Up	40.76%	28.89%	36.44%
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	65.90%	52.13%	61.05%
Total-7-day Follow-Up	39.31%	29.79%	35.96%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NA	NA	NA
6-17 years - 7-Day Follow-Up	NA	NA	NA
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	NA	NA	NA
Total-7-day Follow-Up	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	30.34%	26.92%	29.08%
Cholesterol Testing (1-11)	23.60%	23.08%	23.40%
Blood Glucose and Cholesterol Testing (1-11)	21.35%	17.31%	19.86%
Blood Glucose Testing (12-17)	36.47%	48.65%	40.16%
Cholesterol Testing (12-17)	23.53%	22.97%	23.36%
Blood Glucose and Cholesterol Testing (12-17)	20.59%	21.62%	20.90%
Blood Glucose Testing (Total)	34.36%	39.68%	36.10%
Cholesterol Testing (Total)	23.55%	23.02%	23.38%
Blood Glucose and Cholesterol Testing (Total)	20.85%	19.84%	20.52%

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates	Statewide Average
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.02%	0.83%	0.96%
Appropriate Treatment or Children with URI (uri)			
3 months-17 Years	67.17%	71.87%	68.24%
18-64 Years	53.69%	72.00%	57.31%
65+ Years	NA	NA	NA
Total	66.71%	71.87%	67.89%
Use of Imaging Studies for Low Back Pain (lbp)	NA	NA	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	0.00%	NA	0.00%*
18-64 years - >=31 Days covered	0.00%	NA	0.00%*
65+ - >=15 Days covered	NA	NA	NA
65+ - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	0.00%	NA	0.00%*
Total - >=31 Days covered	0.00%	NA	0.00%*
Access/Availability of Care			
Annual Dental Visit (adv)			
2-3 Years	45.15%	41.74%	45.15%
4-6 Years	64.54%	60.08%	64.54%
7-10 Years	70.36%	65.22%	70.36%
11-14 Years	66.76%	61.25%	66.76%
15-18 Years	59.17%	51.96%	59.17%
19-20 Years	44.52%	38.60%	44.52%
Total	63.37%	58.00%	63.37%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD - Alcohol Abuse or Dependence (13-17)	NA	NA	NA
Engagement of AOD - Alcohol Abuse or Dependence (13-17)	NA	NA	NA
Initiation of AOD - Opioid Abuse or Dependence (13-17)	NA	NA	NA
Engagement of AOD - Opioid Abuse or Dependence (13-17)	NA	NA	NA
Initiation of AOD - Other Drug Abuse or Dependence (13-17)	62.86%	NA	NA
Engagement of AOD - Other Drug Abuse or Dependence (13-17)	5.71%	NA	NA

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates	Statewide Average
Initiation of AOD - Total (13-17)	64.10%	NA	66.13%*
Engagement of AOD - Total (13-17)	5.13%	NA	3.23%*
Initiation of AOD - Alcohol Abuse or Dependence (18+)	NA	NA	NA
Engagement of AOD - Alcohol Abuse or Dependence (18+)	NA	NA	NA
Initiation of AOD - Opioid Abuse or Dependence (18+)	NA	NA	NA
Engagement of AOD - Opioid Abuse or Dependence (18+)	NA	NA	NA
Initiation of AOD - Other Drug Abuse or Dependence (18+)	NA	NA	NA
Engagement of AOD - Other Drug Abuse or Dependence (18+)	NA	NA	NA
Initiation of AOD - Total (18+)	NA	NA	NA
Engagement of AOD - Total (18+)	NA	NA	NA
Initiation of AOD - Alcohol Abuse or Dependence (Total)	NA	NA	NA
Engagement of AOD - Alcohol Abuse or Dependence (Total)	NA	NA	NA
Initiation of AOD - Opioid Abuse or Dependence (Total)	NA	NA	NA
Engagement of AOD - Opioid Abuse or Dependence (Total)	NA	NA	NA
Initiation of AOD - Other Drug Abuse or Dependence (Total)	53.57%	NA	55.42%*
Engagement of AOD - Other Drug Abuse or Dependence (Total)	7.14%	NA	6.02%*
Initiation of AOD - Total (Total)	53.85%	51.43%	53.00%
Engagement of AOD - Total (Total)	6.15%	2.86%	5.00%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	NA	NA	NA
Postpartum Care	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	59.52%	NA	59.52%*
12-17 Years	60.87%	59.46%	60.38%
Total	60.36%	50.82%	56.98%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	64.93%	64.05%	64.61%
15 Months-30 Months	72.09%	58.82%	71.53%

Measure/Data Element	United HEDIS MY 2020 CHIP Rates	Molina HEDIS MY 2020 CHIP Rates	Statewide Average
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	40.02%	38.81%	39.60%
12-17 Years	36.37%	31.56%	34.83%
18-21 Years	19.64%	18.84%	19.40%
Total	36.97%	34.6%	36.19%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR indicates that the rate was not reported.
*: This statewide average includes CCO rates with small denominators.

United CHIP rates fell by 10 percentage points or more for the Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure for the Glucose Testing (12-17) and Glucose Testing (Total) Activity indicators and the Annual Dental Visits Measure. While Molina CHIP did not have any MY 2019 data to compare against, their ADV measure rates were as low as the United CHIP rates for ADV.

Non-HEDIS Performance Measure Validation – CAN Program

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by the CCOs for 2020 are listed in *Table 38: CAN Adult and Child Core Set Measure Rates*. The statewide averages have been included where applicable.

Table 38: CAN Non-HEDIS Performance Measure Rates

Measure	United MY 2020 Rates	Magnolia MY 2020 Rates	Molina MY 2020 Rates	Statewide Average
Adult Core Set Measures				
Primary Care Access and Preventative Care				
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)				
Ages 18 - 64	0.50%	0.57%	0.79%	0.57%
Ages 65+	0.47%	0.00%	NA	0.31%*
Total	0.50%	0.57%	0.79%	0.57%
Maternal and Perinatal Health				
PC-01: ELECTIVE DELIVERY (PC-01)				
Women with elective vaginal deliveries or elective cesarean sections	NR	0.00%	NR	Not Available**
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)				
Most or moderately effective contraception - 3 days	13.51%	13.75%	13.02%	13.45%

Measure	United MY 2020 Rates	Magnolia MY 2020 Rates	Molina MY 2020 Rates	Statewide Average
Most or moderately effective contraception - 60 days	46.22%	47.02%	53.28%	48.44%
LARC - 3 Days	0.58%	0.88%	0.68%	0.71%
LARC - 60 Days Reported	8.54%	9.66%	10.13%	9.34%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)				
Most or moderately effective contraception rate	25.13%	25.58%	27.90%	25.82%
LARC rate	3.37%	3.39%	3.70%	3.44%
Care of Acute and Chronic Conditions				
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)				
Ages 18 - 64	26.06	29.44	23.74	27.20
Ages 65+	0.00	0.00	NA	0.00*
Total	26.01	29.38	23.74	27.16
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)				
Ages 40 - 64	39.01	87.85	58.16	65.32
Ages 65+	115.61	160.77	NA	142.25*
Total	39.34	88.21	58.14	65.64
HEART FAILURE ADMISSION RATE (PQI-08)				
Ages 18 - 64	44.35	59.86	54.93	52.93
Ages 65+	115.61	160.77	NA	142.25*
Total	44.46	60.07	54.92	53.07
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)				
Ages 18 - 39	0.88	3.07	4.24	2.43
HIV VIRAL LOAD SUPPRESSION (HVL - AD)				
Ages 18 - 64	12.00%	12.43%	17.12%	12.76%
Ages 65+	NA	NA	NA	NA
Total	11.79%	12.19%	16.81%	12.52%
Behavioral Health Care				
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)				
Ages 18 - 64	1.03%	1.28%	4.66%	1.57%
Ages 65+	NA	NA	NA	NA
Total	1.03%	1.28%	4.66%	1.56%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)				
Ages 18 - 64	4.82%	3.39%	5.18%	4.29%
Ages 65+	NA	NA	NA	NA
Total	4.82%	3.38%	5.18%	4.29%

Measure	United MY 2020 Rates	Magnolia MY 2020 Rates	Molina MY 2020 Rates	Statewide Average
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)				
Overall	54.63%	32.73%	51.03%	37.83%
Prescription for Buprenorphine	53.24%	32.32%	49.48%	37.15%
Prescription for Oral Naltrexone	2.31%	0.74%	1.55%	1.05%
Prescription for Long-acting, injectable naltrexone	0.00%	0.00%	0.52%	0.06%
Prescription for Methadone	0.00%	0.08%	0.00%	0.06%
Child Core Set Measures				
Primary Care Access and Preventative Care				
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)				
Ages 12 - 17	0.79%	0.87%	0.65%	0.81%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)				
Age 1 Screening	25.75%	3.09%	26.53%	18.67%
Age 2 Screening	41.74%	6.03%	40.39%	23.28%
Age 3 Screening	42.13%	5.56%	35.75%	23.75%
Total Screening	35.96%	4.84%	28.43%	21.28%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)				
Total (Newborn < 91 Days at Dx)	NA	NA	NA	NA
Maternal and Perinatal Health				
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)				
Most or moderately effective contraception - 3 days	2.00%	2.11%	2.22%	2.09%
Most or moderately effective contraception - 60 days	51.59%	45.25%	53.02%	49.64%
LARC - 3 Days	0.47%	0.79%	0.81%	0.67%
LARC - 60 Days Reported	12.13%	12.14%	11.90%	12.08%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)				
Most or moderately effective contraception rate	30.09%	30.66%	29.30%	30.27%
LARC Rate	2.66%	2.65%	2.51%	2.64%
Dental and Oral Health Services				
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)				
Numerator 1 At Least One Sealant	34.80%	NR	NR	Not Available**
Numerator 2 All Four Molars Sealed	20.85%	NR	NR	Not Available**
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)				
Ages 1 - 20	46.44%	46.13%	45.90%	46.25%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.
*: This statewide average includes CCO rates with small denominators.
**: Since only one health plan reported this rate, a statewide average cannot be calculated

Non-HEDIS Performance Measure Validation – CHIP Program

Table 39: CHIP Adult and Child Core Set Measure Rates, provides an overview of rates reported by United and Molina for the CHIP population.

Table 39: CHIP Non-HEDIS Performance Measure Rates

Measure	United MY 2020 Rates	Molina MY 2020 Rates	Statewide Average
Adult Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	NA	0.23%	0.23%*
Ages 65+	NA	NA	NA
Total	NA	0.23%	0.23%*
Maternal and Perinatal Health			
PC-01: ELECTIVE DELIVERY (PC-01)			
Women with elective vaginal deliveries or elective cesarean sections	NR	NR	NR
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	NA	9.49	9.49*
Ages 65+	NA	NA	NA
Total	NA	9.49	9.49*
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	NA	0.00	0.00*
Ages 65+	NA	NA	NA
Total	NA	0.00	0.00*
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	NA	0.00	0.00*
Care of Acute and Chronic Conditions			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA

Measure	United MY 2020 Rates	Molina MY 2020 Rates	Statewide Average
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
Child Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	0.71%	0.56%	0.66%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	NA	NA	NA
Age 2 Screening	48.41%	51.27%	48.81%
Age 3 Screening	43.78%	46.19%	44.19%
Total Screening	46.04%	48.33%	46.40%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)			
Total (Newborn < 91 Days at Dx)	NA	NA	NA
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception - 3 days	NA	NA	NA
Most or moderately effective contraception - 60 days	NA	NA	NA
LARC - 3 Days	NA	NA	NA
LARC - 60 Days	NA	NA	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	29.82%	24.54%	28.17%
LARC Rate	2.49%	1.71%	2.25%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	35.32%	NR	Not Available**
Numerator 2 All Four Molars Sealed	21.12%	NR	Not Available**
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)			
Ages 1 - 20	55.36%	45.90%	51.91%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.
*: This statewide average includes CCO rates with small denominators.
**: Since only one health plan reported this rate, a statewide average cannot be calculated.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

DOM-requires each health plan to conduct performance improvement projects for the following topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Each health plan is required to submit performance improvement projects to CCME for review annually. CCME validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Twenty-three projects were validated for the three health plans. Results of the validation and project status for each project are displayed in the sections that follow.

CAN PIP VALIDATION RESULTS

United submitted four performance improvement projects for validation. Those projects included Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness: COPD/Asthma. United's PIPs had one primary issue: improvement in and outcomes of care. Two of their four PIPs showed a decline in outcomes, including care management to reduce preterm deliveries and behavioral health readmission care management enrollment. *Table 40: United CAN PIPs* provides an overview of each PIP, the validation results and intervention.

Table 40: United CAN PIPs

<table>
<tr><th colspan="2">Behavioral Health Readmissions</th></tr>
<tr><td colspan="2">The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest readmission rate from 19.2% to 17.7% and the enrollment indicator had a decline from 46% to 38%. Individual facility rates were reported as well for each of the five facilities.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>73/74=99%
High Confidence in Reported Results</td><td>79/80=99%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Collaboration with high volume Hinds County outpatient and inpatient providers in order to schedule and facilitate meetings to discuss ways to improve readmissions rates by increasing the seven day-follow-up appointment.
• Meds to Beds Program to provide transition solutions to coordinate care and discharge medications for members discharging from inpatient facilities.
• Enhanced Case Management.</td></tr>
<tr><th colspan="2">Improved Pregnancy Outcomes</th></tr>
<tr><td colspan="2">The Improved Pregnancy Outcomes PIP goal is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment. The baseline rate was 92.21% and the remeasurement #1 rate was 91.48%. This rate reflects a decline in the prenatal care visit rate, although it was above the DOM goal rate of 90.1%.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>67/72=93%
High Confidence in Reported Results</td><td>74/75=99%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Home visit care management services in seven underserved communities in MS.
• Care management for high-risk pregnant members and their babies less than a year old.
• The Optum Whole Person Care Program provides telephonic and/or face-to-face outreach to high-risk members to educate the member and help with establishing an obstetric practice.
• Dedicated maternity Member Services Team for telephonic outreach to low-risk members or to members whose risk is unknown to identify any barriers such as transportation childcare and connect the member to support resources.
• Member and provider education with the First Steps packets and the OB toolkits.
• National Healthy Starts program to address social needs.</td></tr>
</table>

Sickle Cell Disease Outcomes	
The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28% and declined to 26.43% in 2020. This is improvement as a lower rate is better.	
Previous Validation Score	**Current Validation Score**
66/71=93% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Outreach to providers encouraging the use of hydroxyurea for patient who do not have a pharmacy claim for hydroxyurea. • Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients. • Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments. • Telehealth campaigns and after hour care newsletters.	
Respiratory Illness: COPD/Asthma	
The Respiratory Illness PIP examines the COPD exacerbations and pharmacotherapy management HEDIS rate and the AMR measure assessing controller medication to total medication ratio HEDIS rate. The bronchodilators baseline rate was 74.96% which improved to 75.13% although it was still below the goal rate of 84.71%. The corticosteroids baseline rate was 42.24% which improved to 54.02% at remeasurement one, but still below the goal rate of 71.05%. The AMR goal rate was 71.28% and the baseline was 70.70% with an improvement of remeasurement one of 74.08%.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Clinical practice consultants visit high volume practices to discuss Clinical Practice Guidelines and evidence-based Quality Performance Guidelines and assist with interpreting patient care opportunity reports. • Pharmacy outreach to ensure members have educational materials, prescriptions are filled and assist with overrides or claims issues related to prescribed inhalers. • Communication with clinics regarding non-compliant members, patient care opportunity reports, and provider education.	

Magnolia submitted topics including Behavioral Health Readmissions, Reducing Preterm Births, Sickle Cell Disease Outcomes, and Asthma/COPD. Three of the four PIPs for Magnolia did not show improvement in outcomes for the latest remeasurements. The Behavioral Health Readmissions PIP for Hinds County showed an increase in readmissions, the Sickle Cell Disease members who remained on medication during the treatment period declined, and the AMR and COPD HEDIS rates declined in the HEDIS 2020 measurement compared to HEDIS 2019 measurement for the Asthma/COPD PIP.

Table 41: Magnolia CAN PIPs

<table>
<tr><th colspan="2">Behavioral Health Readmissions</th></tr>
<tr><td colspan="2">The Behavioral Health Readmissions PIP aimed at reducing the 30-day psychiatric readmission rates in Hinds County, Brentwood, and MS State Hospital. For this validation, the PIP showed a substantial increase in the readmission rate (2020 annual rate) to 27.69% from the previous year's rate of 13.05%. Magnolia felt the increase was due to a decrease in the total number of admissions and unable to contact members. Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Behavioral Health Care Management Team to provide education and support services to promote adherence to treatment plans, assist with scheduling appointments, and enrolling the member in the care management program. The Clinical Provider Trainer will continue to conduct both telephonic and face-to-face visits with all Hinds County Behavioral Health facilities to provide education and resources to aide in the discharge planning process, address any barriers identified in the discharge planning process, and assist with resolving any other identified issues.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>73/74=99%
High Confidence in Reported Results</td><td>73/74=99%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Telephonic outreach by the Clinical Provider Trainer for Behavioral Health to all Hinds County Behavioral Health facilities to provide education, resources, and address any barriers.
• Direct outreach to members discharged from Hinds County BH facilities by the Behavioral Health Team to complete the TOC Assessment.</td></tr>
<tr><th colspan="2">Reducing Preterm Births</th></tr>
<tr><td colspan="2">The Reducing Preterm Births PIP is a newly initiated PIP with baseline data only. The goal for this PIP is to reduce the preterm birth rate by interventions directed at members with hypertension or pre-eclampsia. The baseline rate was 13.4% with a benchmark of 11.4%.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>N/A</td><td>72/72=100%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Completing Notification of Pregnancy (NOP) as applicable
• Enrolling member in the Start Smart for Baby program
• Refer to Care Management for continuous follow up
• Identify various methodologies to enhance patient education and engagement to increase early intervention. Develop materials on controlling hypertension during pregnancy, distribute to members as needed.
• Develop a plan and criteria to distribute blood pressure cuffs to member.</td></tr>
</table>

<table>
<tr><th colspan="2">Sickle Cell Disease Outcomes</th></tr>
<tr><td colspan="2">The goal of the Sickle Cell Disease Outcomes PIP is to increase the compliance rate of Hydroxyurea for members who are prescribed to take the medication. Magnolia did not meet the goal that 47% of members with a diagnosis of Sickle Cell Disease who were dispensed a prescription for Hydroxyurea and remained on the medication during the treatment period. Results were recorded at 35.5% in 2019, 34.7% in 2020, and 20.6% in 2021.
Magnolia will continue to focus efforts on interventions making an impact, including direct member outreach from the Pharmacy Team to provide education on the importance of medication adherence, assessing for potential barriers or concerns, providing education on 90-day fills and converting more prescriptions to 90-day fills, assisting with medication refills as needed, and referring to Care Management as needed. The Pharmacy Team will also continue mailing letters to the providers of members identified as having a new diagnosis of Sickle Cell or a new prescription for Hydroxyurea quarterly to promote collaboration and medication adherence.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>73/74= 99%
High Confidence in Reported Results</td><td>73/74= 99%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and also on the importance of medication adherence.
• Pharmacy Team mailed letters to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment.
• Pharmacy Team outreached all members who received letters to provide education and to address any barriers/concerns.
• Referrals to Care Management as needed.</td></tr>
<tr><th colspan="2">Asthma/COPD</th></tr>
<tr><td colspan="2">The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and who had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year. This indicator uses the HEDIS measure, Asthma Medication Ratio (AMR). A decrease in percentile range was noted from baseline (71.15%) to remeasurement period 1 (70.24%) with a goal of 76.86%.
For the adult population, this PIP measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. This indicator uses the HEDIS measure, Use of Spirometry testing in the Assessment, and Diagnosis of COPD (SPR). A decrease in percentile range was noted from baseline (28.38%) to remeasurement period 1 (26.49%) with a goal of 36.82%.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>80/80=100%
High Confidence in Reported Results</td><td>73/74= 99%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Direct outreach by the Population Health Management Team to non-compliant members identified in both the Asthma Medication Ratio (AMR) and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations.
• Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population.
• Education on the AMR & SPR measures in provider newsletters by the QI Team.</td></tr>
</table>

Molina submitted seven PIPs for validation. The topics included: Behavioral Health Readmissions, Asthma Medication Ratio, Pharmacotherapy Management of COPD Exacerbation, Follow-up 7 and 30 Days After Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. Although vast improvements were shown regarding Molina's PIP process and reporting, there were some issues with the PIPs showing improved outcomes. Three out of seven PIPS showed a decline in outcomes. The Asthma Medication Ration (AMR) rate declined, Behavioral Health readmissions in Hinds County increased, and BMI percentile documentation rates declined in the most recent remeasurement. The table that follows provides an overview of those PIPs, validation results and interventions.

Table 42: Molina CAN PIPs

Behavioral Health Readmissions	
The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions The Behavioral Health Readmissions for Hinds County showed an increase in readmissions from the overall 2020 rate of 23.8% to Q1 2021 at 27.7%. Enrollment in high-risk case management for unique readmitted patients is reported to be 100%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Community connectors • Primary care initiative • Scheduling process changed • Onsite d/c planning • Transition of Care letters sent to members • Patient Outreach	
Asthma Medication Ratio	
The aim for the Asthma PIP is to increase the compliance rate or member who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The rate reduced from 66% to 60.8% in Q2 2021, with a goal of 71%.	
Previous Validation Score	**Current Validation Score**
28/62= 45.2% Not Credible	73/74=99% High Confidence in Reported Results
Interventions	

- Asthma education video on proper use of the inhaler
- Monitoring of the non-compliant members and encourage providers to contact members to close the gap in care
- Telephone call campaign to encourage members to get their annual wellness exams
- Provider toolkits and educational materials
- Member educational materials

Pharmacotherapy Management of COPD Exacerbation (PCE)	
The COPD PIP focuses on improving the rate of COPD members who are dispensed a systemic corticosteroid within 14 days of an acute event. The PCE measure is used and both rates improved to above goal rate. For systemic corticosteroid, the rate improved from 40% to 69.4% with a goal of 67%. The bronchodilator rate improved from 80% to 83.3% with a goal of 81.8%.	
Previous Validation Score	**Current Validation Score**
28/62= 45.2% Not Credible	80/80=100% High Confidence in Reported Results
Interventions	
• Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products. • Provider Education: The Provider Toolkit is a quick reference guide for providers. This kit includes the 2021 revised HEDIS Tip Sheets to support the providers in meeting the goals of the NCQA HEDIS measures, MHMS resources (i.e., useful phone and fax numbers), and tips to increase member satisfaction.	

Follow-up 7 and 30 Days After Hospitalization for Mental Illness	
Measures the percentage of behavioral health discharges for which the member received follow-up within 7 days and 30 days of discharge. The 7-day rate improved from 8.1% in Q1 to 26.3% in Q2. The goal is 28%. For 30-day follow up, the rate also improved from 16.9% in Q1 to 46% in Q2 with a goal of 50%.	
Previous Validation Score	**Current Validation Score**
28/62= 45.2% Not Credible	80/80=100% High Confidence in Reported Results
Interventions	
• TOC Coaches: Once notified of assigned admitted members, the TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan. • Discharge planning checklist • Processes to improve efficiency of scheduling follow-up appointments • Provider Education	

Prenatal and Postpartum Care	
The aim of the Prenatal and Postpartum Care PIP is to improve the percentage of deliveries that receive a prenatal care visit as a member of Molina in the first trimester. And improve the percentage of deliveries that had a postpartum visit on or between 21-56 days of delivery. Both measures improved but are not yet at the goal rate. For prenatal care, the rate improved from 89.67% to 90.3% with a goal of 93.6%. The post-partum rate improved from 30.8% to 35% with a goal of 74.3%.	
Previous Validation Score	**Current Validation Score**
28/62= 45.2% Not Credible	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member incentives-Gift cards and car seats • Member outreach events • Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize electric breast pump for the first 6 months of their child's life.	
Sickle Cell Disease	
The aim for the Sickle Cell Disease PIP is to increase the rate of case management services for members with Sickle Cell Disease (SCD). The rate improved from 49% to 5.7% in Q2 2021.	
Previous Validation Score	**Current Validation Score**
28/62= 45.2% Not Credible	80/80=100% High Confidence in Reported Results
Interventions	
• Internal monitoring and tracking for inpatient care and ED visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration: Working in collaboration with MS Sickle Cell Foundation (MSCF). MSCF is a non-profit 501(c)3 that has been in existence in MS since 1996. The goal of this organization is to improve the lives of individuals and families in MS, living with sickle cell disease. QI is also in collaboration with MHMS internal teams, mainly Health Care Services and Member and Community Engagement. • Member educational materials	
Obesity	
The Obesity PIP focuses on the child population. The BMI percentile, Nutrition, and Counseling HEDIS rates are utilized. The rates did not show improvement from Q1 to Q2. For BMI Percentile, the rate went from 12.6% to 12.5%, with a goal of 61.3%. The nutrition rate went from 11.5% to 7.3% with a goal of 52.3%. The counseling rate declined from 8.4% to 5.4% with a goal of 57.4%.	
Previous Validation Score	**Current Validation Score**
28/62= 45.2% Not Credible	73/74=99% High Confidence in Reported Results

Interventions
• Provider Education • Member Incentives • Member outreach and member events for awareness and education

For the 2020 EQR, Molina submitted seven PIPs for validation. All of those projects, except the Behavioral Health Readmission project, received a validation score of "Not Credible". Molina submitted a corrective action plan to address the validation issues. For the 2021 EQR, CCME found Molina had implemented the corrective actions and Molina's validation scores improved. See *Table 43: Previous Quality Improvement Projects (CAN) CAP Items – Molina for a summary of those deficiencies and the corrective actions taken.*

Table 43: Previous Quality Improvement Projects (CAN) CAP Items—Molina

Standard	EQR Comments
IV D. Quality Improvement Projects (CAN)	
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	All projects except Behavioral Health Readmission received a validation score within the "Not Credible" range and did not meet the validation requirements. The following items were not documented: •Data analysis and rationale for choosing the topic •Sampling information •Data analysis plan •Goal and benchmark rates •Analysis of findings •Barriers and interventions linked to each barrier Details of the validation activities and recommendations for the PIPs are found in Attachment 3, CCME EQR Validation Worksheets. *Corrective Action: The performance improvement projects should be documented on the CCME provided template and include all required elements. Correct the issues identified below regarding the PIPs.*
Molina's Response: To ensure compliance, starting 2nd Quarter 2021, Quality Improvement will use the template provided by CCME for MSCAN quarterly and annual reporting of Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal/Postpartum Care and Sickle Cell Disease Performance Improvement Projects. All elements in the template will be addressed for each PIP (please see example Asthma PIP uploaded to portal). **Molina Comments-June 16, 2021:** Applicable slides have been updated to include the correct standard from Molina's contract with DOM. Related slides from the QI workplan have been updated and are being provided with Molina's response. Due to the updates, the QI Work Plan will be presented for review and approval during the 2nd Quarter 2021 QIC meeting. Upon approval, the revised QI Work Plan will be used for submission of quarterly and annual DOM reports.	

Standard	EQR Comments
CAN Performance Improvement Projects: Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal and Post-partum Care, Sickle Cell Disease	
Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Data analysis is not offered in PIP report proposal for rationale to initiate study. *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include narrative summary of the rationale and data supporting the need of the PIP.	
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	Sampling information not provided in the report. *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include information on the sampling plan, if applicable.	
Did the plan employ valid sampling techniques that protected against bias?	Information is not documented in the PIP report. *Include information on sampling technique(s); if not applicable, indicate in the report using a PIP report template.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include information on sampling techniques, if applicable.	
Did the study design clearly specify the sources of data?	Data sources are not indicated in proposal. *Include information on sources of data.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include data source information.	
Did the study design prospectively specify a data analysis plan? (1)	Data analysis plan is not documented. *Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include a quarterly and annual data analysis plans, per DOM reporting frequency. beginning 2nd Quarter 2021, all MSCAN PIP reports will include data source information.	
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	No findings presented. *Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include quarterly and annual numerical results and findings, per DOM reporting frequency.	
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis of baseline is not offered in report and follow-up activities are not documented. *Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will include a quarterly and annual analysis of the baseline, per DOM reporting frequency.	

Standard	EQR Comments
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions not documented in the report. *Add the barriers and interventions linked to each barrier to the report.*
Molina's Response: Beginning 2nd Quarter 2021, all MSCAN PIP reports will document interventions implemented for the PIP.	

CHIP PIP VALIDATION RESULTS

For the CHIP population, United submitted four PIPs for validation. Topics included Adolescent Well Child Visits/Child and Adolescent Well Care Visits, Follow Up After Hospitalization for Mental Illness, Reducing Adolescent and Childhood Obesity, and Getting Needed Care CAHPS. Two of the four PIPs showed a decline in outcomes. The Getting Needed Care composite percentile rate declined and the HEDIS rate regarding weight assessment and counseling for children and adolescents declined from the previous measurement. A summary of the PIPs and interventions underway are listed in *Table 44: United CHIP PIPs*.

Table 44: United CHIP PIPs

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
The Adolescent Well Child Visits (AWC)/Child and Adolescent Well Care Visits (WCV) PIP goal is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year. The AWC measure was retired and replaced with the WCV measures. This measure looks at the percentage of members completing at least one comprehensive wellness visit during the calendar year. For this review only the baseline rates were provided for the 12-17-year-olds. The baseline rate for 2020 was 36.37% and the baseline rate for 18-21-year-olds was 19.64%.	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	73/73/=100% Hight Confidence in Reported Results
Interventions	
• Phone calls to noncompliance members and after hour and weekend clinic days. Staff collaborated with participating clinics to close care gaps. • Clinical practice consultants and clinical transformation consultants conduct educational sessions with providers on HEDIS requirements. • Resumption of the Farm to Fork activities for member to receive educational materials regarding wellness visits and immunizations.	

<table>
<tr><th colspan="2">Follow Up After Hospitalization for Mental Illness</th></tr>
<tr><td colspan="2">The goal for the Follow-Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7-day and 30-day follow-up visits. For this review period the PIP documentation report showed that the 30-day follow up rate improved from 61.39% to 64.55% which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.15% to 37.27% in 2020, then improved to 39.31% for MY 2020/RY2021. The goal rate for United is 30.07% which is above the goal rate but below the NCQA rate of 46.22%.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>80/80=100%
High Confidence in Reported Results</td><td>80/80=100%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay.
• Continue demographic workflow to improve capture of current contact numbers for enrollees.
• Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCP to communicate relevant treatment information involving member care.
• Network notes and Optum news and updates for UBH clinicians and facilities.
• Case management initiates calls to schedule follow-up appointments.</td></tr>
<tr><th colspan="2">Reducing Adolescent and Childhood Obesity</th></tr>
<tr><td colspan="2">The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity. All rates declined from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate. Measure one declined slightly from 64.96% to 64.23%, but it is above United’s goal of 33.17%; and below the NCQA rate of 80.5%. Measure two declined from 55.96% in reporting year (RY) 2019 to 52.07% in RY2020. United’s goal for measure two is 42.34%, so that goal has been exceeded; the NCQA goal is 71.55% which was not exceeded. Measure three declined slightly from 50.12% in RY2020 to 49.15% in RY2021. United’s goal for measure three is 34.25%, so the current rate exceeded the United goal rate, but it below the NCQA goal of 66.79%.</td></tr>
<tr><th>Previous Validation Score</th><th>Current Validation Score</th></tr>
<tr><td>100/100=100%
High Confidence in Reported Results</td><td>94/95 = 99%
High Confidence in Reported Results</td></tr>
<tr><th colspan="2">Interventions</th></tr>
<tr><td colspan="2">• Member and provider education.
• Phone calls to noncompliant members.
• After hour and weekend clinic days.
• Member events such as health fairs and Farm to Fork events.
• Clinical Practice Consultants conduct routine visits to PCPs to provide education on HEDIS measures and appropriate coding and billing.
• Community outreach activities such as the Farm to Fork program and health fairs.</td></tr>
</table>

Getting Needed Care CAHPS	
For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019 and then it reduced again slightly to 82.3%. This is below the NCQA 50th percentile rate and the United goal of 91.19%.	
Previous Validation Score	**Current Validation Score**
99/100=99% High Confidence in Reported Results	94/95=99% High Confidence in Reported Results
Interventions	
• Member education regarding the provider network and how to access care. • Clinical Practice Consultants make face to face visits with high volume clinics to discuss the CAHPS survey. • Provide member education during phone calls and town hall meetings regarding United's provider network. • Offer case management to providers to support or expedite referrals.	

Molina submitted four PIPs for the CHIP populations. Those included: Adolescent Well Care/Well Child, Asthma Medication Ratio, Obesity – Ages 3 to 19, and Follow-up After Hospitalization for Mental Illness – Ages 6 to 19. Like Molina's CAN PIPs, Molina showed substantial improvements in the PIP processes and reporting. Baseline data was reported for all four PIPS. The next cycle of reviews will allow for an evaluation of trending for the PIP rates and identify any issues with PIP performance.

Table 45: Molina CHIP PIPs

Adolescent Well Care/Well Child	
The aim for the Well Care/Well Child PIP is to increase the number of CHIP members who receive at least 6 or more well care/well child visits during the first 0-15 months of life. The baseline rate for this PIP was 42.59% with a goal of 55.79%.	
Previous Validation Score	**Current Validation Score**
28/62=45.2% Not Credible	72/72=100% High Confidence in Reported Results
Interventions	
• Provider education with periodic face-to-face visits offering HEDIS toolkits, non-compliant member list, provider portal training and HEDIS Tip Sheets for well visits. • Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale. • Member incentives provided on the day of the screening.	

Asthma Medication Ratio (AMR)	
The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. The baseline rates for Q1 2021 are presented in the documentation. For the AMR PIP, the baseline rate was presented at 84.5% with a goal of 71.28%, so the HEDIS measure is above goal at baseline.	
Previous Validation Score	**Current Validation Score**
28/62=45.2% Not Credible	72/72=100% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of the inhaler. • Telephone campaigns to encourage members to get their annual wellness exams. • Provider education with toolkits and assistance with member outreach.	
Obesity- Ages 3 to 19	
The Obesity PIP's aim is to increase the percentage of CHIP member who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. For the Obesity PIP, the rates for all three components were 0%. The BMI percentile goal is 61.31%; the Nutrition goal rate is 52.31%; and the physical activity counseling goal is 57.42%.	
Previous Validation Score	**Current Validation Score**
28/62=45.2% Not Credible	72/72=100% High Confidence in Reported Results
Interventions	
• Provider toolkits to help facilitate tracking reports and address areas needed. • Member education, community outreach, and incentives.	
Follow-up After Hospitalization for Mental Illness (FUH)- Ages 6 to 19	
The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate was 14.29% at baseline with a goal of 50%. The 7-day baseline rate was 7.14% with a goal of 28.3%.	
Previous Validation Score	**Current Validation Score**
28/62=45.2% Not Credible	72/72=100% High Confidence in Reported Results
Interventions	
• Transition of Care collaborative on-site discharge planning. • Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation. • Implementation of a Discharge Planning Checklist. • Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge.	

For the 2020 EQR, Molina submitted four PIPs for validation. All of those projects received a validation score of “Not Credible” . Molina submitted a corrective action plan

to address the validation issues. For the 2021 EQR, CCME found Molina had implemented the corrective actions and Molina's validation scores improved. See *Table 46: Previous Quality Improvement Projects (CAN) CAP Items – Molina for a summary of those deficiencies and the corrective actions taken.*

Table 46: Previous Quality Improvement Projects (CHIP) CAP Items—Molina

Standard	EQR Comments
IV D. Quality Improvement Projects (CHIP)	
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	All projects received a validation score within the "Not Credible" rage and failed to meet the validation requirements. The following items were not documented: •Data analysis and rationale for choosing the topic •Sampling information •Data analysis plan •The goal and benchmark rates •Analysis of findings •Barriers and interventions linked to each barrier Details of the validation activities and recommendations for the PIPs may be found in *Attachment 3, CCME EQR Validation Worksheets*. *Corrective Action: The performance improvement projects should be documented on the CCME provided template and include all required elements. Correct the issues identified below regarding the PIPs.*
Molina's Response: To ensure compliance, starting 2nd Quarter 2021, Quality Improvement will use the template provided by CCME for MSCAN quarterly and annual reporting of Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal/Postpartum Care and Sickle Cell Disease Performance Improvement Projects. All elements in the template will be addressed for each PIP (please see example Asthma PIP uploaded to portal).	
CHIP Performance Improvement Projects: Medication Management for People with Asthma, Follow Up After Hospitalization for Mental Illness, Obesity, Well Care	
Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Data analysis is not offered in PIP report proposal for rationale to initiate study. *Corrective Action: Include a summary of the rationale and data analysis that led to initiation of this PIP.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include narrative summary of the rationale and data supporting the need of the PIP.	
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	Sampling information not provided in the report. *Corrective Action: Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*

Standard	EQR Comments
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include information on the sampling plan, if applicable.	
Did the plan employ valid sampling techniques that protected against bias?	Information is not documented in the PIP report. *Corrective Action: Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include information on sampling techniques, if applicable.	
Did the study design clearly specify the sources of data?	Data sources are not indicated in proposal. *Corrective Action: Include information on sources of data.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include data source information.	
Did the study design prospectively specify a data analysis plan? **(1)**	Data analysis plan is not documented. *Corrective Action: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include a quarterly and annual data analysis plans, per DOM reporting frequency.	
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	No findings presented. *Corrective Action: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include quarterly and annual numerical results and findings, per DOM reporting frequency.	
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis of baseline is not offered in report and follow-up activities are not documented. *Corrective Action: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include quarterly and annual numerical results and findings, per DOM reporting frequency.	
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions not documented in the report. *Corrective Action: Add the barriers and interventions linked to each barrier to the report.*
Molina's Response: Beginning 2nd Quarter 2021, all CHIP PIP reports will include a quarterly and annual analysis of the baseline, per DOM reporting frequency.	

Table 47: Quality Improvement Comparative Data, provides an overview of each health plan's scores for the Quality Improvement standards.

Table 47: Quality Improvement Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met	Met	**Strength:** ▶ The health plans have QI program descriptions that described the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.
The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities	Met	Met	Met	Met	Met	
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met	
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Met ↑	Met ↑	
Quality Improvement Committee						
The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met	Met	
The QI Committee meets at regular intervals	Met	Met	Met	Met	Met	
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met	Met	
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures"	Met	Met	Met	Met	Met ↑	**Strengths:** ▶ The CCOs were fully compliant with all information systems standards and HEDIS determination standards for the CAN and CHIP HEDIS performance measures. ▶ Based on Aqurate's validation of performance measure rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. **Weaknesses:** ▶ While the CCOs have sufficient systems and processes in place, the rates reported for the Adult and Child Core Set measures indicate that

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						the CCOs need to improve monitoring for gaps in data and monitor for effective utilization of services to improve performance. ▶ All CCOs did not report at least one or more HEDIS and/or Adult and Child Core Set measures that were required for reporting by DOM for MY 2020. ▶ Source code review and/or primary source verification revealed inconsistencies in measure rate reporting for some measures amongst the CCOs. **Recommendations:** ▶ CCOs should pay special attention to supplemental data accuracy as well as opportunities to leverage more supplemental data to calculate HEDIS as well as non-HEDIS rates. ▶ Continue working toward improvement of non-HEDIS measure rates and ensure that all available data sources are explored to calculate non-HEDIS rates. ▶ CCOs should work with DOM to obtain CMS Adult and Child Core set

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						measure interpretation/clarification to ensure accuracy of rate reporting.
Quality Improvement Projects						
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met	Met	Met	Met	**Strengths:** ▶ All plans submitted appropriate documentation for the performance improvement projects. ▶ Topics selected for the performance improvement projects aligned with DOM's quality strategy. **Weakness:** ▶ When year-over-year trending was available, the outcomes of care declined for several performance improvement projects. **Recommendations:** ▶ In efforts to improve outcomes of care, plans should determine if there are additional barriers to improving rates that are relevant for providers and/or members for each PIP. Interventions to address additional barriers identified should be developed and implemented.
The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met	Met	Met	Met ↑	Met ↑	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	= *Quality* = *Timeliness* = *Access to Care*
						When possible, changes in rates should be assessed in association with each intervention individually to determine which interventions are most effective to improve processes of care.
Provider Participation in Quality Improvement Activities						
The CCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met	**Strength:** • United and Magnolia track EPSTD services and monitor claims to identify members with abnormal findings and assist with follow-up as needed.
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met	
The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines	Met	Met	Met	Met	Met	
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Initial visits for newborns CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Initial visits for newborns	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: EPSDT screenings and results CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Well-Baby and Well-Child screenings and results	Met	Met	Met	Met	Met	
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Diagnosis and/or treatment for children CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Diagnosis and/or treatment for children	Met	Met	Met	Partially Met ↑	Partially Met ↑	
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Met	Met	Partially Met	Partially Met	
The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met	Met	

E. Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

United's Utilization Management (UM) Program is integrated within the UnitedHealthcare Clinical Services area, and the Chief Medical Officer (CMO), in collaboration with the Clinical Services Vice President, provides oversight to Clinical Services. Magnolia's UM Program is structured within the Population Health Management and Clinical Operations Department, and the Vice President of Population Health & Clinical Operations is responsible for the daily management of UM activities. Molina's UM Program is structured within the Health Care Services (HCS) Program, and the Associate Vice President of HCS, in consultation with the CMO, has authority and responsibility for HCS Program development and implementation. Each plan ensures that network practitioners can provide input in UM activities, such as appeals, grievances, and UM guidelines and criteria through participation on the Physician Advisory Committee (United), Clinical Policy Committee (Magnolia), and Health Care Services Committee (Molina).

Each plan has a UM Program Description and policies and procedures that define and describe UM activities and provide guidance to staff. For Molina, CCME identified incorrect information and/or omitted information in CAN and CHIP policies related to extensions of urgent prior authorization requests and processes for CHIP Independent External Reviews.

Appropriate staff conduct reviews of service authorization requests using McKesson's InterQual guidelines, MCG (Milliman) guidelines, State criteria, and/or internal clinical coverage policies. Additionally, American Society of Addiction Medicine (ASAM) criteria are used for some behavioral health determinations. Each health plan assesses the consistency of criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers. All reviewers received passing scores. Molina hired a full-time nurse auditor to ensure consistent and appropriate reviewer performance and documentation.

Review of the plans' approval and denial files reflected timely and consistent decision-making using evidenced-based criteria and relevant medical information. Adverse Benefit Determination notices were written in clear language, suitable for layperson understanding, and included instructions for requesting an appeal.

Each plan has developed and implemented a Care Management Program and a Population Health Management Program according to requirements in the *CAN* and *CHIP Contracts*. Care management techniques are used to ensure comprehensive, coordinated care for all members in various risk levels, and follow a standard outreach process as it applies to

continual care, transitional care, and discharge planning. Additionally, the plans incorporate Population Health Management activities into the UM Program to assist with identifying and providing physical and behavioral health services to at-risk members. United updated the Care Management Program and transitioned to a new model of care in November 2021, and the change is reflected in the revised 2021 United Healthcare C&S Care Model Program Description. For Molina, CCME could not identify documentation of processes for addressing continuity of care when a CAN or CHIP member disenrolls from the health plan (such as transferring the member's care management history, six months of claims history, and other pertinent information) according to requirements in the *CAN Contract, Section 9 (A) (4)* and the *CHIP Contract, Section 8 (A) (3)*.

Care Management files indicate care management activities were conducted as required and HIPAA verification, identifying care-gaps, and social determinants of health were consistently addressed. Qualified licensed health professionals, such as nurses and social workers, who are appropriate for the member's health condition, conducted health risk assessments. For United CAN, CCME identified incorrect timeframe documentation for notifying the member's physician of a member's discharge.

As noted in *Table 48*, United CAN and CHIP had deficiencies during the 2020 EQR related to timeliness of UM decisions. United adequately addressed these issues by revising the UM Program Description and Policy UCSMM 06.16 Initial Review Timeframes, to align with contractual requirements. See *Table 48: Previous Utilization management Program CAP Items—United* for the deficiencies identified and United's response to those deficiencies.

Table 48: Previous Utilization Management Program CAP Items—United

Standard	EQR Comments
V A. Utilization Management (UM) Program - CAN	
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	The timeframe for allowing a provider to submit additional information for a service authorization noted in the *CAN Contract, Section 5 (J) (6)* and in Policy UCSMM.06.16, Initial Review Timeframes, page 9, was not included in the 2020 UM Program Description Addendum. The timeframe for notifying a member of the termination, suspension, or reduction of a previously authorized service listed in the *CAN Contract, Section 5 (L) (1)* and on page 14 of the 2020 UM Program Description Addendum was not included in Policy UCSMM.06.16, Initial Review Timeframes. *Corrective Action: Edit the UM Program Description to meet all service authorization timeframe requirements in the CAN Contract, Section 5 (J) (6) and to be consistent with Policy UCSMM.06.16, Initial Review Timeframes. Edit Policy UCSMM.06.16, Initial Review*

Standard	EQR Comments
	Timeframes, to include all timeframe requirements for denial notices, as noted in CAN Contract, Section 5 (L) (1).
United's Response: UHC updated the UM Program Description and the UCSMM 06.16 Initial Review Timeframes Policy to align with the contract. Future updates will have a second staff review of documents for thoroughness and accuracy. Supporting Documentation: •CAN 08_Attachment 1_UHC CAP_UCSMM 06.16 Initial Review Timeframes Policy_Corrected •CAN 08_Attachment 2_UHC CAP_2020 UM PD Addendum_Corrected	
V A. Utilization Management (UM) Program - CHIP	
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	The following service authorization timeframe requirement is found in Policy UCSMM.06.16, Initial Review Timeframes, but is omitted from the 2020 CHIP UM Program Description Addendum: "Contractor will notify the requesting provider of additional medical information needed and Contractor must allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If Contractor does not receive the additional medical information, Contractor shall make a second attempt to notify the requestor of the additional medical information needed and Contractor must allow one (1) business day or three (3) calendar days for the requestor to submit medical information to Contractor." Refer to the *CHIP Contract, Section 5 (I) (4)*. The following timeframe requirement for denial notices is found in the 2020 CHIP UM Program Description Addendum, but is omitted from Policy UCSMM.06.16, Initial Review Timeframes: "For termination, suspension or reduction of previously authorized Medicaid-covered services, within 10 calendar days of the date of the Action for previously authorized services as permitted under 42 C.F.R. § 431, Subpart E." Refer to the *CHIP Contract, Section 5 (K)*. *Corrective Action Plan: Edit the UM Program Description to meet all service authorization timeframe requirements in the CHIP Contract, Section 5 (I) (4), and to be consistent with Policy UCSMM.06.16, Initial Review Timeframes. Edit Policy UCSMM.06.16, Initial Review Timeframes, to include all timeframe requirements for denial notices, as noted in the CHIP Contract, Section 5 (K).*
United's Response: **1/19/2021 - INITIAL RESPONSE:** UHC updated the UM Program Description and the UCSMM 06.16 Initial Review Timeframes Policy to align with the contract. Future updates will have a second staff review of documents for thoroughness and accuracy. Supporting Documentation: •CHIP 19_Attachment 1_UHC CAP_UCSMM 06.16 Initial Review Timeframes Policy_Corrected •CHIP 19_Attachment 2_UHC CAP_2020 UM PD Addendum_Corrected **2/8/2021 - REVISED RESPONSE:** UHC identified updates to the 2020 UM Program Description with yellow highlighting (see page 17). Supporting Documentation: •CHIP 19_Attachment 1_UHC CAP_2020 UM PD Addendum_2.8.2021	

Appeals

42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260

The plans have established policies that are consistent with contractual requirements and Federal Regulations for handling both CAN and CHIP appeals of adverse benefit determinations. Definitions of the terms "adverse benefit determination" and "appeal" and information about who may file an appeal are correctly documented. Procedures for filing appeals are clearly and consistently documented in policies, Member Handbooks, Provider Manuals, and on websites. Every plan ensures members can receive appeal information and assistance in languages other than English by contacting Member Services.

The plans acknowledged awareness of the 2021 updates to the appeal process, according to *CFR 438.402 (c)(3),* which no longer requires a member's verbal appeal to be followed by a signed written appeal and will ensure appeal documents are updated upon approval from DOM.

Review of appeal files reflected timely appeal acknowledgements, resolutions, and notifications of determinations. Appeal notices are written clearly and provide instructions for CAN members to request a State Fair Hearing and CHIP members to request an Independent External Review.

Issues related to appeal processes and documentation in policies, programs descriptions, case files, and on websites included:

- Appeal instructions posted on the member website are not available in Spanish as are other materials, such as the Member Handbook and member rights and responsibilities (United).
- Appeals notices lacked information that members have the right to request and receive benefits while the Independent External Review is pending, and that the member can be held liable for the cost (United).
- The process for requesting an Independent External Review is omitted from a CHIP policy (Molina).

As noted in *Table 49*, during the 2020 EQR for United, deficiencies were noted related to information for the appeal process not provided in the unsecured area of the CAN and CHIP websites and the CAN appeal resolution notice template instructing members they could request an independent external review instead of a State Fair Hearing. United revised the websites and the documents to address these deficiencies.

Table 49: Previous Appeals CAP Items—United

Standard	EQR Comments
V C. Appeals – CAN	
The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;	The procedure for filing an appeal is correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CAN Member Handbook, and CAN Care Provider Manual. However, CCME did not identify information for the appeal process or procedure on the CAN website. During the onsite teleconference, United staff confirmed that appeals information is located on the Member Portal, not on the public website. However, the *CAN Contract, Section 6 (H)* requires the plan to provide specific, up-to-date appeals information on a non-secure section of the website. *Corrective Action Plan: Include information on appeal processes and procedures on the non-secured section of the CAN website, as required by the CAN Contract, Section 6 (H).*
United's Response: UHC created a new link on the non-secure section of the website. UHC will review the non-secure section of the A&G website on a biannual basis, to ensure appeal processes and procedures align with the contract. https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN-Appeals_Grievance.pdf Supporting Documentation: CAN 09_Attachment 1_UHC CAP_Web A&G	
1.6 Written notice of the appeal resolution as required by the contract;	The CAN appeal resolution notice template, MS Member Admin or Clinical Uphold, instructs members to file an independent external review instead of a State Fair Hearing as required by the *CAN Contract, Exhibit D*. During the onsite teleconference, United staff reported the template was previously corrected and forwarded the correct version to CCME. Upon review of the resubmitted template CCME identified the language remains uncorrected. *Corrective Action Plan: Correct the appeal resolution notice template, MS Member Admin or Clinical Uphold, to reflect members can request a State fair Hearing instead of an independent external review.*
United's Response: UHC's Clinical Uphold template was updated to reflect members can request a State Fair Hearing. Supporting Documentation: •CAN 10_Attachment 1_UHC CAP_MS Member Clinical Uphold	
V C. Appeals – CHIP	
The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	The procedure for filing an appeal is correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CHIP Member Handbook, and CHIP Care Provider Manual. However, CCME did not identify information for appeals processes and procedures on the CHIP website. During the onsite teleconference, United staff confirmed that appeals information is located on the Member Portal, not on the public website. However,

Standard	EQR Comments
1.2 The procedure for filing an appeal;	the *CHIP Contract, Section 6 (H)* requires the plan to provide specific, up-to-date appeals information on a non-secure section of the website. *Corrective Action Plan: Include information on appeals processes and procedures on the non-secured section of the CHIP website, as required in the CHIP Contract, Section 6 (H).*
United's Response: UHC created a new link on the non-secure section of the website. UHC will review the non-secure section of the A&G website on a biannual basis, to ensure appeal processes and procedures align with the contract. Supporting Documentation: •https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN-Appeals_Grievance.pdf •CHIP 20_Attachment 1_UHC CAP_Web A&G	

As noted in *Table 50*, during the 2020 EQR period, Magnolia had deficiencies in standards related to registering and responding to member appeals. Deficiencies identified included issues with outdated terms for "adverse benefit determination" in the UM Program Description and not clearly describing who can be an authorized representative in the Provider Manual. Magnolia has revised the documents to address these deficiencies.

Table 50: Previous Appeals CAP Items—Magnolia

Standard	EQR Comments
V C. Appeals	
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	The terms "appeal" and "adverse benefit determination," as well as who can file an appeal, are defined in Policy MS.UM.08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, and the Provider Manual. The following documentation issues were identified: •The UM Program Description has outdated terms such as "adverse medical necessity decision" and "adverse determination" instead of the correct term of "adverse benefit determination." •The Member Handbook (page 71) provides examples of people who can file an appeal, but it does not specify these are people who can be the member's authorized representative. •The Provider Manual states that the member's authorized representative can file an appeal, but it does not describe who can be an authorized representative. *Corrective Action: Edit the Utilization Management Program Description to replace outdated terms for "adverse benefit determination." Refer to the CAN Contract, Section 2 (A). Edit the*

Standard	EQR Comments
	Member Handbook and Provider Manual to clarify and describe who can act as a member's authorized representative.
Magnolia's response: Updated member handbook on page 73 of the uploaded word document. Also updated the form to read Authorized User Form. Updated UM Program description submitted. Updated Provider Manual submitted. Page 58 – Updated grievance section to include the name of the responsible party form (authorized representative form). Page 59 – Added authorized representative description.	

As noted in *Table 51*, during the 2020 EQR period Molina had deficiencies in CAN and CHIP standards related to procedures for filing appeals. Issues identified included incorrect or omitted instructions on the CAN and CHIP websites, and in the CHIP Member Handbook and Provider Manual. Molina has revised the websites and documents to address these deficiencies.

Table 51: Previous Appeals CAP Items—Molina

Standard	EQR Comments
V C. Appeals (CAN)	
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;	Appeals procedures and instructions are documented in Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, the Provider Manual, and on the website. CCME identified the following documentation issues on the website: •The address provided to submit written appeals includes has a P.O. Box in North Charleston, SC instead of Capitol St. in Jackson, MS. •The website incorrectly states appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the notice of Adverse Benefit Determination. •The website does not indicate that an authorized representative can file on the member's behalf. •The website does not address that members can present evidence or examine their case file at any time during the appeals process. *Corrective Action: Edit the CAN website to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal to meet requirements of the CAN Contract, Section (K).*
We have updated our website to include the correct address to file an appeal. How to Appeal a Denial | Medicaid | Molina Healthcare of Mississippi We have updated our website to read "All appeals must be filed within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (denial letter)." This language is consistent with the Provider Manual and Member Handbook. We have updated our website to read "We can accept your appeal from someone else with your permission. For Example:	

<table>
<tr><th>Standard</th><th>EQR Comments</th></tr>
<tr><td colspan="2">• A friend
• A family member
• A provider part of Molina
• A provider that is not part of Molina
• A lawyer”
This language is consistent with our provider manual and member handbook.
We have updated our website to read “You have the opportunity to present Molina with evidence of the facts or law about your case, in person or in writing.” And “You, or someone legally authorized to do so, can ask us for a complete copy of your case file at any time, including medical records (subject to Health Insurance Portability and Accountability Act (HIPAA) requirements), a copy of the guidelines (criteria), benefits, other documents and records, and any other information related to your appeal. These can be provided free of charge.”
Instructions and procedures for filing an appeal to meet requirements of the CAN Contract, Section (K) have been added to the website.</td></tr>
<tr><td colspan="2">V C. Appeals (CHIP)</td></tr>
<tr><td>1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:

1.2 The procedure for filing an appeal</td><td>Appeals procedures and instructions are documented in Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, Provider Manual, and on the website. CCME identified the following documentation issues on the website:
•The website incorrectly states that appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the notice of Adverse Benefit Determination letter.
•The website does not address or describe that someone else, an authorized representative, can file on the member’s behalf.
•The website does not address that members can present evidence or examine their case file at any time during the appeals process.
Additionally, the CHIP Member Handbook, Provider Manual, and website do not specify that a written appeal request must follow a verbal appeal request within 30 days after the call, unless expedited, as required by the CHIP Contract, Section 6 (K).
Corrective Action: Edit the CHIP website to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal. Revise the CHIP Member Handbook, Provider Manual, and website to indicate written appeal request must follow a verbal appeal request within 30 days after the call, unless expedited to meet requirements in the CHIP Contract, Section (K).</td></tr>
</table>

Standard	EQR Comments
We have updated our website to include the correct address to file an appeal. How to Appeal a Denial | CHIP | Molina Healthcare of Mississippi We have updated our website to read "All appeals must be filed within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (denial letter)." This language is consistent with the Provider Manual and Member Handbook. We have updated our website to read "We can accept your appeal from someone else with your permission. For Example: • A friend • A family member • A provider part of Molina • A provider that is not part of Molina • A lawyer" This language is consistent with our provider manual and member handbook. We have updated our Provider Manual, Member Handbook, and Website to read "If you call to file your appeal, you must send Molina a signed, written appeal request within 30 calendar days after you first called us, unless you ask for an expedited (fast) plan appeal."	

Even though isolated instances of staff not following UM guidelines were noted, CCME did not identify trends or patterns of noncompliance. Overall, no major issues were identified with review of the UM Program, and UM services are provided according to established processes and DOM requirements.

An overview of all scores for the Utilization Management section is illustrated in *Table 52: Utilization Management Services Comparative Data*.

Table 52: Utilization Management Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Utilization Management (UM) Program						
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Met	Met	Met	Met	Met	**Strength:** ▶ Each plan ensures that network practitioners can provide input in UM activities, such as appeals, grievances, and UM guidelines and criteria through committee participation.
Structure of the program	Met	Met	Met	Met	Met	
Lines of responsibility and accountability	Met	Met	Met	Met	Met	
Guidelines/standards to be used in making utilization management decisions	Met	Met	Met	Met	Met	
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met ↑	Met ↑	Met	Partially Met ↓	Partially Met ↓	
Consideration of new technology	Met	Met	Met	Met	Met	
The appeal process, including a mechanism for expedited appeal	Met	Met	Met	Met	Met	
The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met	
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met	
Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
Services that require prior authorization by the CCO include only the services specified by the Mississippi Division of Medicaid.	Met	Met	Met	Met	Met	**Strengths:** ▶ Service Authorization requests are completed within timeframe requirements according to policy guidelines and CAN and CHIP contract requirements. ▶ The CCOs assess the consistency of criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers. ▶ Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used. **Weakness:** ▶ Policies have incorrect or omitted information related to extensions of urgent prior authorization requests and requirements for
Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met	
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met	
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met	
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met	Met	
The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	= *Quality* = *Timeliness* = *Access to Care*
The CCO has established policies and procedures for prior authorization of medications	Met	Met	Met	Met	Met	requesting approval for extensions from DOM. **Recommendation:** • Ensure policies include complete and correct information regarding extensions for urgent prior authorization requests and requirements to request approval of extensions from DOM. Refer to the *CAN Contract, Section 5 (J) (6)* and *CHIP Contract, Section 5 (I)(4)*.
Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Met	
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met	
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met	
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met	
A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met	
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met	
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including	Met	Met	Met	Met	Met	**Strength:** ▶ Appeal files submitted for review were well organized and included pertinent information. **Weaknesses:** ▶ United and Molina demonstrated areas of weakness in documentation of appeal processes and requirements in policies, websites, etc. ▶ Documentation in CAN and CHIP appeal files reflected United did not consistently follow the United appeal policy requirement that the appeal timeframe starts the day United receives the verbal or written request. **Recommendations:** • Ensure documentation of appeal processes and requirements is complete and correct in policies, on websites, etc.
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met ↑	Met	Met	
The procedure for filing an appeal	Met ↑	Met ↑	Met	Met ↑	Met ↑	
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met	
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met	
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Written notice of the appeal resolution as required by the contract	Met ↑	Partially Met ↓	Met	Met	Partially Met ↓	• Ensure staff are following guidelines for appeal start times documented in policies.
Other requirements as specified in the contract	Met	Met	Met	Met	Met	
The CCO applies the appeal policies and procedures as formulated	Partially Met ↓	Partially Met ↓	Met	Met	Met	
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met	
Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met	Met	Met	
Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
The CCO has developed and implemented a Care Management and a Population Health Program	Met	Met	Met	Met	Met	**Strength:** ▶ Magnolia is conducting a COVID-19 project that includes outreach and education to all plan members. **Weakness:** ▶ Plan documentation was noted with incorrect or missing information related to case
The CCO uses varying sources to identify members who may benefit from Care Management	Met	Met	Met	Met	Met	
A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met	Met	Met	Met	management continuity of care and transitional care processes. **Recommendations:** • Edit policies to include care management processes for: addressing continuity of care when a member disenrolls from a health plan according to requirements in the *CAN Contract, Section 9 (A) (4)* and *CHIP Contract, Section 8 (A) (3)*. • Ensure policies address transitional care management requirements for notifying providers within 14 days of a member's discharge. Refer to the *CAN Contract, Section (9) (B)(1.d)*.
Evaluation of co-morbidities or multiple complex health care conditions	Met	Met	Met	Met	Met	
Demographic information	Met	Met	Met	Met	Met	
Member's current treatment provider and treatment plan, if available	Met	Met	Met	Met	Met	
The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment	Met	Met	Met	Met	Met	
The risk level assignment is periodically updated as the member's health status or needs change	Met	Met	Met	Met	Met	
The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met	Met	
The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met	Met	Met	Met	
The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	Met	Met	Met	Partially Met ↓	Partially Met ↓	
CAN: The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants. CHIP: The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants	Met	Met	Met	Met	Met	
Transitional Care Management						
The CCO monitors continuity and coordination of care between PCPs and other service providers	Met	Met	Met	Met	Met	

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Met	Met	Met	Met	Met	
The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process	Met	Met	Met	Met	Met	
The CCO meets other Transition of Care contract requirements	Met	Met	Met	Met	Met	
Annual Evaluation of the Utilization Management Program						
A written summary and assessment of the effectiveness of the UM program is prepared annually	Met	Met	Met	Met	Met	
The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met	Met	

F. Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

United has delegation agreements with the entities identified in *Table 53: United Delegated Entities and Services*.

Table 53: United Delegated Entities and Services

United Delegated Entities	United Delegated Services
•OptumHealth (United Behavioral Health	Behavioral health case management, utilization management, quality management, network contract management, and claims processing
•Dental Benefit Providers	Dental network services and 3rd party dental administrator
•Medical Transportation Management	Non-Emergency Transportation (NET) benefit services broker, provider network, claims processing, quality management, and call center operations
•eviCore National	Radiology and cardiology management services and prior authorizations
•MARCH Vision Care	Vision and eye care benefit administration services, network contract management, call center operations, and claims processing
•Optum RX	Pharmacy benefit administration services
•Hattiesburg Clinic •River Region Health System •HubHealth •University Physicians, PLLC •HCA Physician Services •Health Choice, LLC •North Mississippi Medical Center •Ochsner •Premier Health •Memorial Hospital at Gulfport	Credentialing and recredentialing

Magnolia has delegation agreements with the entities identified in *Table 54: Magnolia Delegated Entities and Services*.

Table 54: Magnolia Delegated Entities and Services

Magnolia Delegated Entities	Magnolia Delegated Services
•Envolve Dental	Dental claims, network, utilization management, credentialing, and quality management
•Envolve Vision	Vision services claims, network, utilization management, credentialing, and quality management
•Envolve Pharmacy Solutions	Pharmacy claims, network, utilization management, credentialing
•Envolve PeopleCare - NurseAdvice Line	24/7 Nurse call center
•Medical Transportation Management, Inc. (MTM)	Non-emergency transportation claims, network, utilization management, credentialing, and quality management
•National Imaging Associates, Inc. (NIA)	Radiology utilization management
•Baptist Memorial Health Care-Baptist Health Services Group •Hattiesburg Clinic, PA •LSU Healthcare Network (New Orleans) •Magnolia Regional Health Center •Management and Network Services, LLC •Memorial Hospital at Gulfport •Mississippi Health Partners •Mississippi Physicians Care Network •North Mississippi Medical Clinic/North MS Healthlink •Ochsner Clinic Foundation •Premier Health, Inc. •Rush Health Systems •St. Jude Children’s Research Hospital •University of Mississippi Medical Center	Credentialing and recredentialing

Molina has delegation agreements with the following entities:

Table 55: Delegated Entities and Services

Molina Delegated Entities	Molina Delegated Services
•SKYGEN	Dental benefit administration
•CareMark	Pharmacy benefit administration

Molina Delegated Entities	Molina Delegated Services
•March Vision	Vision network, claims administration, and call center services
•MTM	Non-emergent medical transportation and customer service
•Baptist Memorial Medical Group (BMMG) •George Regional Health System (GRHS) •Hattiesburg Clinic, PA (HBC) •Memorial Hospital at Gulfport (MGP) •Mississippi Physicians Care Network (MPCN) •Magnolia Regional Health Center (MRHC) •North Mississippi Health Services (NMHS) •Oschner Health System (OCH) •Premier Health (SRMC) •University of Mississippi Medical Center (UMMC)	Credentialing and recredentialing

Each of the CCO's has policies and procedures that document processes for delegation of services and activities, including general delegation requirements, performance monitoring, annual oversight, and corrective action and/or termination of delegation agreements.

Pre-delegation assessments are conducted ensure potential delegates can perform the activities to be delegated in compliance with standards and applicable contractual and regulatory requirements. Upon approval of the delegation, delegation agreements are executed to specify the activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.

CCME reviewed documentation of pre-delegation assessments and annual oversight conducted by the health plans for the delegated entities.

For United and Magnolia, no issues were identified from review of delegate oversight documentation.

Molina's Credentialing Delegation Requirements policy (DO005) did not address site visits for providers credentialed by delegated credentialing entities and collection of fingerprints for CHIP providers designated as high risk by DOM. File review worksheets for

credentialing delegates did not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for CHIP providers designated as high-risk by DOM.

Based on the findings of the 2021 EQR, it was evident that Molina did not address or correct the findings from the 2020 EQR. See *Table 56: Previous Delegation CAP Items—Molina* for the findings of the previous EQR and Molina's responses to those findings.

Table 56: Previous Delegation CAP Items—Molina

Standard	EQR Comments
VI. Delegation (CAN)	
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	The site assessments and reassessments specified in the *CAN Contract, Section 7 (E)* were not included in the monitoring tools. *Corrective Acton: Update the credentialing and recredentialing monitoring tools to include the site assessments and reassessments as specified in the CAN Contract, Section 7 (E).*
Molina's Response: Molina's intention is to sub-delegate site visit responsibilities to our existing Credentialing delegates who demonstrate ability to perform the function. (See draft of updated Delegation Agreement should we decide to move forward with using our delegates for this process.) In the event the Credentialing delegate is unwilling or unable to take on site visit responsibilities, Molina Healthcare will be responsible for completion of the visit.	
VI. Delegation (CHIP)	
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	The site assessments and reassessments specified in the *CHIP Contract, Section 7 (E)* and the fingerprinting requirements for high-risk providers, as required by the *CHIP Contract, Section 7 (E) (6),* were not included on the monitoring tools. *Corrective Action: Update the credentialing and recredentialing monitoring tools to include the site assessments, reassessments, and the fingerprinting requirements noted in the CHIP Contract Section 7 (E).*
Molina's Response: Molina's intention is to sub-delegate site visit responsibilities to our existing Credentialing delegates who demonstrate ability to perform the function. (See draft of updated Delegation Agreement should we decide to move forward with using our delegates for this process.) In the event the Credentialing delegate is unwilling or unable to take on site visit responsibilities, Molina Healthcare will be responsible for completion of the visit.	

Table 57, Delegation Services Comparative Data illustrates the scoring for each standard reviewed during the 2021 EQR as well as strengths, weaknesses, and recommendations.

Table 57: Delegation Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	Met	Met	Met	Met	Met	**Strength:** ▶ Pre-delegation assessments are conducted, and appropriate written delegation agreements are in place for all delegated entities. **Weaknesses:** ▶ Monitoring tools do not include all required elements or incorrectly indicate elements are not applicable. ▶ Monitoring documentation does not indicate all delegated activities are included in the monitoring and oversight conducted. **Recommendations:** • The plans should ensure delegation monitoring tools include all required elements and accurately reflect contractual requirements. • The plans should ensure monitoring is conducted for all activities delegated to each entity.
The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	Met	Met	Met	Not Met ↓	Not Met ↓	

G. Provider Access Study and Provider Directory Validation

CCME conducted biannual validations of network access/availability and provider directory accuracy for each of the CCOs. The objectives were to determine if provider contact information was accurate and to assess appointment availability. The methodology involved two phases:

Phase 1: CCME conducted a telephonic survey to determine if CCO-provided PCP contact information was accurate with regard to telephone, address, accepting the CCO, and accepting new Medicaid patients. Appointment availability for urgent and routine care was also evaluated.

Phase 2: CCME verified the accuracy of provider directory-listed address, phone, and panel status against PCP contact information confirmed during the telephonic access-study. An overall accuracy rate was determined.

The following is a summary of the most recent validation results.

United CAN Summary. Phase 1 results found that 63 of 87 providers (72%) confirmed the file contained the correct address and phone number. Of those 63, 48 (76%) confirmed they accepted UnitedHealthcare CAN. Of those 48, 27 (56%) indicated they were accepting new patients. Access and availability for routine appointments was 73% and availability for urgent appointments was 69%.

The 48 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for the 48 providers evaluated, 79% (n=38) had accurate information for all three components evaluated: address, phone number, and panel status information.

Discrepancies in the directory were most common for telephone and status for accepting new patients—21% reported a different phone number during the access study call from the phone number provided in the directory and 21% reported a different panel status. When compared to the access study results, 19% reported a different address in the provider directory.

United CHIP Summary. Phase 1 results found that 57 of 93 providers (61%) confirmed the file contained the correct address and phone number. Of those 57, 24 (51%) confirmed they accept United CHIP. Of those 24, 16 (67%) indicated they were accepting new patients. Access and availability for routine appointments was 70% and availability for urgent appointments was 58%.

The 24 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found 67% (n=16) of the 24 providers that

were evaluated for provider directory validation had accurate information for all three components evaluated including address, phone number, and panel status information. There were providers with specific elements listed accurately, but with inaccuracies in other elements.

Discrepancies in the directory were most common in status for accepting new patients—33% reported a different panel status. When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

Magnolia CAN Summary. Phase 1 results found that 47 of 78 providers (60%) confirmed the file contained the correct address and phone number. Of those 47, 40 (85%) confirmed they accepted Magnolia Health Plan. Of those 40, 35 (88%) indicated they were accepting new patients. Access and availability for routine appointments was 82% and availability for urgent appointments was 76%.

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

Molina CAN Summary. Phase 1 results found that 21 of 89 providers (24%) confirmed the file contained the correct address and phone number. Of those 21, 14 (83%) confirmed they accepted Molina CAN. Of those 14, 12 (86%) indicated they were accepting new patients. The 14 providers considered a successful contact were evaluated for provider directory validation in Phase 2. Access and availability for routine appointments was 75% and availability for urgent appointments was 67%.

The 14 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for the 14 providers, 71% (n=10) had accurate information for all three components evaluated: address, phone number, and panel status information. There were providers with some specific elements listed accurately and with inaccuracies in other elements.

Discrepancies in the directory were most common for telephone, location, and status for accepting new patients (29% reported a different phone number during the access study call compared to the phone number provided in the directory and 29% reported a different panel status). When compared to the access study results, 29% (4 out of 14) reported a different address in the provider directory.

Molina CHIP Summary. Phase 1 results found that 55 of 83 providers (66%) confirmed the file contained the correct address and phone number. Of those 55, 40 (72%) confirmed

they accept Molina CHIP. Of those 40, 34 (85%) indicated they were accepting new patients. Access and availability for routine appointments was 68% and availability for urgent appointments was 33%.

The 40 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found 93% (n=37) of the 40 providers that were evaluated for provider directory validation had accurate information for all three components evaluated including address, phone number, and panel status information. There were providers with specific elements listed accurately, but with inaccuracies in other elements.

Discrepancies in the directory were most common in status for accepting new patients (33% reported a different panel status). When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

H. Behavioral Health Member Satisfaction Survey

CCME contracted with DataStat, Inc. an NCQA Certified CAHPS Survey Vendor to conduct an Experience of Care and Behavioral Health Outcomes (ECHO) Survey, developed by the Agency for Healthcare Research and Quality (AHRQ), to learn about the experiences of adult and child members who have received counseling or treatment from a provider. The survey addresses key topics such as access to counseling and treatment, provider communication, plan information, and overall rating of counseling and treatment received. For MississippiCAN, attempts were made to survey 3,549 enrollee households, and for Mississippi CHIP, attempts were made to survey 2,366 enrollee households. The surveys for both MississippiCAN and Mississippi CHIP were conducted by mail during the period from October 26, 2021, through February 16, 2022, using a standardized survey procedure and questionnaire.

Summary of Overall Rating Question—MississippiCAN

Response options for the counseling or treatment rating question range from 0 (worst) to 10 (best). In the table below, ratings of 8, 9, or 10 are considered achievements, and the achievement score is presented as a proportion of enrollees whose response was an achievement.

The MississippiCAN overall rating is presented along with each plan's rating in Figure 2: Overall Rating Question—MississippiCAN. Statistical testing is performed between the MississippiCAN overall score and each plan score. A significantly higher or lower score is indicated by an arrow above the bar.

Figure 2: Overall Rating Question—MississippiCAN

Overall Rating Question

	Q28. Rating of counseling or treatment
MSCAN Overall	70.8%
Molina Healthcare	50.0%
UnitedHealthcare	74.7%
Magnolia Health	69.6%

↓↑Statistically significantly higher/lower than MSCAN Overall

Summary of Composites—MississippiCAN

For each of five domains of member experience, Getting Treatment Quickly, How Well Clinicians Communicate, Getting Treatment and Information from the Plan, Perceived Improvement, and Information about Treatment Options, a composite score is calculated. The composite scores are intended to give a summary assessment of how MississippiCAN performed across the domain.

MississippiCAN overall composite scores are presented along with the composite scores for each plan. Statistical testing is performed between the MississippiCAN overall score and each plan score. A significantly higher or lower score is indicated by an arrow above the bar.

In *Table 58* below, proportions of positive responses are reported as achievement scores. For the Getting Treatment Quickly and How Well Clinicians Communicate composites, responses of "Usually" or "Always" are considered achievements. For the Getting Treatment and Information from the Plan composite, responses of "Not a problem" are considered achievements. For the Perceived Improvement composite, responses of "Much better" or "A little better" are considered achievements. Responses of "Yes" are considered achievements for the Information about Treatment Options.

Figure 3: Composites—MississippiCAN

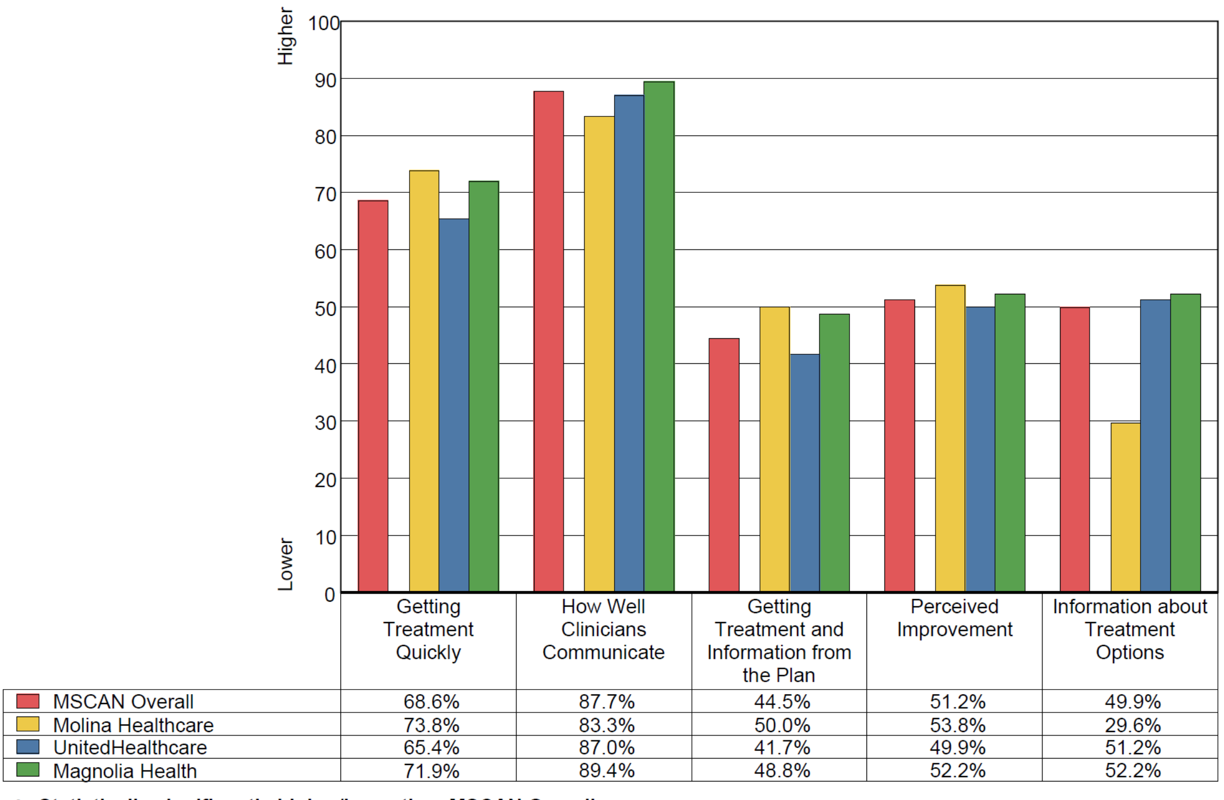

Table 58: Sample Disposition—MississippiCAN Adult Medicaid

	MSCAN Overall	Molina	United	Magnolia
First mailing - sent	3549	1183	1183	1183
First mailing - usable and eligible survey returned	246	20	127	99
Second mailing - sent	3092	1104	980	1008
Second mailing - usable and eligible survey returned	113	7	50	56
Third mailing - sent	2700	1015	832	853
Third mailing - usable and eligible survey returned	76	12	35	29
Total - usable and eligible surveys	435	39	212	184
Ineligible: According to population criteria[1]	152	69	43	40
Ineligible: Language barrier	0	0	0	0

	MSCAN Overall	Molina	United	Magnolia
Ineligible: Deceased	3	1	1	1
Ineligible: Mentally or physically unable to complete survey	2	1	1	0
Bad / no address[2]	526	103	157	166
Refusal	2	0	1	1
Nonresponse[3]	2529	970	768	791
Response Rate	**12.8%**	**3.5%**	**18.6%**	**16.1%**

[1]Population criteria: The designated respondent must be enrolled in the health plan and meet the age requirements of the survey methodology.
[2]No valid contact information provided in sample.
[3]Unavailable by mail; includes bad / no contact information

Note: *Response Rate = Total Usable and Eligible Surveys / Total Cases - Total Ineligible Cases*

Key Strengths and Opportunities for Improvement—MississippiCAN

The following tables display the ten questions most highly correlated with MississippiCAN member satisfaction with counseling and treatment (Q28), their corresponding achievement scores, and correlations. Achievement scores are considered "high" when the score is 85% or higher. Among the ten items, the five questions with the highest achievement scores are presented first as Key Strengths. These are areas that appear to matter the most to members, and where the health plan is doing well. The five questions with the lowest achievement scores are presented second, as Opportunities for Improvement. These are areas that appear to matter the most to members, but where the health plan is not doing as well and could focus quality improvement efforts.

Table 59: Key Strengths—MSCAN Adult Medicaid

Question	MississippiCAN Achievement Score	Correlation w/ satisfaction
Q13. Clinicians usually or always showed respect	90.8	0.57
Q11. Clinicians usually or always listened carefully	89.7	0.48
Q15. Usually or always felt safe with clinicians	89.3	0.66
Q12. Clinicians usually or always explained things	88.4	0.48
Q14. Clinicians usually or always spent enough time	84.8	0.67

Table 60: Opportunities for Improvement—MSCAN Adult Medicaid

Question	MississippiCAN Achievement Score	Correlation w/ satisfaction
Q5. Usually or always got urgent treatment as soon as needed	71.8	0.46
Q27. Care responsive to cultural needs	79.3	0.46
Q29. A lot or somewhat helped by treatment	79.7	0.71
Q22. Given as much information as wanted to manage condition	81.3	0.45
Q18. Usually or always involved as much as you wanted in treatment	83.3	0.59

Summary of Overall Rating Question—Mississippi CHIP

Response options for the counseling or treatment rating question range from 0 (worst) to 10 (best). In the table below, ratings of 8, 9, or 10 are considered achievements, and the achievement score is presented as a proportion of enrollees whose response was an achievement.

The Mississippi CHIP overall rating is presented along with each plan's rating. Statistical testing is performed between the Mississippi CHIP overall score and each plan score. A significantly higher or lower score is indicated by an arrow above the bar.

Figure 4: Overall Rating Question—Mississippi CHIP

Overall Rating Question

	Q29. Rating of counseling or treatment
MSCHIP Overall	73.5%
Molina Healthcare	71.0%
UnitedHealthcare	74.2%

↑↓ **Statistically significantly higher/lower than MSCHIP Overall**

Summary of Composites—Mississippi CHIP

For each of four domains of member experience, Getting Treatment Quickly, How Well Clinicians Communicate, Getting Treatment and Information from the Plan, and Perceived Improvement, a composite score is calculated. The composite scores are intended to give a summary assessment of how Mississippi CHIP performed across the domain.

Mississippi CHIP overall composite scores are presented along with the composite scores for each plan. Statistical testing is performed between the Mississippi CHIP overall score and each plan score. A significantly higher or lower score is indicated by an arrow above the bar.

In *Table 61* below, proportions of positive responses are reported as achievement scores. For the Getting Treatment Quickly and How Well Clinicians Communicate composites, responses of "Usually" or "Always" are considered achievements. For the Getting Treatment and Information from the Plan composite, responses of "Not a problem" are considered achievements. For the Perceived Improvement composite, responses of "Much better" or "A little better" are considered achievements.

Figure 5: Composites—Mississippi CHIP

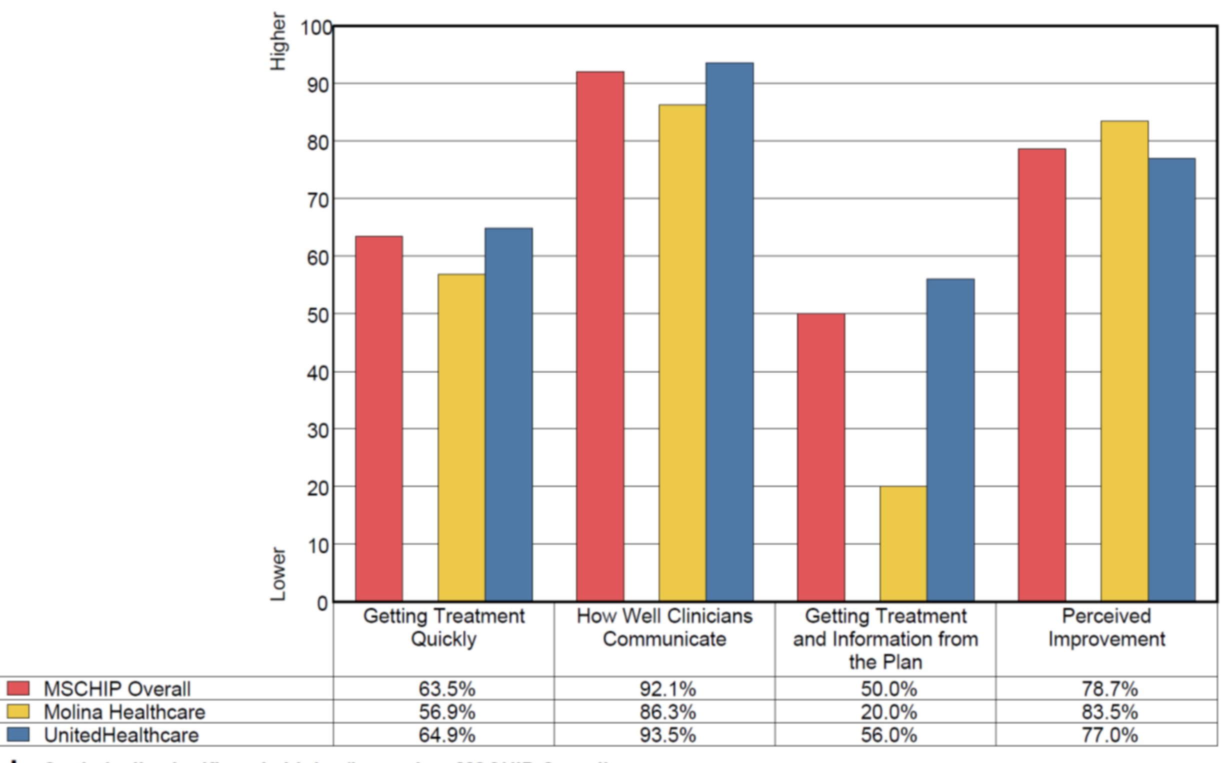

Table 61: Sample Disposition—Mississippi CHIP

	MSCHIP Overall	Molina	United
First mailing - sent	2366	1183	1183
First mailing - usable and eligible survey returned	109	25	84
Second mailing - sent	2172	1102	1070
Second mailing - usable and eligible survey returned	56	16	40
Third mailing - sent	1971	1000	971
Third mailing - usable and eligible survey returned	35	9	26
Total - usable and eligible surveys	200	50	150
Ineligible: According to population criteria[1]	141	113	28
Ineligible: Language barrier	0	0	0
Ineligible: Deceased	0	0	0

	MSCHIP Overall	Molina	United
Bad / no address[2]	136	58	78
Refusal	1	0	1
Nonresponse[3]	1888	962	926
Response Rate	**9.0%**	**4.7%**	**13.0%**

[1]Population criteria: The designated respondent must be enrolled in the health plan and meet the age requirements of the survey methodology.
[2]No valid contact information provided in sample.
[3]Unavailable by mail; includes bad / no contact information

Note: Response Rate = Total Usable and Eligible Surveys / Total Cases - Total Ineligible Cases

Key Strengths and Opportunities for Improvement—Mississippi CHIP

The following tables display the ten questions most highly correlated with Mississippi CHIP member satisfaction with counseling and treatment (Q29), their corresponding achievement scores, and correlations. Achievement scores are considered "high" when the score is 85% or higher.

Among the ten items, the five questions with the highest achievement scores are presented first as Key Strengths. These are areas that appear to matter the most to members, and where the health plan is doing well. The five questions with the lowest achievement scores are presented second, as Opportunities for Improvement. These are areas that appear to matter the most to members, but where the health plan is not doing as well and could focus quality improvement efforts.

Table 62: Key Strengths—Mississippi CHIP

Question	Mississippi CHIP Achievement Score	Correlation with Satisfaction
Q14. Clinicians usually or always showed respect	95.5	0.48
Q13. Clinicians usually or always explained things	94.2	0.42
Q12. Clinicians usually or always listened carefully	92.3	0.44
Q15. Clinicians usually or always spent enough time	91.0	0.48
Q20. Usually or always got professional help wanted for child	87.7	0.66

Table 63: Opportunities for Improvement—Mississippi CHIP

Question	Mississippi CHIP Achievement Score	Correlation with Satisfaction
Q38. Told about other ways to get treatment after benefits were used up	11.1	0.56
Q3. Usually or always got help by telephone	47.4	0.44
Q42. Getting help from customer service was not a problem	63.6	0.64
Q23. Given as much information as wanted to manage condition	76.5	0.46
Q30. A lot or somewhat helped by treatment	78.5	0.56

FINDINGS SUMMARY

For the 2021-2022 EQRs, overall areas of concern included:

- Credentialing policies and processes.
- Missing information about appointment access standards and medical record retention in Provider Manuals, and Provider Directories that did not include all required elements.
- Grievance resolutions letters that did not contain language at appropriate reading level.
- For Performance Measures, rates reported for the Adult and Child Core Set measures indicate that the CCOs need to improve monitoring for gaps in data and monitor for effective utilization of services to improve performance. All CCOs did not report at least one or more HEDIS and/or Adult and Child Core Set measures for which DOM required reporting for MY 2020.Source code review and/or primary source verification revealed inconsistencies in measure rate reporting for some measures amongst the CCOs.
- For Performance Improvement Projects, when year-over-year trending was available, the outcomes of care declined for several performance improvement projects.
- Molina’s policies did not provide complete information about processes for conducting medical record review audits, omitted or included incorrect information related to extensions of urgent prior authorization requests and requesting approval for extensions from DOM, and did not include complete information about transitional care management requirements.

- For Molina, delegation oversight monitoring tools did not include all required elements or incorrectly indicated elements were not applicable. Also, monitoring documentation does not indicate all delegated activities are included in the monitoring and oversight conducted.
- United and Molina had issues with documentation of appeal processes and requirements.

Regarding compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*, the most improvement was shown in the 2021 EQRs by Molina (CAN) in four areas and by Molina CHIP in three areas. United (CAN) and Magnolia (CAN) improved in two areas. United (CHIP) showed improvement in only one area. United (CHIP) had the highest number of areas showing decline from the previous EQR in two areas, followed by United (CAN) and Molina (CAN and CHIP) in one area each. Magnolia had no areas with a decline in score.

Table 64: Annual Review Comparisons reflects the total percentage of standards scored as “Met” for the 2019 through 2021 EQRs. For the most recent reviews, the percentages with up arrow (↑) indicate improvement over the prior year’s review findings. Those with a down arrow (↓) represent a reduction in the prior review findings.

Table 64: Annual Review Comparisons

		Availability of Services and Assurances of Adequate Capacity and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Confidentiality	Grievance and Appeal Systems	Sub-contractual Relationships and Delegation	Practice Guidelines	Health Information Systems	Quality Assessment and Performance Improvement Program
United CAN	2021	100% ↑	100%	100%	92% ↓	100%	91% ↑	100%	100%	100%	100%
	2020	89%	100%	100%	98%	100%	80%	100%	100%	100%	100%
	2019	100%	100%	100%	88%	100%	75%	50%	100%	75%	100%
United CHIP	2021	100%↑	100%	100%	97% ↓	100%	82% ↓	100%	100%	100%	100%
	2020	89%	100%	100%	98%	100%	85%	100%	100%	100%	100%
	2019	90%	100%	100%	90%	100%	75%	50%	100%	75%	100%
Magnolia CAN	2021	100%	100%	100%	97% ↑	100%	100% ↑	100%	100%	100%	100%
	2020	100%	100%	100%	93%	100%	90%	100%	100%	100%	100%
	2019	80%	94%	100%	93%	100%	75%	100%	91%	100%	100%
*Magnolia CHIP	2019	80%	94%	100%	93%	100%	65%	100%	78%	100%	100%
Molina CAN	2021	100% ↑	94% ↓	100%	97% ↑	100%	100% ↑	50%	100%	100%	89% ↑
	2020	89%	100%	100%	96%	100%	95%	50%	100%	100%	79%
**Molina CHIP	2021	100% ↑	89% ↓	100%	95% ↑	100%	95%	50%	100%	100%	89% ↑
	2020	89%	100%	100%	88%	100%	95%	50%	100%	100%	78%

**Magnolia did not have the CHIP Program in 2020 and 2021.*
***Molina's first EQR was in 2020.*
Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100