Managed Care Program Annual Report (MCPAR) for Mississippi: Mississippi Coordinated Access Network (MSCAN)

Due date	Last edited	Edited by	Status
12/27/2023	12/27/2023	Mykala Stevenson	In progress

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Mississippi
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Lucretia Causey
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	lucretia.causey@medicaid.ms.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Not answered
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	Not answered
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	Not answered

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2023
A6	**Program name** Auto-populated from report dashboard.	Mississippi Coordinated Access Network (MSCAN)

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	Plan name	Magnolia Health Plan Molina Healthcare of MS UnitedHealthcare Community Plan of MS

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	BSS entity name	Gainwell Technologies - Fiscal Agent

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	862,377
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	404,992

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	Other third-party vendor Other, specify – Myers & Stauffer LC

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The State Medicaid Agency (SMA) conducted two PI activities during the past year in the MississippiCAN manged care program. Activities were focused on specific payment issues with our three Coordinated Care Organizations (CCOs). 1) The SMA reviewed encounter claims relative to Ordering, Referring, Prescribing (ORP) providers rendering services to Medicaid beneficiaries. The review consisted of encounter data with dates of services ranging over an 8-year span. ORP rules state providers enrolled in the Medicaid program as an ORP provider are only allowed to order, refer and/or prescribe items and services for Medicaid beneficiaries. The SMA determined from its review that the three CCOs improperly paid funds to billing providers for services rendered by ORP providers. 2) The SMA reviewed encounter data relative to Medicaid provider, Mississippi Department of Health (MSDH)-Family Planning Clinic and encounter rates. After review of encounter claims for a review period of five years, the SMA determined that the three CCOs appeared to have been paying the provider less than the encounter rate established for this provider for services that qualify for the rate.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in	Exhibit A MSCAN Contract Amendment 4, Section 12 - Program Integrity

	plan contracts, as required by 42 CFR 438.608(d)(1)(i).	
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The Contractor will be responsible for collecting the overpayment for any provider audited when approved by the SMA. The SMA shall conduct investigations related to suspected provider FWA cases and reserve the right to pursue and retain recoveries for any and all types of claims which the Contractor does not have an active investigation. The Contractor shall confer with the SMA before initiating any recoupment or withhold of any program integrity related funds to ensure the recovery recoupment or withhold is permissible. If the Contractor obtains funds in cases where recovery recoupment or withhold is prohibited as outlined in Section 12, the Contractor will return the funds to the SMA.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The state tracks compliance through Special Investigations Unit (SIU) regulatory reporting. The Contractor is required to report overpayments annually to the SMA.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Member Listing Report shall be provided to the Contractor sufficiently in advance of the Member's Enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, described in Sections 6.C, Member Identification Card, and 4.B, Choice of a Network Provider, of this Contract, respectively. The Division and the Contractor shall reconcile each Member Listing Report as expeditiously as is feasible but no later than the twentieth (20th) day of each month. The CCOs submit a weekly disenrollment report that includes deceased members.

BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The Contractor must notify the SMA of any provider that will be terminated from the program within forty-eight (48) hours. Notification must include the reason for termination, date of termination, and any termination notification to the provider. There is a high-level review of all provider terminations including "for cause" terminations. DOM will be ensuring that future monitoring efforts include a detailed review of the "for cause" termination requirements as outlined in the contract.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5%	No

	or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	State requires the return of overpayments. Myers & Stauffer Encounter Validation Report https://medicaid.ms.gov/programs/managed-care/measuring-managed-care-performance/ The state is assuming that overpayments referred to in this question are for overpayments initially paid to providers.

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	CONTRACT BETWEEN THE STATE OF MISSISSIPPI DIVISION OF MEDICAID OFFICE OF THE GOVERNOR AND A COORDINATED CARE ORGANIZATION (CCO) July 1, 2017 - June 30, 2023 UnitedHealthcare of Mississippi, Inc. d/b/a UnitedHealthcare Community Plan of Mississippi Molina Healthcare of MS, Inc. Magnolia Health Plan
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2017
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medicaid.ms.gov/mississippican-resources/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation

C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	404,992
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	During the Public Health Emergency (PHE), regular Medicaid members have not been terminated unless the member is deceased, moved out of state, or voluntarily termed. However, based on member redetermination outcomes, the number of members enrolled in managed care has decreased, and these members have transitioned to regular Medicaid.

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Monitoring and reporting Contract oversight Program integrity
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Exhibit A MSCAN Contract Amendment 4, Section 11 - Reporting Requirements, S. Member Encounter Data

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Exhibit A MSCAN Contract Amendment 4, Section 16 - Default and Termination, E. Liquidated Damages
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	The state would benefit from CMS standardization of encounter claim guidance, federal regulations and contract language for all encounter claim types, especially pharmacy. Validation of paid amounts on drug claims reported by managed care plans was more challenging and administratively burdensome without the assistance of a vendor. CMS standardization would allow the state to enforce compliance with specific requirements of encounter claim data submissions.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Timely resolution for standard appeals is "within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires. Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)."
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Timely resolution for expedited appeals is "no longer than 72 hours after the Contractor receives the request for an Expedited Resolution of an Appeal."
C1IV.4	**State definition of "timely" resolution for grievances**	Timely resolution for grievances is "within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as

	Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	the Member's health condition requires. Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)."

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	"Mississippi is a rural state facing a major shortage of health care professionals, particularly for citizens in small, isolated communities. A slow economy and sparse population base impact many health care providers' decisions to work in these sites. Limited opportunities for continuing education and dialogue with colleagues leave many health care professionals feeling isolated. (1) In addition, such rural providers have limited access to medical facilities that are equipped to handle patients needing acute care. Recruiting health care professionals to rural areas is a growing problem, not only within this rural state, but nationally." Hart-Hester, Susan, and Charlotte Thomas. "Access to health care professionals in rural Mississippi. (Original Article)." Southern Medical Journal, vol. 96, no. 2, Feb. 2003, pp. 149+. Gale Academic OneFile, link.gale.com/apps/doc/A98828111/AONE?u=anon~abac88e5&sid=googleScholar&xid=cc74c576. Accessed 18 July 2022.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	"Monitoring Resources include Quarterly GeoAccess Reporting; EQR Network Validation; Monthly Quality Meetings; and Complaint/Grievance Reporting DOM partners with MCPs for innovative outreach methods for at-risk members. Some of the outreach measures used in remote areas include mobile care units, health fairs, and telehealth."

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 34

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 34

C2.V.2 Measure standard

Two (2) within fifteen (15) miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 34

C2.V.2 Measure standard

Two (2) within thirty (30) miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialists Adult and Pediatric	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Specialists Adult and Pediatric	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dental Providers Adult and Pediatric	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dental Providers Adult and Pediatric	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Subspecialty Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
	Rural	Adult and pediatric

Dental Subspecialty Providers

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Durable Medical Equipment Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Durable Medical Equipment Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) open twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacies	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

One (1) open twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacies	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 34

C2.V.2 Measure standard

One (1) within sixty (60) minutes or sixty (60) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dialysis Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 34

C2.V.2 Measure standard

One within ninety (90) minutes or ninety (90) miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dialysis Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 34

C2.V.2 Measure standard

Well Care Visit-No to exceed thirty (30) calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Biannual

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

25 / 34

C2.V.2 Measure standard

Routine Sick Visit-Not to exceed seven (7) calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Biannual

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

26 / 34

C2.V.2 Measure standard

Urgent Care Visit-Not to exceed twenty-four (24) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Biannual

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

27 / 34

C2.V.2 Measure standard

Not to exceed seven (7) calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

28 / 34

C2.V.2 Measure standard

Routine Visit-Not to exceed forty-five (45) calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental (Routine Visit)	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

29 / 34

C2.V.2 Measure standard

Urgent Visit-Not to exceed forty-eight (48) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental (Urgent Visit)	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

30 / 34

C2.V.2 Measure standard

Routine Visit-Not to exceed twenty-one (21) calendar days

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Urgent Visit-Not to exceed twenty-four (24) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge-Not to exceed seven (7) calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Urgent Care Providers-Not to exceed twenty-four (24) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

34 / 34

C2.V.2 Measure standard

Emergency Providers-Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care Providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	"Mississippi Envision (ms-medicaid.com) https://www.ms-medicaid.com/msenvision/mscanInfo.do Conduent staff at 1-800-884-3222 This is the fiscal agent for the reporting period. Due to the transition of our fiscal agent from Conduent to Gainwell, the link is no longer valid."
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The DOM website details these services as follows: Beneficiaries may contact Gainwell and/or the Mississippi Division of Medicaid (DOM), Office of Coordinated Care, Member Services in multiple ways including by phone, postal mail, and fax.If you speak another language, assistance services, free of charge, are available to you. Call 1-800-421-2408 (Deaf and Hard of Hearing VP: 1-228-206-6062). For more information, read our Notice of Non-Discrimination. Notice of Non-Discrimination - Mississippi Division of Medicaid (ms.gov)
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Requires weekly reporting that captures the number of MSCAN calls; number of calls by type; number of calls transferred to the respective CCOs; and the number of enrollment change forms returned, processed, and received. In evaluation of the data collected, DOM requires performance improvement efforts be made to address any areas identified as needing improvement.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Magnolia Health Plan** 160,447 **Molina Healthcare of MS** 156,891 **UnitedHealthcare Community Plan of MS** 87,654
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Magnolia Health Plan** 18.6% **Molina Healthcare of MS** 18.2% **UnitedHealthcare Community Plan of MS** 10.2%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Magnolia Health Plan** 39.6% **Molina Healthcare of MS** 38.7% **UnitedHealthcare Community Plan of MS** 21.6%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Magnolia Health Plan** 94.6% **Molina Healthcare of MS** 92% **UnitedHealthcare Community Plan of MS** 92.6%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Magnolia Health Plan** Program-specific statewide **Molina Healthcare of MS** Program-specific statewide **UnitedHealthcare Community Plan of MS** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A **UnitedHealthcare Community Plan of MS** N/A
D1II.3	**MLR reporting period discrepancies**	**Magnolia Health Plan**

Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	No
	Molina Healthcare of MS
	No
	UnitedHealthcare Community Plan of MS
	No

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Magnolia Health Plan** The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 30th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider. **Molina Healthcare of MS** The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 30th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider. **UnitedHealthcare Community Plan of MS** The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 30th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider.

D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Magnolia Health Plan** 80% **Molina Healthcare of MS** 64% **UnitedHealthcare Community Plan of MS** 53%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Magnolia Health Plan** 100% **Molina Healthcare of MS** 100% **UnitedHealthcare Community Plan of MS** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Magnolia Health Plan** 556 **Molina Healthcare of MS** 376 **UnitedHealthcare Community Plan of MS** 622
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 20 **UnitedHealthcare Community Plan of MS** 86
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A **UnitedHealthcare Community Plan of MS**

	actively receiving LTSS at the time that the appeal was filed).	N/A
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A **UnitedHealthcare Community Plan of MS** N/A
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided	**Magnolia Health Plan** 479 **Molina Healthcare of MS**

	by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	330 **UnitedHealthcare Community Plan of MS** 410
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Magnolia Health Plan** 77 **Molina Healthcare of MS** 44 **UnitedHealthcare Community Plan of MS** 197
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Magnolia Health Plan** 507 **Molina Healthcare of MS** 369 **UnitedHealthcare Community Plan of MS** 612
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Magnolia Health Plan** 41 **Molina Healthcare of MS** 1 **UnitedHealthcare Community Plan of MS** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	**Magnolia Health Plan** 1,837 **Molina Healthcare of MS**

	denial, in whole or in part, of payment for a service that was already rendered.	6 **UnitedHealthcare Community Plan of MS** 10
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Magnolia Health Plan** 1 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0

were related to the plan's denial of an enrollee's request to dispute a financial liability.	**UnitedHealthcare Community Plan of MS** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Magnolia Health Plan** 9 **Molina Healthcare of MS** 14 **UnitedHealthcare Community Plan of MS** 17
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Magnolia Health Plan** 36 **Molina Healthcare of MS** 41 **UnitedHealthcare Community Plan of MS** 87
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**Magnolia Health Plan** 29

	Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Molina Healthcare of MS** 20 **UnitedHealthcare Community Plan of MS** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Magnolia Health Plan** 57 **Molina Healthcare of MS** 30 **UnitedHealthcare Community Plan of MS** 28
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Magnolia Health Plan** 170 **Molina Healthcare of MS** 49 **UnitedHealthcare Community Plan of MS** 274
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 4 **UnitedHealthcare Community Plan of MS** 8
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that	**Magnolia Health Plan** 0 **Molina Healthcare of MS**

	were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	N/A **UnitedHealthcare Community Plan of MS** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Magnolia Health Plan** 20 **Molina Healthcare of MS** 68 **UnitedHealthcare Community Plan of MS** 128
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Magnolia Health Plan** 235 **Molina Healthcare of MS** 150 **UnitedHealthcare Community Plan of MS** 61

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Magnolia Health Plan** 7 **Molina Healthcare of MS** 2 **UnitedHealthcare Community Plan of MS** 6
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 1 **UnitedHealthcare Community Plan of MS** 5
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Magnolia Health Plan** 5 **Molina Healthcare of MS** 1 **UnitedHealthcare Community Plan of MS** 1
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision**	**Magnolia Health Plan** 1

	Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Magnolia Health Plan** 1 **Molina Healthcare of MS** 1 **UnitedHealthcare Community Plan of MS** 0
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Magnolia Health Plan** 1 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Magnolia Health Plan** 949 **Molina Healthcare of MS** 787 **UnitedHealthcare Community Plan of MS** 532
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 82 **UnitedHealthcare Community Plan of MS** 75
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A **UnitedHealthcare Community Plan of MS** N/A

D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A **UnitedHealthcare Community Plan of MS** N/A

	grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 787 **UnitedHealthcare Community Plan of MS** 524

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 9 **UnitedHealthcare Community Plan of MS** 11
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** 5 **Molina Healthcare of MS** 26 **UnitedHealthcare Community Plan of MS** 72
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient	**Magnolia Health Plan** 1 **Molina Healthcare of MS**

	mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	0 **UnitedHealthcare Community Plan of MS** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** 1 **Molina Healthcare of MS** 9 **UnitedHealthcare Community Plan of MS** 3
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** 9 **Molina Healthcare of MS** 139 **UnitedHealthcare Community Plan of MS** 12
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A **UnitedHealthcare Community Plan of MS** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based	**Magnolia Health Plan** N/A **Molina Healthcare of MS** N/A

	(HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**UnitedHealthcare Community Plan of MS** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** 17 **Molina Healthcare of MS** 12 **UnitedHealthcare Community Plan of MS** 22
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Magnolia Health Plan** 511 **Molina Healthcare of MS** 122 **UnitedHealthcare Community Plan of MS** 404
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Magnolia Health Plan** 405 **Molina Healthcare of MS** 470 **UnitedHealthcare Community Plan of MS** 8

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 64 **UnitedHealthcare Community Plan of MS** 2
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Magnolia Health Plan** 4 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 11

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Magnolia Health Plan** 22 **Molina Healthcare of MS** 330 **UnitedHealthcare Community Plan of MS** 2
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 36 **UnitedHealthcare Community Plan of MS** 172
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 4

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Magnolia Health Plan** 418 **Molina Healthcare of MS** 357 **UnitedHealthcare Community Plan of MS** 49
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Magnolia Health Plan** 11 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal**	**Magnolia Health Plan** 0 **Molina Healthcare of MS**

	(including requests to expedite or extend appeals) Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	0 **UnitedHealthcare Community Plan of MS** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Magnolia Health Plan** 0 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Magnolia Health Plan** 26 **Molina Healthcare of MS** 0 **UnitedHealthcare Community Plan of MS** 292

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 57

Complete

D2.VII.1 Measure Name: Adult Body Mass Index Assessment 1 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Adult BMI Assessment measure. The measure assesses members 18–74 years of age who had their body mass index (BMI) documented during an outpatient visit in the current or previous year. Magnolia numerator-11490 Magnolia denominator-24549 Molina numerator-1944 Molina denominator-4288 United numerator-10270 United denominator-19329 "

Measure results

Magnolia Health Plan

46.80%

Molina Healthcare of MS

45.34%

UnitedHealthcare Community Plan of MS

53.13%

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS-AD)

2 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2372

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

51.90%

Molina Healthcare of MS

42.40%

UnitedHealthcare Community Plan of MS

46.30%

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CSS-AD)

3 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

32

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

54.30%

Molina Healthcare of MS

53%

UnitedHealthcare Community Plan of MS

55%

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women Ages 21-24 (CHL-AD)

4 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

33

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

63.70%

Molina Healthcare of MS

45.10%

UnitedHealthcare Community Plan of MS

59%

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women Ages 16-20 (CHL-CH)

5 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

33

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

49.80%

Molina Healthcare of MS

39%

UnitedHealthcare Community Plan of MS

47.50%

Complete

D2.VII.1 Measure Name: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)

6 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0418/0418e

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

.6%

Molina Healthcare of MS

.5%

UnitedHealthcare Community Plan of MS

.7%

Complete

D2.VII.1 Measure Name: Screening for Depression and Follow-Up Plan: Ages 12 -17 (CDF-CH)

7 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0418/0418e

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

1.21%

Molina Healthcare of MS

1.61%

UnitedHealthcare Community Plan of MS

1.33%

Complete

D2.VII.1 Measure Name: Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

39

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure was not collected this year.

Measure results

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV-CH)

9 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

40.80%

Molina Healthcare of MS

20.20%

UnitedHealthcare Community Plan of MS

39.50%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30-CH)

10 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

65.30%

Molina Healthcare of MS

62.70%

UnitedHealthcare Community Plan of MS

66.10%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months of Life (W15-CH)

11 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Magnolia numerator- 3511 Magnolia denominator- 6291 Molina numerator- 3260 Molina denominator- 5962 United numerator- 3808 United denominator-6672

Measure results

Magnolia Health Plan

55.81%

Molina Healthcare of MS

54.68%

UnitedHealthcare Community Plan of MS

57.07%

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)

12 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

24

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

52.72%

Molina Healthcare of MS

45.74%

UnitedHealthcare Community Plan of MS

55.96%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS-CH) Combo 10

13 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

38

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

20.7

Molina Healthcare of MS

20.2

UnitedHealthcare Community Plan of MS

19.2

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA-CH) Combo 2

14 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

24.3

Molina Healthcare of MS

13.6

UnitedHealthcare Community Plan of MS

22.6

Complete

D2.VII.1 Measure Name: Developmental Screening in the First Three Years of Life (DEV-CH)

15 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1448

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

5.4

Molina Healthcare of MS

33.2

UnitedHealthcare Community Plan of MS

5.4

Complete

D2.VII.1 Measure Name: PC-01 Elective Delivery (PC01-AD)

16 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0469/0469e

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The only CCO to report this measure was Molina.

Measure results

Magnolia Health Plan

N/A

Molina Healthcare of MS

67.83

UnitedHealthcare Community Plan of MS

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care (PPC-AD)

17 / 57

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

70.32

Molina Healthcare of MS

43.13

UnitedHealthcare Community Plan of MS

96.84

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) Most or Moderately Effective Contraception - 3 days

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

11.17

Molina Healthcare of MS

10.42

UnitedHealthcare Community Plan of MS

13.43

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) Most or Moderately Effective Contraception - 90 days

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

40.7

Molina Healthcare of MS

40.25

UnitedHealthcare Community Plan of MS

54.35

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21 to 44 (CCW-AD) Most Effective

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2903/ 2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

23.21

Molina Healthcare of MS

15.62

UnitedHealthcare Community Plan of MS

23.63

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21 to 44 (CCW-AD) LARC

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2903/ 2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

2.29

Molina Healthcare of MS

1.32

UnitedHealthcare Community Plan of MS

2.43

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP-AD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

18

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

53.8

Molina Healthcare of MS

47.4

UnitedHealthcare Community Plan of MS

60.3

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB-AD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

58

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

41.85

Molina Healthcare of MS

32.37

UnitedHealthcare Community Plan of MS

40.1

Complete

D2.VII.1 Measure Name: (CDC) HbA1c Testing

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

57

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Magnolia numerator- 363 Magnolia denominator- 411 Molina numerator- 337 Molina denominator- 411 United numerator- 1357United denominator- 411

Measure results

Magnolia Health Plan

88.32

Molina Healthcare of MS

82

UnitedHealthcare Community Plan of MS

86.86

Complete

D2.VII.1 Measure Name: (CDC): Patients with Diabetes received Statin Therapy (SPD)

25 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia numerator- 2079 Magnolia denominator- 3416 Molina numerator- 170 Molina denominator- 331 United numerator- 298 United denominator- 2352"

Measure results

Magnolia Health Plan

60.86

Molina Healthcare of MS

51.36

UnitedHealthcare Community Plan of MS

12.67

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)

26 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

59

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia numerator- 217 Magnolia denominator- 411 Molina numerator- 257 Molina denominator- 411 United numerator- 186 United denominator- 411"

Measure results

Magnolia Health Plan

52.8

Molina Healthcare of MS

62.53

UnitedHealthcare Community Plan of MS

45.26

Complete

D2.VII.1 Measure Name: Diabetes Short-Term Complications Admission Rate (PQI-01-AD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

272

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia - 25.15 Admissions per 100,000 Member Months Molina - 27.84 Admissions per 100,000 Member Months"

Measure results

Magnolia Health Plan

25.15

Molina Healthcare of MS

27.84

UnitedHealthcare Community Plan of MS

27.73

Complete

D2.VII.1 Measure Name: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05-AD)

28 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

275

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia - 53.64 Admissions per 100,000 Member Months. Molina - 54.18 Admissions per 100,000 Member Months United - "

Measure results

Magnolia Health Plan

53.64

Molina Healthcare of MS

54.18

UnitedHealthcare Community Plan of MS

59.79

Complete

D2.VII.1 Measure Name: Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroid

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia numerator- 295 Magnolia denominator- 573. Molina numerator- 36 Molina denominator- 124 United numerator- 230 United denominator- 461"

Measure results

Magnolia Health Plan

51.48

Molina Healthcare of MS

29.03

UnitedHealthcare Community Plan of MS

49.89

Complete

D2.VII.1 Measure Name: Heart Failure Admission Rate (PQI-08-AD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

277

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia - 48.75 Admissions per 100,000 Member Months Molina - 37.25 Admissions per 100,000 Member Months"

Measure results

Magnolia Health Plan

48.75

Molina Healthcare of MS

37.25

UnitedHealthcare Community Plan of MS

59.49

Complete

D2.VII.1 Measure Name: Asthma in Younger Adults Admission Rate (PQI-15-AD)

31 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

283

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Magnolia - 2.91 Admissions per 100,000 Member Months Molina - 4.52 Admissions per 100,000 Member Months"

Measure results

Magnolia Health Plan

2.91

Molina Healthcare of MS

4.52

UnitedHealthcare Community Plan of MS

3.44

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmission Rate (PCR-AD)

32 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1768

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

1.0126

Molina Healthcare of MS

1.1014

UnitedHealthcare Community Plan of MS

1.0248

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio: Ages 19-64 (AMR-AD)

33 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Medicaid Adult Core Set Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

59.4

Molina Healthcare of MS

55.5

UnitedHealthcare Community Plan of MS

56.9

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression (HVL-AD)

34 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

2082/3210e

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

29

Molina Healthcare of MS

15.7

UnitedHealthcare Community Plan of MS

20.8

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) LARC - 3 days

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

.46

Molina Healthcare of MS

.51

UnitedHealthcare Community Plan of MS

.91

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) LARC - 90 days

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

7.37

Molina Healthcare of MS

6.28

UnitedHealthcare Community Plan of MS

11.37

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Initiation Total

37 / 57

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

43.05

Molina Healthcare of MS

43.95

UnitedHealthcare Community Plan of MS

45.31

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Engagement Total

38 / 57

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

8.76

Molina Healthcare of MS

10.93

UnitedHealthcare Community Plan of MS

9.13

Complete

D2.VII.1 Measure Name: Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)

39 / 57

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

27

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure was not collected this year.

Measure results

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM-AD) Acute Phase

40 / 57

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Molina numerator- 549 Molina denominator- 729

Measure results

Magnolia Health Plan

49.53

Molina Healthcare of MS

59.77

UnitedHealthcare Community Plan of MS

47.93

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM-AD) Continuation Phase

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Molina numerator- 446 Molina denominator- 729

Measure results

Magnolia Health Plan

30.85

Molina Healthcare of MS

37.78

UnitedHealthcare Community Plan of MS

29.18

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) 30 Days

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

22.51

Molina Healthcare of MS

47.61

UnitedHealthcare Community Plan of MS

50.8

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) 7 Days

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

69.6

Molina Healthcare of MS

57.7

UnitedHealthcare Community Plan of MS

69.4

Complete

D2.VII.1 Measure Name: SSD-AD Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1932

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

69.6

Molina Healthcare of MS

57.7

UnitedHealthcare Community Plan of MS

69.4

Complete

D2.VII.1 Measure Name: HPCMI-AD Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2607

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure was not collected this year.

Measure results

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

Complete

D2.VII.1 Measure Name: OHD-AD Use of Opioids at High Dosage in Persons Without Cancer

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2940

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

1.3

Molina Healthcare of MS

3.4

UnitedHealthcare Community Plan of MS

0.8

Complete

D2.VII.1 Measure Name: COB-AD Concurrent Use of Opioids and Benzodiazepines

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3389

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This measure was not collected this year.

Measure results

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

Complete

D2.VII.1 Measure Name: OUD-AD Use of Pharmacotherapy for Opioid Use Disorder

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3400

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

40.2

Molina Healthcare of MS

50.1

UnitedHealthcare Community Plan of MS

37.3

Complete

D2.VII.1 Measure Name: FUH-CH Follow-Up After Hospitaliztion for Mental Illness 30 Days ages 6-17

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

65.34

Molina Healthcare of MS

61.71

UnitedHealthcare Community Plan of MS

66.96

Complete

D2.VII.1 Measure Name: FUH-CH Follow-Up After Hospitalization for Mental Illness 7 Days ages 6-17

50 / 57

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

56

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

31.79

Molina Healthcare of MS

24.33

UnitedHealthcare Community Plan of MS

28.31

Complete

D2.VII.1 Measure Name: APP-CH Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics Total

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

62.1

Molina Healthcare of MS

59.1

UnitedHealthcare Community Plan of MS

59.7

Complete

D2.VII.1 Measure Name: FUM-CH Follow-Up After Emergency Department Visit for Mental Illness 30 Days ages 6-17

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

54.49

Molina Healthcare of MS

50.67

UnitedHealthcare Community Plan of MS

55.73

Complete

D2.VII.1 Measure Name: FUM-CH Follow-Up After Emergency Department Visit for Mental Illness 7 Days ages 6-17

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

37.82

Molina Healthcare of MS

30.67

UnitedHealthcare Community Plan of MS

39.69

Complete

D2.VII.1 Measure Name: AMR Asthma Medication Ratio Ages 5-11

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

83

Molina Healthcare of MS

80.77

UnitedHealthcare Community Plan of MS

82.22

Complete

D2.VII.1 Measure Name: AMR Asthma Medication Ratio Ages 12-18

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

71.14

Molina Healthcare of MS

66.67

UnitedHealthcare Community Plan of MS

78.52

Complete

D2.VII.1 Measure Name: ADD-CH Follow-Up Care for Children Prescribed ADHD Medication Condition and Maintenance Initiation Phase

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

55.14

Molina Healthcare of MS

36.56

UnitedHealthcare Community Plan of MS

49.82

Complete

D2.VII.1 Measure Name: ADD-CH Follow-Up Care for Children Prescribed ADHD Medication Condition and Maintenance Continuation Phase

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

71.08

Molina Healthcare of MS

59.35

UnitedHealthcare Community Plan of MS

66.57

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Magnolia Health Plan** 5 **Molina Healthcare of MS** 2 **UnitedHealthcare Community Plan of MS** 2
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Magnolia Health Plan** 37 **Molina Healthcare of MS** 41 **UnitedHealthcare Community Plan of MS** 23
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Magnolia Health Plan** 0.23:1,000 **Molina Healthcare of MS** 0.39:1,000 **UnitedHealthcare Community Plan of MS** 0.15:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Magnolia Health Plan** 8 **Molina Healthcare of MS**

		19 **UnitedHealthcare Community Plan of MS** 28
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Magnolia Health Plan** 0.049:1,000 **Molina Healthcare of MS** 0.18:1,000 **UnitedHealthcare Community Plan of MS** 0.2:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Magnolia Health Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Molina Healthcare of MS** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **UnitedHealthcare Community Plan of MS** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Magnolia Health Plan** 30 **Molina Healthcare of MS** 4 **UnitedHealthcare Community Plan of MS** 5
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the	**Magnolia Health Plan** 0.18:1,000 **Molina Healthcare of MS**

	state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	0.038:1,000 **UnitedHealthcare Community Plan of MS** 0.0319:1,000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Magnolia Health Plan** "Period: 7/1/22 through 6/30/23 Total SIU FWA collections: $5,276 High Dollar claim reviews: $562,150 Medical Record Type Reviews:$4,747,986 Third Party Liability Reviews:$5,680,105 Other Post Pay Reviews:$3,801,388" **Molina Healthcare of MS** The previous annual report was submitted on or about January 13, 2023 and was for reporting period of Calendar Year 2022. The total amount recovered as reported was $280,445.84 **UnitedHealthcare Community Plan of MS** "The date of the report: 7/1/22 through 6/30/23 The dollar amount of Overpayments recovered: $13,219,925.12 The ration of the dollar amount of overpayments recovered as a percent of premimum revenue: 1.14%"
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Magnolia Health Plan** Weekly **Molina Healthcare of MS** Weekly **UnitedHealthcare Community Plan of MS** Weekly

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Gainwell Technologies - Fiscal Agent** Subcontractor
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Gainwell Technologies - Fiscal Agent** Enrollment Broker/Choice Counseling