Constellation Quality Health

Magnolia Health Plan

2023 External Quality Review

Submitted: November 27, 2023

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Magnolia Health Plan (Magnolia). This report contains a description of the process and the results of the 2023 External Quality Review (EQR) conducted by Constellation Quality Health, formerly The Carolinas Center for Medical Excellence, on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) Program.

The goals of the review were to:

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

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

Provider Network Access Call Studies and Provider Directory Validations are conducted on a quarterly basis and are reported separately.

Summary and Overall Findings

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

- Availability of Services (*§ 438.206, § 457.1230*)
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*
- Disenrollment *(§ 438.56)*
- Enrollee Rights *(§ 438.100)*
- Emergency and Post Stabilization Service *(§ 438.114)*

In 2022, DOM implemented a centralized credentialing process. Therefore, the Mississippi CCOs are not responsible for credentialing and recredentialing their providers, and an assessment of CCO compliance with Provider Selection *(§ 438.214, § 457.1233)* is not included in this report.

To assess Magnolia's compliance with standards set forth in 42 CFR Part 438 and 457, Constellation Quality Health's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration

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

Magnolia has established processes and guidelines for developing, reviewing, approving, and maintaining policies. Policies are reviewed at least annually and when needed due to changes in laws, regulations, and contractual requirements. Onsite discussion confirmed that new and revised policies are presented to the Clinical Policy Committee for review and approval. However, this is not addressed in Policy CC.COMP.22, Policy Management.

Review of the Organizational Chart and onsite discussion confirmed staffing is sufficient to ensure all required activities can be conducted and all contractually required services are provided to members. All key positions are filled.

The Compliance and Ethics Program Description 2023, 2023 Fraud, Waste and Abuse (FWA) Plan, and related policies and procedures describe processes for ensuring compliance and guarding against fraud, waste, and abuse. The Centene Corporation Business Ethics and Code of Conduct addresses expectations for ethical business conduct and practices. Magnolia's Compliance Officer reports directly to the health plan's President/CEO and the governing Board. The Compliance Officer plans, implements, and monitors the Compliance Program. The Compliance Committee meets at least quarterly and as needed. Its responsibilities include reviewing the Compliance Program Description and Work Plan, reviewing the effectiveness of

the Compliance Program, and supporting the Compliance Officer. Review of Compliance Committee minutes along with onsite discussion revealed that when voting members are unable to attend a Compliance Committee meeting, they may appoint a designee to attend in their place. However, the committee minutes did not reflect that designees attended for the voting members.

Magnolia requires initial compliance training for new employees and annual compliance training for all employees. Members of the Board of Directors are provided with a copy of the Business Ethics and Conduct policy and must give written acknowledgement that they have received and will comply with the policy.

Magnolia has an established pharmacy lock-in program to detect, prevent, and respond to abuse of the pharmacy benefit. Most required components of the program are included in Policy MS.PHAR.15, Pharmacy Lock-In Program. However, although the policy addresses the availability of an emergency supply of medication, it does not note that the emergency supply of medication is limited to a 72-hour supply.

The EQR revealed that Magnolia has infrastructure capable of meeting contractual and information systems requirements. Magnolia exceeds the State's claims payment timeliness requirements. The health plan performs regular risk assessments to identify potential risks to both physical and virtual infrastructure and to aid the organization in implementing precautionary measures in the case of disaster recovery and business continuity.

Provider Services

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

Appropriate processes are in place for new provider orientation and ongoing provider education. In addition to formal provider education processes, the Provider Manual is a comprehensive resource of information providers will need to function effectively and appropriately within the network.

Magnolia educates providers about medical record documentation standards and assesses provider compliance accordingly. For the annual medical record audit, providers must meet 90% of the requirements for medical recordkeeping or be subject to corrective action. For the 2022 Medical Record Audit, all practices included in the audit met the scoring threshold of 90% or more. Opportunities for improvement were noted for four of the practices, and recommendations were offered.

Magnolia adopts clinical practice and preventive health guidelines from nationally recognized sources. Prior to adoption, and with each annual review, physician members of Magnolia

committees review the guidelines. The guidelines are routinely distributed to providers, and to members and potential members upon request.

Constellation Quality Health's validation review of Magnolia's provider network found that, overall, Magnolia met the requirements of the Network Adequacy Validation. Magnolia evaluates the availability of network providers at least annually against contractually required standards by considering geographic access mapping, other network adequacy reports, and results of member satisfaction surveys regarding practitioner availability. Geographic access standards for primary care providers are documented in policy, but no policy specified the geographic access standards for other provider types. Appointment access standards are also documented in policy, but the standard for specialists was omitted. Magnolia conducts annual call studies to assess provider compliance with the standards. For the call study conducted in Q2 2023, success rates ranged from 69.09% to 91.43%, and compliance for various appointment types ranged from 91% to 100%.

SPH Analytics/Press Ganey, a National Committee for Quality Assurance Certified Survey Vendor, conducted the 2022 Provider Satisfaction Survey for Magnolia. The response rate was 7.9%. This low response rate may affect generalizability of the results.

Member Services

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

Member rights and responsibilities as well as methods of communicating the rights and responsibilities are documented in health plan policy. The rights and responsibilities are listed in the Member Handbook, on the website, and included in the New Member Packet. The packet includes a Member Handbook, the member's ID Card along with a Welcome Letter, a Benefit Booklet, contact information for the health plan, information about the website, various forms, and brochures. The Member Handbook is a rich resource for members to understand Magnolia's services, processes, and requirements. Appropriate processes are in place for notifying members of changes in services, benefits, and providers.

Magnolia informs members about preventive health and chronic disease management services in a variety of ways such as the Member Handbook, newsletters, the website, birthday reminder cards, telephonic outreach, and community events. The My Health Pays incentive program rewards members for healthy behaviors by providing pre-paid cards allowing purchases of appropriate items.

Magnolia ensures member materials are developed in a manner to ensure they are easily understood by members by using the contractually required reading level and font sizes, providing materials in alternate languages and formats, and providing free translation and

interpreter services along with the option for text telephone 711 services for persons with hearing or speech disabilities.

Member Services call data is collected, analyzed, and monitored to identify opportunities for improvement. Action plans are developed based on identified opportunities. The Service Quality Improvement Subcommittee and the Quality Improvement Committee monitor call center trends. All call center performance metrics for 2022 were met. Call Center staff use interactive scripts, which are reviewed annually and approved by DOM. Call center staff receive quarterly training various topics, such as the Medicaid Program, the MississippiCAN Program, customer service, etc.

Appropriate processes are in place for member disenrollment. Policy MS.ELIG.05, Disenrollment, addresses how and when members may request disenrollment and circumstances under which members may request "for cause" disenrollment and under which members may be involuntarily disenrolled.

Magnolia's processes for addressing grievances are described in policies, the Member Handbook, Provider Manual, and website. No issues were noted with the documentation. Grievances are logged, categorized, and maintained as required. Summaries of complaint and grievance actions, trends, and root causes are reported quarterly to the Quality Improvement Committee to identify opportunities for improvement. Review of a random sample of grievance files revealed no concerns.

Magnolia contracts with Press Ganey to conduct both the child and adult member satisfaction surveys. For MY 2022, the survey response rates ranged from 19.4% to 13.4% and showed improvement from the previous year's rates. Survey results were reported to the Performance Improvement Committee and to providers.

Quality Improvement

42 CFR §438.330, 42 CFR §457.1240(b), and 42 CFR Part 441, Subpart B

Magnolia has developed a Quality Improvement (QI) Program with an overall goal of improving the health status of the members. The 2023 Quality Program Description included specific goals, objectives, and priorities to help achieve this overall goal. The structure of the program, staffing, and data analytic resources are clearly outlined in the program description. Information about the QI Program is shared with providers and members. However, the QI Program Description found on Magnolia's website was the 2022 QI Program Description and not the 2023 QI Program Description.

Magnolia has developed a Health Equity Program that identifies disparities, prioritizes projects, and collaborates across the community to reduce inequities through evidence-based

methodologies targeting members, providers, and communities. Magnolia achieved full Health Equity Accreditation in 2022.

The Quality Improvement Committee (QIC) continues to be Magnolia's senior leadership committee accountable to the Board of Directors. The QIC acts as an oversight committee and receives regular reports from all subcommittees that are accountable to the committee. The committee meets at least quarterly, and the decisions made by the committee are recorded in the minutes and made available to each member. Network providers specializing in Pediatrics, Family Medicine, and Psychiatry act as voting members of the QIC.

Magnolia provides coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and educates members and providers regarding the services and resources available. A Monthly Report is generated to identify members needing follow-up care after an EPSDT screening. If the report indicates a member has an abnormal finding, Magnolia monitors the member's claims to assess if treatment was sought. If there is no evidence that treatment was sought, outreach is made to the provider and the member to determine the care needed and assist with arranging a follow-up appointment.

The evaluation of the effectiveness of the QI program is conducted annually. Magnolia submitted the 2022 Quality Management Program Evaluaiton, which included the results of all the activities conducted in 2022. The analysis for each activity was included as well as identified barriers and opportunities for improvements.

Performance Measure Validation: All relevant Healthcare Effectiveness Data and Information Set (HEDIS) performance measures for the CAN populations were compared between the current review year (MY 2022) and the previous year (MY 2021). The changes from 2021 to 2022 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial increases or decreases in rate from 2021 to 2022. A substantial increase or decrease is a change in rate of 10% or more. There were no HEDIS MY 2022 measure rates that decreased more than 10 percentage points.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Asthma Medication Ratio (amr)			
51-64 Years	45.70%	56.20%	10.50%
Kidney Health Evaluation for Patients With Diabetes (ked)			

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Kidney Health Evaluation for Patients With Diabetes (65-74)	15.63%	32.26%	16.63%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	28.63%	41.46%	12.83%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	16.30%	34.76%	18.46%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days (Total)	27.20%	40.83%	13.63%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	15.48%	33.73%	18.25%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2022 and the previous year (MY 2021). The change from 2021 to 2022 is reported in the following table. The rate changes shown in green indicate substantial (>10%) improvement and those shown in red indicate substantial (>10%) decline. There were no non-HEDIS Adult Core Set and Child Core Set measure rates that decreased more than 10 percentage points.

Table 2: CAN Non-HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 65+	151.17	225.56	74.39
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 65+	0.00	75.19	75.19
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 3-5	8.29%	27.51%	19.22%
Ages 6-7	9.29%	31.44%	22.15%
Ages 8-9	8.84%	31.31%	22.47%
Ages 10-11	8.00%	29.16%	21.16%
Ages 12-14	7.06%	25.65%	18.59%
Ages 15-18	4.70%	17.83%	13.13%
Total Ages 1-20	6.88%	24.15%	17.27%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Ages 3-5	6.54%	25.24%	18.70%
Ages 6-7	8.71%	30.75%	22.04%
Ages 8-9	8.65%	30.92%	22.27%
Ages 10-11	7.90%	28.98%	21.08%
Ages 12-14	6.94%	25.44%	18.50%
Ages 15-18	4.64%	17.65%	13.01%
Total Ages 1-20	6.21%	23.08%	16.87%

Performance Improvement Project Validation: Validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the CMS protocol *EQR Protocol 1: Validating Performance Improvement Project*s. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

For this review, Magnolia submitted four PIPs. Topics for those PIPs included Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness. All the PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 3: Behavioral Health Readmission PIP

Behavioral Health Readmission	
The Behavioral Health Readmission PIP is focused on reducing 30-day readmissions for members discharged from a behavioral health facility and to increase case management enrollment for those that are readmitted. This PIP showed improvement in the latest rate from 26.88% in 2021 to 25.9% in 2022, with a goal of 6%. Many interventions have been implemented over the five-year PIP period.	
Previous Validation Score	Current Validation Score
80/80 = 100% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Member Outreach • Facility collaboration • Staff Additions for Transition of Care Assessments • Clinical Provider Training • Discharge Bags • Medicine Planners for Patients • Member Education	

Table 4: Reducing Preterm Births PIP

Reducing Preterm Births	
The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with HTN/preeclampsia who give birth prior to 37 weeks gestation. The baseline rate was 14.47% and the third remeasurement rate was 15.05%. This rate increased which reflects a lack of improvement, as the goal is to reduce the preterm birth rate.	
Previous Validation Score	Current Validation Score
72/73= 99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Completing Notification of Pregnancy as applicable. • Enrolling member in the Start Smart for Baby program. • Refer to Care Management for continuous follow-up. • Medical record review for monitoring and tracking	

Table 5: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
The Sickle Cell Disease PIP focuses on increasing compliance with Hydroxyurea for eligible members throughout the treatment period. This PIP measures the rate of members with sickle cell disease that remain compliant with the medication during their treatment period. The baseline rate was 37.5%, decreasing to 25.87% in 2023. The goal is to increase the rate to 47%. Thus, the most recent rate did not show improvement in year over year trending.	
Previous Validation Score	Current Validation Score
80/80 = 100% Hight Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• The Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and on the importance of medication adherence. • Letters are mailed to the providers of those members identified, encouraging the provider to discuss medication adherence at the member's next scheduled appointment. • Outreach is conducted for all members who received letters to provide education and to address any barriers/concerns. • Texting campaigns to encourage medication refill reminders.	

Table 6: Asthma/COPD PIP

Asthma/COPD	
The Asthma/COPD PIP focuses on the percentage of members 12–18 years of age with persistent asthma and the spirometry test for members 40 and older with COPD. This indicator uses the HEDIS measure, Asthma Medication Ratio (AMR). The AMR rate was 71.15% at baseline, which has essentially not changed in 2022 at 71.15%, with a goal of 76.86%. The spirometry testing rate was 28.38% at baseline which has declined to 22.27% for 2022, the goal is 36.82%.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the AMR and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Distribution of the updated HEDIS Quick Reference Guides for MY2023 to Providers. • The Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Interactive texting campaigns for medication refill and missed refill reminders.	

Utilization Management

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

The Magnolia Utilization Management Program Description 2023 and various policies outline the scope, objective, and staff responsibilities for the health plan's Utilization Management (UM) Program for behavioral health and physical health services. Policy MS.PHAR.09, Pharmacy Operations, outlines the procedures for Magnolia's pharmacy program.

Magnolia's Chief Medical Director provides oversight of the UM Program. The Behavioral Health Practitioner and Pharmacy Director provide clinical oversight for their respective programs. Magnolia's UM Reviewers are licensed health professionals who conduct initial medical necessity reviews using evidence based clinical criteria when determining medical necessity. Referral Specialists are non-licensed staff who assist with administrative tasks for the clinical staff. Standard authorizations are processed within three calendar days and/or two business days. Pharmacy and expedited requests are processed within 24 hours. Inter-Rater Reliability (IRR) Testing, case audits, and peer reviews are conducted with Medical Directors and other UM staff to ensure consistency in applying clinical criteria.

Constellation's review of the sample approval and denial files demonstrated that the reviews were performed by appropriate licensed health practitioners and completed in a timely manner.

Policy CC.CM.02, Care Coordination /Care Management Services, Policy CC.CM.01, Care/Case Management, and the UM Program Description outline the process, scope, and objectives of the case management and disease management program. Additionally, there are several disease specific program descriptions that outline specialized care for members with chronic medical conditions. Transitional care management services are provided to members that are in the discharge planning process.

Referrals for potential care management services are initiated from various sources and direct referrals are considered a high priority. Following the referral, a health risk assessment is completed and reviewed by a health professional. A treatment plan is then developed, and a copy is provided to the member. Members are provided care management activities based upon their identified needs and risk level. Reassessments are conducted yearly or if there is a significant change in the member's condition.

The review of a sample of case management files revealed care management activities were conducted appropriately and according to contractual requirements.

Magnolia's process for handling a request for an appeal is detailed in Policy MS.PRVR.27, Provider Complaints, Grievances and Appeals, Policy MS.UM08, Appeal of UM Decisions, the Member Handbook, the UM Program Description, Provider Manual, and website. Appeals are appropriately categorized and analyzed for trends and opportunities for quality improvement and reported to the QIC on a quarterly basis.

A sample of appeal files was reviewed. Two appeal files did not contain acknowledgement letters. All of the appeals were reviewed by an appropriate physician and were processed timely.

Delegation

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

Magnolia delegates to subcontractors and/or vendors to perform some health plan activities, including UM and claims processing for dental, vision, pharmacy, non-emergency transportation, and radiology services.

All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Policy MS.QI.14, Oversight of Delegated Vendor Services, describes the processes for oversight and monitoring of all delegates.

Annual oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports. The reports are reviewed and analyzed for outliers and any noted inconsistencies. The results of this monitoring are presented to the Joint Oversight Committee for review and approval. It was noted in the 2022

Annual Audit Report for Envolve Pharmacy Solutions that the name for this delegate had been changed to Centene Pharmacy Solutions. Magnolia staff explained this represented only a name change. There were no changes (benefits, claims, etc.) that affected any members. However, the Member Handbook, page 57, references Envolve Pharmacy Solutions as the pharmacy benefit manager.

Corrective Action Plans and Recommendations from Previous EQR

During the 2022 EQR, 13 standards were scored as "Partially Met", and no standards were scored as "Not Met." The following provides a high-level summary of those deficiencies:

- The Compliance Committee Charter states members are expected to attend 75% of the meetings. Review of the submitted Compliance Committee meeting minutes revealed that one voting member only attended 50% of the meetings.
- Review of submitted Credentialing Committee minutes confirmed the quorum was established for each of the meetings. However, three voting committee members did not meet the attendance requirement. This finding has been noted for three consecutive years.
- Policy MS.PRVR.10, Evaluation of the Accessibility of Services, incorrectly documented the appointment access standard for routine appointments with Behavioral Health/Substance Use Disorders providers and related provider appointments post-discharge from an acute psychiatric hospital. Also, the policy did not specify the timeframes for routine and urgent dental appointments and appointment timeframes for urgent care and emergency care providers.
- Page 28 of the Provider Manual addresses flu and pneumonia vaccines and states limitations of one flu shot per 12 months and two pneumonia shots per lifetime. The Provider Manual does not include COVID-19 vaccines, which are included in the Member Handbook, page 19.
- Page 30 of the Provider Manual addresses Plastic Surgeon services and states, "All services must be in office settings…" However, the Member Handbook, page 20, does not include this limitation.
- The Provider Manual directs the reader to the website to view the full lists of Preventive Health Guidelines and Clinical Practice Guidelines. However, the hyperlinks provided are non-functional, returning an error message. This finding was originally noted in the previous EQR.
- Magnolia's policy defines the timeline for resolving complaints and grievances. Complaints are resolved within one calendar day, and grievances are resolved within 30 calendar days. The policy mentions that Magnolia may extend this timeframe and will give members written notice of the reason for the extension. However, the policy and the notice sent to

the member regarding the need for the extension do not offer the member's right to file a grievance related to the extension.

- A sample of denial decisions made by Magnolia was reviewed and the Adverse Benefit Determination notices incorrectly mentioned that an oral request for an appeal must be followed with a written request unless the request is for an expedited appeal. Also, the Adverse Benefit Notice letter template incorrectly states that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.
- Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, the Provider Manual, and Magnolia's website incorrectly stated that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.
- Appeal acknowledgement letter templates were missing the member's right to submit comments, documents, or other information relevant to the appeal and the member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.
- The notice sent to members regarding an extension of the appeal resolution timeframe did not mention the members' right to file a grievance if they disagreed with the extension. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website.
- Issues noted in the sample of appeal files reviewed included a resolution notice sent to the member prior to the date of the decision, failure to notify members of denial of expedited appeal processing and transition to a standard appeal process, failure to resolve an appeal within the required timeframe, and failure to send one acknowledgement letter.
- Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, incorrectly state the timeframe for continued access to providers who are no longer available through the CCO's network as 90 calendar days.

Conclusions

Overall, Magnolia met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 7: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Magnolia's compliance scores relative to each of the 13 Subpart D and QAPI standards above that were reviewed for Magnolia.

Table 7: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	15	13	87%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	18	18	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* • Emergency and Post Stabilization Service (§ 42 C.F.R. 438.114)	Utilization Management, Section V. B	12	12	100%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	20	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	9	9	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	19	100%
• Disenrollment Requirements and Limitations (§ 438.56)	Member Services, Section III. D	2	2	100%
• Enrollee Rights Requirements (§ 438.100)	Member Services, Section III. A	3	3	100%
• Emergency and Post Stabilization Service (§ 42 C.F.R. 438.114)	Utilization Management, Section V. B	1	1	100%

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

As noted in the table above, issues were noted with the following:

- For Availability of Services and Assurances of Adequate Capacity and Services, health plan policies did not include the geographic access standards for providers other than PCPs and appointment access standards for specialists.

Table 8, Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2022 review. For 2023, 183 of 188 standards received a score of "Met." Five standards were scored as "Partially Met."

Table 8: Scoring Overview - CAN

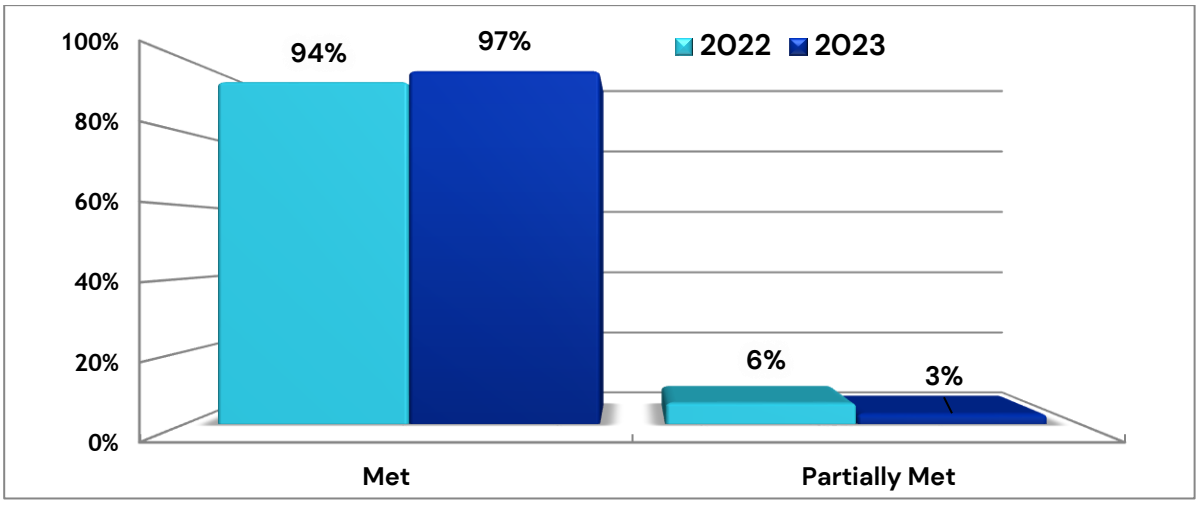
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	30	1	0	0	0	31	96.8%
2023	29	2	0	0	0	31	93.5%
Provider Services							
2022	79	5	0	0	0	84	94%
2023	47	2	0	0	0	49	95.9%
Member Services							
2022	32	1	0	0	0	33	97%
2023	33	0	0	0	0	33	100%
Quality Improvement							
2022	19	0	0	0	0	19	100%
2023	19	0	0	0	0	19	100%
Utilization							
2022	49	5	0	0	0	54	90.7%
2023	53	1	0	0	0	54	98.1%
Delegation							
2022	1	1	0	0	0	2	50%
2023	2	0	0	0	0	2	100%
Totals							
2022	210	13	0	0	0	223	94%
2023	183	5	0	0	0	188	97%

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

The 2023 Annual EQR shows that Magnolia achieved "Met" scores for 97% of the standards reviewed, and 3% of the standards were scored as "Partially Met."

The chart that follows provides a comparison of the current review results to the 2022 review results for Magnolia.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number.

Recommendations and Opportunities for Improvements

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

Table 9: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for policy development and ongoing review. Policies are housed in locations that are readily accessible by staff.	✓		
All key positions are filled, and overall staffing is sufficient.	✓		
Magnolia processes claims at a rate that exceeds DOM requirements.		✓	
Magnolia continuously works with its Quality and HEDIS team to improve rates, providing oversight and integrity checks.	✓		
Processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse are well documented in Magnolia's Compliance and Ethics Program Description 2023, 2023 FWA Plan, and related policies and procedures.	✓		
The Centene Corporation Business Ethics and Code of Conduct addresses expectations for ethical business conduct and practices and covers a variety of related topics.	✓		
Magnolia requires compliance training within 30 days of hire for new employees and annually for all employees. Compliance training is mandatory, and staff who do not complete the training may be subjected to disciplinary action, including termination.	✓		
Provider Services			

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for notifying providers of their assigned members and for providers to verify member eligibility and enrollment.			✓
Magnolia routinely evaluates the adequacy of its network and uses correct parameters to evaluate geographic access to providers as well as appointment access with providers.			✓
Various activities are conducted to ensure the cultural competency of Magnolia's provider network.			✓
For the appointment access study conducted by Magnolia, compliance with appointment access standards was over 90% for each appointment type.			✓
Provider Directories are routinely updated and include all required elements.			✓
Provider Access Study successful contact rate increased from the previous year.			✓
Initial and ongoing provider education activities are sufficient to ensure providers can function effectively within Magnolia's network.	✓		
Magnolia adopts PHGs and CPGs and makes them available to providers, members, and potential members.	✓		
Magnolia educates providers about medical record documentation standards and routinely assesses provider compliance with those standards.	✓		
Member Services			
Member rights and responsibilities are documented in policy, the Member Handbook, the Provider Manual, and on Magnolia's website. Members are educated about their rights and responsibilities in various ways.	✓		
New members are educated about the health plan, programs, benefits, and various processes and requirements through the Member Handbook, website, the New Member Packet, welcome calls, newsletters, etc.			✓
Appropriate processes are in place for notifying members of changes in benefits, services, and the provider network.			✓
Magnolia ensures member materials are written at appropriate reading levels and available in alternate formats. Translation and interpretation services are provided.			✓
Call Center staff use approved scripts that are reviewed at least annually and presented to DOM for review and approval. Call center staff receive routine education about the Medicaid program, the MississippiCAN Program, customer service, transferring members to a Care Manager, State Plan Amendments, etc.	✓		
Call center performance is monitored to identify opportunities for improvement with action taken to address any identified opportunities. All call center performance metrics were met in 2022.	✓		
Magnolia partners with certain providers who allow Magnolia to schedule appointments and send appointment reminders using the Appointment Wizard.			✓
Member satisfaction results for Child and Adult are examined internally.	✓		
Of the sample grievance files reviewed for the 2023 EQR, all were acknowledged and resolved timely.		✓	
Quality Improvement			
Magnolia achieved full Health Equity Accreditation in 2022.	✓		
The 2023 QI Work Plan format was updated and contained extensive details and information.	✓		
All four PIPs received validation scores within the High Confidence in Reported Results Range.	✓		

Strengths	Quality	Timeliness	Access to Care
There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Magnolia followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.	✓		
The following HEDIS MY 2022 measure rates and non-HEDIS Adult Core Set and Child Core Set measure rates were strengths for Magnolia since their rates had a greater than 10% improvement: • AMR Age 51-64 indicator improved by over 10 percentage points. • Kidney Health Evaluation for Patients with Diabetes (KED) Age 65-74 indicator improved by over 16 percentage points, however; eligible population was very small, slightly over 31 for both years. • Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) 7 days Age 18-64 indicator improved by over 18 percentage points, 30 days Age 18-64 improved by over 12 percentage points, Total 7 days indicator improved by over 18 percentage points and 30 days indicator improved by over 13 percentage points. • COPD or asthma in older adults' admission rate (PQI-05): Age 65+ indicator rate increased significantly; however, there were only two numerator compliant records in the prior year and three in 2022. • Heart failure admission rate (PQI-08) Age 65+ indicator rate increased significantly; however, there were no numerator compliant records in the prior year and one in 2022. • Topical fluoride for children (TLF-CH) Rate 1 and Rate 2 indicators showed significant improvement by over 13 percentage points for all but two (Age 1-2 and ages 19-20) indicators.	✓		
There were no HEDIS MY 2022 measure rates or non-HEDIS Adult Core Set and Child Core Set measure rates that decreased more than 10 percentage points.	✓		
Utilization Management			
Magnolia's target percentage goal of 100% for timeliness adherence for standard and urgent outpatient requests was maintained for at least 11months this past year.		✓	
Magnolia's target percentage goal for timeliness adherence of 98% for standard inpatient and urgent requests was maintained for twelve months this past year.		✓	
Mississippi members receiving care management services are mailed a copy of their care plan goals once their treatment plan is completed.	✓		
The Appeals and Grievance team assists filers with the Authorized Representative Form by prefilling information for a quick and convenient return of this form.			✓
The sample of appeal files reviewed for this EQR were resolved timely.		✓	
Delegation			
Annual oversight and monitoring activities are conducted for all delegates through review of relevant monthly, quarterly, and annual reports. The reports are reviewed and analyzed for outliers and inconsistencies. The results of this monitoring are presented to the Joint Oversight Committee for review and approval.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Provider Services				
Policy CC.COMP.22 states each policy has a Policy Manager responsible for reviewing and revising the policy. After annual and ad hoc revisions, Policy Approvers who are directors or vice president level staff review and approve or reject the policy. Onsite discussion confirmed policies also go to the Clinical Policy Committee for review and approval. However, this is not addressed in Policy CC.COMP.22.	Recommendation: Revise Policy CC.COMP.22 to include information related to policy review by the Clinical Policy Committee.	✓		
For the previous EQR, Magnolia was given a corrective action to reinforce attendance expectations with members of the committee. However, for the quarterly meeting minutes for June 14, 2022, through June 21, 2023, two members of the committee did not appear to meet the 75% attendance requirement. During the onsite discussion of this finding, Magnolia staff reported that these committee members were represented by proxy for the meetings they did not attend. However, this was not reflected in the minutes. After the onsite, revised minutes were submitted, indicating the proxy attendees.	Corrective Action: Ensure Compliance Committee attendance by proxy is accurately documented in all minutes.	✓		
Policy MS.PHAR.15, Pharmacy Lock-In Program, addresses the availability of a temporary or emergency supply of medication. However, the policy does not address that the emergency supply of medication is limited to a 72-hour supply.	Corrective Action Plan: Revise Policy MS.PHAR.15, Pharmacy Lock-In Program, to include that an emergency supply of medication is limited to a 72-hour supply, as noted in the *CAN Contract, Section 11 (F) (3).*	✓		
Provider Services				
Policy MS.CONT.01, Provider Network, does not specify the geographic access parameters for any providers other than PCPs. It states Magnolia ensures "Access to all other provider types and the full range of medical specialties necessary to provide	Corrective Action: Ensure geographic access standards for all provider types are included in a policy.			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
covered services as required by DOM."				
Policy MS.PRVR.10, Evaluation of the Accessibility of Services, defines appointment access standards, but does not include the appointment access standard for specialists.	Corrective Action Plan: Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include appointment access standards for all providers, as defined in the CAN Contract, CAN Contract, Section 7 (B) 2, Table 7.			✓
Response rates for provider satisfaction surveys remain low and may affect generalizability of the results	Recommendation: Continued efforts should be made to gather a better representation of providers for the provider satisfaction surveys.	✓		
Member Services				
Response rates for member satisfaction surveys remain low and may affect generalizability of the results	Recommendation: Continued efforts should be made to gather a better representation of the members for the member satisfaction surveys.	✓		
Quality Management				
Information regarding Magnolia's Quality Improvement Program is shared with members and providers via the website. However, the QI Program Description found on Magnolia's website was outdated.	Recommendation: Update the website to include current information about the Quality Improvement Program.	✓		
Three of the four PIPs experienced a decline in the indicator rates.	Recommendation: Asses the current interventions to determine if changes are needed.	✓		
During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates.	Recommendation: Improve processes around oversight of the software vendor and ensure they follow the specifications when calculating the performance measures.	✓		
Based on the review of the HEDIS Compliance Audit Final Audit Report, and the discussions during the PMV onsite review, it was identified that there were opportunities for improvement in communication and oversight between the corporate	Recommendation: Improve communication and oversight with the corporate HEDIS team and centralized operations to ensure accuracy, monitoring and tracking for the DOM required performance measures.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
HEDIS team, centralized operations and the CCO.				
Utilization Management				
Turning Point (a vendor) uses clinical guidelines referenced in appeal determination notices. However, Turning Point is not referenced as a vendor in Magnolia's UM policies and Program Description.	Corrective Action: Update UM policies and procedures and the Magnolia Health Utilization Management Program Description 2023 to include information that Magnolia uses a vendor, Turning Point, for some UM and appeals determinations.	✓		
Delegation				
It was noted in the 2022 Annual Audit Report for Evolve Pharmacy Solutions, the name for this delegate had been changed to Centene Pharmacy Solutions. Magnolia staff explained this represented only a name change. There were no changes (benefits, claims, etc.) that affected any members. However, the Member Handbook, page 57 references Envolve Pharmacy Solutions as the pharmacy benefit manager.	Recommendation: Update all materials to reflect the name change for the Pharmacy Benefit Manager.	✓		

METHODOLOGY

The process Constellation Quality Health used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the four federally mandated EQR activities of compliance determination, validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On July 5, 2023, Constellation Quality Health sent notification of the initiation of the annual EQR to Magnolia (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN Program.

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

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on August 4, 2023, for review at the Constellation Quality Health offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on October 18, 2023, and October 19, 2023. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Magnolia's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*, and the Contract requirements between Magnolia and DOM. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review are identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheets included in each of the following sections.

A. Administration

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

The review of the Administration section includes policy development and management, health plan staffing, information systems capabilities, compliance and program integrity, and confidentiality.

Magnolia has established processes and guidelines for developing, reviewing, approving, and maintaining policies. Policies are reviewed at least annually and when needed due to changes in laws, regulations, and contractual requirements. The health plan adopts corporate policies when possible and uses addenda when necessary to capture state-specific processes and requirements. Policy CC.COMP.22, Policy Management, indicates each policy has a Policy Manager who is responsible for reviewing and revising the policy, and Policy Approvers who are directors or vice president level staff review and approve or reject the policy. Onsite discussion confirmed policies also go to the Clinical Policy Committee for review and approval. However, this is not addressed in Policy CC.COMP.22. Staff can access policies on the health plan's policy management platform, RSA Archer, and on the company's intranet.

Review of the Organizational Chart and onsite discussion confirmed staffing is sufficient to ensure all required activities can be conducted and all contractually required services are provided to members. All key positions are filled.

Magnolia's Compliance and Ethics Program Description 2023 (Compliance Plan), 2023 Fraud, Waste and Abuse (FWA) Plan, and related policies and procedures describe processes for ensuring compliance and guarding against fraud, waste, and abuse. The Centene Corporation Business Ethics and Code of Conduct (Code of Conduct) addresses expectations for ethical business conduct and practices, and covers a variety of topics, including, but not limited to, fraud, waste and abuse detection and prevention, protecting confidential information and information security, conflicts of interest, and procedures for reporting concerns, violations, etc.

The Compliance Plan also describes the roles and responsibilities of the Compliance Officer and Compliance Committee. The Compliance Officer reports directly to the Coordinated Care Organization (CCO) President/Chief Executive Officer and governing Board, and is responsible for planning, implementing, and monitoring the Compliance Program. The Compliance Committee is a cross-functional team of individuals with varying responsibilities in the organization, as well as employees and managers of key operating units. The committee meets at least quarterly and as needed. The Compliance Committee, reviews the Compliance Program Description and Work Plan, supports the Compliance Officer, reviews the effectiveness of the Compliance Program by monitoring audit results, metrics, and key

indicators, and ensures prompt, effective corrective actions are taken for any identified deficiencies.

The 2023 Compliance Committee Charter lists the purpose and objectives of the committee. It defines the meeting frequency as quarterly and the quorum requirement that at least 50% of the voting members be in attendance. The charter states members are expected to attend 75% of the meetings. For the previous EQR, it was found that one voting member only attended 50% of the meetings, and corrective action was given to reinforce attendance expectations with committee members. However, for the quarterly meeting minutes for June 14, 2022, through June 21, 2023, two members of the committee did not appear to meet the 75% attendance requirement. Magnolia staff reported during onsite discussion that the absent members appointed designees to attend in their place. This, however, was not reflected in the minutes. After the onsite, revised minutes indicating the designees who attended for the committee members were submitted. The revised minutes were not considered in the scoring for this finding.

Table 10: 2022 Compliance/Program Integrity CAP Items

Standard	EQR Comments	2023 EQR Findings
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	The Compliance Committee Charter states the committee meets quarterly and as needed, is chaired by the Compliance Officer, and defines membership of the committee. Members are expected to attend 75% of the meetings, and the quorum is defined as the presence of 50% of voting members. Review of the submitted Compliance Committee meeting minutes revealed that one voting member only attended 50% of the meetings. *Corrective Action Plan: Reinforce attendance expectations with members of the Compliance Committee.*	Initial review of Compliance Committee minutes showed that two committee members did not appear to meet the attendance requirement for the Compliance Committee. Magnolia reported that designees represented the absent members. This, however, was not documented in the attendance records for the meetings in question.
Magnolia's 2022 Response: Compliance team will continue to check availability of members prior to scheduling meetings. During the Q1 meeting, education will be provided on the compliance committee expectations.		

Magnolia requires compliance training for new employees within 30 days of hire and annually for all employees. Training is conducted through a variety of methods, including interactive in-services, on-line training, newsletters, etc. Members of the Board of Directors are provided with a copy of the Business Ethics and Conduct policy and must give written acknowledgement of receipt and that they will comply with the policy.

Magnolia encourages reporting of compliance and/or fraud, waste, and abuse (FWA) concerns; allows anonymous reporting, maintains confidentiality when possible; and prohibits retaliation for individuals who make good faith reports of issues or concerns. Information about methods to ask compliance questions and to report potential risks, including FWA, is disseminated through various forums, such as department meetings, emails, the intranet, posters displayed throughout the workplace, etc.

The 2023 Fraud, Waste and Abuse (FWA) Plan, Attachment M of the 2023 FWA Plan, and multiple policies and procedures address processes to prevent, detect, and respond to reports of actual or suspected FWA.

Magnolia has an established pharmacy lock-in program to detect, prevent, and respond to abuse of the pharmacy benefit. Members included in the program are restricted to one pharmacy and one controlled substance provider. Policy MS.PHAR.15, Pharmacy Lock-In Program, addresses program processes and requirements. Although the policy addresses the availability of an emergency supply of medication, it does not note that the emergency supply of medication is limited to a 72-hour supply.

Health Information Systems

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

Magnolia provided documentation demonstrating that its infrastructure is capable of meeting DOM contractual requirements as well as information system (IS) requirements. Magnolia exceeds the State's timeliness requirements by averaging greater than 99% of clean claims being paid in 30 days and averaging 100% of clean claims being paid in 90 days. Magnolia performs regular risk assessments to identify potential risks to both physical and virtual infrastructure and to aid the organization in implementing precautionary measures in the case of disaster recovery and business continuity. Magnolia's resiliency strategies address its diverse infrastructure that is comprised of both cloud and traditional data centers. Revision timestamps indicate the organization regularly reviews and updates its documentation.

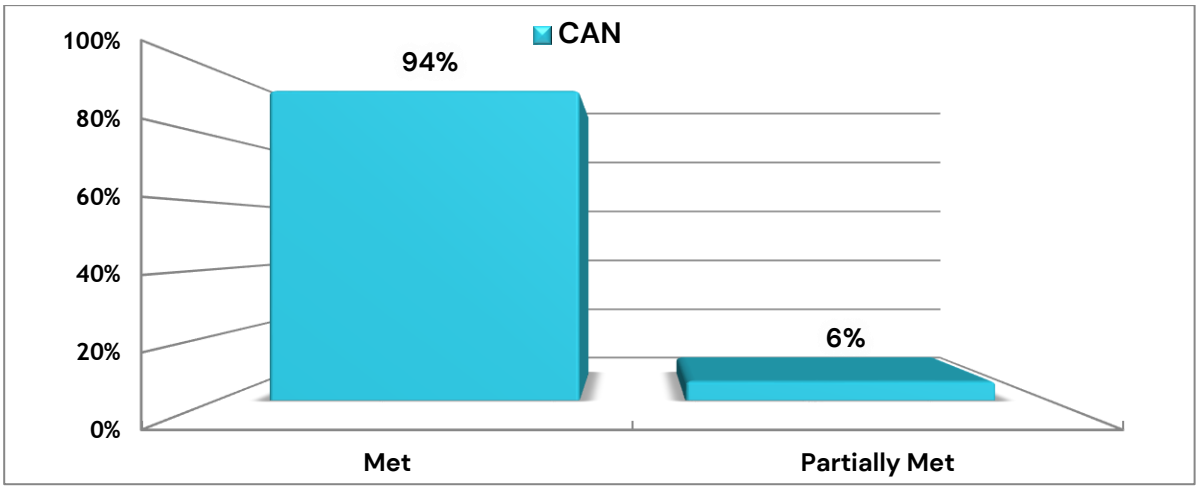
Confidentiality

§ 438.224

Multiple policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality and HIPAA requirements.

As illustrated in *Figure 2: Administration Findings*, 94% of the standard s in the Administration section were scored as "Met."

Figure 2: Administration Findings



Scores were rounded to the nearest whole number.

Table 11: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for policy development and ongoing review. Policies are housed in locations that are readily accessible by staff.	✓		
All key positions are filled, and overall staffing is sufficient.	✓		
Magnolia processes claims at a rate that exceeds DOM requirements.		✓	
Magnolia continuously works with its Quality and HEDIS team to improve rates, providing oversight and integrity checks.	✓		
Processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse are well documented in Magnolia's 2023 Compliance Plan, FWA Plan, and related policies and procedures.	✓		
The Centene Corporation Business Ethics and Code of Conduct addresses expectations for ethical business conduct and practices and covers a variety of related topics.	✓		
Magnolia requires compliance training within 30 days of hire for new employees and annually for all employees. Compliance training is mandatory, and staff who do not complete the training may be subjected to disciplinary action, including termination.	✓		

Table 12: Administration Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy CC.COMP.22 states each policy has a Policy Manager responsible for reviewing	Recommendation: Revise Policy CC.COMP.22 to include information	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
and revising the policy. After annual and ad hoc revisions, Policy Approvers who are directors or vice president level staff review and approve or reject the policy. Onsite discussion confirmed policies also go to the Clinical Policy Committee for review and approval. However, this is not addressed in Policy CC.COMP.22.	related to policy review by the Clinical Policy Committee.			
For the previous EQR, Magnolia was given a corrective action to reinforce attendance expectations with members of the committee. However, for the quarterly meeting minutes for June 14, 2022, through June 21, 2023, two members of the committee did not appear to meet the 75% attendance requirement. During the onsite discussion of this finding, Magnolia staff reported that these committee members were represented by proxy for the meetings they did not attend. However, this was not reflected in the minutes.	Corrective Action: Ensure Compliance Committee attendance by proxy is accurately documented in all minutes.	✓		
Policy MS.PHAR.15, Pharmacy Lock-In Program, addresses the availability of a temporary or emergency supply of medication. However, the policy does not address that the emergency supply of medication is limited to a 72-hour supply.	Corrective Action Plan: Revise Policy MS.PHAR.15, Pharmacy Lock-In Program, to include that an emergency supply of medication is limited to a 72-hour supply, as noted in the *CAN Contract, Section 11 (F) (3).*	✓		

ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CC.COMP.22, Policy Management, addresses Magnolia's processes for developing, reviewing, approving, and maintaining policies. Magnolia's policies are reviewed and approved at least annually and as needed for changes in laws, regulations, or contractual requirements. The health plan adopts corporate policies when possible and uses addenda when necessary to capture state-specific processes and requirements. Policy CC.COMP.22 states each policy has a Policy Manager responsible for reviewing and revising the policy. After annual and ad hoc revisions, Policy Approvers who are directors or vice president level staff review and approve or reject the policy. Onsite discussion confirmed policies also go to the Clinical Policy Committee for review and approval. However, this is not addressed in Policy CC.COMP.22. Magnolia uses the RSA Archer platform for policy management. Staff can access policies on the RSA Archer platform or on the company's intranet site. *Recommendation: Revise Policy CC.COMP.22 to include information related to policy review by the Clinical Policy Committee.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Aaron Sisk is Magnolia's Plan President & Chief Executive Officer (CEO).
1.2 *Chief Operating Officer;	X					Michael Todaro is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Lewis (Trip) Peebles is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Ajoy Kodali is the Chief Information Officer.
1.4.1 *Information Systems personnel;	X					Documentation in the Information Systems Capabilities Assessment (ISCA) Tool indicates adequate staffing for information systems. Onsite discussion confirmed reports and encounter data are provided to DOM by Trip Peebles and Andrew Friday, Manager of Compliance and Reporting.
1.5 Claims Administrator;	X					The Organizational Chart lists Jennifer Hobock as the Manager, Claims Configuration and Business. She serves as the Claims Administrator.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 *Provider Services Manager;	X					Cynthia Douglas, Vice President, Network Development and Contracting, serves as the Provider Services Manager.
1.6.1 *Provider contracting and education;	X					
1.7 *Member Services Manager;	X					Kennesha Higgins, Senior Manager of Customer Service, is the Member Services Manager.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					
1.9 Utilization Management Coordinator;	X					Michael Adcock is the Vice President, Population Health and Clinical Operations. Christie Moody is the Director, Medical Management, and Kimberly Ball is the Senior Manager, Medical Management Operations.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Carrie Mitchell is the Vice President, Quality Management and Jeff Martin is the Director, Quality Improvement.
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Dr. Jeremy Erwin is the Chief Medical Director. Additional Medical Directors include Bri May, MD (Pediatrics) and Dianna Tate, MD (Pediatrics). Dr.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Sarah Gantz Pannel, DO (Psychiatry) is the Behavioral Health Medical Director.
1.13 *Compliance Officer.	X					Nicole Litton, Vice President of Compliance, is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia's Information Systems Capabilities Assessment (ISCA) documentation defines their internal claims benchmark as 99% of clean claims paid within 30 Days, and that 100% of clean claims are paid within 90 days. Magnolia provided 12 months of claims processing data for the ISCA review. These data showed that Magnolia regularly exceeds DOM's requirements for timeliness. Claims are processed through the Amisys system and undergo a comprehensive adjudication process which validates all claims processing required information.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia relies on the State's 834 files for enrollment. Magnolia retrieves member data from the 834 files which are loaded daily in the United Member Viewer (UMV) enrollment system and reconciled with state enrollment data monthly. Provider data is stored in the Portico system and are verified against a state provider roster to ensure validity and credentialing.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					HEDIS, HEDIS-like measure rate reports and other DOM required measure rate reports are stored and processed with National Committee for Quality Assurance (NCQA)-certified HEDIS software (Inovalon). Additionally, Magnolia states that all reports are reviewed both by corporate partners and business owners to ensure data accuracy, validate performance measure rates, and compare historical performance statistics.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia has an appropriate disaster recovery and business continuity plan for its IT resources. The organization has implemented strategies to address the differences in its infrastructure which includes the data centers and cloud environments. The recovery and business continuity plans are tested, reviewed, and updated annually. Magnolia is ISO 27001 and HITRUST Certified and has strict policies and procedures in place to aid in disaster recovery and business continuity.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					Magnolia's Compliance and Ethics Program Description 2023 (Compliance Plan), 2023 Fraud, Waste and Abuse (FWA) Plan, and related policies and procedures describe processes for ensuring compliance and guarding against fraud, waste, and abuse.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Centene Corporation Business Ethics and Code of Conduct addresses expectations for ethical business conduct and practices, and covers a variety of topics, including but not limited to: • FWA detection and prevention • inside information • protecting confidential information and information security • records and information management • conflicts of interest • procedures for reporting concerns, violations, etc.
2.2 Identification of the Compliance Officer;						The Compliance Plan describes the roles and responsibilities of the Compliance Officer. These include but are not limited to planning, implementing, and monitoring the Compliance Program. The Compliance Officer reports directly to the President/CEO and governing Board.
2.3 Information about the Compliance Committee;						The Compliance Plan describes the roles and responsibilities of the Compliance Committee, including but not limited to, reviewing the Compliance Plan and Work Plan, supporting the Compliance Officer, reviewing the effectiveness of the Compliance Program by monitoring audit results, metrics, and key indicators, and ensuring prompt, effective corrective actions are taken for identified deficiencies.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Compliance training and education;						Information about compliance training is found in Policy CC.COMP.10, Enterprise Compliance Training, and in the Compliance Plan. Compliance training is conducted for new employees within 30 days of hire and annually for all employees. Training is conducted through a variety of methods, including interactive in-services, on-line training, newsletters, etc. Compliance training is mandatory, and staff who do not complete the training may be subjected to disciplinary action, including termination. Members of the Board of Directors are provided with a copy of the Business Ethics and Conduct policy and must give written acknowledgement of receipt and that they will comply with the policy.
2.5 Lines of communication;						As noted in the Compliance Plan, Magnolia maintains processes for submitting, recording, and responding to compliance questions and reports of non-compliance. These processes are designed to maintain confidentiality whenever possible, allow anonymous reporting and communication, and ensure there is no retaliation for those making good faith reports of issues or concerns. Information about methods to ask compliance questions and to report potential risks, including FWA, is disseminated to all employees, the governing body, subcontractors, etc., through forums, such as department meetings, emails, mailings, CNET (the Centene intranet), posters displayed throughout the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						workplace, departmental leadership, Provider Manuals, provider updates, the website, etc.
2.6 Enforcement and accessibility;						Employees are advised of disciplinary guidelines through multiple methods, including policies and procedures, compliance training, intranet articles and videos, workplace posters, and live presentations. Staff and providers are informed of the degrees of disciplinary actions that may be taken for noncompliance with company standards and policies as well as applicable statutes and regulations. Factors considered in determining disciplinary action include the nature of the violation, ramifications of the violation, direct or indirect involvement of the individual, and the willfulness of the violation. Also considered are whether the violation was isolated or part of a pattern of conduct, whether the individual reported and/or withheld information about the violation, the degree of cooperation with investigation, any disciplinary action previously taken for similar violations, etc.
2.7 Internal monitoring and auditing;						As noted in the Compliance Plan, Magnolia conducts ongoing internal evaluation processes as well as Third Party Risk Management activities. Ongoing internal evaluation processes include periodic compliance audits using internal and/or external auditors with expertise in federal and state statutes, regulations, and federal health care program requirements. These audits focus on company programs or divisions, and relationships with third-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						party contractors, to assess compliance with specific rules and policies. Written reports with results are provided to the Compliance Officer, governing body, etc., and specify areas in need of corrective action. Third Party Risk Management activities include monitoring third-party compliance with performance standards and reporting.
2.8 Response to offenses and corrective action;						The Compliance Plan addresses investigations conducted for suspected and/or reported noncompliance to determine if there was a violation of applicable law or compliance requirements. If a violation is determined, steps are taken to correct the issue. Corrective actions are tailored to address the identified misconduct and are monitored after implementation to evaluate the effectiveness of the action. In addition to corrective action, responses may include referral to law enforcement and or reporting to regulatory bodies, including state or federal authorities.
2.9 Exclusion status monitoring.						Policy CC.COMP.36, Centene Screening for Exclusions from Federal and State Health Care Programs, Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, and Policy CC.PDM.01, Initial and Ongoing Monitoring of Sanctions Against Non-Par Providers, include information about the monthly exclusion screening processes conducted.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				The Compliance Plan provides an overview of the Compliance Committee and its roles and responsibilities. The Compliance Committee is a cross-functional team of individuals with varying responsibilities in the organization, as well as employees and managers of key operating units. The committee meets at least quarterly and as needed. The 2023 Compliance Committee Charter lists the purpose and objectives of the committee. The charter confirms the committee meets on a quarterly basis, and that the Compliance Officer is the Committee Chairperson. As noted in the charter, members are expected to attend 75% of the meetings, and the quorum is established with the presence of 50% of the voting members. The charter lists voting members of the committee. For the previous EQR, Magnolia was given a corrective action to reinforce attendance expectations with members of the committee. However, for the quarterly meeting minutes for June 14, 2022, through June 21, 2023, the following did not appear to meet the 75% attendance requirement: • Chief Operating Officer attended 50% • Chief Financial Officer attended 25% During the onsite discussion of this finding, Magnolia staff reported that these committee members were represented by proxy for the meetings they did not attend. However, this was not reflected in the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						minutes. After the onsite, revised minutes were submitted, indicating the proxy attendees. *Corrective Action Plan: Ensure Compliance Committee attendance by proxy is accurately documented in all minutes.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The FWA Plan, Attachment M of the 2023 FWA Plan, and multiple policies and procedures address processes to prevent and detect potential or suspected FWA.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The triage team within the Special Investigations Unit (SIU) logs and evaluates all referrals related to FWA. Each incident is assigned a number for tracking. If determined that SIU investigation is warranted, the case and related information is referred to an SIU Investigator. The SIU Investigator reviews contract and regulatory requirements to verify that the referred activity warrants further investigation. After the initial investigation, a preliminary report is completed and submitted to SIU Management for approval and determination of next steps.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The 2023 FWA Plan and Attachment M of the 2023 FWA Plan address payment suspensions and recoupments.
7. The CCO implements and maintains a Pharmacy Lock-In Program.		X				Policy MS.PHAR.15, Pharmacy Lock-In Program, describes the program that was designed to detect, prevent, and/or respond to abuse of the pharmacy benefit. Members in the program are restricted to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						one pharmacy and one controlled substance provider. The policy addresses: • Identification of members for inclusion for the program through referral from DOM and through internal monitoring. Internal inclusion and exclusion criteria are found in the policy. • Member notification of inclusion and of the availability of a hearing 30 days before restrictions are implemented. • The member's ability to request a change in pharmacy due to moving, transportation barriers, etc. • The availability of a temporary or emergency supply of medication. However, the policy does not address that the emergency supply of medication is limited to a 72-hour supply. • Provision of care management and education reinforcement • Review after the initial one-year lock-in period and then every six months to determine the need for continued lock-in. *Corrective Action Plan: Revise Policy MS.PHAR.15, Pharmacy Lock-In Program, to include that an emergency supply of medication is limited to a 72-hour supply, as noted in the CAN Contract, Section 11 (F) (3).*
I E. Confidentiality *42 CFR § 438.224*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Multiple policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality and HIPAA requirements.

B. Provider Services

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

The review for Provider Services includes adequacy of the provider network, provider education about health plan processes and requirements, development of and education about clinical practice (CPGs) and preventive health guidelines (PHGs), provider medical record documentation standards and medical record audits, and the provider satisfaction survey.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

New provider orientation is conducted within 30 days of a new provider's contract effective date. Topics covered in the orientation are listed in the Provider Orientation Core Elements attachment to Policy CC.PRVR.13, Provider Orientations. Ongoing provider education is conducted to keep providers informed of any changes that would impact them as providers within Magnolia's network. Ongoing education is given through newsletters, the web-based provider "Newsroom," mailings, in-person and/or virtual interactions, etc. In addition to formal provider education processes, the Magnolia Health Provider Manual is a comprehensive resource of information providers will need to function effectively and appropriately within the network.

Magnolia defines requirements for provider medical record documentation in health plan policy and educates providers about the standards in the Provider Manual. An annual assessment of provider medical recordkeeping practices is conducted to assess provider compliance with the medical record documentation standards, as described in Policy MS.QI.13, Medical Record Review. Providers must meet 90% of the requirements for medical recordkeeping and 100% for claim validation or be subject to corrective action. Elements scoring below 90% are considered deficient and in need of improvement.

For the 2022 Medical Record Audit, six practices were included, all of which met the scoring threshold of 90% or more. However, opportunities for improvement were noted for four of the practices, and recommendations were offered.

Table 13: 2022 Provider Education CAP Items

Standard	EQR Comments	2023 EQR Findings
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	Page 28 of the Provider Manual addresses flu and pneumonia vaccines and states limitations of one flu shot per 12 months and two pneumonia shots per lifetime. The Provider Manual does not include COVID-19 vaccines, which are included in the Member Handbook, page 19. Page 30 of the Provider Manual addresses Plastic Surgeon services and states, "All services must be in office settings…" However, the Member Handbook, page 20, does not include this limitation. Corrective Action Plan: Revise the Provider Manual to correct the issues noted with vaccine coverage and plastic surgeon services.	The issues identified during the previous EQR were corrected.
Magnolia's 2022 Response: Provider Manual has been updated with these changes.		

Practice Guidelines

§ 438.236, § 457.1233

Magnolia adopts CPGs and PHGs from nationally recognized sources. Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, describes procedures for adopting PHGs and CPGs. The guidelines are presented to appropriate committees for physician review and adoption. The guidelines are reviewed at least annually and updated for significant new scientific evidence or changes in national standards. Magnolia distributes the guidelines via the Provider Manual, the Magnolia Health website, and/or provider newsletters, and provides the guidelines to members and potential enrollees upon request.

An issue identified during the previous EQR along with Magnolia's response and the current status of the finding are addressed in the table below.

Table 14: 2022 Preventive Health and Clinical Practice Guidelines CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	The Provider Manual directs the reader to the website to view the full list of Preventive Health Guidelines. However, the hyperlink provided is non-functional, returning an error message. This is a finding originally noted during the previous EQR. *Corrective Action Plan: Revise the Provider Manual to include the correct hyperlink to the list of guidelines on Magnolia's website or remove the hyperlink and provide detailed information about where to locate the guidelines.*	The 2023 Provider Manual was revised to include navigation directions for accessing the guidelines and removed the hyperlinks. This appropriately addressed the corrective action from last year's review.
Magnolia's 2022 Response: The provider manual is currently being revised to remove the hyperlink and add detailed information. Provider Manual will be submitted for DOM's approval through the document submission process.		

Network Adequacy Validation

42 CFR § 438.68 (a), 42 CFR § 438.14(b)(1) 42 CFR § 457.1218. 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Constellation Quality Health conducted a validation review of Magnolia's provider network following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the CCO is meeting network standards defined by the State. To validate Magnolia's network, Constellation Quality Health requested and reviewed:

- Member demographics, including total enrollment and distribution by age ranges, sex, and county of residence
- Geographic access assessments, network development plans, enrollee demographic studies, population needs assessments, provider-to-enrollee ratios, in-network and out-of-network utilization data, provider panel size limitations
- A complete list of network providers
- The total numbers of unique primary care and specialty providers in the network
- A completed Provider Network File Questionnaire
- Provider Appointment Standards and health plan policies
- Provider Manual and Member Handbook
- A sample provider contract

A desk review of these documents was conducted to assess network adequacy. In addition, the results of the most recent Telephone Access Study were considered.

Overall, Magnolia met the requirements of the Network Adequacy Validation. The results of the Telephone Access Study conducted by Constellation Quality Health in Q3 2023 identified weaknesses regarding the provider contact information and the availability of routine and urgent appointments. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

The following is an overview of the results for each activity.

Provider Network File Questionnaire

Constellation reviewed the Provider Network File Questionnaire (PNFQ) and noted that Magnolia uses Portico for their provider enrollment system. JAVA and Pega are the logic systems used to load, store, and update information. Verification is conducted through CenProv. The member facing directory is updated every 24 hours by way of an interfacing process.

The state has time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. Information Systems Capability Assessments (ISCA) evaluation demonstrated that the organization and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

Magnolia has established processes for notifying primary care providers (PCPs) of the members assigned to their panels. Magnolia provides a current patient listing to all network PCPs who are registered on the secure provider web portal. Providers without access to the portal and those who would like additional copies of the member panel may contact Provider Relations. Providers can verify member eligibility and enrollment by logging onto DOM's Envision website or the Magnolia Provider Portal, using Magnolia's automated member eligibility Interactive Voice Response (IVR) system, and calling Provider Services.

Magnolia evaluates the availability of network providers at least annually against contractually required standards by considering geographic access mapping and other network adequacy reports, and results of member satisfaction surveys regarding practitioner availability. Magnolia runs geographic access reports at least quarterly. Policy MS.CONT.01, Provider

Network, appropriately defines geographic access standards for PCPs. The policy does not specify the geographic access parameters for any other provider types. It states only that Magnolia ensures "Access to all other provider types and the full range of medical specialties necessary to provide covered services as required by DOM." No policy that defined geographic access standards for other provider types was identified. GeoAccess reports dated 4/25/23 confirm use of appropriate geographic access parameters for PCPs and specialists.

Policy MS.PRVR.10, Evaluation of the Accessibility of Services, defines appointment access standards for network providers and processes for evaluating provider compliance with the standards. However, the policy does not include the appointment access standard for specialists. Magnolia conducts telephonic or onsite surveys and audits for primary care, behavioral health, and specialty providers. Corrective action plans are implemented for providers who do not meet the compliance goal of 90% for the telephone surveys. In addition, Magnolia also monitors CAHPS survey results and grievance and appeal data to assess appointment accessibility. For Magnolia's call study conducted in Q2 2023, success rates ranged from 69.09% to 91.43%, and compliance for various appointment types ranged from 91% to 100%.

Magnolia conducts various activities to ensure the network can serve members with hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations. These activities include collecting and analyzing member demographic information, collecting provider linguistic and cultural information, conducting disparity assessments, and producing a Cultural Competency Plan.

Table 15: 2022 Adequacy of the Provider Network CAP Items

Standard	EQR Comments	2023 EQR Findings
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	When comparing the access standards in Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to the *CAN Contract, Section 7 (B) 2*, the following issues were noted: OFor BH/SUD providers, the policy indicates routine appointments should be scheduled within 10 business days. OFor BH/SUD appointments post-discharge from an acute psychiatric hospital (when the CCO is aware of the discharge), the policy lists the timeframe as 14 calendar days. OThe policy does not specify timeframes for dental appointments (routine visits and urgent care visits). OThe policy does not specify the timeframes for Urgent Care or Emergency Care Providers.	All issues identified during the 2022 EQR were appropriately addressed.

Standard	EQR Comments	2023 EQR Findings
	Corrective Action Plan: Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include the correct timeframes for routine BH/SUD appointments and for BH/SUD appointments post-discharge from an acute psychiatric hospital (when the CCO is aware of the discharge). Add the timeframes for routine and urgent care dental appointments, general urgent care providers, and emergency care providers.	
Magnolia's 2022 Response: MS.PRVR.10 has been updated and uploaded. Redline version of updates has been uploaded. Item 3 MS.PRVR.10_Evaluation_of _Accessibility_Services102122 redline.		

Provider Access and Availability Study

Constellation Quality Health conducts Telephonic Provider Access Studies twice yearly for each CCO. Full details of these call studies are reported to DOM separately. For the most recent study conducted in Q3 2023, improvement was shown from the previous study that was conducted in Q4 2022. See *Table 16*.

Table 16: Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q4 2022	24 of 78	31%	<.001
Q3 2023	58 of 90	64%	

For Q3 2023, Magnolia submitted a total of 2,216 unique PCPs for the CAN population and a random sample of 95 was drawn for Phase 1. Of the 95 PCPs contacted, five calls were answered by voicemail and thereby, omitted from the denominator in the success rate formula. After accounting for the voicemail answered calls, the Phase 1 success rate was 64% (58 of 90). This is a statistically significant improvement in successful contacts from the previous rate of 31% (p<.001). The routine appointment compliance rate was 61% and the urgent appointment compliance rate was 49%, both improvements from the previous study. Provider directory validation had an attempted 58 PCP verifications, and the accuracy rate was 57% (33 of 58).

The next call study will take place in February 2024.

Provider Satisfaction Survey Validation

SPH Analytics/Press Ganey, a National Committee for Quality Assurance Certified Survey Vendor, conducted the 2022 Provider Satisfaction Survey on behalf of Magnolia. Of the 2,500 providers included in the provider sample, 197 valid surveys were collected, yielding a response rate of 7.9%. The low response rate for the provider satisfaction survey may affect generalizability of the results.

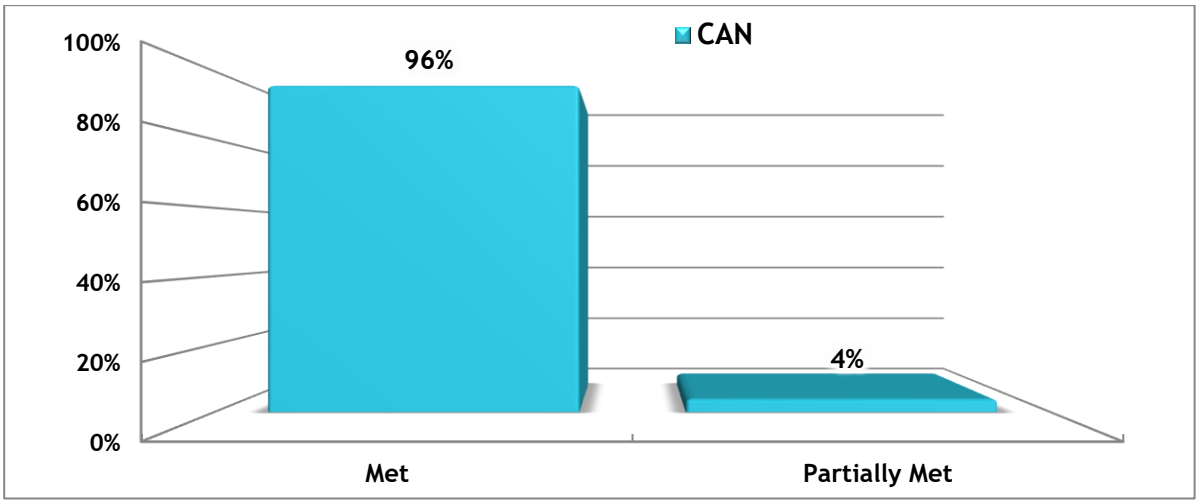
Table 17 offers the section of the worksheet that needs improvement, the reason, and the recommendation.

Table 17: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Of the 2,500 sample providers, 197 responded, creating a response rate of 7.9%. This is a decrease from last year's rate of 9.2%. This is a low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution.	Continued efforts should be made to gather a better representation of the providers.

As displayed in *Figure 3: Provider Services Findings*, 96% of the Provider Services standards were scored as "Met."

Figure 3: Provider Services Findings



Scores were rounded to the nearest whole number.

Table 18: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for notifying providers of their assigned members and for providers to verify member eligibility and enrollment.			✓
Magnolia routinely evaluates the adequacy of its network and uses correct parameters to evaluate geographic access to providers as well as appointment access with providers.			✓
Various activities are conducted to ensure the cultural competency of Magnolia's provider network.			✓
For the appointment access study conducted by Magnolia, compliance with appointment access standards was over 90% for each appointment type.			✓
Provider Directories are routinely updated and include all required elements.			✓
Provider Access Study successful contact rate increased from the previous year's rate.			✓
Initial and ongoing provider education activities are sufficient to ensure providers can function effectively within Magnolia's network.	✓		
Magnolia adopts PHGs and CPGs and makes them available to providers, members, and potential members.	✓		
Magnolia educates providers about medical record documentation standards and routinely assesses provider compliance with those standards.	✓		

Table 19: Provider Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MS.CONT.01, Provider Network, does not specify the geographic access parameters for any providers other than PCPs. It states Magnolia ensures "Access to all other provider types and the full range of medical specialties necessary to provide covered services as required by DOM."	Corrective Action: Ensure geographic access standards for all provider types are included in a policy.			✓
Policy MS.PRVR.10, Evaluation of the Accessibility of Services, defines appointment access standards, but does not include the appointment access standard for specialists.	Corrective Action Plan: Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include appointment access standards for all providers, as defined in the *CAN Contract, Section 7 (B) 2, Table 7.*			✓
Response rates for provider satisfaction surveys remain low and may affect generalizability of the results	Recommendation: Continued efforts should be made to gather a better representation of providers for the provider satisfaction surveys.	✓		

PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)*						
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.01, PCP Member Panel Reports, states Primary Care Providers (PCPs) are informed of members assigned to them via the provider web portal and hard copy. Magnolia provides a current patient listing to all network PCPs who are registered on the secure provider web portal, which is updated within five business days of receiving the member listing from DOM. Providers who do not have access to the portal or who would like additional copies of the member panel may contact Provider Relations. The PCP Panel/Patient List is sent to the provider within five business days of a provider's request
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Providers can verify member eligibility and enrollment by logging onto DOM's Envision website or the Magnolia Provider Portal, using Magnolia's automated member eligibility Interactive Voice Response (IVR) system, and calling Provider Services.
1.3 The CCO tracks provider limitations on panel size to determine	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
providers that are not accepting new patients.						
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					As noted in Policy CC.PRVR.47, Evaluation of Practitioner Availability, Magnolia defines PCPs as family/general practitioners, internists, and pediatricians. Magnolia evaluates the availability of network PCPs at least annually against contractually required standards by considering geographic access mapping and other network adequacy reports, and results of member satisfaction survey regarding practitioner availability. Policy MS.CONT.01, Provider Network, appropriately defines geographic access standards for primary care providers (PCPs). The GeoAccess report dated April 25, 2023, confirms use of appropriate geographic access parameters for PCPs.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.		X				For the previous EQR, Policy CC.PRVR.47, Evaluation of Practitioner Availability, included tables with all of the geographic access standards listed, but the policy submitted for the current EQR did not include the tables. It stated, "Practitioner Availability Standards– can be found on the Accreditation Network SharePoint site…" Policy MS.CONT.01, Provider Network, does not specify the geographic access parameters for any providers other than PCPs. It states Magnolia ensures "Access to all other provider types and the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						full range of medical specialties necessary to provide covered services as required by DOM." After the onsite, a revised, draft version of Policy MS.CONT.01 was submitted showing the health plan is adding the specific geographic access standards for all provider types. This revised policy was not considered when scoring this standard. *Corrective Action Plan: Ensure geographic access standards for all provider types are included in a policy.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Magnolia runs geographic access reports at least quarterly. Magnolia submitted the 2023: Practitioner Availability Report (for Measurement Year 2022) and the 2023: Assessment of Network Adequacy for Physical and Behavioral Health Report (for Measurement Year 2022). Both were dated 06/2023 and included overall results, quantitative and qualitative analyses, identified barriers, opportunities for improvement, and planned interventions.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical	X					Magnolia conducts various activities to ensure its provider network can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
needs, and accessibility considerations.						activities are documented in Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), Policy MS.QI.22, Cultural Competency, and Policy CC. PRVR.47, Evaluation of Practitioner Availability. Magnolia collects and analyzes member demographic information and provider linguistic and cultural concordance with the membership to identify cultural, linguistic, disparity, and accessibility needs of members. Magnolia also conducts disparity assessments and produces a Cultural Competency Plan. The Cultural Competency Plan describes processes to ensure culturally competent services are provided to all members.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire (PNFQ) was reviewed. Magnolia uses Portico for their provider enrollment system. JAVA and Pega are the logic systems used to load, store, and update information. Verification is conducted through CenProv. The member facing directory is updated every 24 hours by way of an interfacing process.
1.10 The CCO formulates and acts within written policies and	X					Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, documents the process for taking

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.						action against a network practitioner for quality reasons. The Quality Improvement and Credentialing Committees monitor network providers for the quality and safety of practitioner services. The Credentialing Committee ultimately determines whether, after investigation, it is necessary to suspend, restrict, or terminate a provider's network participation. When action is taken, the network practitioner is notified in writing and informed of appeal rights. Magnolia reports to the National Practitioner Data Bank, state licensing boards, etc. as required when adverse action is taken against a network practitioner. Procedures for identifying, monitoring, investigating, and analyzing potential or suspected quality of care incidents are addressed in Policy CC.QI.17, Potential Quality of Care Incidents.
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MS.PRVR.10, Evaluation of the Accessibility of Services, defines appointment access standards, but does not include the appointment access standard for specialists. All appointment access standards are appropriately documented in the Provider Manual and Member Handbook. According to Policy CC.PRVR.48, Evaluation of the Accessibility of Services, Magnolia measures

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appointment accessibility to primary care, behavioral health, and specialty care services annually through a variety of methods, including CAHPS surveys, monitoring grievance and appeal data, and telephonic or onsite surveys and audits for primary care, behavioral health, and specialty providers. *Corrective Action Plan: Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include appointment access standards for all providers, as defined in the CAN Contract, CAN Contract, Section 7 (B) 2, Table 7.*
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					Magnolia measures appointment accessibility to primary care, behavioral health, and specialty care services annually by conducting telephonic or onsite surveys and audits for primary care, behavioral health, and specialty providers. The compliance goal is 90%. If not met, a written corrective action plan is implemented, and the provider is allowed time to implement changes before being re-audited. If the goal is not met on re-audit, the provider is presented to the Credentialing Committee, or other appropriate committee, for review and recommendations for additional corrective action. This process is found in Policy CC.PRVR.48, Evaluation of the Accessibility of Services,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The MSCAN Provider Appointment Availability-PCP and OB-GYN and MSCAN Provider Appointment Availability-Behavioral Health reports provide results for call studies conducted in Q2 2023. • For PCPs, the success rate was 69.09% with 100% compliance for well visits and routine sick visits. The compliance rate for urgent care visits was 97%. • For OB-GYNs, the success rate was 90% with 100% compliance for well visits and routine sick visits. The compliance rate for urgent care visits was 94%. For Behavioral Health providers, the success rate was 91.43% with 100% compliance for routine visit and post discharge appointments. The compliance rate for urgent care visits was 91%.
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The state has time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Analytics software. Information Systems Capability Assessment (ISCA) evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.
II B. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					The procedure for conducting new provider orientation within 30 days of the contract effective date is found in Policy CC.PRVR.13, Provider Orientations. This process applies to all contracted PCPs, specialists, hospitals, and ancillary providers who are not part of an existing in-network group or facility. Topics covered in the orientation are listed in the Provider Orientation Core Elements attachment to the policy.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services,	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and services provided under fee-for-service payment by DOM;						
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					The Provider Manual addresses Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and specifies that providers should follow the American Academy of Pediatrics (AAP) Bright Futures' Periodicity Schedule and the Advisory Committee on Immunization Practices' (ACIP) Recommended Immunization Schedule.
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The Provider Manual includes an overview of the Pharmacy Program and directs the reader to the website for additional information. It references the Preferred Drug List, exception requests, generic substitutions, the Pharmacy Benefit Manager, prior authorizations, the emergency drug supply, etc.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					The Provider Manual (page 72) states, "Magnolia requires all practitioners and providers to cooperate with all QI activities and allow Magnolia to use practitioner and/or provider performance data to ensure success of the QAPI program." It further states, "This system provides a continuous cycle for assessing the quality of care and service among plan initiatives, including preventive health,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Magnolia provides ongoing education to its network providers through newsletters, the web-based provider "Newsroom," mailings, in-person and/or virtual interactions, etc.
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, and that are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, describes procedures for adopting preventive health guidelines (PHGs) and clinical practice guidelines (CPGs). The guidelines are presented to appropriate committees for physician review and adoption. The guidelines are reviewed at least annually and updated for significant new scientific evidence or changes in national standards.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CPG Grid 2023 shows all CPGs were annually reviewed in February 2023.
2. The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members.	X					The 2023 Quality Management Program Description (page 59), states, "Guidelines are distributed to providers via the Provider Manual, the Magnolia Health website, and/or provider newsletters and are available to all members or potential enrollees upon request."
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II D. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MS.QI.13, Medical Record Review, includes processes for monitoring and evaluating provider compliance with medical record documentation standards and maintenance. The policy defines the medical record retention timeframe as at least 10 years for adults and at least 13 years for minors. A copy of the Medical Record Audit Tool is attached to the policy and included the medical records documentation standards.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					As noted in Policy MS.QI.13, Medical Record Review, qualified Magnolia staff or contractors conduct annual assessments of provider medical recordkeeping practices. Providers must meet 90% of the requirements for medical recordkeeping and 100% for claim validation or be subject to corrective action. The goal is 100% compliance with all elements. Elements scoring below 90% are considered deficient and in need of improvement. For the 2022 Medical Record Audit, six practices were included. All the practices met the scoring threshold of 90% or more. However, opportunities

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for improvement were noted for four of the practices, and recommendations were offered.
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					SPH Analytics/Press Ganey, a National Committee for Quality Assurance Certified Survey Vendor, was selected by Magnolia Health Plan to conduct its 2022 Provider Satisfaction Survey. A sample of qualified respondents were providers contracted with Magnolia. There were 197 valid surveys collected out of the total sample of 2,500, equating to a 7.9% response rate. Response rates for provider satisfaction surveys remain low and may affect generalizability of the results. *Recommendation: Continued efforts should be made to gather a better representation of providers for the provider satisfaction surveys*.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the Performance improvement team/committee in May and June 2023 meeting.

C. Member Services

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

The Member Services review includes member rights and responsibilities, member education, call center functions, member enrollment and disenrollment processes and requirements, the member satisfaction survey, and processes for receiving and resolving grievances.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

Member rights and responsibilities are detailed in Policy MS.MBRS.25, Member Rights and Responsibilities. This policy describes the ways in which Magnolia communicates the rights and responsibilities to members, including via the New Member Packet, Member Handbook, and the health plan's website. The review confirmed member rights and responsibilities are consistently documented across the Member Handbook, the Provider Manual, and Magnolia's website.

Member CCO Program Education

42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)

Magnolia provides a New Member Packet to newly enrolled members within 14 days of receiving the member's enrollment information. The packet includes a Member Handbook, the member's ID Card along with a Welcome Letter, a Benefit Booklet, contact information for the health plan, information about the website, various forms, and brochures.

The Member Handbook, included in the New Member Packet, is a rich resource for members to understand Magnolia's services, processes, and requirements. The Member Handbook instructs members about obtaining a Provider Directory and addresses covered benefits, second opinions, and requirements for obtaining out-of-network care. Information about urgent and emergent care, pharmacy benefits and limitations, and the Preferred Drug List is included. Roles and responsibilities of primary care providers are explained in the Member Handbook, as well as information about how to select a primary care provider (PCP) and make appointments. Of note, the Member Handbook mentions that Magnolia partners with certain providers who allow Magnolia to schedule appointments and send appointment reminders using the Appointment Wizard.

The CAN Member Handbook list the hours of operation for the Member Services Call Center, which are compliant with contractual requirements and notes that the Nurse Advice Line is available 24 hours a day, 7 days a week. Onsite discussion confirmed that members may access mental health/substance use disorders around the clock.

Members are informed that they will be notified of changes in services, benefits, and providers in writing as well as through Magnolia's website, addendums to the Member Handbook, at new member orientations, etc. Processes for notifying members of these changes are found in POLICY MS.MBRS.12, Member Notification of Plan Changes, and Policy CC.MBRS.27, Member Advisory of Provider Termination.

Magnolia has processes for ensuring member materials are developed to ensure they are easily understood by members. Member materials do not exceed a sixth grade reading comprehension level, as confirmed by using the Flesch-Kincaid Readability Scale. Appropriate fonts are used for regular and large-print materials. Magnolia can provide member materials in alternate languages and formats, and free translation and interpreter services are also offered. The Member Handbook informs that Magnolia ensures the provision of "free aids and services to people with disabilities to communicate effectively" such as sign language interpreters, free language services for those whose primary language is not English, and alternate language materials. Magnolia also offers text telephone (TTY) 711 services for persons with hearing or speech disabilities.

Member Services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities. The Service Quality Improvement Subcommittee monitors trends related to member and provider call center activities. Results of performance throughout 2022 indicated all performance metrics were met. Call center data includes performance related to the call abandoned rate, the average speed of answer, and the service level. For 2022, Magnolia met the established goals for the year. However, in January and February 2022, pharmacy system errors resulted in an influx of calls to the Member Services Call Center, which impacted the service level for both months. Causes of the system errors were identified, and interventions were developed and implemented.

Call Center staff use interactive scripts for initial welcome calls, outbound calls to new members, assisting members with PCP selection, and responding to general member calls. The scripts are reviewed annually by Magnolia and reviewed and approved by DOM prior to use. In addition, quarterly training is provided to call center staff about the Medicaid Program, the MississippiCAN Program, customer service, State Plan Amendments, etc.

Member Enrollment and Disenrollment

42 CFR § 438.56

Processes and requirements for member disenrollment are documented in Policy MS.ELIG.05, Disenrollment. The policy specifically addresses timeframes for member requests for disenrollment and that members must direct these requests to DOM; "for cause" member requests for disenrollment and circumstances under which a member could request for cause disenrollment; and involuntary disenrollment and circumstances

that may lead to an involuntary disenrollment. Onsite discussion confirmed that prior to requesting member disenrollment for cause, such as disruptive or inappropriate behavior, health plan staff work with applicable members to try to redirect or improve behaviors.

Preventive Health and Chronic Disease Management Education

As noted in Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System, and the 2023 Quality Program Description, Magnolia informs members about preventive health and chronic disease management services in a variety of ways, including but not limited to, the New Member Packet, the Member Handbook, newsletters, and the website. In addition, Magnolia sends birthday reminder cards and other mailings to members as well as providing education through telephonic and digital platform outreach and at community events, such as health fairs. To encourage participation in EPSDT/preventive services, the My Health Pays incentive program is in place to reward members for healthy behaviors. This program provides pre-paid cards that can be used to purchase appropriate items.

Grievances

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

Processes for handling grievances are outlined in Policy MS.MBRS.07, Member Grievance and Complaints, Policy MS.PRVR.27, Provider Complaints, Grievances and Appeals, the Member Handbook, the Provider Manual, and the website. The definitions of grievances and complaints are clear and consistent throughout Magnolia's materials, along with the instructions for verbal or written filing options.

Timelines for acknowledging and resolving complaints and grievances are indicated in policies and materials. Complaints are resolved within one calendar day. Grievances are resolved within 30 calendar days and may be filed at any time. Clinically urgent grievances are resolved within 72 hours of receipt. During the onsite, explanations were provided regarding previous EQR findings about policy and the notice sent to members specific to their right to file a grievance related to an extension request. Magnolia has recently received approval for document revisions, but the steps outlined in the following table have been put into place. Revised wording on the website is in progress.

Table 20: 2022 Grievances CAP Items

Standard	EQR Comments	2023 EQR Findings:
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	Magnolia's policy defines the timeline for resolving complaints and grievances. Complaints are resolved within one calendar day and grievances are resolved within 30 calendar days. The policy mentions that Magnolia may extend this timeframe and will give the member written notice of the reason for the extension. However, this policy and the notice sent to the member regarding the need for the extension does not offer the member's right to file a grievance related to the extension. *Corrective Action Plan: Include in the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing a grievance in Policy MS.MBRS.07, Member Grievance and Complaints Process and in the member notice.*	Policy MS.MBRS.07, Member Grievance and Complaints Process, and notification materials to members have been updated to correctly indicate the member's right to right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing a grievance.
Magnolia's 2022 Response: MS.MBRS.07 policy and MSCAN Member Extension Letter both updated to reflect member's right to file a grievance if they do not agree with extension. Policy MS.MBRS.07 will be included with redline changes to both DOM and EQRO. Redline of updates has been uploaded. Item 7 - Policy MS.MBRS.07 Member Grievance and Complaint Process-Redline-MSCAN-Revised.		

Grievances are logged, categorized, and maintained per contractual requirements. Summaries of complaint and grievance actions, trends, and root causes are reported quarterly to the QIC. Reports are reviewed to establish opportunities to improve quality of service and/or quality of care. The QIC will report findings to the Board of Directors who maintain the final authority, responsibility, and accountability.

Constellation Quality Health reviewed a random sample of grievance files for the current EQR. It was found that all grievances were acknowledged and resolved timely in accordance with policy and contractual guidelines.

Member Satisfaction Survey Validation

Magnolia contracts with Press Ganey to conduct both the child and adult member satisfaction surveys. The surveys were fielded from February through May 2023.

For MY 2022, the adult survey response rate was 19.4%, which is a slight improvement from the previous year's response rate of 17.2%. The MY 2022 Child CAHPS survey response rate was 16.7%, also an increase from the previous year's response rate of 9.2%. The Children with

Chronic Conditions (CCC) response rate was 13.4%, an improvement from the previous year's rate of 10.1%.

Press Ganey summarizes and details all results from the adult and child surveys. The documentation showed an assessment of barriers and interventions to address member satisfaction concerns, and indicated the survey results were reported to the Performance Improvement Committee in May and June of 2023. The survey results were reported to providers in the October 6, 2023, provider newsletter.

As noted in *Figure 4: Member Services Findings*, 100% of the standards for the Member Services review were scored as "Met."

Figure 4: Member Services Findings

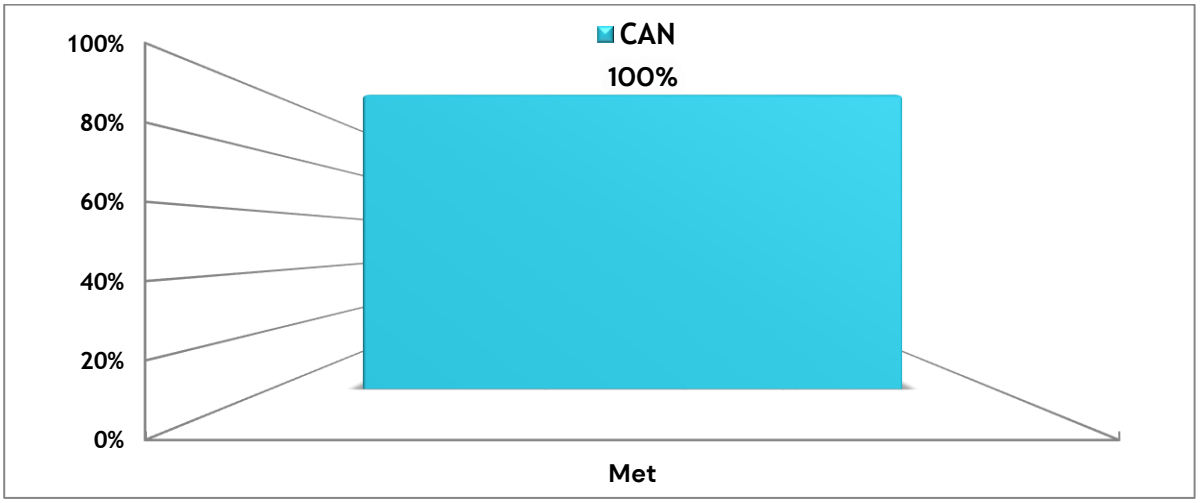


Table 21: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Member rights and responsibilities are documented in policy, the Member Handbook, the Provider Manual, and on Magnolia's website. Members are educated about their rights and responsibilities in various ways.	✓		
New members are educated about the health plan, programs, benefits, and various processes and requirements through the Member Handbook, website, the New Member Packet, welcome calls, newsletters, etc.			✓
Appropriate processes are in place for notifying members of changes in benefits, services, and the provider network.			✓
Magnolia ensures member materials are written at an appropriate reading level and are available in alternate formats. Translation and interpretation services are also provided.			✓
Call Center staff use approved scripts that are reviewed at least annually and presented to DOM for review and approval. Call center staff receive routine education about the	✓		

Strengths	Quality	Timeliness	Access to Care
Medicaid program, the MississippiCAN Program, customer service, transferring members to a Care Manager, State Plan Amendments, etc.			
Call center performance is monitored to identify opportunities for improvement with action taken to address any identified opportunities. All call center performance metrics were met in 2022.	✓		
Magnolia partners with certain providers who allow Magnolia to schedule appointments and send appointment reminders using the Appointment Wizard.			✓
Member satisfaction results for Child and Adult are examined internally.	✓		
Of the sample grievance files reviewed for the 2023 EQR, all were acknowledged and resolved in a timely manner.		✓	

Table 22: Member Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Response rates for member satisfaction surveys remain low and may affect generalizability of the results	Recommendation: Continued efforts should be made to gather a better representation of the members for the member satisfaction surveys.	✓		

MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MS.MBRS.25, Member Rights and Responsibilities, describes the ways in which Magnolia informs members of their rights and responsibilities and how the plan ensures the rights are protected. As noted in the policy, newly enrolled members receive a New Member Packet and Member Handbook upon enrollment. The Member Handbook lists and describes the rights and responsibilities, which can also be viewed on the health plan's website.
2. Member rights include, but are not limited to, the right:	X					Member rights are documented in the Member Handbook, the Provider Manual, and on Magnolia's website.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Member responsibilities are documented in the Member Handbook, the Provider Manual, and on Magnolia's website.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					Within 14 days of receiving enrollment information, Magnolia provides a New Member Packet to newly enrolled members. The packet includes a Member Handbook, the member's ID Card along with a Welcome Letter, a Benefit Booklet, contact information for the health plan, information about the website, various forms, and brochures, etc. Processes for providing this information are detailed in Policy MS.MBRS.01, New Member Packet/Member ID card. The Member Handbook, included in the New Member Packet, instructs members about obtaining a Provider Directory.
1.1 Full disclosure of benefits and services included and excluded in coverage;						A benefits grid of covered services is found in the Member Handbook, pages 19-21. Review of the benefit grid and comparison to the benefit grid in the Provider Manual, pages 27-31. The member benefit documentation is consistent across both documents.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						The Member Handbook informs that members may access second opinions at no cost with network providers, and that second opinions from out of network providers may require authorization.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook includes information related to emergent and urgent medical and behavioral health care, out of network emergency care, etc. The Member Handbook also includes examples of conditions or symptoms for which emergent care is appropriate as well as conditions and symptoms for which urgent care is the more appropriate level of care.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						Information about pharmacy processes, restrictions, medication limitations, prior authorization requirements, etc. is found in the Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Information about the roles and responsibilities of the PCP is included in the Member Handbook. Members are informed about how to select a PCP and that they should see the PCP for all basic medical care, how to make appointments, and what to do after the PCP's normal business hours. Of note, the Member Handbook mentions that Magnolia partners with certain providers who allow Magnolia to schedule appointments and send appointment reminders using the Appointment Wizard.
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 A description of EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						The Member Handbook instructs that the Provider Directory includes information about network providers, such as addresses, phone numbers, languages spoken, etc. It also includes that members can obtain information about network providers by using the online "Find a Provider" tool on the website. Members are also informed that they can obtain a copy of the Provider Directory by contacting Member Services or by going to Regional DOM offices, local Women, Infants and Children offices, and Magnolia's office in Ridgeland, MS.
1.17 Instructions for reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.19 Information about advance directives;						An overview of advance directives is included in the Member Handbook. The overview includes the purpose of advance directives, how to obtain forms to implement an advance directive, and information about notifying providers of the presence of an advance directive. The Member Handbook includes the types of advance directives and informs that members cannot be subjected to discrimination for having an advance directive. The telephone number for reporting complaints about noncompliance with advance directives to the State Survey and Certification Division of the State Department of Health is included.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					POLICY MS.MBRS.12, Member Notification of Plan Changes, describes the process for notifying members of changes in benefits, services, and provider location and service changes. As noted in the policy, members are notified in writing of any material change to the MississippiCAN Program 30 calendar days before the intended effective date Also, members will be notified in writing when there are changes to covered services, benefits, or processes for accessing benefits at least 14 days before implementing the change.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy CC.MBRS.27, Member Advisory of Provider Termination, covers processes for notifying members of a provider termination. As noted in the policy, members are given written notice of a provider's termination at least 30 calendar days before the effective date of the termination. If less than 30 days' advance notice is possible, the member will be given written notification within 15 calendar days of receipt or issuance of the termination notice.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Magnolia's member materials do not exceed a sixth grade reading level as evaluated by the Flesch-Kincaid method. Appropriate fonts for regular and large print materials are used. Documents are available in prevalent non-English languages and can be translated into other languages upon request. Oral interpretation can also be provided. These processes are documented in Policy MS.MBRS.06, Member Materials Readability and Translation.
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					The Member Handbook, page 2, informs that Magnolia ensures the provision of "free aids and services to people with disabilities to communicate effectively" such as sign language interpreters, free language services for those whose primary language is not English, and alternate language materials. Magnolia also offers text telephone (TTY)

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Relay 711 services for persons with hearing or speech disabilities. Additional information is found in Policy CC.MBRS.16, Hard of Hearing/Language Specific Interpreter Services, and in Policy MS.MBRS.17, Telecommunication Devices/Services.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					Policy MS.COMM.01, Marketing: General Guidelines for Marketing Activities, covers guidelines for marketing activities and states, "Magnolia employees follow the marketing guidelines set forth by the Mississippi Division of Medicaid (DOM) when interacting with potential members and providers." As noted in the policy: • Magnolia will ensure the readability level does not exceed sixth grade. • Magnolia will submit all marketing and incentive materials to DOM for approval prior to use. • All marketing/promotional activities will comply with federal and state laws, including HIPAA, antikickback statues, etc. • Magnolia may be sanctioned or fined for violations related to marketing.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The policy lists allowable and prohibited marketing and outreach activities and states Magnolia will maintain a log of marketing complaints that tracks resolution and includes a provision that staff outside of the Marketing Department must be involved in resolving those complaints. Complaints that cannot be resolved will be forwarded to DOM for investigation and resolution.
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					As noted in Policy CC.MBRS.09 MS Addendum, Member & Provider Services Calls, and confirmed during onsite discussion, the hours of operation for the Member Services Call Center are compliant with contractual requirements. The nurse advice line operates 24 hours a day, 7 days a week.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Call Center staff use interactive scripts for initial welcome calls, outbound calls to new members, assisting members with PCP selection, and responding to member calls in general. The scripts are reviewed annually by Magnolia and reviewed and approved by DOM prior to use. Quarterly training is provided to call center staff. The trainings include the Medicaid Program, the MississippiCAN Program, customer service, transferring members to a Care Manager, State Plan Amendments, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					The Quality Management Program Evaluation 2022 confirms Magnolia Call Center Quality Specialists monitor call center statistics monthly and results are reported to the Quality Improvement Committee. For 2022, call center data includes: • Abandoned Rate (goal <5%) – 2.86% • Average Speed of Answer (goal < 60 sec) – 16 seconds • Service Level Percentage (goal 85%) – 91.97% The analysis included in the program evaluation indicated that in January and February 2022, Magnolia experienced two pharmacy system errors resulting in an influx of calls and elevated call volumes for several days. This impacted the service level for both months and caused goals not to be met for those specific months and for the first quarter. All goals were met and exceeded for the remaining months. Interventions were developed to address the reason the goals were not met in the first two months. Recommendations for 2023 were also included.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Magnolia allows members freedom of choice when selecting a PCP and includes information in the Welcome Packet about selecting and changing the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PCP. Also, during the new member outreach call, members are educating about their right to select their PCP and staff assist members as needed with choosing a provider. New members are allowed a maximum of 30 days to select a PCP. If no PCP is chosen, the health plan assigns a PCP for the member. Members can change their selected or assigned PCP at any time by using the secure member portal and by contacting Member Services. These processes are found in Policy MS.ELIG.03, Primary Care Provider (PCP) Selection and Change. In addition, Policy MS.ELIG.01, Primary Care Provider (PCP) Auto-Assignment, addresses the process for auto-assignment of a PCP. When assigning PCPs, factors considered include current provider relationships, language needs (if known), age, gender, enrollment of other family members, and area of residence.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Processes and requirements for member disenrollment are documented in Policy MS.ELIG.05, Disenrollment. The policy specifically addresses timeframes for member requests for disenrollment and that members must direct these requests to DOM; "for cause" member requests for disenrollment and circumstances under which a member could request for cause disenrollment; and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						involuntary disenrollment and circumstances that may lead to an involuntary disenrollment. Onsite discussion confirmed that prior to requesting for-cause member disenrollment, health plan staff work with the member to try to redirect or improve behaviors.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					As noted in Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System, and the 2023 Quality Program Description, Magnolia informs members about preventive health and chronic disease management services in a variety of ways, including: • The New Member Packet • Member Handbook • Newsletters • CCO website • Birthday reminder cards and other mailings • Telephonic or digital platform outreach • Community events such as health fairs To encourage participation in EPSDT/preventive services, the My Health Pays incentive program is in place to reward members for healthy behaviors.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						This program provides pre-paid cards that can be used to purchase appropriate items.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					Magnolia identifies pregnant members in a variety of ways. All pregnant members receive educational materials. In addition, the Member Handbook includes information about what members should do when they become pregnant, offers information about available pregnancy and maternity services, and educates members about programs such as Start Smart for Your Baby® and the Puff Free Pregnancy Program.
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					Magnolia contracts with SPH/Press Ganey to conduct both the child and adult surveys, which were fielded from February through May 2023. For MY 2022, the adult CAHPs survey response rate was 19.4%, which is a slight improvement from the previous year's response rate of 17.2%.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The MY 2022 Child CAHPS survey response rate was 16.7%, also an increase from the previous year's response rate of 9.2%. The CCC response rate was 13.4%, which is also an improvement from the previous year's rate of 10.1%. The documentation showed assessment of barriers and interventions to address member satisfaction concerns. Response rates for member satisfaction surveys remain low and may affect the generalizability of the results. *Recommendation: Continued efforts should be made to gather a better representation of the members for the member satisfaction surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from adult and child surveys.
3. The CCO reports results of the member satisfaction survey to providers.	X					The survey results were reported to providers in the October 6, 2023, provider newsletter.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					Findings were reported to the Performance Improvement Committee in May and June of 2023.
III G. Grievances						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07, Member Grievance and Complaints, Policy MS.PRVR.27, Provider Complaints, Grievances and Appeals, the 2023 Member Handbook, 2023 Magnolia Health Provider Manual, and website provide information about processes for handling grievances.
1.1 Definition of a grievance and who may file a grievance;	X					Policy MS.MBRS.07, Member Grievance and Complaints, the Member Handbook, Provider Manual, and website appropriately define a grievance as "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					Complaints are resolved within one calendar day, and grievances are resolved within 30 calendar days and may be filed at any time. Clinically urgent grievances are resolved within 72 hours of receipt.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
for the period specified in the contract.						
2. The CCO applies the grievance policy and procedure as formulated.	X					The sample of grievance files reviewed for the 2023 EQR were acknowledged and resolved in a timely manner.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Summaries of complaint and grievance actions, trends, and root causes are reported quarterly to the Quality Improvement Committee (QIC).
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					Magnolia reported that if a member verbalizes dissatisfaction when requesting a PCP change, the request is handled as a grievance.

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b), and 42 CFR Part 441, Subpart B

The review of Quality Improvement (QI) encompasses the QI program descriptions, work plans, program evaluations, and validation of performance measures and performance improvement projects.

Magnolia has developed a Quality Improvement (QI) Program with an overall goal of improving the health status of the members. The 2023 Quality Program Description included specific goals, objectives, and priorities to help achieve this overall goal. The structure of the program, staffing, and data analytic resources are clearly outlined in the QI Program Description. Magnolia's Board of Directors is the governing body designated for oversight of the program. The board has delegated the authority and responsibilities for the development and implementation of the program to the Quality Improvement Committee (QIC). The QIC directs subcommittees to implement improvement activities based on performance trends, and member, provider and system needs.

Information about the QI Program is shared with providers and members. Policy MS.QI.02, Quality Improvement Operations addresses how this information is shared. The policy mentions information may be distributed in a newsletter or via the internet. However, the QI Program Description found on Magnolia's website, was the 2022 QI Program Description, not the 2023 version.

Magnolia has developed a Health Equity Program that identifies disparities, prioritizes projects, and collaborates across the community to reduce inequities through evidence-based methodologies targeting members, providers, and communities. Magnolia achieved full Health Equity Accreditation in 2022.

The QIC continues to be Magnolia's senior leadership committee accountable to the Board of Directors. The purpose of this committee is to perform oversight of all Magnolia quality activities to assess the appropriateness of care delivered, and to continuously improve the quality of services provided to members. The QIC acts as an oversight committee and receives regular reports from all subcommittees that are accountable to the committee. The QIC has a committee charter that outlines the committee's responsibilities, structure, and operational requirements. At least annually, the committee reviews the charter in conjunction with other QI documents. The committee meets at least quarterly, and the decisions made by the committee are recorded in the minutes and made available to each member.

Network providers specializing in Pediatrics, Family Medicine, and Psychiatry act as voting members of the QIC. At minimum, five members, including three plan staff and two external providers must be present for a quorum.

By contract, Magnolia requires providers to actively participate in the QI activities. The Provider Profiling Program and Provider Analytics is available to report provider performance. The Provider Profile results include provider performance on per member per month cost, utilization data, peer group comparisons, patient engagement, quality measure trends and readmissions by disease state. The Provider Analytic dashboard located on the Provider Web Portal is updated monthly and is available to primary care providers (PCPs). A qualified designee—such as the Medical Director or Quality Improvement Designee—will then meet with the provider to discuss the dashboard results, identify any barriers to performance, and determine what intervention is necessary for performance improvement. Strategies and agreed-upon goals are developed with the provider. Follow-up visits are scheduled as appropriate to ensure progress toward improvement is being made.

Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines, addresses the development, adoption, revision, and performance monitoring conducted for the clinical and preventive practice guidelines. The guidelines monitored are Diabetes Care, Prenatal Care, Attention Deficit and Hyperactivity Disorder, and Depression.

Magnolia provides coverage for all Early and Periodic Screening, Diagnostic, and Testing (EPSDT) services and educates members and providers regarding the services and resources available. Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service and MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System provides an overview of Magnolia's process for monitoring and reporting compliance with the EPSDT program. A Monthly Report is generated to identify members needing follow-up care after an EPSDT screening. If the report indicates a member has an abnormal finding, Magnolia monitors the member's claims to assess if treatment was sought. If there is no evidence that treatment was sought, outreach is made to the provider and the member to determine the care needed and assist with arranging a follow-up appointment.

The evaluation of the effectiveness of the QI program is conducted annually. Magnolia submitted the 2022 Quality Management Program Evaluaiton, which included the results of all the activities conducted in 2022. The analysis for each activity was included as well as identified barriers and opportunities for improvements.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. DOM has selected a set of PMs to evaluate the quality of care and services delivered by Magnolia to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating PMs. The final PM validation results reflected the measurement period of January 1 through December 31, 2022.

Per the contract between the CCOs and DOM, the CCOs were required to submit HEDIS data to NCQA. To ensure the HEDIS rates were accurate and reliable, DOM required each CCO to undergo an NCQA HEDIS Compliance Audit. Magnolia contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Aqurate reviewed the CCOs' final audit reports (FARs), information systems compliance tools, and Interactive Data Submission System (IDSS) files approved by Magnolia's NCQA-licensed organization. Aqurate found that the CCO's information systems and processes were compliant with the applicable standards and HEDIS reporting requirements for HEDIS MY 2022.

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

Aqurate reviewed several aspects crucial to the calculation of PM data: data integration, data control, and documentation of PM calculations. The following are some of the main steps in Aqurate's validation process:

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

Data Control — The CCO's organizational infrastructure must support all necessary information systems; its quality assurance practices, and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated the Magnolia's data control processes and determined that the data control processes in place were acceptable.

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

All relevant CAN HEDIS performance measures were compared for the current review year (MY 2022) to the previous year (MY 2021), and the changes from 2021 to 2022 are reported in *Table 23: CAN HEDIS Performance Measure Results*. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

Table 23: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	46.80%	44.79%	-2.01%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	49.88%	58.39%	8.51%
Counseling for Nutrition	44.28%	51.09%	6.81%
Counseling for Physical Activity	42.82%	48.66%	5.84%
Childhood Immunization Status (cis)			
DTaP	75.43%	72.51%	-2.92%
IPV	91.73%	89.05%	-2.68%
MMR	90.02%	87.35%	-2.67%
HiB	86.13%	84.91%	-1.22%
Hepatitis B	89.54%	89.78%	0.24%
VZV	89.29%	87.35%	-1.94%
Pneumococcal Conjugate	74.94%	74.45%	-0.49%
Hepatitis A	77.37%	78.83%	1.46%
Rotavirus	76.89%	74.45%	-2.44%
Influenza	29.68%	28.47%	-1.21%
Combination #3	68.13%	67.15%	-0.98%
Combination #7	55.72%	55.23%	-0.49%
Combination #10	24.09%	20.68%	-3.41%
Immunizations for Adolescents (ima)			
Meningococcal	55.96%	57.66%	1.70%
Tdap/Td	75.91%	79.32%	3.41%
HPV	21.65%	25.30%	3.65%
Combination #1	55.23%	57.42%	2.19%
Combination #2	20.19%	24.33%	4.14%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Lead Screening in Children (lsc)	69.62%	65.80%	-3.82%
Breast Cancer Screening (bcs)	50.85%	52.23%	1.38%
Cervical Cancer Screening (ccs)	57.18%	54.26%	-2.92%
Chlamydia Screening in Women (chl)			
16-20 Years	48.69%	49.78%	1.09%
21-24 Years	57.22%	63.74%	6.52%
Total	49.77%	51.48%	1.71%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Appropriate Testing for Pharyngitis (3-17)	75.14%	74.96%	-0.18%
Appropriate Testing for Pharyngitis (18-64)	60.82%	63.76%	2.94%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	73.17%	73.59%	0.42%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	21.84%	22.27%	0.43%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	51.48%	47.92%	-3.56%
Bronchodilator	80.28%	77.34%	-2.94%
Asthma Medication Ratio (amr)			
5-11 Years	81.03%	83.00%	1.97%
12-18 Years	70.25%	71.14%	0.89%
19-50 Years	59.94%	60.70%	0.76%
51-64 Years	45.70%	56.20%	10.50%
Total	70.95%	73.21%	2.26%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	49.39%	53.77%	4.38%
Persistence of Beta-Blocker Treatment After a Heart Attack	75.00%	80.43%	5.43%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	75.00%	74.90%	-0.10%
Statin Adherence 80% - 21-75 years (Male)	58.27%	56.54%	-1.73%
Received Statin Therapy - 40-75 years (Female)	72.81%	72.98%	0.17%
Statin Adherence 80% - 40-75 years (Female)	50.60%	51.89%	1.29%
Received Statin Therapy - Total	73.84%	73.94%	0.10%
Statin Adherence 80% - Total	54.27%	54.26%	-0.01%
Cardiac Rehabilitation (cre)			
Cardiac Rehabilitation - Initiation (18-64)	1.42%	3.59%	2.17%
Cardiac Rehabilitation - Engagement1 (18-64)	1.77%	5.13%	3.36%
Cardiac Rehabilitation - Engagement2 (18-64)	1.42%	1.54%	0.12%
Cardiac Rehabilitation - Achievement (18-64)	0.35%	0.00%	-0.35%
Cardiac Rehabilitation - Initiation (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (65+)	NA	NA	NA

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Cardiac Rehabilitation - Engagement2 (65+)	NA	NA	NA
Cardiac Rehabilitation - Achievement (65+)	NA	NA	NA
Cardiac Rehabilitation - Initiation (Total)	1.42%	3.55%	2.13%
Cardiac Rehabilitation - Engagement1 (Total)	1.77%	5.08%	3.31%
Cardiac Rehabilitation - Engagement2 (Total)	1.42%	1.52%	0.10%
Cardiac Rehabilitation - Achievement (Total)	0.35%	0.00%	-0.35%
Effectiveness of Care: Diabetes			
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
Hemoglobin A1c (HbA1c) Testing	88.32%	-	-
PoorHbA1cControl	52.80%	49.15%	-3.65%
AdequateHbA1cControl	38.69%	42.34%	3.65%
Eye Exam for Patients With Diabetes (EED)	67.40%	63.99%	-3.41%
Blood Pressure Control for Patients With Diabetes (BPD)	54.74%	57.42%	2.68%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	15.68%	17.01%	1.33%
Kidney Health Evaluation for Patients With Diabetes (65-74)	15.63%	32.26%	16.63%
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	15.68%	17.10%	1.42%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	60.86%	62.46%	1.60%
Statin Adherence 80%	50.84%	49.77%	-1.07%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	49.45%	49.53%	0.08%
Effective Continuation Phase Treatment	31.65%	30.85%	-0.80%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	47.87%	55.14%	7.27%
Continuation and Maintenance (C&M) Phase	61.81%	71.08%	9.27%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	68.36%	65.34%	-3.02%
6-17 years - 7-Day Follow-Up	41.16%	36.49%	-4.67%
18-64 years - 30-Day Follow-Up	57.75%	55.51%	-2.24%
18-64 years - 7-Day Follow-Up	34.35%	31.79%	-2.56%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	63.91%	61.59%	-2.32%
7-Day Follow-Up	38.31%	34.72%	-3.59%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	50.50%	54.49%	3.99%
6-17 years - 7-Day Follow-Up	38.50%	37.82%	-0.68%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
18-64 years - 30-Day Follow-Up	41.20%	48.06%	6.86%
18-64 years - 7-Day Follow-Up	26.91%	28.62%	1.71%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	44.91%	50.34%	5.43%
Total- 7-Day Follow-Up	31.54%	31.89%	0.35%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	28.63%	41.46%	12.83%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	16.30%	34.76%	18.46%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days (Total)	27.20%	40.83%	13.63%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	15.48%	33.73%	18.25%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	0.00%	28.26%	NC
7-Day Follow-Up: 13-17 Years	0.00%	15.22%	NC
30-Day Follow-Up: 18+ Years	7.36%	27.72%	NC
7-Day Follow-Up: 18+ Years	4.68%	15.79%	NC
30-Day Follow-Up: Total	6.65%	27.79%	NC
7-Day Follow-Up: Total	4.23%	15.71%	NC
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	22.83%	28.66%	5.83%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	22.83%	28.93%	6.10%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	71.34%	69.64%	-1.70%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	70.19%	74.58%	4.39%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	74.51%	74.47%	-0.04%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	56.99%	58.23%	1.24%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	34.04%	37.39%	3.35%
Cholesterol Testing (1-11)	23.30%	26.99%	3.69%
Blood Glucose and Cholesterol Testing (1-11)	20.81%	24.56%	3.75%
Blood Glucose Testing (12-17)	48.98%	49.32%	0.34%
Cholesterol Testing (12-17)	29.83%	33.83%	4.00%
Blood Glucose and Cholesterol Testing (12-17)	27.52%	30.75%	3.23%
Blood Glucose Testing (Total)	42.89%	44.49%	1.60%
Cholesterol Testing (Total)	27.17%	31.07%	3.90%
Blood Glucose and Cholesterol Testing (Total)	24.78%	28.25%	3.47%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NQ	NQ	NQ
Appropriate Treatment for Upper Respiratory Infection (uri)			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	71.73%	73.20%	1.47%
Appropriate Treatment for Upper Respiratory Infection (18-64)	56.32%	58.47%	2.15%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	69.88%	71.61%	1.73%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	43.33%	50.27%	6.94%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	43.74%	41.85%	-1.89%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	43.46%	49.01%	5.55%
Use of Imaging Studies for Low Back Pain (lbp)	71.49%	71.42%	-0.07%
Use of Opioids at High Dosage (hdo)	1.15%	1.37%	0.22%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	11.40%	13.42%	2.02%
Multiple Pharmacies	1.96%	1.03%	-0.93%
Multiple Prescribers and Multiple Pharmacies	0.82%	0.55%	-0.27%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	3.18%	3.93%	0.75%
18-64 years - >=31 Days covered	2.36%	2.62%	0.26%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	3.18%	3.92%	0.74%
Total - >=31 Days covered	2.36%	2.62%	0.26%
Access/Availability of Care			

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	84.81%	83.73%	-1.08%
45-64 Years	91.21%	90.28%	-0.93%
65+ Years	80.15%	78.69%	-1.46%
Total	87.48%	86.62%	-0.86%
Annual Dental Visit (adv)			
2-3 Years	48.49%	51.32%	2.83%
4-6 Years	66.5%	69.60%	3.10%
7-10 Years	68.29%	71.19%	2.90%
11-14 Years	65.5%	67.12%	1.62%
15-18 Years	58.14%	59.38%	1.24%
19-20 Years	41.27%	43.60%	2.33%
Total	62.51%	64.83%	2.32%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	75.93%	81.25%	NC
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	3.70%	6.25%	NC
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	68.46%	63.14%	NC
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.23%	5.51%	NC
Total: Initiation of AOD Treatment: 13-17 Years	66.33%	66.55%	NC
Total: Engagement of AOD Treatment: 13-17 Years	4.42%	5.46%	NC
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	36.88%	44.83%	NC
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	4.47%	7.00%	NC
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	35.43%	45.50%	NC
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	13.16%	16.22%	NC
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	37.52%	41.30%	NC
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.51%	8.11%	NC
Total: Initiation of AOD Treatment: 18+ Years	35.07%	43.05%	NC
Total: Engagement of AOD Treatment: 18+ Years	6.63%	8.76%	NC

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	39.27%	47.47%	NC
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.43%	7.07%	NC
Opioid abuse or dependence: Initiation of AOD Treatment: Total	35.79%	46.75%	NC
Opioid abuse or dependence: Engagement of AOD Treatment: Total	12.92%	15.58%	NC
Other drug abuse or dependence: Initiation of AOD Treatment: Total	41.99%	45.66%	NC
Other drug abuse or dependence: Engagement of AOD Treatment: Total	5.32%	7.57%	NC
Total: Initiation of AOD Treatment: Total	38.25%	46.36%	NC
Total: Engagement of AOD Treatment: Total	6.40%	8.31%	NC
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	93.67%	95.86%	2.19%
Postpartum Care	74.70%	70.32%	-4.38%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	63.56%	57.11%	-6.45%
12-17 years	66.80%	65.46%	-1.34%
Total	65.53%	62.11%	-3.42%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	55.81%	57.39%	1.58%
15 Months-30 Months	62.42%	65.35%	2.93%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	45.29%	45.44%	0.15%
12-17 Years	38.77%	38.53%	-0.24%
18-21 Years	20.20%	20.77%	0.57%
Total	41.02%	40.82%	-0.20%

NA: Denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR: Rate was not reported.
NQ: Not Required
NC: Not calculated due to break in trending.
-: New measure, no prior year or change data available for reporting.

As shown in the table above, the following HEDIS MY 2022 measure rates had a greater than 10% improvement:

- Asthma Medication Ratio (AMR) Age 51-64 indicator improved by over 10 percentage points.

- Kidney Health Evaluation for Patients with Diabetes (KED) Age 65-74 indicator improved by over 16 percentage points, however; eligible population was very small, just over 31 for both years.
- Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) 7 days Age 18-64 indicator improved by over 18 percentage points, 30 days Age 18-64 improved by over 12 percentage points, Total 7 days indicator improved by over 18 percentage points, and 30 days indicator improved by over 13 percentage points.

There were no HEDIS MY 2022 measure rates that decreased more than 10 percentage points.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2022 and the previous year (MY 2021). The change from 2021 to 2022 is reported in the following table. Rate changes shown in green indicate a substantial (>10%) improvement, and rates shown in red indicate a substantial (>10%) decline.

Table 24: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2021 Rate	MY 2022 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
Colorectal Cancer Screening (COL-AD)			
Ages 46-49	-	21.78%	NA
Ages 50-64	42.24%	48.57%	6.33%
Ages 65-75	47.60%	39.64%	-7.96%
Total	46.28%	43.92%	-2.36%
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.74%	0.61%	-0.13%
Ages 65+	0.00%	3.86%	3.86%
Total	0.74%	0.64%	-0.10%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception – 3 days	11.24%	11.17%	-0.07%
Most or moderately effective contraception – 60 days	41.06%	-	NA
Most or moderately effective contraception – 90 days	-	40.70%	NA
LARC - 3 Days	0.44%	0.46%	0.02%
LARC - 60 Days Reported	7.65%	-	NA
LARC - 90 Days Reported	-	7.37%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			

Measure	MY 2021 Rate	MY 2022 Rate	Change
Most or moderately effective contraception rate	23.41%	23.21%	-0.20%
LARC rate	2.38%	2.29%	-0.09%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	25.20	25.52	0.32
Ages 65+	NA	NA	NA
Total	25.15	25.46	0.31
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	53.10	59.71	6.61
Ages 65+	151.17	225.56	74.39
Total	53.64	60.72	7.08
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	48.86	51.24	2.38
Ages 65+	0.00	75.19	75.19
Total	48.75	51.30	2.55
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	2.91	1.03	-1.88
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	31.30%	29.12%	-2.18%
Ages 65+	NA	NA	NA
Total	31.60%	29.02%	-2.58%
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	1.32%	1.33%	0.01%
Ages 65+	NA	NA	NA
Total	1.32%	1.33%	0.01%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	3.35%	3.20%	-0.15%
Ages 65+	NA	NA	NA
Total	3.35%	3.20%	-0.15%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	33.65%	40.16%	6.51%
Prescription for Buprenorphine	33.17%	36.77%	3.60%
Prescription for Oral Naltrexone	0.57%	0.91%	0.34%
Prescription for Long-acting, injectable naltrexone	0.10%	0.13%	0.03%
Prescription for Methadone	0.00%	2.74%	2.74%
Child Core Set Measures			

Measure	MY 2021 Rate	MY 2022 Rate	Change
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	0.88%	1.21%	0.33%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	3.50%	5.19%	1.69%
Age 2 Screening	4.05%	5.72%	1.67%
Age 3 Screening	3.59%	5.46%	1.87%
Total Screening	3.69%	5.41%	1.72%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	1.81%	1.42%	-0.39%
Most or moderately effective contraception – 60 days	43.01%	-	NA
Most or moderately effective contraception – 90 days	-	44.50%	NA
LARC - 3 Days	0.73%	0.53%	-0.20%
LARC - 60 Days Reported	12.70%	-	NA
LARC - 90 Days Reported	-	10.11%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	28.76%	28.32%	-0.44%
LARC Rate	2.24%	2.29%	0.05%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	46.74%	54.40%	7.66%
Numerator 2 All Four Molars Sealed	31.22%	37.76%	6.54%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.25%	0.79%	0.54%
Ages 1-2	15.46%	22.74%	7.28%
Ages 3-5	47.15%	58.72%	11.57%
Ages 6-7	53.31%	64.64%	11.33%
Ages 8-9	53.59%	64.49%	10.90%
Ages 10-11	51.25%	61.41%	10.16%
Ages 12-14	47.07%	55.92%	8.85%
Ages 15-18	39.12%	46.60%	7.48%
Ages 19-20	24.12%	27.74%	3.62%
Total Ages <1-20	41.91%	50.85%	8.94%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	4.26%	11.81%	7.55%
Ages 3-5	8.29%	27.51%	19.22%

Measure	MY 2021 Rate	MY 2022 Rate	Change
Ages 6–7	9.29%	31.44%	22.15%
Ages 8–9	8.84%	31.31%	22.47%
Ages 10–11	8.00%	29.16%	21.16%
Ages 12–14	7.06%	25.65%	18.59%
Ages 15–18	4.70%	17.83%	13.13%
Ages 19–20	3.00%	9.27%	6.27%
Total Ages 1–20	6.88%	24.15%	17.27%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1–2	1.31%	6.31%	5.00%
Ages 3–5	6.54%	25.24%	18.70%
Ages 6–7	8.71%	30.75%	22.04%
Ages 8–9	8.65%	30.92%	22.27%
Ages 10–11	7.90%	28.98%	21.08%
Ages 12–14	6.94%	25.44%	18.50%
Ages 15–18	4.64%	17.65%	13.01%
Ages 19–20	2.95%	9.07%	6.12%
Total Ages 1–20	6.21%	23.08%	16.87%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	1.78%	4.01%	2.23%
Ages 3–5	0.17%	0.43%	0.26%
Ages 6–7	0.00%	0.00%	0.00%
Ages 8–9	0.00%	0.00%	0.00%
Ages 10–11	0.00%	0.00%	0.00%
Ages 12–14	0.00%	0.00%	0.00%
Ages 15–18	0.00%	0.00%	0.00%
Ages 19–20	0.00%	0.00%	0.00%
Total Ages 1–20	0.19%	0.44%	0.25%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting;
BR: Biased Rate;
–: New measure, no prior year or change data available for reporting.

For the CAN Non-HEDIS measures, there were three measures that demonstrated a significant increase in the rate. Those include:

- Chronic obstructive pulmonary disease (COPD) or asthma in older adults' admission rate (PQI-05): Age 65+ indicator rate increased significantly. However, there were only two numerator compliant records in the prior year and three in 2022.
- Heart failure admission rate (PQI-08) Age 65+ indicator rate increased significantly. However, there were no numerator compliant records in the prior year and one in 2022.

- Topical fluoride for children (TLF-CH) Rate 1 and Rate 2 indicators showed significant improvement by over 13 percentage points for all but two (Age 1-2 and ages 19-20) indicators.

There were no non-HEDIS Adult Core Set and Child Core Set measure rates that decreased more than 10 percentage points.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

PIP Validation Results

For this review, Magnolia submitted four PIPs. Topics for those PIPs included Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness. All the PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 25: Behavioral Health Readmission PIP

Behavioral Health Readmission	
The Behavioral Health Readmission PIP is focused on reducing 30-day readmissions for members discharged from a behavioral health facility and to increase case management enrollment for those that are readmitted. This PIP showed improvement in the latest rate from 26.88% in 2021 to 25.9% in 2022, with a goal of 6%. Many interventions have been implemented over the five-year PIP period.	
Previous Validation Score	Current Validation Score
80/80 = 100% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	

Behavioral Health Readmission
• Member Outreach • Facility collaboration • Staff Additions for Transition of Care Assessments • Clinical Provider Training • Discharge Bags • Medicine Planners for Patients • Member Education

Table 26: Reducing Preterm Births PIP

Reducing Preterm Births	
The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with HTN/preeclampsia who give birth prior to 37 weeks gestation. The baseline rate was 14.47%, and the third remeasurement rate was 15.05%. This rate increased which reflects a lack of improvement, as the goal is to reduce the preterm birth rate.	
Previous Validation Score	Current Validation Score
72/73= 99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Completing Notification of Pregnancy as applicable. • Enrolling member in the Start Smart for Baby program. • Refer to Care Management for continuous follow-up. • Medical record review for monitoring and tracking.	

Table 27: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
The Sickle Cell Disease PIP focuses on increasing compliance with Hydroxyurea for eligible members throughout the treatment period. This PIP measures the rate of members with sickle cell disease that remain compliant with the medication during their treatment period. The baseline rate was 37.5%, decreasing to 25.87% in 2023. The goal is to increase the rate to 47%. Thus, the most recent rate did not show improvement year over year trending.	
Previous Validation Score	Current Validation Score
80/80 = 100% Hight Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	

Sickle Cell Disease Outcomes
• The Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and on the importance of medication adherence. • Letters are mailed to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment. • Outreach is conducted to all members who received letters to provide education and to address any barriers/concerns. • Texting campaigns to encourage medication refill reminders.

Table 28: Asthma/COPD PIP

Asthma/COPD	
The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and the spirometry test for members 40 and older with COPD. This indicator uses the HEDIS measure, AMR. The AMR rate was 71.15% at baseline, which has essentially not changed in 2022 at 71.15%, with a goal of 76.86%. The spirometry testing rate was 28.38% at baseline which has declined to 22.27% for 2022. The goal is 36.82%.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the AMR and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Distribution of the updated HEDIS Quick Reference Guides for MY2023 to Providers. • The Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Interactive texting campaigns for medication refill and missed refill reminders.	

Constellation Quality Health provided Magnolia recommendations for the Reducing Preterm Births, Sickle Cell Disease Outcomes, and the Asthma/COPD PIPs. They are displayed in *Table 29: Performance Improvement Project Recommendations*.

Table 29: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Reducing Preterm Births	Was there any documented, quantitative improvement in processes or outcomes of care?	The baseline rate was 14.47% and the remeasurement number 3 rate was 15.05%. This rate reflects an increase in the rate that reflects a lack of improvement, as the goal is to reduce the preterm birth rate to 11.04%.	Continue to monitor interventions and efforts toward member education and member tracking, as well as member self-monitoring to work toward reducing the preterm birth rate.
Sickle Cell Disease Outcomes	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent rate did not show improvement in year-over-year trending for medication compliance.	Continue ongoing interventions of texting campaigns and multi-team outreach to ensure members have the information needed to remain compliant.
Asthma/COPD	Was there any documented, quantitative improvement in processes or outcomes of care?	The AMR rate showed no change from the baseline rate of 71.15%. The Spirometry testing rate was 28.38% at baseline which has declined to 22.27% for 2022.	Continue member and provider education, texting campaign, and the health equity dashboard to identify members that need additional resources.

Details of the validation activities for the PMs and PIPs, and specific outcomes related to each activity, may be found in *Attachment 3, Constellation Quality Health EQR Validation Worksheets*.

As noted in *Figure 5: Quality Improvement Findings*, 100% of the standards in the Quality Improvement section were scored as "Met."

Figure 5: Quality Improvement Findings

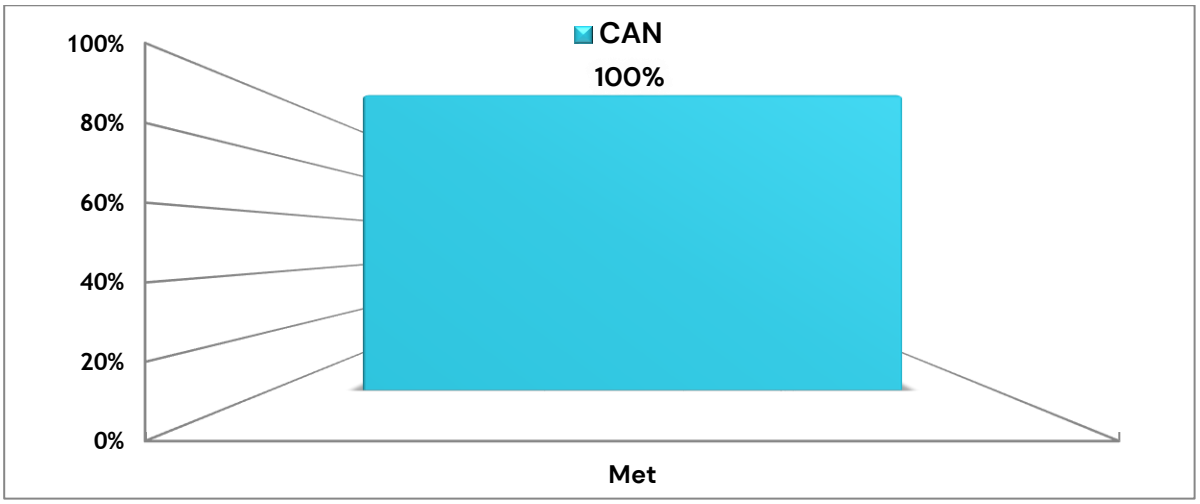


Table 30: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Magnolia achieved full Health Equity Accreditation in 2022.	✓		
The format for the 2023 QI Work Plan was updated and contained extensive details and information.	✓		
All four PIPs received validation scores within the High Confidence in Reported Results Range.	✓		
There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Magnolia followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.	✓		
The following HEDIS MY 2022 measure rates and non-HEDIS Adult Core Set and Child Core Set measure rates were strengths for Magnolia since their rates had a greater than 10% improvement: • Asthma Medication Ratio (AMR) Age 51-64 indicator improved by over 10 percentage points. • Kidney Health Evaluation for Patients with Diabetes (KED) Age 65-74 indicator improved by over 16 percentage points, however; eligible population was very small, just over 31 for both years. • Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) 7 days Age 18-64 indicator improved by over 18 percentage points, 30 days Age 18-64 improved by over 12 percentage points, Total 7 days indicator improved by over 18 percentage points and 30 days indicator improved by over 13 percentage points. • Chronic obstructive pulmonary disease (COPD) or asthma in older adults' admission rate (PQI-05): Age 65+ indicator rate increased significantly; however, there were only two numerator compliant records in the prior year and three in 2022. • Heart failure admission rate (PQI-08) Age 65+ indicator rate increased significantly; however, there were no numerator compliant records in the prior year and one in 2022.	✓		

Strengths	Quality	Timeliness	Access to Care
• Topical fluoride for children (TLF-CH) Rate 1 and Rate 2 indicators showed significant improvement by over 13 percentage points for all but two (Age 1-2 and ages 19-20) indicators.			
There were no HEDIS MY 2022 measure rates or non-HEDIS Adult Core Set and Child Core Set measure rates that decreased more than 10 percentage points.	✓		

Table 31: Quality Improvement Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Information regarding Magnolia's Quality Improvement Program is shared with members and providers via the website. However, the QI Program Description found on Magnolia's website was outdated.	Recommendation: Update the website to include current information about the QI Program.	✓		
Three of the four PIPs experienced a decline in the indicator rates.	Recommendation: Asses the current interventions to determine if changes are needed.	✓		
During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates.	Recommendation: Improve processes around oversight of the software vendor and ensure they follow the specifications when calculating the PMs.	✓		
Based on the review of the HEDIS Compliance Audit Final Audit Report, and the discussions during the PMV onsite review, it was identified that there were opportunities for improvement in communication and oversight between the corporate HEDIS team, centralized operations and the CCO.	Recommendation: Improve communication and oversight with the corporate HEDIS team and centralized operations to ensure accuracy, monitoring and tracking for the DOM required PMs.	✓		

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Magnolia has developed a Quality Improvement (QI) Program with an overall goal of improving the health status of the members. The 2023 Quality Program Description included specific goals, objectives, and priorities to help achieve this overall goal. The structure of the program, staffing and data analytic resources are clearly outlined in the program description. Magnolia's Board of Directors is the governing body designated for oversight of the program. The board has delegated the authority and responsibilities for the development and implementation of the program to the Quality Improvement Committee. The Quality Improvement Committee directs subcommittees to implement improvement activities based on performance trends, and member, provider, and system needs. Information about the QI Program is shared with Providers and Members. Policy MS.QI.02, Quality Improvement Operations addresses how this information is shared. The policy mentions information may be distributed in a newsletter or via the internet. However, the QI Program Description found on Magnolia's website, was the 2022 QI Program Description, not the 2023 version.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the website to include current information about the QI Program.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Magnolia has developed a Health Equity Program that identifies disparities, prioritizes projects, and collaborates across the community to reduce inequities through evidence-based methodologies targeting members, providers, and communities. Magnolia achieved full Health Equity Accreditation in 2022.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					The QI Work Plan is developed annually after the completion of the QI Program Evaluation from the previous year. The 2022 and 2023 QI Work Plans were received. Both work plans included the yearly quality improvement activities, the individual responsible for each task, target dates, quarterly updates, and any previously identified issues.
IV B. Quality Improvement Committee						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) continues to be Magnolia's senior leadership committee accountable to the Board of Directors. The purpose of this committee is to perform oversight of all Magnolia quality activities to assess the appropriateness of care delivered, and to continuously improve the quality of services provided to members. The QIC acts as an oversight committee and receives regular reports from all subcommittees that are accountable to the committee. The QIC committee has a committee charter that outlines the committee's responsibilities, structure, and operational requirements. At least annually, the committee reviews the charter in conjunction with other QI documents. The committee meets at least quarterly, and the decisions made by the committee are recorded in the minutes and made available to each member.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Network providers specializing in Pediatrics, Family Medicine, and Psychiatry, act as voting members of the QIC. At minimum, five members including three plan staff and two external providers must be present for a quorum.
3. The QI Committee meets at regular intervals.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the performance measure rates. During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates. *Based on the review of the HEDIS Compliance Audit Final Audit Report, and the discussions during the PMV onsite review, it was identified that there were opportunities for improvement in communication and oversight between the corporate HEDIS team, centralized operations and the CCO.* *Recommendations:*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• *Improve processes around oversight of the software vendor and ensure they follow the specifications when calculating the performance measures (PMs).* • *Improve communication and oversight with the corporate HEDIS team and centralized operations to ensure accuracy, monitoring and tracking for the DOM required PMs.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					For this review, Magnolia submitted four PIPs. Topics for those PIPs included Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell disease Outcomes, and Respiratory Illness.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All the PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. Three of the four PIPs experienced a decline in the indicator rates. *Recommendation: Asses the current interventions to determine if changes are needed.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					By contract, Magnolia requires providers to actively participate in the QI activities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					The Provider Profiling Program and Provider Analytics is available to report provider performance. The Provider Profile results include provider performance on per member per month cost, utilization data, peer group comparisons, patient engagement, quality measure trends and readmissions by disease state. The Provider Analytic dashboard located on the Provider Web Portal is updated monthly and is available to PCPs. A qualified designee—such as the Medical Director or Quality Improvement Designee—will then meet with the Provider to discuss the dashboard results, identify any barriers to performance, and determine what intervention is necessary for performance improvement. Strategies and agreed-upon goals are developed with the provider. Follow-up visits are scheduled as appropriate to ensure progress toward improvement is being made.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines addresses the development, adoption, revision, and performance monitoring conducted for the clinical and preventive practice guidelines. The guidelines monitored are Diabetes Care, Prenatal Care, Attention Deficit and Hyperactivity Disorder, and Depression.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						Magnolia provides coverage for all Early and Periodic Screening, Diagnostic, and Testing (EPSDT) services and educates members and providers regarding the services and resources available. Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service and MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System provides an overview of Magnolia's process for monitoring and reporting compliance with the EPSDT program.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					A Monthly Report is generated to identify members needing follow-up care after an EPSDT screening. If the report indicates a member has an abnormal finding, Magnolia monitors the member's claims to assess if treatment was sought. If there is no evidence that treatment was sought, outreach is made to the provider and the member to determine the care needed and assist with arranging a follow-up appointment.
4.3 Diagnosis and/or treatment for children.	X					
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					The evaluation of the effectiveness of the QI program is conducted annually. Magnolia submitted the 2022 Quality Management Program Evaluation, which included the results of all the activities conducted in 2022. The analysis for each activity was included as well as identified barriers and opportunities for improvements.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

E. Utilization Management

42 CFR § 438.210 (a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

Magnolia's Utilization Management Program Description 2023 and various policies outline the scope, objective, and staff responsibilities within the Utilization Management (UM) Program for physical health and behavioral health services. Policy MS.PHAR.09, Pharmacy Operations, outlines the Pharmacy Program. Envolve Pharmacy Solutions is the pharmacy benefit manager for Magnolia and is responsible for the management of all pharmaceutical services for members.

Magnolia's Chief Medical Director provides oversight of the UM Program. The responsibilities of the Chief Medical Officer entail clinical supervision, conducting Level II Medical Necessity Reviews, and participating in committees. The Behavioral Health Director provides clinical management of the behavioral health program that includes participation in Population Health and Clinical Operations rounds and in committees. The Pharmacy Director provides oversight of the pharmacy program and is responsible for performing clinical reviews, conducting second level reviews, and monitoring pharmacy utilization.

Coverage and Authorization of Services

42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228

Magnolia's UM Reviewers are licensed health professionals in their respective disciplines that conduct initial medical necessity reviews and utilize evidence based clinical coverage guidelines such as InterQual, Long Term Acute Care, American Society of Addiction Medicine (ASAM), and state specific guidelines in performing medical necessity determinations. Any updates and revisions to clinical coverage policies are reviewed and approved annually by the Clinical Policy Committee. During the onsite, it was discussed that Turning Point clinical guidelines are used for medical necessity determinations. However, Turning Point is not referenced as a vendor for UM and appeals determinations in Magnolia's UM policies and UM Program Description. Standard authorizations are processed within three calendar days or two business days. Pharmacy and Expedited Requests are processed within 24 hours.

If a request for authorization of services does not meet standard UM criteria, a Medical Director conducts a second level review. During onsite discussion, Magnolia shared that Referral Specialists, which are non-licensed professionals assist with administrative tasks for the clinical practitioners.

During the onboarding process, UM staff and other personnel involved in clinical decision-making sign a form acknowledging that there are no financial incentives to providers or UM staff for making adverse benefit determinations. Also, Inter-Rater Reliability (IRR) Testing is

conducted with Medical Directors and other UM staff to ensure consistency in applying clinical criteria. The IRR target goal is 90% and the 2022 annual IRR scores yielded a score of 95.7%, surpassing the target goal. Additionally, Magnolia shared that case audits occur monthly, and that Medical Affairs conduct Medical Director Peer Reviews and Therapist Peer Reviews for quality assurance.

Constellation's review of a sample of approval files revealed that the reviews were conducted by appropriate licensed health practitioners and were completed in a timely manner. Also, in review of the UM Program Evaluation, Magnolia's target percentage goal for timeliness compliance was maintained for at least eleven months for standard outpatient prior authorization requests and twelve months for inpatient authorization requests.

Table 32 displays the issues noted during the previous EQR related to Adverse Benefit Notices and letter templates incorrectly stating that an oral request for an appeal must be followed in writing unless the request was for an expedited appeal. The table also includes the corrective actions and Magnolia's response. As shown, it was found that Magnolia corrected the issue. Also, the sample denial files reflected that the files were reviewed by an appropriate physician prior to the adverse benefit decision and the decisions were appropriately communicated to the member.

Table 32: 2022 Medical Necessity Determinations CAP Items

Standard	EQR Comments	2023 EQR Findings
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	CCME reviewed a sample of denial decisions made by Magnolia and found all the Adverse Benefits Notices incorrectly mention that an oral request for an appeal by members must be followed up in writing unless the request is for an expedited appeal. Also, the Adverse Benefit Notice letter template incorrectly mentions that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal. *Corrective Action Plan: Correct the Adverse Benefit Notices and remove the requirement that a member must follow an oral request for appeal with a written request.*	The issues identified in the previous EQR were corrected.
Magnolia's 2022 Response: Adverse benefit notices removed this requirement. Letter has been uploaded.		

Appeals

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

Processes for handling appeals are detailed in Policy MS.PRVR.27, Provider Complaints, Grievances and Appeals, Policy MS.UM08, Appeal of UM Decisions, the Member Handbook, the UM Program Description, the Provider Manual, and on the website. Information includes definitions of related terminology, processes, and requirements for filing an appeal, the appeal review process, etc. A sample of appeal files was reviewed. All were processed in a timely manner and reflected that an appropriate physician made the appeal determinations. However, two files did not contain acknowledgement letters.

During the previous EQR, Magnolia was requiring written appeals to follow oral requests for appeals. Also, the acknowledgement letter was missing several requirements. *Table 33: 2022 Appeals CAP Items* provides an overview of these deficiencies. For the current review, Constellation Quality Health found the corrections had been made and were awaiting DOM approval.

Table 33: 2022 Appeals CAP Items

Standard	EQR Comments	2023 EQR Findings
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;	The following documents incorrectly mention an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal. •Policy MS.UM08, Appeal of UM Decisions •UM Program Description •Member Handbook •Provider Manual •Magnolia's website The appeal acknowledgement letter was missing: •The member's right to submit comments, documents, or other information relevant to the appeal. •The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired. *Corrective Action Plan: Correct Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, the Provider Manual, and Magnolia's website and remove the requirement that a member must follow-up an oral request for an appeal with a written request. Also, correct the Acknowledgement Letter and include all the*	The requirement that a member must follow-up an oral request for an appeal with a written rest was removed from Magnolia's written materials. During the onsite discussion, it was discussed that approved revisions to the website are currently in process.

Standard	EQR Comments	2023 EQR Findings
	requirements listed in Policy MS.UM08, Appeal of UM Decisions.	
Magnolia's 2022 Response: MS.UM.08 policy currently reflects the contract language that no written appeal request is needed following an oral appeal request. The Acknowledgement letter has been updated to reflect a member has the right to submit information relevant to the appeal request and member's right to present information within a reasonable distance. A policy will be included to reflect correct language. A screenshot will be provided to show evidence of the updates made to the Member Handbook, Provider Manual, and website.		
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	The member notice regarding an appeal resolution extension does not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website. *Corrective Action Plan: Include the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing an appeal in the member notice, the Member Handbook, Provider Manual and on Magnolia's website.*	Two appeal files reviewed in this EQR did not contain acknowledgement letters.
Magnolia's 2022 Response: MSCAN Appeal extension letter has been updated to reflect that the member has the right to file a grievance if they do not agree with Magnolia's decision to extend an appeal request.		
2. The CCO applies the appeal policies and procedures as formulated.	A sample of appeal files was reviewed. The following issues were identified: •In one file, the resolution notice was sent to the member prior to the date of the decision. •There were two files where the appeal was requested as expedited and the member was not notified of the decision to deny the request for expedited resolution. •One appeal was not resolved within the required timeframe and one acknowledgement letter was not sent. *Corrective Action Plan: Initiate a process to monitor appeals to ensure all requirements are met.*	Of the sample of appeal files reviewed for this EQR, all were resolved in a timely manner.
Magnolia's 2022 Response: Magnolia has developed an audit tool with all appeal requirements. On a monthly basis, Grievance / Appeal Supervisor / Manager / Designee will pull a random sample of 10 completed appeals per appeal coordinator to be audited against the audit tool to ensure all appeal requirements are being met. The audit tool template will be included to provide evidence of the toll being used for auditing appeal requirements.		

Appeals are appropriately categorized and analyzed for trends and opportunities for quality improvement. Appeals data is reported to the Quality Improvement Committee on a quarterly basis.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

Policy CC.CM.02, Care Coordination /Care Management Services, Policy CC.CM.01, Care/Case Management, and the UM Program Description outline the process, scope, and objectives of the case management and disease management program. Additionally, there are several disease specific program descriptions that outline specialized care for chronic conditions, such as diabetes and heart conditions, and lifestyle management programs that are offered to the members.

Referrals for care management services are received from various sources such as caregivers, providers, hospital discharge planners, community entities, self-referrals, etc. Also, internal data sources such as member prioritization reports, hospital data, and claims data aid in identification of potential care management referrals. Magnolia shared during onsite discussion that ImpactPro is a predictive modeling system that analyzes several metrics to identify members who may be candidates for care management services. Direct referrals are considered a high priority and Magnolia shared that contact is initiated within 24 to 48 hours for high priority cases.

Members are provided care management activities based upon their identified needs, goals, and risk level. Reassessments are conducted yearly and if there is a significant change in the member's condition. The member's person-centered plan is reviewed and updated based upon the member's identified needs.

Magnolia provides disease management services for members with specialized medical needs such as asthma, diabetes, lifestyle management, etc. Transitional Care Management services with a collaborative interdisciplinary team are provided to members that are in the discharge planning process from an institutional setting or hospital.

A sample of case management files was reviewed and reflected that the care management activities of assessment, treatment planning, and care coordination occurred appropriately, based upon the member's identified needs and risk stratification level.

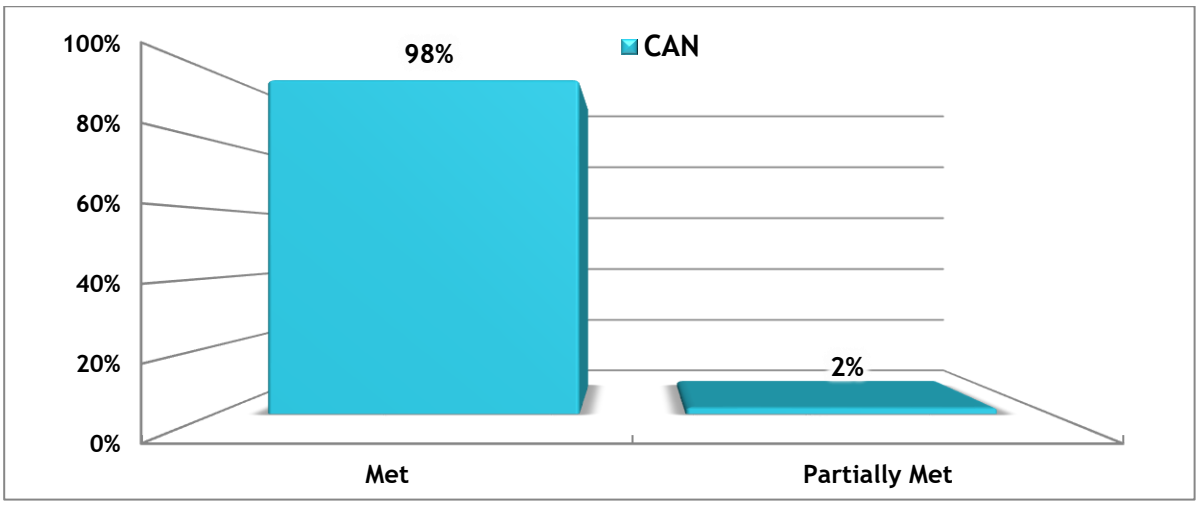
In the previous EQR, Constellation Quality Health noted that, Policy CC.MBRS.27, Member Advisory of Provider Termination and Policy MS.UM.24, Continuity and Coordination of Services, incorrectly stated a member has 90 calendar days of continued course of treatment when a provider is no longer in Magnolia's network. During this EQR, it is noted that Magnolia corrected the identified issue and the previously stated polices reflected the correct timeframe according to contractual standards. See *Table 34* for the specific issue, corrective actions, and Magnolia's response:

Table 34: 2022 Care Management CAP Items

Standard	EQR Comments	2023 EQR Findings
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions: 7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;	For continued access to providers who are no longer available through the CCO's network, Policy MS.PRVR.23, Provider Termination, states the timeframe allowed is up to 60 calendar days. Onsite discussion confirmed the allowed timeframe is 60 calendar days. Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, incorrectly state the timeframe as 90 calendar days. *Corrective Action Plan: Revise Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, to reflect the correct timeframe for allowing a continuing course of treatment when a provider is no longer in Magnolia's network.*	The issues identified in the previous EQR related to revising policies to reflect the correct timeframe for allowing a continuing course of treatment of 60 days when a provider is no longer in Magnolia's network were corrected.
Magnolia's 2022 Response: The updated MS.PRVP.23 Provider Termination has been uploaded. The MS.MBRS.27 policy has been uploaded. This is the Mississippi version of CC.MBRS.27 and is the controlling policy for the Member Advisory of Provider termination.		

As noted in *Figure 6: Utilization Management Findings*, 98% of the Utilization Management standards were scored as "Met."

Figure 6: Utilization Management Findings



Scores were rounded to the nearest whole number.

Table 35: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Magnolia's target percentage goal of 100% for timeliness adherence for standard and urgent outpatient requests was maintained for at least eleven months this past year.		✓	
Magnolia's target percentage goal for timeliness adherence of 98% for standard inpatient and urgent requests was maintained for twelve months this past year.		✓	
Mississippi members receiving care management services are mailed a copy of their care plan goals once their treatment plan is completed.	✓		
The sample of appeal files reviewed for this EQR found that all appeals were resolved timely.		✓	
The Appeals and Grievance (A&G) team assists filers with the Authorized Representative Form by prefilling information for a quick and convenient return of this form.			✓

Table 36: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Turning Point (a vendor) uses clinical guidelines referenced in appeal determination notices. However, Turning Point is not referenced as a vendor in Magnolia's UM policies and Program Description.	Corrective Action: Update UM policies and procedures and the Magnolia Health Utilization Management Program Description 2023 to include information that Magnolia uses a vendor, Turning Point, for some UM and appeals determinations.	✓		

UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Magnolia Health Utilization Management Program Description 2023 and various policies outline the scope, objective, and staff responsibilities within the UM Program for physical health and behavioral health services. Policy MS.PHAR.09, Pharmacy Operations, outlines Magnolia's pharmacy program.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;		X				Evidence based clinical criteria such as InterQual, American Society of Addiction Medicine, State Criteria, individualized member's clinical needs, etc. are utilized in performing clinical determinations according to Policy CC.UM.02 Clinical Decision Criteria and Application and the Utilization Management Program Description. Annually, the clinical criteria and policy applications are reviewed and approved by the Clinical Coverage Policy Committee. Turning Point (a vendor) uses clinical guidelines referenced in appeal determination notices. However, Turning Point is not referenced as a

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						vendor in Magnolia's UM policies and Program Description. *Corrective Action: Update UM policies and procedures and the Magnolia Health Utilization Management Program Description 2023 to include information that Magnolia uses a vendor, Turning Point, for some UM and appeals determinations.*
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Standard authorization requests are processed within three calendar days or two business days. Pharmacy and expedited requests are processed within 24 hours as described in Policy MS.PHAR.09, Pharmacy Program, the Utilization Management Program Description, and Policy MS.UM.05, Timeliness of UM Decisions and Notifications.
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					During the onboarding process, the UM Staff and other personnel involved in the clinical decision process sign a form acknowledging that there is no financial incentive to providers or UM staff for performing adverse benefit determinations as described in the UM Program Description and Policy MS.UM.04.01, Affirmative Statement About Incentives.
2. Utilization management activities occur within significant oversight by the	X					Magnolia's Chief Medical Director provides oversight of the UM Program. The responsibilities of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Medical Director or the Medical Director's physician designee.						the Chief Medical Director entail clinical supervision, conducting Level II Medical Necessity Reviews, and participating in committees. The Behavioral Health Director provides clinical management of the behavioral health program that includes participation in committees and in Population Health and Clinical Operations rounds. The Pharmacy Director provides oversight of the pharmacy program and is responsible for performing clinical reviews, conducting second level reviews, and monitoring pharmacy utilization.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					
V B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 4*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					As described in Policy CC.UM.02, Clinical Decision Criteria, and the Utilization Management Program Description, Magnolia utilizes clinical guidelines such as InterQual, Long Term Acute Care, American Society of Addiction Medicine (ASAM), and state specific guidelines in determining medical necessity. Annually, any updates and revisions are reviewed and approved by the Clinical Policy Committee.
2. Utilization management decisions are made using predetermined	X					Constellation's review of a sample of approval files demonstrated consistency in utilizing evidence-based criteria and relevant medical information.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
standards/criteria and all available medical information.						
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					To ensure consistency in application of clinical criteria, Medical Directors and UM staff participate in Inter-Rater Reliability (IRR) testing. The target goal is 90% and results are reported to the Utilization Committee Meeting for review and feedback. For 2022, the overall IRR testing score was 95.7%, surpassing the target goal. However, several staff participated in remediation training and received a passing score after retesting. Additionally, Magnolia shared that case audits occur monthly, and that Medical Affairs conduct Medical Director Peer Reviews and Therapist Peer Reviews for quality assurance.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Envolve Pharmacy Solutions is the pharmacy benefit manager for Magnolia and is responsible for the management of all pharmaceutical services for health plan members as described in Policy MS.PHAR.09, Pharmacy Program.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					As outlined in the Pharmacy Program Description, Envolve Pharmacy Solutions conducts prior authorizations reviews within 24 hours of the request. Also, an overview of the prior authorization process is outlined in Policy CC.PHAR, Prior Authorization and Medical Necessity Criteria Addendum, and Policy MS.PHAR.09, Pharmacy Program.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy MS.UM 12, Emergency Services, and the Member Handbook provide a descriptive outline of the emergency care and stabilization guidelines.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					As described in the UM Program Description and Policy CC.UM.04, Appropriate UM Professionals, licensed health professionals conduct initial medical necessity reviews. Second level reviews are conducted by Medical Director when medical necessity criteria are not met on the initial review. During onsite discussion, Magnolia shared that Referral Specialists are non-licensed staff who assist with administrative tasks. Review of a sample of approval files reflected that appropriately trained reviewers made UM decisions.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the sample approval files yielded that the files were completed in a timely manner according to contractual standards. Also, in review of the UM Program Evaluation, Magnolia's target percentage goal for timeliness adherence was 100% for standard and urgent outpatient requests and this targeted goal was maintained for at least eleven months. Also, the target percentage goal for timeliness adherence was 98% for standard inpatient and urgent requests and the health plan maintained the target goal for 12 months.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of a sample of denial files confirmed denial decisions were issued by appropriate physicians.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for	X					The sample of denial files reviewed reflected that the adverse benefit decisions were promptly communicated to the provider and included an

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the denial of service and the procedure for appeal.						overview of the appeal and State Fair Hearing process.
V C. Appeals *42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					Processes for handling appeals are detailed in Policy MS.PRVR.27, Provider Complaints, Grievances and Appeals, Policy MS.UM08, Appeal of UM Decisions, the Member Handbook, the Magnolia Health Utilization Management Program Description 2023, the Provider Manual, and website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeals are defined consistently as an adverse benefit determination in the 2023 Member Handbook, Policy MS.UM08, Appeal of UM Decisions, and the UM Program Description.
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Timelines for resolving appeals are described in Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, and the Member Handbook. Standard appeals are acknowledged in writing within 10 calendar days of the receipt of a request for an appeal.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.	X					Of the sample of appeal files reviewed for the 2023 EQR, it was found that all appeals were resolved timely.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeals are appropriately categorized and analyzed for trends and opportunities for quality improvement and reported to the Quality Improvement Committee on a quarterly basis.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Policy CC.CM.02, Care Coordination /Care Management Services, Policy CC.CM.01, Care/Case Management, and the UM Program Description outline the process, scope, and objectives of the case management and disease management program. Additionally, specialized program descriptions outline specialized care for chronic conditions such as diabetes, heart conditions, and lifestyle management programs for members.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Referrals for potential care management services are received from various sources such as caregivers, providers, hospital discharge planners, community entities, self-referrals, etc. Direct referrals are considered a high priority and Magnolia shared that contact is initiated within 24 to 48 hours for high priority cases. Also, internal data sources such as member prioritization reports, hospital data, and claims data aid in member identification for potential care management services, as described in Policy CC.CM.02, Care Coordination/Care Management Services. During onsite discussion, Magnolia shared that ImpactPro is a predictive modeling system that analyzes several metrics to identify potential members for care management services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Once a referral is initiated, a health risk assessment is completed within 30 days of identification. Contact may be initiated sooner if the member presents with more urgent needs as outlined in Policy CC.CM.02, Care Coordination/Care Management Services. The health risk assessment includes the member's demographic information, current provider, the member's condition, community supports, etc.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					The health risk assessment is reviewed by a qualified health professional and a care plan that addresses the member's needs, goals, barriers, etc. is completed within 30 days. This process is described in Policy CC.CM.02, Coordination/Care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Management Services. Members are mailed a copy of their completed care plans.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					As outlined in Policy CC.CM.02, Care Coordination/Care Management Services, reassessments are conducted yearly and for significant changes in the member's condition. The member's person-centered plan is also reviewed and updated based upon the member's identified needs.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					Policy MS.CM.01, Care Management Program and Program Description, outlines the predictive modeling process that aids in stratifying the members into the most appropriate risk level. Also, members assigned the medium risk level will also receive low risk level services. Review of the sample case management files reflected that care management activities of assessment, treatment planning, and care coordination occurred appropriately based upon the member's identified needs and risk stratification level.
9. The CCO provides members assigned to the high risk level all the services	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.						
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Magnolia provides disease management services for members with specialized medical needs such as asthma, diabetes, lifestyle management (e.g., weight management, exercising, etc.) as outlined in the various Program Descriptions, Member Handbook, and Policy MS.CM.05, Disease Specific Education Materials. The overall disease management program goal is to promote wellness and management of chronic medical conditions.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					As described in Policy MS.CM.99, Transitional Care Management Process, members that are in the discharge planning process from an institutional clinical or inpatient setting receive transitional care services with a collaborative interdisciplinary team to ensure linkage to appropriate community

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resources and a successful transition to their community setting.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					
4. The CCO meets other Transition of Care requirements.	X					
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

F. Delegation

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

Magnolia delegates to subcontractors and/or vendors to perform some health plan activities, including utilization management and claims processing for dental, vision, pharmacy, non-emergency transportation, and radiology services.

For this review, Magnolia reported six delegation agreements as shown in *Table 37: Delegated Entities and Services*.

Table 37: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve Dental	Dental Administrator, Claims, Network, Utilization Management, Credentialing and Quality Management
Envolve Vision	Vision Services, Claims, Network, Utilization Management, Credentialing and Quality Management
Centene Pharmacy Solutions	Pharmacy Benefit Manager, Claims, Network, Utilization Management, Credentialing and Quality Management
Medical Transportation Management, Inc. (MTM)	Non-Emergency Transportation Claims, Network, Utilization Management, Credentialing and Quality Management
National Imaging Associates, Inc. (NIA)	Radiology Utilization Management
Turning Point	Musculoskeletal Surgical Quality and Safety and Utilization Management

All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Policy MS.QI.14, Oversight of Delegated Vendor Services, describes the processes for oversight and monitoring of all delegates.

Prior to delegation, Magnolia conducts a pre-delegation assessment. This process requires the potential delegate to submit documentation supporting its ability to successfully perform the delegated functions and/or services, in accordance with applicable federal and DOM Contract requirements. For this EQR, there were no new delegated entities.

Annual oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports. The reports are reviewed and analyzed for outliers and any noted inconsistencies. The results of this monitoring are presented to the Joint Oversight Committee for review and approval. Annual audit reports,

monitoring tracking reports, and Joint Oversight Committee meeting minutes for each of the six delegates were provided.

It was noted that in the 2022 Annual Audit Report for Envolve Pharmacy Solutions, the name for this delegate had been changed to Centene Pharmacy Solutions. Magnolia staff explained this represented only a name change. There were no changes (benefits, claims, etc.) that affected any members. However, the 2023 Member Handbook, page 57, references Envolve Pharmacy Solutions as the pharmacy benefit manager.

Magnolia met all the requirements in the Delegation section of this EQR as shown in *Figure 7: Delegation Findings*.

Figure 7: Delegation Findings

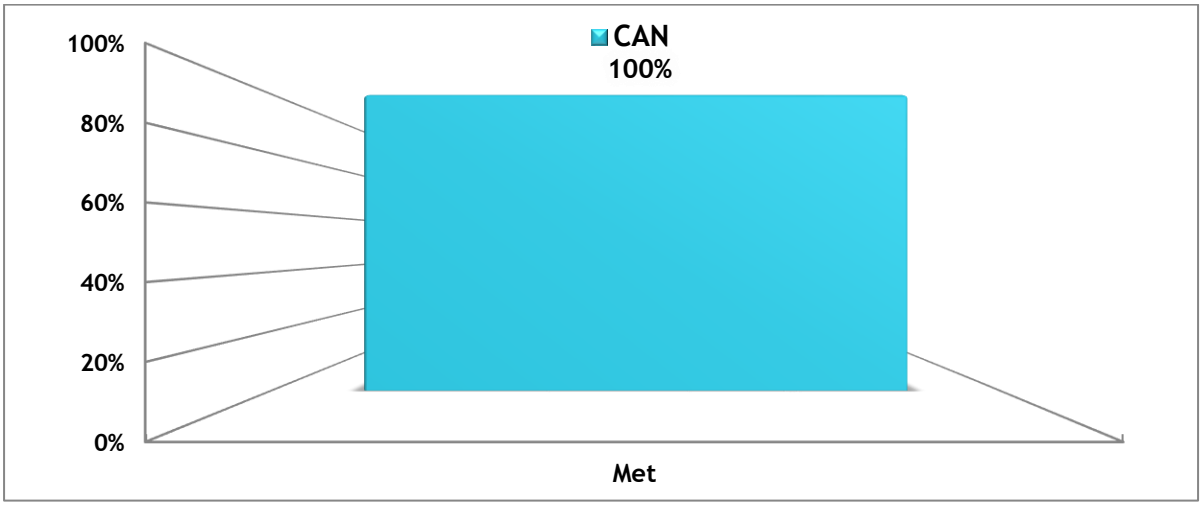


Table 38: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Annual oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports. The reports are reviewed and analyzed for outliers and any noted inconsistencies. The results of this monitoring are presented to the Joint Oversight Committee for review and approval.	✓		

Table 39: Delegation Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
It was noted in the 2022 Annual Audit Report for Evolve Pharmacy Solutions, the name for this delegate had been changed to Centene Pharmacy Solutions. Magnolia staff explained this represented only a name change. There were no changes (benefits, claims, etc.) that affected any members. However, the Member Handbook, page 57 references Envolve Pharmacy Solutions as the pharmacy benefit manager.	Recommendation: Update all materials to reflect the name change for the Pharmacy Benefit Manager.	✓		

DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Magnolia delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include utilization management and claims processing for dental, vision, pharmacy, non-emergency transportation, and radiology services.
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					Annual oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports. The reports are reviewed and analyzed for outliers and any noted inconsistencies. The results of this monitoring are presented to the Joint Oversight Committee for review and approval. The annual audit reports, monitoring tracking reports, and the Joint Oversight Committee meeting minutes for each of the six delegates were provided. It was noted in the 2022 Annual Audit Report for Envolve Pharmacy Solutions, the name for this delegate had been changed to Centene Pharmacy Solutions. Magnolia staff explained this represented only a name change. There were no changes (benefits, claims, etc.) that affected any members. However, the 2023 Member Handbook, page 57,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						references Envolve Pharmacy Solutions as the pharmacy benefit manager. *Recommendation: Update all materials to reflect the name change for the Pharmacy Benefit Manager.*

Attachments

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

Attachment 1: Initial Notice and Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
3600 Glenwood Avenue, Suite 120, Raleigh, NC 27612 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

July 5, 2023

Aaron Sisk
President and CEO
Magnolia Health Plan
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157

Dear Mr. Sisk:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2023 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN Program (MSCAN) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

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

The virtual onsite visit will be conducted on **October 18, 2023,** and **October 19, 2023,** for the MississippiCAN Program.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** list should be provided to CCME no later than **August 4, 2023**.

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)

cc: DOM

Magnolia Health Plan

External Quality Review 2023 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

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

2. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, key managers responsible for the functions, and any vacancies. For all staff required in the MSCAN Contract, Section 1 (M), indicate whether the staff are in-state, the number of FTEs, and any required credentials. For contractually required key positions, provide the percentage of time allocated to the MSCAN contract and the CHIP contract, as well as any other lines of business.

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

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base for the MSCAN Program, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. Provider identified limitations on panel size considered in the network assessment

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

6. A completed Provider Network File Questionnaire

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

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

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

10. The Quality Improvement work plans for MSCAN for 2022 and 2023.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN Program that have been planned and completed during the previous year and any interim information available for projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e., analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with non-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction.
    c. For projects with measures derived from administrative electronic systems:
        - full source code documentation of how the measure was processed and calculated for the PIP.

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

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

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

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

17. Reports of medical record reviews completed in 2022 and 2023 and a copy of the tools used to complete these reviews for MSCAN providers.

18. A complete list of all MSCAN members enrolled in the Care Management Program from August 2022 through July 2023. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis that triggered the need for care management.

19. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for August 2022 to July 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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

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

22. A copy of any member newsletters, educational materials, and/or other mailings. Include any training plans for educating members about the MSCAN Program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Include any training plans and initial provider orientation materials used for educating providers about the MSCAN Program.

24. A copy of the grievance, complaint, and appeal logs for the MSCAN Program for the months of August 2022 through July 2023.

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

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the MSCAN Program. Please include:
    a. Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    b. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

27. Preventive health guidelines recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

28. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

29. For the MSCAN Program, a list of physicians currently available for utilization consultation/review and their specialties.

30. A copy of the provider handbook or manual for the MSCAN Program.

31. A sample provider contract for the MSCAN Program.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*

b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and enrollment data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
d. A copy of the IT Disaster Recovery Plan.
e. A copy of the most recent disaster recovery or business continuity plan test results.
f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
g. A copy of the policies or program description that address the information systems security and access management. Please also include policies with respect to email and PHI.
h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of August 2022 through July 2023.

33. Provide a listing of delegates conducting activities for the MSCAN Program. Include both local health plan delegates and corporate delegates that conduct activities for Mississippi using the following format:

Date of Initial Delegation	Name of Delegated Entity	Delegated Functions	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management contract, etc.).

35. Results of the most recent monitoring conducted for all delegated entities. Include a full description of the procedure and/or methodology used, a copy of any tools used, and any reports of activities submitted by the subcontractor to the CCO.

36. Please provide the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS® Measurement Year 2022 (MY 2022) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2022 1NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for all supplemental data sources that are utilized for all

Folder	Requested Document	Description
		measures included under PMV review. If the CCO did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) CSV and Excel workbooks for MSCAN for MY 2022.
c.	HEDIS MY 2022 Final Audit Report (FAR) from the Licensed Organization for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization for MY 2022.
d.	NCQA certification for certified measure code used to generate each of the HEDIS measures	• If your CCO contracted directly with NCQA for automated source code review (ASCR) to have measure logic certified, please provide a copy of your NCQA ASCR final measure certification for the HEDIS measures reported. • If your CCO used [2]HEDIS Certified Measures [SM,] to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each non-HEDIS measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production.
f.	Numerator positive case listings for the HEDIS and non-HEDIS measures	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. CCME will select a random sample from this list of 100 compliant records to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the site review.
g.	List of exclusions and numerator compliant records via medical record review (MRR) for the HEDIS measures	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 36 g) a list of the first 100 numerator compliant records and exclusions/valid data errors that are identified through medical record review.

Folder	Requested Document	Description
		CCME will select a random sample to conduct the medical record review validation.
h.	Rate Reporting template populated with data for non-HEDIS measure rates	CCME will provide the rate reporting template for both the CMS Adult and Child Core Set non-HEDIS measures which must be populated by the CCO with final data (denominators, numerators, and rates) for each measure for the MSCAN population.

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

37. Provide electronic copies of the following files for MSCAN:
    a. Twenty-five medical necessity denial files for the MSCAN Program for the months of August 2022 through July 2023. Of the 25 requested files, include five behavioral health and five pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used to make the denial determination for each file.
    b. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN Program for the months of August 2022 through July 2023, including any medical information and approval criteria used to make the decision.

       Note: Appeal, Grievance, and Care Management files will be selected from the logs received with the desk materials. The CCO will then be asked to send electronic copies of the files to CCME.

These materials:

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

Attachment 2: Materials Requested for Onsite Review

Magnolia – MississippiCAN

External Quality Review 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.

2. Any policy that describes the process for initial adoption and ongoing review of clinical practice and preventive health guidelines.

3. A copy of Policy MS.PRVR.19, Provider Directory. If this policy has been retired, please provide an alternate policy containing the information.

4. A copy of the Business Ethics and Code of Conduct.

5. A copy of Policy MS.PHAR.15, Pharmacy Lock-In Program or another policy that addresses the pharmacy lock-in program.

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

Attachment 3: EQR Validation Worksheets

- Member Satisfaction Survey Validation CAN
- Provider Satisfaction Survey Validation CAN
- PM Validation CAN
- PIP Validation CAN
- Network Validation CAN

EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**CAHPS MEMBER SATISFACTION – ADULT**
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* Press Ganey Adult CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Adult CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Adult CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Adult CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Adult CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Adult CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 19.4% which is an improvement from last year's response rate of 17.2% response rate is lower than the National Committee for Quality Assurance target rate and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Adult CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 13.4% for MY2022 (212 out of 1972) which is an improvement over the previous year's response rate of 10.1%. This response rate is lower than the National Committee for Quality Assurance target rate and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. Documentation: Press Ganey Child CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. Documentation: Press Ganey Child CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. Documentation: Press Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. Documentation: Press Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. Documentation: Press Ganey Child CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. Documentation: Press Ganey Child CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 16.7% for MY2022 which is an improvement over the previous year's response rate of 9.2%. This response rate is lower than the National Committee for Quality Assurance target rate and may introduce bias into the generalizability of the findings. Documentation: Press Ganey Child CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. Documentation: Press Ganey Child CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. Documentation: Press Ganey Child CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**PROVIDER SATISFACTION SURVEY**
Validation Period	2022
Review Performed	2023

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

Survey Element		Element Met / Not Met	Comments and Documentation
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

Survey Element		Element Met / Not Met	Comments and Documentation
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Survey data were analyzed. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Appropriate tests were utilized. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Conclusions were supported by data analysis. Documentation: SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics/Press Ganey MY 2022 Provider Satisfaction Survey Final report

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2023**
Review Performed:	**10/18/2023**

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	Met	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	Met	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	Met	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health – MSCAN**
Name of PM:	CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
Fully Compliant

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health - MSCAN**
Name of PM:	CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
Fully Compliant

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)**
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)**
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	MAGNOLIA HEALTH MSCAN
Name of PM:	COLORECTAL CANCER SCREENING (COL-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	HIV VIRAL LOAD SUPPRESSION (HVL- AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	ORAL EVALUATION, DENTAL SERVICES (OEV-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

VALIDATION SUMMARY			
Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	**Not Met**	**0**
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	70
Measure Weight Score	75
Validation Findings	93.33%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Met**	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

VALIDATION SUMMARY			
Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Not Met	0
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	70
Measure Weight Score	75
Validation Findings	93.33%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	HEART FAILURE ADMISSION RATE (PQI-08-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

VALIDATION SUMMARY			
Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Not Met	0
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	70
Measure Weight Score	75
Validation Findings	93.33%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and Magnolia's vendor corrected the source code. Magnolia confirmed that the corrected source code was used to calculate the final rates.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

VALIDATION SUMMARY			
Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Not Met	0
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	70
Measure Weight Score	75
Validation Findings	**93.33%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Magnolia Health Plan
Name of PM:	TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)
Reporting Year:	2023
Review Performed:	10/18/2023

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	N/A	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	N/A	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	N/A	

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

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

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

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PIP Validation Worksheet

Plan Name:	Magnolia
Name of PIP:	IMPROVED PREGNANCY OUTCOMES
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Preterm birth is the leading cause of infant death in MS
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported for baseline and remeasurement 1 In table format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Repeated measures are included in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of baseline in relation to benchmark rates.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The baseline rate was 14.47%, and the most

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		recent rate was 15.05%. The goal is to reduce the rate to 11.04%. Recommendation: *Continue to monitor interventions and efforts toward member education and member tracking, as well as member self-monitoring to work toward reducing preterm birth rate.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	74
Project Possible Score	75
Project Rating Score	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR PIP Validation Worksheet

Plan Name:	Magnolia
Name of PIP:	BEHAVIORAL HEALTH READMISSIONS (CLINICAL)
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Hinds County has a high rate of readmissions.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure is clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measured changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The inpatient readmissions PIP showed improvement in the latest rate from 26.88% in 2021 to 25.9% with a goal of 6%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement appears to be related to the interventions for member education and ToC assessment.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR PIP Validation Worksheet

Plan Name:	**Magnolia**
Name of PIP:	**RESPIRATORY ILLNESS**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Childhood asthma is a major concern in MS. COPD is the fourth leading cause of death.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services were addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations were included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are clearly defined: Asthma Medication Ratio – 50% and COPD Spirometry testing

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specified data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data was being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements were documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	AMR rate was 71.15% at baseline, which had no change in 2022 at 71.15%, with a goal of 76.86%. Spirometry testing rate was 28.38% at baseline and declined to 22.27% for 2022, the goal is 36.82%. *Recommendation: Continue member and provider education, texting campaign, and health equity dashboard to identify members that need additional resources.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	**74**
Project Possible Score	**75**
Project Rating Score	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR PIP Validation Worksheet

Plan Name:	**Magnolia**
Name of PIP:	**SICKLE CELL DISEASE**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	In 2018, a low percentage of members were compliant with taking their Hydroxyurea.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported in table format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Repeated measures were included in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of baseline and remeasurements in relation to benchmark rates.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The rate was 37.5% at baseline, decreasing to 25.87% in 2023. The goal is to increase the rate to 47%. Recommendation: *Continue ongoing interventions of texting campaigns and multi-team outreach to ensure members have the information needed to remain compliant.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Unable to judge.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	74
Project Possible Score	75
Project Rating Score	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR Network Validation Worksheet

Plan Name:	**Magnolia**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the CCO to the EQRO? **(1)**	**MET**	Data sources for appropriate timepoints were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? **(1)**	**MET**	All variables were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? **(1)**	**MET**	Missing data was addressed.
1.4 Do the CCO's data enable valid, reliable, and timely calculations of the indicators? **(1)**	**MET**	Data allowed valid and reliable calculations.
1.5 Did the CCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? **(1)**	**MET**	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the CCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? **(1)**	**MET**	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? **(1)**	**MET**	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? **(1)**	**NA**	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the CCO include appropriate calculations and sound methodology? **(5)**	**MET**	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.1 Are the methods selected by the CCO appropriate for the state? **(10)**	**MET**	Methods aligned with State standards.
2.2 Are the methods selected by the CCO appropriate to the state Medicaid and CHIP population(s)? **(10)**	**MET**	Methods aligned with populations.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.3 Are the methods selected by the CCO adequate to generate the data needed to calculate the indicators according to the State's expectations? **(10)**	**MET**	Methods generated required data for NA assessment.
2.4 Does the CCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? **(1)**	**MET**	Provider network file questionnaire indicated appropriate provider classification.
2.5 If the CCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? **(1)**	**MET**	Sound sampling methods were applied, wherein necessary.
2.6 If the CCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? **(1)**	**MET**	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. **(1)**	**MET**	Random sampling was utilized wherein required.
2.8 Does the CCO's approach for measuring time/distance indicators match the state's expectation? **(1)**	**MET**	Approach for time/distance aligned with State requirements.
2.9 Does the CCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? **(1)**	**MET**	Ratio calculations were conducted according to State requirements.
2.10 Does the CCO's approach for determining the maximum wait time for an appointment match the state's expectation? **(1)**	**MET**	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? **(10)**	**MET**	Methods are objective and use of third-party vendors wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? **(10)**	**MET**	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF CCO NETWORK ADEQUACY RESULTS		
3.1 Did the CCO produce valid results? **(10)**	**MET**	Results were judged to be valid.
3.2 Did the CCO produce accurate results? **(10)**	**MET**	Results were judged to be accurate.
3.3 Did the CCO produce reliable and consistent results? **(10)**	**MET**	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the CCO accurately interpret its results? **(10)**	**MET**	Findings were interpreted and analyzed by CCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

Step	Possible Score	Score
Activity 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.74	1	1
1.8	NA	NA
1.9	5	5
Activity 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Activity 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
Total	99	99

Points Earned	99
Possible Score	99
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*