Constellation Quality Health

Magnolia Health Plan

2024 External Quality Review

Submitted: December 12, 2024

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 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 2024 External Quality Review (EQR) conducted by Constellation Quality Health (Constellation) 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) contract 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, performance measures, network adequacy, and member and provider satisfaction surveys; and an Information Systems Capability 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'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 develops policies and procedures to guide staff in conducting health plan operations, reviews the policies at least annually, and educates staff about new/revised policies. Staff may access policies through Magnolia's policy management platform and an intranet site.

All contractually required key positions are filled and overall staffing is sufficient to conduct all required activities and provide all required services.

Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against fraud, waste, and abuse are thoroughly documented in the Compliance and Ethics Program Description 2024, the Fraud, Waste and Abuse Plan (FWA Plan) and its related Mississippi addendum, and in related policies and procedures. Magnolia's Compliance Committee advises the Compliance Officer and assists with maintaining the Compliance Program. The review confirmed Magnolia implemented a corrective action from the previous EQR related to documentation of Compliance Committee member attendance by proxy.

Appropriate processes are in place for annual mandatory compliance training for employees and subcontractors. In addition to the compliance training, the Centene Business Ethics and Code of Conduct outlines ethical and compliance standards for all employees.

Magnolia maintains and educates staff about open lines of communication through which they may ask compliance questions and report compliance issues and suspected fraud, waste, and abuse. Magnolia ensures confidential reporting through telephone hotlines and a web portal, and by limiting discussion of investigations to those with direct knowledge of, or assisting in, the investigation.

Magnolia has an established Pharmacy Lock-in Program to detect and prevent abuse of the pharmacy benefit by restricting members to one pharmacy and/or one prescriber for controlled substance prescriptions. The review confirmed Magnolia appropriately addressed the corrective action from the previous EQR to include information about the 72-hour emergency supply of medications when members are in the Lock-in Program in the appropriate policy.

On average, Magnolia pays 99% of clean claims within 30 days and 99.99% within 90 days. Magnolia has robust processes and sufficient checks to ensure enrollment data and member demographic information are collected when available, and to capture all relevant claims data to ensure accuracy. Magnolia was not able to provide all requested ISCA supporting documentation due to the proprietary nature of Centene's software and technology processes; however, Magnolia demonstrated during the onsite its data collection and storage capabilities, processing procedures, and claim data tabulation and processing. Magnolia has a documented disaster recovery plan and a business continuity plan that are updated yearly and tested regularly.

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

Centralized credentialing was implemented by DOM in 2022; however, many documents reference credentialing and recredentialing as if they were still health plan responsibilities.

Appropriate provider orientation and ongoing education processes are in place. In addition to provider education, the Provider Manual is a comprehensive resource for providers to operate effectively within Magnolia's network. A discrepancy was noted in the limitation of orthotics and prosthetics when comparing the Provider Manual and Member Handbook.

Magnolia defines medical record documentation standards for providers in policy, educates providers about the documentation standards through the Provider Manual, and assesses provider compliance with the medical record documentation standards through an annual medical record review process. For the 2023 Medical Record Review, scores ranged from 99.25% to 100%. Magnolia identified an area of opportunity to reinforce education regarding documentation of pediatric immunizations.

Magnolia adopts and educates providers about clinical practice guidelines (CPGs) and preventive health guidelines (PHGs). The Provider Manual refers the reader to the website to access the guidelines. The list of guidelines on Magnolia's website included hyperlinks that were non-functional, returned error messages, or required an account and/or membership to access the information.

Constellation validated Magnolia's 2023 provider satisfaction survey and found the response rate was 5.2%, a decrease from the previous year. The net satisfaction score was 75.5% and the net loyalty score was 65.5%. Several measures increased significantly from 2022, and no measures decreased significantly. Results were presented to the Performance Improvement team/committee in December 2023 and January 2024.

Network Adequacy Validation:
Geographic and appointment access standards for network providers are defined in policy. Magnolia assesses the geographic adequacy of the network through quarterly geographic access reports and a formal annual evaluation that considers member satisfaction results. Review of the geographic access reporting revealed the use of incorrect time standards for dental providers. Provider compliance with appointment access standards is assessed annually, while considering member satisfaction survey results and complaint/grievance data. Results of the 2023 appointment access study in the 2023 Quality Management Program Evaluation reflected incorrect appointment access standards and did not include results of the 2023 after-hours survey. Magnolia has developed the Culturally and Linguistically Appropriate Services Program to identify and address areas of health inequity. Overall, Magnolia met the requirements for Network Adequacy Validation.

Elements that must be included in the Provider Directory are documented in policy. The online Provider Directory includes all required elements; however, the printed Provider Directory did not include the group affiliation (practice name) for individual providers. Magnolia validates Provider Directory information through vendor and health plan audits, provider outreach activities, face-to-face meetings, etc.

Constellation conducts Telephonic Provider Access Studies twice a year for each CCO. The results of the Telephone Access Study conducted by Constellation in Q3 2024 showed a successful contact rate of 32%, which was a decline from the previous study's successful contact rate of 66% (Q1 2024). The routine appointment compliance rate was 83% and the urgent appointment compliance rate was 29%. From Q1 2024 to Q3 2024, the routine and urgent appointment availability rates improved. The Provider Directory Validation showed an accuracy rate of 72% (a 13% decline from the previous study's rate of 85%). For full information about the Q3 2024 study, refer to the Provider Access Study and Directory Validation Report for Quarter 3, 2024.

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

Members' rights and responsibilities are documented in Magnolia's policies, member and provider materials, and listed on Magnolia's website. Information regarding the health plan is provided to new members in the New Member Packet and sent to members within 14 days of enrollment. The packet contains a Member Handbook, the member's ID Card, a Welcome Letter, a Benefit Booklet, contact information for the health plan, information about the website, various forms, and educational brochures.

Members receive information in the Member Handbook about how to obtain a Provider Directory and choose a primary care physician (PCP). The Member Handbook addresses covered benefits, second opinions, 24-hour access to care, requirements for obtaining out-of-network care, and the Preferred Drug List.

Members are informed that they will be notified of changes in services, benefits, and providers in writing, through Magnolia's website, and via addendums to the Member Handbook. Onsite discussion highlighted the website notification and Member Handbook updates specific to the Gainwell Pharmacy change effective July 1, 2024.

Member materials are developed using the appropriate font and reading level 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. 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, alternate language materials, and TTY/TTD services.

Member Services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities. The Quality Management Program Evaluation indicated that all performance metrics were met throughout 2023.

The grievance management processes are outlined in policies, the Member Handbook, Provider Manual, and on the website. The definitions of grievances and complaints, instructions for filing verbally or in writing, and the resolution timeframe are clearly and consistently documented throughout Magnolia's materials.

Grievances are logged, categorized, and maintained per contractual requirements. Summaries of complaint and grievance actions, trends, and opportunities for improvement are reported

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

Magnolia contracts with Press Ganey, a certified vendor, to conduct the adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Surveys were fielded from February 2024 to April 2024. For Measure Year (MY) 2023, the adult CAHPS survey had a response rate of 16.1%, which is lower than last year's rate of 19.4%. The largest improvement was in the rating of specialists, and the largest decline was in the measure regarding Customer Service. The MY 2023 child CAHPS survey had a decline in the response rate from 16.7% to 10.1%. The largest improvement was in the rating of personal doctors, and the largest decline occurred in the rating of specialists. The child with chronic conditions (CCC) survey had a response rate of 9.3%, which is lower than last year's rate of 13.4%. The largest increase was in the rating of specialists, and the largest decline was in coordination of care. The documentation demonstrated the assessment of barriers and interventions to address member satisfaction concerns.

Quality Improvement

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

Magnolia's Quality Improvement (QI) Program is comprehensive. The 2024 Quality Program Description (QI Program Description) describes a systematic approach to improving the quality and safety of clinical care and services provided to members. The program integrates quality assurance, management, and improvement into all staff roles and department functions and is overseen by the Board of Directors. Magnolia utilizes reliable methods like Healthcare Effectiveness Data Informational Set (HEDIS), CAHPS, and CMS Core Measures to monitor and improve performance. The Chief Medical Director serves as the senior quality executive responsible for the QI Program. The Behavioral Health Medical Director is the designated practitioner responsible for the behavioral health aspects of the QI Program.

Credentialing and recredentialing are mentioned several times in the QI Program Description. Page 14 of the QI Program Description specifically mentions the Credentialing Committee has the responsibility for credentialing and recredentialing physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners. The program description does not include Magnolia's current responsibilities related to credentialing and recredentialing since DOM implemented centralized credentialing.

The QI Program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. It also focuses on health disparity reduction and cultural competency, ensuring that services are delivered in a culturally and linguistically competent manner.

A Quality Work Plan is used as part of Magnolia's Quality Program. The work plan includes the yearly planned activities, the individual(s) accountable for each task, specific start and completion dates, data collection methods and analysis, and quarterly updates. The work plan is reviewed by the Quality Improvement Committee (QIC) on a regular basis and is a fluid document that is frequently updated to document progress throughout the year. For this EQR, Magnolia provided the 2023 and 2024 work plans.

The QIC is the senior management lead committee, accountable directly to the Board of Directors, and is responsible for the QI Program. Members of the QIC include senior management staff, clinical staff, and network practitioners. 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. Voting members must attend 75% of scheduled meetings. In 2023 there were eight voting members who did not meet this attendance requirement. Also, line nine of the 2023 QI Work Plan included an activity to ensure the QIC had adequate representation of external providers. This activity was to ensure there was at least one behavioral health provider, and to ensure there was a pediatrician, family practice provider, internal medicine provider, nurse practitioner, and specialist. The 2023 QIC minutes and the 2024 committee membership list did not include an internal medicine provider or a specialist as a member of this committee.

Magnolia monitors provider performance through profiling reports focusing on PCPs. Policy MS.QI.23, Provider Profiling Program, outlines the process by which Magnolia develops, implements, monitors, and distributes provider profiling reports to PCPs. This program aims to increase provider awareness of their performance and improve health outcomes for members by recognizing providers who deliver quality care.

Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, outlines Magnolia's policy and procedures for providing EPSDT services for Medicaid recipients under 21. It details the commitment to providing comprehensive preventive health screenings and improving children's health. Magnolia runs monthly reports to identify members needing follow-up care after an EPSDT screening. If abnormal findings are detected, the EPSDT Coordinator or QI designee monitors claims for evidence of treatment and follows up with providers and parents or guardians to ensure necessary care is provided.

Magnolia evaluates the QI Program through an annual evaluation that includes an analysis and evaluation of the overall effectiveness of the Quality Program, including progress toward influencing network-wide safe clinical practices and an evaluation of the adequacy of resources and training related to the Quality Program. The 2023 Magnolia Health Quality Management Program Evaluation included a description of completed and ongoing studies and quality activities that address quality and safety of clinical care and quality of service. Trending

of measures collected over time to assess performance and interventions implemented to address issues are also included. The findings are presented to the Quality Improvement Committee and the Board of Directors for approval annually.

Performance Measure Validation:

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. Performance measure validation determines the extent to which the CCO followed the specifications established for the National Committee for Quality Assurance (NCQA) HEDIS measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted the validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2023, through December 31, 2023.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Magnolia's NCQA-licensed organization. Aqurate found that Magnolia's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS MY 2023.

All relevant HEDIS performance measures for the CAN population for the current review year (2023) were compared to the previous year (2022) and the changes from 2022 to 2023 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the CAN HEDIS measures found to have substantial increases or decreases in rate from 2022 to 2023. A substantial increase or decrease is a change in rate greater than 10%.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2022	HEDIS MY 2023	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Adult BMI Assessment (ABA)	44.79%	62.05%	17.26
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
6-17 years - 30-Day Follow-Up	54.49%	64.64%	10.15
Substantial Decrease in Rate (>10% decrease)			
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (65-74)	32.26%	18.60%	-13.66
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			

Measure/Data Element	HEDIS MY 2022	HEDIS MY 2023	Change from 2022 to 2023
18-64 years - 30-Day Follow-Up	48.06%	37.26%	-10.80

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for 2023 and the previous year (2022) and the changes from 2022 to 2023 are reported in the Quality Improvement section of this report. *Table 2: CAN Non-HEDIS Measures with Substantial Changes in Rates* highlights the CAN Non-HEDIS measures found to have substantial increases or decreases in rate from 2022 to 2023. A substantial increase or decrease is a change in rate greater than 10%.

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

Measure/Data Element	HEDIS MY 2022	HEDIS MY 2023	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception – 90 days	40.70%	51.64%	10.94
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	29.12%	39.30%	10.18
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 90 days	44.50%	57.62%	13.12
Substantial Decrease in Rate (>10% decrease)			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 65+	225.56	106.72	-118.84
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 65+	75.19	0	-75.19

Performance Improvement Project Validation:

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the CMS-developed protocol 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. For this review, Magnolia submitted three PIPs. Topics for those PIPs included Reducing Preterm Births, Sickle Cell Disease, and Asthma/COPD. Magnolia indicated they were in the process of working on a fourth PIP regarding Follow-up After Hospitalization for Mental Illness. The three PIPs validated scored in the "High Confidence in Reported Results" range as noted in the table that follows.

Details of each PIP's status and related interventions are included in the Quality Improvement section of this report.

Table 3: Performance Improvement Projects

Performance Improvement Project	Previous Validation Score	Current Validation Score
Reducing Preterm Births	74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Sickle Cell Disease Outcomes	74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Asthma/COPD	74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results

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 (UM) Program is explained in the UM Program Description 2024 as well as in numerous policies and procedures. The scope and goals of the UM Program are outlined and a detailed description of roles and qualifications for the UM leadership staff positions is provided.

Authority, oversight, and lines of responsibility of the UM Program are clearly identified within the policies and procedures. Policy CC. UM.01, Program Description, states that the Chief Medical Director has operational responsibility for and provides support to Magnolia's UM Program.

The UM process encompasses the following program components: 24-hour nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning, and care coordination. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, scheduled inpatient services, or emergent/urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting provider and member (when applicable) have been notified of the determination.

Appropriately licensed, qualified staff supervise the UM process and render all medical necessity decisions based upon InterQual criteria or other established guidelines, as referenced in Policy CC.UM.04, Appropriate UM Professionals. A physician or other appropriately licensed health care professional issues all medical necessity denials. Reviewers employed by or under contract to perform utilization review are appropriately qualified, trained, and hold current professional licensure. There are mechanisms in place for appeals, including expedited appeals.

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timeframes are in place for providers to notify the Plan of a service request and for the health plan to make UM decisions and subsequently notify the member and provider. At the time of an adverse benefit determination, members and providers are notified verbally and/or in writing of the availability of an appropriate practitioner reviewer to discuss the adverse benefit determination, and how to contact a reviewer for specific cases.

Constellation's review of sample approval and denial files found that the criteria and procedures for the evaluation of medical necessity of services for members were applied consistently.

Magnolia describes processes for handling verbal and written appeals in Policy MS.UM08, Appeal of UM Decisions, the Member Handbook, and the UM Program Description. The term "appeal" is defined in policy, the Member Handbook, Provider Manual, UM Program Description, and on the Magnolia's website as a request to review an adverse benefit determination. Timeframes for the acknowledgement and resolution of standard and expedited appeals are indicated in member and provider materials. The EQR found that all appeals sampled were processed in a timely manner and reflected that an appropriate physician made the appeal determinations.

Various policies outline the purpose, scope, and goals of the care management program for Mississippi members. Members are referred for care management services through various referral sources. Once a member is identified as a potential candidate for care management services, a referral is initiated to conduct an initial assessment. Following completion of the treatment plan, care management activities are provided to members based upon their identified needs and risk level assignment.

Magnolia offers disease management programs to address specific health related needs to members. Transitional care management services are also provided to manage transitional care for members across healthcare settings. Based upon review of the sample care management files, care management interventions were provided to members based upon their assigned risk level and identified needs.

Delegation

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

Magnolia has delegation agreements with 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. A pre-delegation review is conducted prior to the activation of the delegation agreement. This review includes evaluating the entity's program, associated policies and procedures, staffing capabilities, and performance record to ensure

compliance with Magnolia, State, NCQA, Health Insurance Portability and Accountability Act (HIPAA), and other applicable regulatory standards. Magnolia monitors performance through routine reporting, oversight meetings, and annual evaluations to ensure compliance with standards. Corrective action plans are required for any deficiencies identified. Severe or unresolved deficiencies may lead to the revocation of the delegation agreement. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

Corrective Action Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation requires the plan to submit a Corrective Action Plan for each standard identified as not fully met. Technical assistance is provided until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which Magnolia implemented the actions to address deficiencies identified during the previous EQR and found that Magnolia addressed and implemented appropriate corrective action for all findings. Details regarding the 2023 Corrective Action Plan can be found in *Attachment 4: Assessment of Corrective Action Plans from Previous EQR*.

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 4: 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 4: 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 *(§ 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	20	20	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
	Utilization Management, Section V. C			
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	3	3	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	9	8	89%
• 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 preceding table, issues were found with the following:

- The Envolve Dental Network Analysis (Geo Access mapping) for dental providers reflected that incorrect time standards were used to evaluate geographic access. Also, the printed Provider Directory did not include all the required elements.
- Magnolia's website includes nonfunctional, erroneous, or restricted hyperlinks to CPGs and PHGs.

Table 5: Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2023 review. For 2024, 186 of 189 standards received a score of "Met." Three standards were scored as "Partially Met."

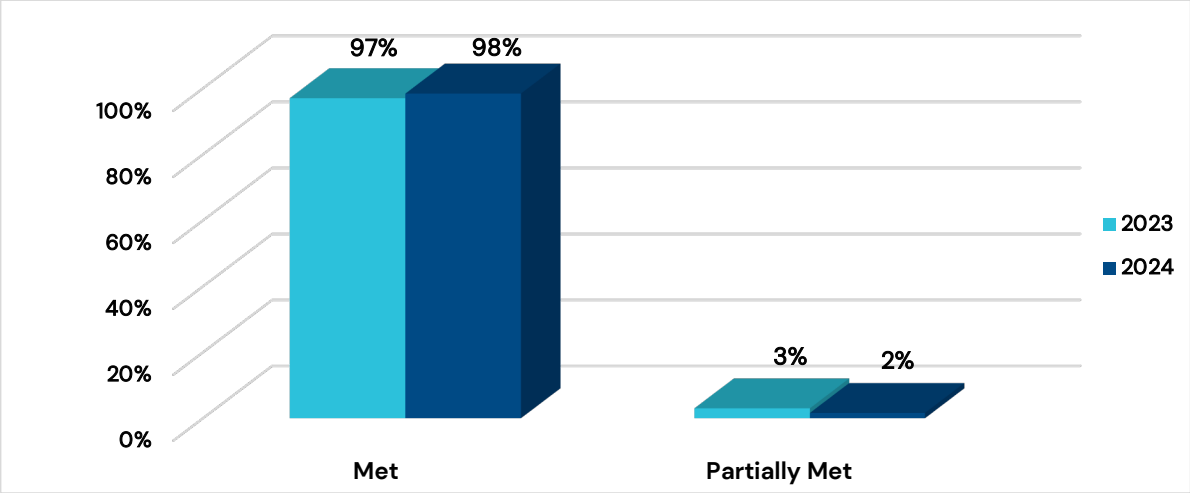
Table 5: Scoring Overview – CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	29	2	0	0	0	31	93.5%
2024	31	0	0	0	0	31	100%
Provider Services							
2023	47	2	0	0	0	49	95.9%
2024	46	3	0	0	0	49	93.9%
Member Services							
2023	33	0	0	0	0	33	100%
2024	33	0	0	0	0	33	100%
Quality Improvement							
2023	19	0	0	0	0	19	100%
2024	19	0	0	0	0	19	100%
Utilization							
2023	53	1	0	0	0	54	98.1%
2024	54	0	0	0	0	54	100%
Delegation							
2023	2	0	0	0	0	2	100%
2024	3	0	0	0	0	3	100%
Totals							
2023	**183**	**5**	**0**	**0**	**0**	**188**	**97%**
2024	**186**	**3**	**0**	**0**	**0**	**189**	**98%**

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

The 2024 Annual EQR found that Magnolia achieved "Met" scores for 98.4% of the standards reviewed and "Partially Met" scores for 1.6% of the standards reviewed. The figure that follows provides a comparison of the current review results to the 2023 review results for Magnolia.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number.

Recommendations and Opportunities for Improvement

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

Table 6: Strengths and Weaknesses Related to Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for policy development and ongoing management.	✓		
Health plan staffing is sufficient to ensure the CCO can conduct all required activities and provide all required services. There is currently only one staff vacancy.	✓		
Magnolia meets internal and state defined guidelines for percentage of clean claims paid.		✓	
Magnolia has a disaster recovery and business continuity plan that is well documented and tested.	✓		
Magnolia has robust processes with multiple levels of checks to ensure accuracy and data completeness.	✓		
Processes for ensuring compliance and guarding against FWA are thoroughly documented in the Compliance Plan, the FWA Plan and state-specific addendum, and in policies and procedures.	✓		
Magnolia's Pharmacy Lock-in Program meets all contractual requirements.	✓		
Multiple policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality and HIPAA requirements.	✓		
Provider Services			

Strengths	Quality	Timeliness	Access to Care
Providers can view panel assignments through the secure provider web portal and may request a printed list of member assignments by contacting Provider Relations and/or the Provider Services Call Center. Various mechanisms are in place for providers to verify member eligibility.			✓
Magnolia monitors the status of providers' panels to ensure there are enough providers with open panels to provide appropriate member access.			✓
Geographic access standards for all provider types are appropriately documented in policy, and Magnolia conducts routine monitoring to ensure network adequacy.			✓
Magnolia conducts an annual assessment of members' cultural, ethnic, racial, and linguistic needs and adjusts the network as needed.	✓		✓
Magnolia conducts routine audits of provider compliance with appointment and after-hours access standards.			✓
Initial and ongoing provider education processes are sufficient to ensure providers have the information needed to operate within Magnolia's network.	✓		✓
Magnolia adopts CPGs and PHGs from nationally recognized entities to guide providers and members when making healthcare decisions.	✓		✓
Magnolia routinely assesses provider compliance with medical record documentation standards.	✓		
Magnolia reported that they are developing a website enhancement that will include a provider demographic tool to allow providers to update their panel sizes/limitations, physical and billing address, etc.	✓		
Member Services			
Members are informed of rights and responsibilities consistently and in a variety of ways for convenient review.	✓		
Magnolia notified members and offered timely assistance regarding the Gainwell Pharmacy change via website and the Member Handbook.	✓	✓	✓
The Member Services call center performance metrics were all met throughout 2023.	✓		
The Community Connects Team has dedicated staff to provide member education about preventive health, resources, and disease management information.			✓
The sample of Magnolia's grievance files reviewed for the 2024 EQR were acknowledged and resolved in a timely manner.		✓	
Quality Improvement			
The Quality Program addresses a wide range of areas including access to care, quality of care, preventive care, health disparity reduction, and population health management.	✓		
Magnolia uses a data driven approach to monitor performance and measure the effectiveness of quality initiatives.	✓		
The validation of the performance improvement projects found the projects meet the validation requirements and scored in the High Confidence range.	✓		
Magnolia's HEDIS auditor found that the CCO was fully compliant with all Information Systems standards and determined that Magnolia submitted valid and reportable rates for all HEDIS measures in scope of the audit.	✓		
There were no concerns with Magnolia's data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Magnolia followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.	✓		

Strengths	Quality	Timeliness	Access to Care
The following HEDIS and CMS Core Set MY 2023 measure rates were strengths for Magnolia since their rates had a greater than 10 percentage point improvement: • The Adult BMI Assessment (ABA) measure improved by over 17 percentage points. • The Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD) measure improved by over 17 percentage points for the most or moderately effective contraception-90 days indicator. • The Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure increased by 10.15 percentage points for the 6-17 years - 30-Day Follow-Up indicator. • The HIV Viral Load Suppression measure (HVL - AD) improved by over 10 percentage points for the ages 18-64 indicator. • The Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH) measure improved by over 13 percentage points for the most or moderately effective contraception-90 days indicator.	✓		
Utilization Management			
The turnaround timeliness measures for non-urgent pre-service, urgent pre-service, outpatient non-urgent preservice, outpatient urgent pre-service, and post service reviews exceeded their performance goals of 98% during 2023.		✓	
Review of sample denial files reflected that all were processed timely and reviewed by appropriate health care professionals. The rationale for denial was clearly stated and communicated to members and providers within required timeframes.		✓	
My Health Pays is a member incentive program that promotes personal healthcare engagement by offering financial incentives for members to participate in wellness visits.	✓		
Puff Free Pregnancy is a smoking cessation program to promote a healthy pregnancy for mothers.	✓		
Constellation reviewed a sample of appeals and found that all were acknowledged and resolved in a timely manner and reflected the appropriately credentialed reviewers.		✓	
Delegation			
Magnolia's delegation oversight program includes a thorough pre-delegation review, ongoing monitoring, and annual evaluations to ensure that delegated entities meet Magnolia's standards and regulatory requirements.	✓		
The Delegation Oversight Program has a structured approach for identifying deficiencies and implementing corrective actions through Corrective Action Plans. This proactive approach helps in addressing issues promptly and improving the performance of delegated entities.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Provider Services				
The Geo Access mapping included in the Envolve Dental Network Analysis dated October 1, 2024, utilized incorrect geographic	*Corrective Action Plan: Conduct Geo Access mapping for dental providers using the correct parameters and submit to Constellation for review. Ensure*			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
access time standards for dental providers. The parameters used were: • 1 general/pediatric dentist within 30 miles or 60 minutes (urban) • 1 general/pediatric dentist within 60 miles or 120 minutes (rural) • 1 dental specialist within 30 miles or 60 minutes (urban) • 1 dental specialist within 60 miles or 120 minutes (rural) The *CAN Contract, Section 7 (B)* states the parameters for both general/pediatric dentists and dental subspecialty providers are 1 within 30 minutes or 30 miles (urban) and 1 within 60 minutes or 60 miles (rural).	*Envolve uses correct parameters for all future Geo Access mapping.*			
Several documents referenced credentialing as if it continues to be a health plan responsibility, including: • The 2024 Practitioner Availability Report for measurement year 2023 • Policy CC. PRVR.47, Evaluation of Practitioner Availability • The Culturally and Linguistically Appropriate Services Program Description • Policy MS.QI.13, Medical Record Review	*Recommendation: Ensure all applicable documents appropriately state current health plan activities and remove incorrect references to health plan credentialing for Medicaid providers.*	✓		
The 2023 Quality Management Program Evaluation indicates Magnolia conducted an after-hours telephonic survey in 2023. Results of the after-hours survey were not included in the program evaluation. Also, the results of the appointment access survey in the 2023 Quality Management Program Evaluation reflected incorrect appointment access standards for all provider appointment types except PCP well care visits and PCP urgent care visits.	*Recommendation: Ensure that reporting of appointment access surveys reflects the correct parameters for the various appointment types.*	✓		✓
The printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers.	*Corrective Action: Ensure the printed Provider Directory includes all required information. Refer to the CAN Contract, Section 6 (E) and 42 C.F.R. § 438.10 (h).*			✓
When comparing documentation of benefits in the Provider Manual and Member Handbook, a discrepancy was noted for Orthotics and Prosthetics. The Provider Manual page 22, states, "limited to children	*Recommendation: Revise the Member Handbook or Provider Manual, as applicable, to reflect the correct limitation for orthotics and prosthetics.*			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
under 21 years" while the Member Handbook, page 20, states "no limit."				
During onsite discussion, Magnolia confirmed that ongoing provider education is not addressed in a policy.	*Recommendation: Revise an existing policy or develop a new policy to document Magnolia's processes for providing ongoing provider education.*	✓		
The review of the list of CPGs and PHGs on Magnolia's website revealed that multiple hyperlinks were either non-functional, resulted in "page not found" or "page has been moved" error messages, required the reader to create an account and log in to access the information, or required membership with the entity to access the information.	*Corrective Action Plan: Revise the hyperlinks to the CPGs and PHGs on Magnolia's website to ensure providers can access the information.*	✓		✓
The low response rate for the 2023 Provider Satisfaction Survey (5.2%) may not reflect the population of providers. Thus, results should be interpreted with caution.	*Recommendation: Continued efforts should be made to gather a better representation of the providers and increase education on the importance of the survey.*	✓		
Quality Improvement				
The QI Program Description does not include Magnolia's current responsibilities related to credentialing and recredentialing since DOM implemented centralized credentialing.	*Recommendation: Update the QI Program Description to include Magnolia's current responsibilities related to credentialing and recredentialing.*	✓		
According to the Quality Improvement Committee Charter, voting members must attend 75% of scheduled meetings. In 2023 there were eight voting members who did not meet this attendance requirement.	*Recommendation: Committee members who don't meet the attendance requirements for the Quality Improvement Committee should be replaced.*	✓		
Line nine of the 2023 QI Work Plan included an activity to ensure the QIC had adequate representation of external providers. This activity was to ensure there was at least one behavioral health provider, and ensure there was a pediatrician, family practice provider, internal medicine provider, nurse practitioner, and specialist. The 2023 QIC minutes and the 2024 committee membership list did not include an internal medicine provider and a specialist.	*Recommendation: Add a network provider who specializes in internal medicine and a specialist to ensure the Quality Improvement Committee has adequate representation as noted in the QI Work Plan.*	✓		
For the Reducing Preterm Births PIP, in the last two remeasurements the rate increased from 15.05% to 15.44%, which is not a substantial increase, but lower is better so this reflects a lack of improvement.	*Recommendation: Determine if additional interventions may assist in reducing preterm births; enhance member education on assessing for signs of pre-eclampsia.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The following HEDIS and CMS Core Set MY 2023 measure rates were determined to be areas of opportunity for Magnolia since their rates had a greater than 10 percentage point decline: • The Kidney Health Evaluation for Patients With Diabetes (KED) measure decreased by over 13 percentage points for the ages 65-74 indicator. • The Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure decreased by 10.80 percentage points for the 18-64 years - 30-Day Follow-Up indicator. • The Chronic Obstructive Pulmonary Disease (COPD) OR Asthma In Older Adults Admission Rate (PQI-05) measure decreased by 118.84 per 100,000 member months for the Ages 65+ indicator. • The Heart Failure Admission Rate (PQI-08) measure decreased by 75.19 per 100,000 member months for the Ages 65+ indicator.	*Recommendation: Seek opportunities to improve the Kidney Health Evaluation for Patients with Diabetes, Follow-up After Emergency Department Visit for Mental Illness, Chronic Obstructive Pulmonary Disease or Asthma, and the Heart Failure Admission Rate measures.*	✓		
Rate inconsistencies were found in the reported measure data. The responses Magnolia provided are indicative of gaps in processes established for verification and reporting of measure rate data.	*Recommendation: Improve processes for rate reporting, validation, and trending to identify measure rate reporting concerns.*	✓		
Inconsistencies were observed in the reported enrollment data during the Performance Measure Validation. The HEDIS Compliance Audit Final Audit Report also identified areas of improvement in reporting enrollment information.	*Recommendation: Improve processes for maintaining and reporting accurate enrollment counts for measure rate reporting.*	✓		

METHODOLOGY

The process Constellation Quality Health (Constellation) used for this External Quality Review (EQR) was based on protocols the Centers for Medicare & Medicaid Services (CMS) developed for the external quality review of a Medicaid Managed Care Organization (MCO)/Prepaid Inpatient Health Plan (PIHP). The process 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 June 3, 2024, Constellation 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 Coordinated Access Network (CAN) Program.

Further, an invitation was extended to the Coordinated Care Organization (CCO) to participate in a pre-onsite conference call with Constellation and the Mississippi Division of Medicaid (DOM) to provide Magnolia an opportunity to seek clarification on the review process and to ask questions regarding any of the desk materials Constellation requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on July 3, 2024, for review at Constellation's offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on November 6, 2024, and November 7, 2024. The onsite visit focused on areas not covered in the desk review or areas 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 Administration review encompasses policy development and ongoing management, health plan staffing, information systems capabilities, compliance, and program integrity.

Magnolia develops policies and procedures to guide staff and ensure compliance with laws, regulations, contractual requirements, and accreditation standards. All policies are reviewed at least annually and updated as needed. Departmental leadership educates employees about new and revised policies, and staff may access policies through Magnolia's policy management platform and through an intranet site.

Review of the Organizational Chart and onsite discussion confirmed all contractually required key positions are filled and overall staffing is sufficient to conduct all required activities and provide all required services. One Social Services Specialist position is vacant, but Magnolia is currently recruiting candidates to fill the position.

Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against fraud, waste, and abuse (FWA) are addressed comprehensively in the Compliance and Ethics Program Description 2024 (Compliance Plan), the Fraud, Waste and Abuse Plan (FWA Plan) and its related Mississippi addendum, and in related policies and procedures. The Compliance Plan provides an overview of the Compliance Officer's roles and responsibilities for developing, revising, and monitoring the Compliance Program. The Compliance Plan also provides an overview of the Compliance Committee's roles and responsibilities, composition, and meeting frequency.

Magnolia's Compliance Committee is a cross-functional committee that includes members from various departments to advise the Compliance Officer and assist with maintaining the Compliance Program. As noted in the 2024 Compliance Committee charter, the committee meets quarterly and as needed, is chaired by the Compliance Officer, and a quorum is established with the presence of 50% of the voting members. The charter specifies that members must attend at least 75% of the meetings. Constellation's review of Compliance Committee minutes for meetings held from September 2023 through June 2024 reflected the presence of a quorum for each meeting. No attendance issues were noted, and the attendance documentation clearly indicated if a proxy was attending for a voting member. This confirmed that Magnolia implemented the corrective action from the previous EQR related to documentation of Compliance Committee member attendance by proxy.

Annual compliance training is mandatory for all employees and subcontractors. The training emphasizes Magnolia's commitment to compliance with ethical standards and legal

requirements, and is provided through various forums, such as in-service sessions, online forums, and newsletters. The health plan policy states new employees are required to complete compliance training within 30 days of hire, and onsite discussion confirmed Health Insurance Portability and Accountability Act (HIPAA) training is provided on the first day of employment, before the employee is given access to confidential member information. In addition, Magnolia has adopted the Centene Business Ethics and Code of Conduct (Code of Conduct), which outlines ethical and compliance standards for all employees. Magnolia publicizes disciplinary guidelines for employees through policies and procedures, compliance training/materials, Centene intranet (CNET) articles and videos, workplace posters, live presentations, etc.

Magnolia maintains open lines of communication for employees and others to ask compliance questions and report compliance issues and suspected FWA. Staff are educated about communication and reporting options through compliance training activities, meetings, emails, compliance awareness postings on CNET, and workplace posters. Magnolia ensures confidentiality when reporting suspected or actual FWA by offering telephone hotlines and a web portal for reporting. Magnolia also limits discussion of investigations to those with direct knowledge of the issue, or those who could assist in investigation or resolution.

Magnolia has an established Pharmacy Lock-in Program to detect and prevent abuse of the pharmacy benefit by restricting members to one pharmacy and/or one prescriber for controlled substance prescriptions. Information about the Pharmacy Lock-in Program is documented in Policy MS.PHAR.15, Pharmacy Lock-In Program. The policy addresses processes for identifying members for inclusion in the program, criteria for inclusion and exclusion, member notification, temporary overrides, etc. Members may appeal the restriction within 30 days of the effective date on the notification letter and may request a one-time change in the designated pharmacy. The review of Policy MS.PHAR.15 confirmed Magnolia addressed the corrective action from the previous EQR to include information about the 72-hour emergency supply of medications when members are in the Lock-in Program.

Health Information Systems

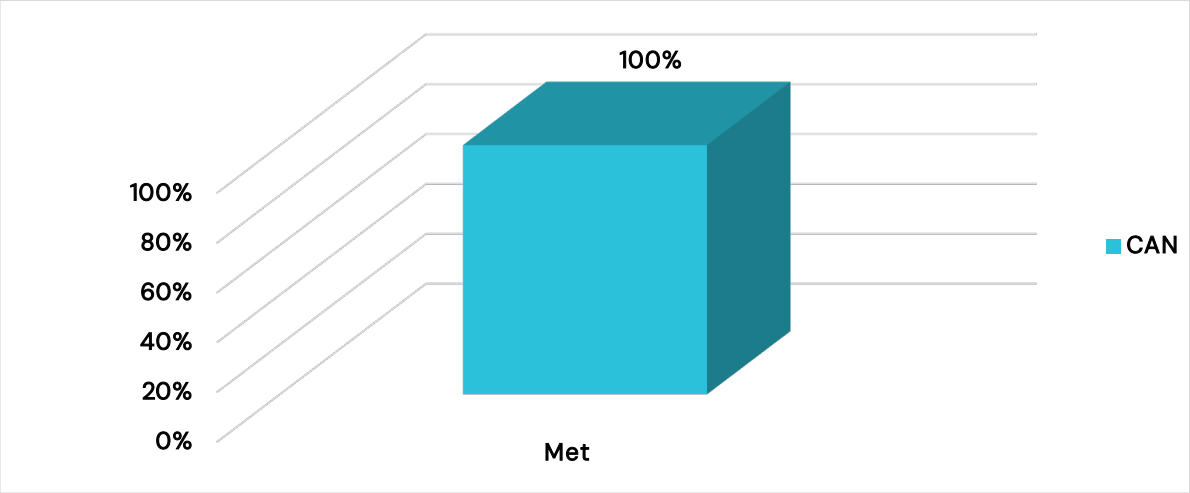
42 CFR § 438.242, 42 CFR § 457.1233 (d)

Magnolia provided up to date Information Systems Capability Assessment (ISCA) documentation for the CAN product line. On average, Magnolia pays 99% of clean claims within 30 days and 99.99% of clean claims within 90 days. This meets the metric set internally by Magnolia and as set by the *Miss. Code Ann. § 83-9-5*, both of which define timeliness as 90% of claims paid in 30 days and 99% of claims within 90 days. Magnolia has robust processes and sufficient checks to ensure that both enrollment data and member demographic information are collected when available. Magnolia takes proper steps to capture all relevant claims data needed to ensure accuracy of enrollment and member demographic data. Magnolia was not

able to provide all requested ISCA supporting documentation due to the proprietary nature of Centene software and technology processes. Magnolia adequately demonstrated their data collection and storage capability, processing procedures, and claim data tabulation and processing. Magnolia also showed adequate support of Quality Assurance (QA) and Utilization Management (UM) program activities and other contractual requirements via attached flowcharts and technical layouts. Magnolia has both a documented disaster recovery (DR) and a business continuity (BC) plan in place along with yearly updates (last updated on 6/27/2023) and DR plan review and testing. Magnolia's DR and BC plans both focus on the recovery of Information Technology capabilities to allow for document recovery and continued operations.

As noted in *Figure 2: Administration Findings*, 100% of the standards in the Administration section were scored as Met.

Figure 2: Administration Findings



Strengths for the Administration section are noted in *Table 7*.

Table 7: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for policy development and ongoing management.	✓		
Health plan staffing is sufficient to ensure the CCO can conduct all required activities and provide all required services. There is currently only one noted staff vacancy.	✓		
Magnolia meets internal and state defined guidelines for percentage of clean claims paid.		✓	
Magnolia has a disaster recovery and business continuity plan that is well documented and tested.	✓		

Strengths	Quality	Timeliness	Access to Care
Magnolia has robust processes with multiple levels of checks to ensure accuracy and data completeness.	✓		
Processes for ensuring compliance and guarding against FWA are thoroughly documented in the Compliance Plan, the FWA Plan and state-specific addendum, and in policies and procedures.	✓		
Magnolia's Pharmacy Lock-in Program meets all contractual requirements.	✓		
Multiple policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality and HIPAA requirements.	✓		

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					Magnolia develops policies and procedures to guide staff and ensure compliance with laws, regulations, contractual requirements, and accreditation standards. As noted in Policy CC.COMP.22, Policy Management, Magnolia adopts corporate policies when possible and includes state-specific requirements in addenda. All policies are reviewed at least annually and updated as needed. Once reviewed/revised, the policy is routed to the assigned Policy Approver (directors or vice president-level contributors from the applicable department) for approval. Onsite discussion confirmed that appropriate committees, as applicable to the department or functional area, review new and revised policies. Magnolia uses RSA Archer as its policy management platform. Staff may access policies via RSA Archer and through an intranet site. Departmental leadership educates employees about new and revised policies.
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						Review of the Organizational Chart and onsite discussion confirmed overall staffing is sufficient to conduct all required activities and to provide all required services to enrolled members. One staff

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
experience. At a minimum, this includes designated staff performing in the following roles:						position is vacant but is currently in recruitment. All contractually required key positions are filled.
1.1 *Chief Executive Officer;	X					
1.2 *Chief Operating Officer;	X					
1.3 Chief Financial Officer;	X					
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					
1.6.1 *Provider contracting and education;	X					
1.7 *Member Services Manager;	X					
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					
1.9 Utilization Management Coordinator;	X					
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					
1.13 *Compliance Officer.	X					
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					On average, Magnolia pays 99% of clean claims within 30 days and 99.99% of clean claims within 90 days. This exceeds the metric set internally by Magnolia and is in compliance with *Miss. Code Ann. § 83-9-5*, which define timeliness as 90% of claims paid in 30 days and 99% of claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia has checks to ensure that both enrollment data and member demographic information are captured correctly. Magnolia also captures data on member and provider characteristics, (such as member enrollment, provider type, distribution of claim types, etc.) to ensure data completeness. Magnolia is able to provide these data to the Mississippi Department of Insurance and any other oversight agencies.
3. The CCO management information system is sufficient to support data reporting to the State and internally for	X					Magnolia was not able to provide all requested ISCA supporting documentation due to the proprietary nature of Centene software and technology processes. Magnolia adequately demonstrated their data

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
CCO quality improvement and utilization monitoring activities.						collection and storage capability, processing procedures, and claim data tabulation and processing. The CCO showed adequate support of QA and UM program activities and other contractual requirements via attached flowcharts and technical layouts. The processes were reviewed and discussed during the virtual site review.
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 both a documented disaster recovery (DR) and a business continuity (BC) plan in place along with yearly updates (last updated on 6/27/2023) and DR plan review and testing. Magnolia's DR and BC plans both focus on the recovery of IT capabilities to allow for document recovery and continued operations.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					Magnolia documents processes for ensuring compliance and guarding against fraud, waste, and abuse in the Compliance Plan, the FWA Plan, a state-specific addendum to the FWA Plan, and in related policies and procedures.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Code of Conduct outlines expectations for ethical business conduct and practices for all employees and covers a variety of topics, including but not limited to: • FWA detection and prevention

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Protecting confidential information and information security • Records and information management • Conflicts of interest • Procedures for reporting concerns, violations, etc. The Code of Conduct provides examples of situations that may be concerning with associated questions and answers about those situations.
2.2 Identification of the Compliance Officer;						An overview of the Compliance Officer's roles and responsibilities is included in the Compliance Plan. They include but are not limited to: • Developing, reviewing, revising, and monitoring the Compliance Program • Coordinating and participating in compliance training programs • Ensuring network providers and contractors are aware of and adhere to Compliance Program requirements • Coordinating internal compliance reviews and monitoring activities • Investigating and taking action on compliance issues • Ensuring appropriate sanctions/exclusion monitoring processes are in place Referring potential fraud investigations to regulatory agencies
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						Annual compliance training is mandatory for all employees and subcontractors, and targeted training is

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provided to corporate officers, managers, and others, as needed. The training emphasizes Magnolia's commitment to compliance with ethical standards and legal requirements, and includes Federal and State statutes, regulations, and guidelines. Forums for compliance training include in-service sessions, online presentations, newsletters, etc. Disciplinary action, including termination of employment, may result from failure to complete the required compliance training. Policy CC.COMP.10, Enterprise Compliance Training, confirms that new employees are required to complete compliance training within 30 days of hire. Onsite discussion confirmed all HIPAA training is provided on the first day of employment, prior to granting access to protected or confidential member information.
2.5 Lines of communication;						Magnolia maintains open lines of communication and ensures employees and others can ask compliance questions or report concerns confidentially and anonymously. Magnolia prohibits retaliation against those who make reports of suspected misconduct. Staff are educated about communication and reporting options through meetings, emails, compliance awareness postings on CNET, workplace posters, the website, etc. Contact information for the various communication forums are provided to all employees, providers, and contractors.
2.6 Enforcement and accessibility;						Centene and Magnolia hold all officers, managers, supervisors, and staff accountable for failure to comply with applicable standards, laws, and procedures.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Magnolia publicizes disciplinary guidelines for employees through policies and procedures, compliance training/materials, CNET articles and videos, workplace posters, live presentations, etc. Noncompliance may result in disciplinary action that can include verbal warnings, suspension, termination, and/or referral to law enforcement agencies if applicable.
2.7 Internal monitoring and auditing;						Magnolia conducts internal monitoring and auditing activities to ensure compliance, identify potential areas of risk, and maintain the integrity of health plan operations. The activities include but are not limited to: • Regular monitoring of the compliance program's implementation and reporting • Periodic compliance audits by internal/external auditors with expertise in federal and state healthcare statutes, regulations, and federal healthcare program requirements • Audits of programs or divisions • Annual reviews to verify actual conformance with the compliance program • Monitoring third-party compliance with performance standards and reporting accuracy through ongoing oversight • Monitoring contractor sanctions and exclusions as well as proper licensure and insurance • Developing appropriate corrective action plans to address identified issues and monitoring the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						implementation of corrective actions to ensure effectiveness
2.8 Response to offenses and corrective action;						Detailed information about investigations of compliance concerns is included in the Compliance Plan. When there are reports or reasonable indications of noncompliance, the Compliance Officer promptly investigates to determine if a significant violation has occurred and takes steps to address the issue. Upon completion of an investigation, corrective actions, if needed, are developed and ongoing monitoring is conducted.
2.9 Exclusion status monitoring.						As noted in the Compliance Plan, Magnolia monitors for employee and vendor sanctions and exclusions to ensure compliance and prevent engagement with individuals or entities that are ineligible to participate in federal healthcare programs. Policy CC.COMP.36, Centene Exclusion Screening Requirements, 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.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					As noted in the Compliance Plan, Magnolia's cross-functional Compliance Committee includes members from various departments. The committee meets at least quarterly to advise the Compliance Officer and assist with maintaining the compliance program.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2024 charter for the Compliance Committee defines the committee's purpose, objectives, membership, and attendance requirements, and indicates the committee is chaired by the Compliance Officer. A quorum is established with the presence of 50% of the voting members. The review of Compliance Committee minutes from September 2023 through June 2024 reflected the presence of a quorum for each meeting. No attendance issues were noted, and the attendance documentation clearly indicated if a proxy was attending for a voting member. This reflects that the corrective action from the previous EQR was implemented to 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, Addendum M to the FWA Plan, and related policies and procedures document Magnolia's processes for preventing, detecting, and responding to potential or suspected FWA.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The FWA Plan and related policies and procedures provide detailed information about investigation processes.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes for provider payment suspensions and recoupments are documented in the FWA Plan and Addendum M of the FWA Plan.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					As documented in Policy MS.PHAR.15, Pharmacy Lock-In Program, Magnolia has an established Pharmacy Lock-in Program to "detect and prevent abuse of the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pharmacy benefit, as defined by specific criteria, by restricting members to one specific pharmacy and controlled substance provider (if one is chosen) for a defined period of time." Review of the policy confirmed Magnolia addressed the corrective action from the previous EQR to add information about the 72-hour emergency supply of medication to the policy.
I E. Confidentiality *42 CFR § 438.224*						
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 Provider Services review encompasses network adequacy, initial and ongoing provider education, clinical practice and preventive health guidelines, practitioner medical record documentation standards and provider compliance with those standards, and the provider satisfaction survey.

The Mississippi DOM implemented centralized credentialing in 2022. However, the review of various documents for the Provider Services section of the EQR revealed multiple references to credentialing and recredentialing as if they were still health plan responsibilities. Examples include Policy MS.QI.13, Medical Record Review, Policy CC. PRVR.47, Evaluation of Practitioner Availability, the 2024 Practitioner Availability Report for measurement year 2023, and the Culturally and Linguistically Appropriate Services Program Description.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Magnolia conducts new provider orientation within 30 days of execution of a new provider contract or the date the provider becomes active in the network. Training attendees are instructed about where to obtain additional information and resources. In addition, Magnolia distributes provider tool kits via mail or electronically to all newly contracted providers. The toolkits include supplemental information about claims and billing, a HEDIS guide, and a copy of the provider orientation presentation. Although provider orientation processes are addressed in a health plan policy, Magnolia staff reported that there is no corresponding policy for ongoing provider education and that ongoing provider education is accomplished through webinars, monthly meetings with providers, weekly e-blasts, and conferences.

The Provider Manual is a comprehensive resource for providers to operate effectively within Magnolia's network. Member benefits and value-added services are covered in the provider orientation sessions and in the Provider Manual. A discrepancy was noted in the limitation of orthotics and prosthetics when comparing member benefit documentation in the Provider Manual and Member Handbook.

Magnolia defines medical record documentation standards for providers in policy, educates providers about the documentation standards through the Provider Manual, and assesses provider compliance with the medical record documentation standards through an annual medical record review process. For the 2023 Medical Record Review, six practices were audited. Overall scores ranged from 99.25% to 100%. Three of the six practices audited were

found to have issues related to updating the immunization records for pediatric members. The documentation indicated Magnolia will increase education to providers about this topic.

Practice Guidelines

§ 438.236, § 457.1233

Magnolia adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) from nationally recognized entities to guide providers and members when making healthcare decisions. The CPGs and PHGs are reviewed at least annually and updated for significant new scientific evidence or changes in national standards. Magnolia educates providers about the guidelines through provider orientation, the health plan's website, provider newsletters, and/or special mailings. The Provider Manual refers the reader to the website to access the guidelines. The list of guidelines on Magnolia's website was comprehensive and included hyperlinks to access the individual guidelines. However, multiple hyperlinks were either non-functional, resulted in "page not found" or "page has been moved" error messages, required the reader to create an account and log in to access the information, or required membership with the entity to access the information.

Provider Satisfaction Survey Validation

Magnolia's 2023 provider satisfaction survey was conducted by SPH Analytics, a National Committee for Quality Assurance (NCQA) certified survey vendor. The response rate was 5.2%, which is a decrease from 7.9% the previous year. The net satisfaction score was 75.5% and the net loyalty score was 65.5%. Several measures increased significantly from 2022, and there were no measures that decreased significantly from 2022. Results were presented to the Performance Improvement team/committee during the December 2023 and January 2024 meetings. *Table 8* indicates the section of the EQR Survey Validation Worksheet that needs improvement, along with the reason and recommendation.

Table 8: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Of the 2,125 sample providers, 111 responded, creating a response rate of 5.2%. This is a decrease from last year's rate of 7.9%. 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 and increase education on the importance of the survey.

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 conducted a validation review of Magnolia's provider network following the CMS protocol, *"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 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. The following is an overview of the results for each activity:

The State has defined time and distance standards for each provider type. Magnolia uses reliable methods to assess network adequacy, including provider access studies and network adequacy time/distance assessments using reliable software. The Information Systems Capability Assessment documentation demonstrated that Magnolia and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.

Provider Network File Questionnaire

The Provider Network File Questionnaire was reviewed. Magnolia uses CenProv as its provider enrollment system. An inter-departmental approach, including network development, operations, and provider data excellence, is used to maintain the provider enrollment data. Pega is the logic system used to load, store, and update provider information. Verification is conducted through CenProv. The digital member facing directory is updated every 24 hours by way of an interfacing process.

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)

Primary care providers (PCPs) are notified of member panel assignments through the secure provider web portal and may request a printed list of member assignments by contacting Provider Relations or the Provider Services Call Center. The panel assignments are posted to the portal and available within five business days of receiving the enrollment data from DOM. Providers can verify member enrollment with Magnolia through the web portal, by contacting Magnolia, and through the Interactive Voice Response system.

Magnolia documents geographic access standards for PCPs and specialty, dental, behavioral health, and other provider types in Policy MS.CONT.01, Provider Network. This reflected that Magnolia addressed the previous year's corrective action to ensure geographic access standards for all provider types are included in a policy. To evaluate its provider network, Magnolia runs at least quarterly geographic access (Geo Access) reports, conducts a formal evaluation at least annually, and considers additional factors such as member satisfaction with practitioner availability.

The Geo Access mapping provided for review confirms use of the correct urban and rural parameters to measure access by county for all provider types except dental providers. For general and specialty dental providers, the Envolve Dental Network Analysis dated October 1, 2024, indicated correct distance parameters were used. However, the time standards were not in compliance with the standards stated in Policy MS.CONT.01 and required by *CAN Contract, Section 7 (B)*.

Appointment access standards are appropriately documented in Policy MS.PRVR.10, Evaluation of the Accessibility of Services, the Provider Manual, and the Member Handbook. This reflects that Magnolia addressed the Corrective Action Plan from the previous EQR to revise Policy MS.PRVR.10 to include appointment access standards for all providers. Magnolia measures provider compliance with appointment accessibility standards at least annually by conducting electronic, telephonic, or onsite audits. Additionally, Magnolia monitors member satisfaction survey results and member complaints/grievances related to appointment access.

Results of Magnolia's 2023 appointment access study were found in the 2023 Quality Management Program Evaluation; however, the results reflected incorrect appointment access standards for all provider appointment types except PCP well care visits and PCP urgent care visits. During onsite discussion, Magnolia reported that the correct parameters were used for the actual appointment access study. Also, the program evaluation referenced an after-hours telephonic survey that was conducted in 2023. The results of the after-hours survey were not included in the program evaluation.

Magnolia's Culturally and Linguistically Appropriate Services Program is in place to identify and address areas of health inequity. Magnolia collects members' and providers' cultural, ethnic, racial, and linguistic data, and conducts an annual assessment of members' needs and the ability of the network to meet those needs. Adjustments are made to the network as needed to address any identified issues.

Elements that must be included in the Provider Directory are documented in Policy MS.PRVR.19, Provider Directory. Review of the online Provider Directory confirmed all required elements are included; however, the printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers. Refer to the *CAN Contract, Section 6 (E)* and *42 C.F.R. § 438.10 (h)*. During the onsite discussion, Magnolia acknowledged this finding and stated practice names can be included in future printings of the Provider Directory. Onsite discussion revealed Magnolia validates Provider Directory information through a variety of activities, including vendor audits of provider information, health plan audits, provider outreach activities, monthly provider face-to-face meetings, etc. Of note, Magnolia reported that they are developing a website enhancement that will include a provider demographic tool to allow providers to update their panel sizes/limitations, physical and billing address, etc.

Overall, Magnolia met the requirements for Network Adequacy Validation. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

Provider Access and Availability Study

Constellation conducts Telephonic Provider Access Studies twice yearly for the CCO. Full details of these call studies are reported to DOM separately. For the most recent study conducted in Q3 2024, a decline in the successful contact rate was shown from the previous study that was conducted in Q1 2023. See *Table 9*.

Table 9: Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q1 2024	62 of 94	66%	<.001
Q3 2024	32 of 100	32%	

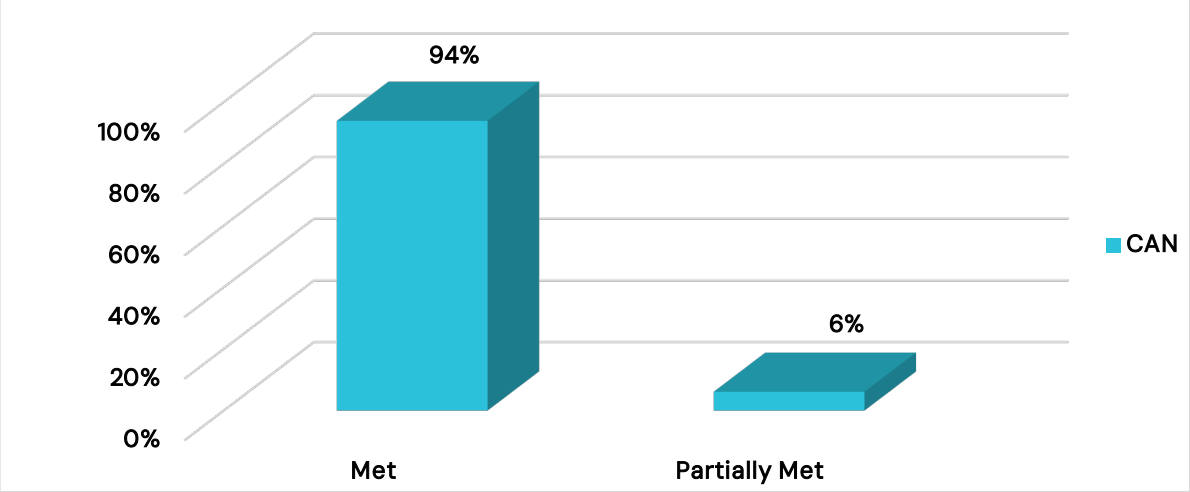
For Q3 2024, Magnolia submitted a total of 2,321 unique PCPs and a random sample of 104 PCPs was drawn for Phase 1. Of the 104 PCPs contacted, four were answered by voicemail and omitted from the denominator in the success rate formula. After accounting for the voicemail answered calls, the Phase 1 success rate was 32% (32 of 100). The success rate declined by

34% from Q1 2024 to Q3 2024. There were 32 attempted PCP provider directory verifications, and the accuracy rate was 72%.

The next call study will take place in Q1 2025.

As displayed in *Figure 3: Provider Services Findings*, 94% of the Provider Services standards were scored as "Met."

Figure 3: Provider Services Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, recommendations, and corrective actions for the Provider Services section are included in the tables that follow.

Table 10: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Providers can view panel assignments through the secure provider web portal and may request a printed list of member assignments by contacting Provider Relations and/or the Provider Services Call Center. Various mechanisms are in place for providers to verify member eligibility.			✓
Magnolia monitors the status of providers' panels to ensure there are enough providers with open panels to provide appropriate member access.			✓
Geographic access standards for all provider types are appropriately documented in policy, and Magnolia conducts routine monitoring to ensure network adequacy.			✓
Magnolia conducts an annual assessment of members' cultural, ethnic, racial, and linguistic needs and adjusts the network as needed.	✓		✓
Magnolia conducts routine audits of provider compliance with appointment and after-hours access standards.			✓
Initial and ongoing provider education processes are sufficient to ensure providers have the information needed to operate within Magnolia's network.	✓		✓

Strengths	Quality	Timeliness	Access to Care
Magnolia adopts CPGs and PHGs from nationally recognized entities to guide providers and members when making healthcare decisions.	✓		✓
Magnolia routinely assesses provider compliance with medical record documentation standards.	✓		
Magnolia reported that they are developing a website enhancement that will include a provider demographic tool to allow providers to update their panel sizes/limitations, physical and billing address, etc.	✓		

Table 11: Provider Services Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The Geo Access mapping included in the Envolve Dental Network Analysis dated October 1, 2024, utilized incorrect geographic access time standards for dental providers. The parameters used were: • 1 general/pediatric dentist within 30 miles or 60 minutes (urban) • 1 general/pediatric dentist within 60 miles or 120 minutes (rural) • 1 dental specialist within 30 miles or 60 minutes (urban) • 1 dental specialist within 60 miles or 120 minutes (rural) The *CAN Contract, Section 7 (B)* states the parameters for both general/pediatric dentists and dental subspecialty providers are 1 within 30 minutes or 30 miles (urban) and 1 within 60 minutes or 60 miles (rural).	*Corrective Action Plan: Conduct Geo Access mapping for dental providers using the correct parameters and submit to Constellation for review. Ensure Envolve uses correct parameters for all future Geo Access mapping.*			✓
Several documents referenced credentialing as if it continues to be a health plan responsibility, including: • The 2024 Practitioner Availability Report for measurement year 2023 • Policy CC. PRVR.47, Evaluation of Practitioner Availability • The Culturally and Linguistically Appropriate Services Program Description • Policy MS.QI.13, Medical Record Review	*Recommendation: Ensure all applicable documents appropriately state current health plan activities and remove incorrect references to health plan credentialing for Medicaid providers.*	✓		
The 2023 Quality Management Program Evaluation indicates Magnolia conducted	*Recommendation: Ensure that reporting of appointment access*	✓		✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
an after-hours telephonic survey in 2023. Results of the after-hours survey were not included in the program evaluation. Also, the results of the appointment access survey in the 2023 Quality Management Program Evaluation reflected incorrect appointment access standards for all provider appointment types except PCP well care and urgent care visits.	*surveys reflects the correct parameters for the various appointment types.*			
The printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers.	*Corrective Action: Ensure the printed Provider Directory includes all required information. Refer to the CAN Contract, Section 6 (E) and 42 C.F.R. § 438.10 (h).*			✓
When comparing documentation of benefits in the Provider Manual and Member Handbook, a discrepancy was noted for Orthotics and Prosthetics. The Provider Manual page 22, states, "limited to children under 21 years" while the Member Handbook, page 20, states "no limit."	*Recommendation: Revise the Member Handbook or Provider Manual, as applicable, to reflect the correct limitation for orthotics and prosthetics.*			✓
During onsite discussion, Magnolia confirmed that ongoing provider education is not addressed in a policy.	*Recommendation: Revise an existing policy or develop a new policy to document Magnolia's processes for providing ongoing provider education.*	✓		
The review of the list of CPGs and PHGs on Magnolia's website revealed that multiple hyperlinks were either non-functional, resulted in "page not found" or "page has been moved" error messages, required the reader to create an account and log in to access the information, or required membership with the entity to access the information.	*Corrective Action Plan: Revise the hyperlinks to the CPGs and PHGs on Magnolia's website to ensure providers can access the information.*	✓		✓
The low response rate for the 2023 Provider Satisfaction Survey (5.2%) may not reflect the population of providers. Thus, results should be interpreted with caution.	*Recommendation: Continued efforts should be made to gather a better representation of the providers and increase education on the importance of the survey.*	✓		

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					Providers are informed of panel assignments through the secure provider web portal and may request a printed list of member assignments by contacting Provider Relations. Providers may also contact the Provider Services Call Center to verify member eligibility and their member panel. The panel assignments are posted to the portal and available within five business days of receiving the enrollment data from DOM. This information was found in Policy MS.PRVR.01, PCP Member Panel Reports.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					All providers can verify member enrollment with Magnolia through the web portal, by contacting Magnolia, and through the Interactive Voice Response system.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
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					Geographic access standards for PCPs are documented within Policy MS.CONT.01, Provider Network. The Geo Access mapping for PCPs confirms

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						use of the correct urban and rural parameters to measure access by county to all PCP provider types.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.		X				Geographic access standards for specialty, dental, behavioral health, and other provider types are documented within Policy MS.CONT.01, Provider Network. Magnolia addressed the previous year's corrective action to ensure geographic access standards for all provider types are included in a policy. The Geo Access mapping for specialty providers confirms access is measured by county using the correct urban and rural parameters to measure access for all specialty provider types. Magnolia submitted the Geo Access Mapping for dental, vision, and pharmacy providers after the onsite. The parameters used to measure access for dental providers were incorrect. The Envolve Dental Network Analysis dated October 1, 2024, indicates the parameters used were: • 1 general/pediatric dentist within 30 miles or 60 minutes (urban) and 1 general/pediatric dentist within 60 miles or 120 minutes (rural) • 1 dental specialist within 30 miles or 60 minutes (urban) and 1 dental specialist within 60 miles or 120 minutes (rural) The *CAN Contract, Section 7 (B)* states the parameters for both general/pediatric dentists and dental subspecialty providers are 1 within 30 minutes

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or 30 miles (urban) and 1 within 60 minutes or 60 miles (rural). *Corrective Action Plan: Conduct Geo Access mapping for dental providers using the correct parameters and submit to Constellation for review. Ensure Envolve uses correct parameters for all future Geo Access mapping.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Processes for evaluating the sufficiency of the provider network are found in Policy CC.PRVR.47, Evaluation of Practitioner Availability. The policy indicates that Magnolia assesses the availability of providers within the network at least annually and analyzes performance against the defined standards. Practitioner availability is measured annually by the Provider Relations Department. Annual data on member satisfaction with practitioner availability is considered in the evaluation. Availability of PCP, specialty, and hospital providers, and others, such as behavioral health providers, is assessed by type and geographic distribution, with standards set for urban and rural areas. Magnolia reported during the onsite that Geo Access reports are run at least quarterly and submitted to DOM. The 2024 Practitioner Availability Report for measurement year 2023 indicated goals were met for PCPs, high-volume and high-impact specialists, and behavioral health providers. Page 12 of the report

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						included the following statement: "The Health Plan will continue to recruit, contract, and credential practitioners as new practices enter the service area and will continue to monitor practitioner availability and address any identified deficiencies." Magnolia has not conducted credentialing activities for Medicaid providers for more than two years. *Recommendation: Ensure all applicable documents appropriately state current health plan activities and remove incorrect references health plan credentialing for Medicaid providers.*
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					Policy CC. PRVR.47, Evaluation of Practitioner Availability, states Magnolia conducts an annual assessment of members' cultural, ethnic, racial, and linguistic needs and adjusts the network as needed. The policy states, "The Plan collects cultural, ethnic, racial, and linguistic (i.e., fluent spoken language) data about practitioners on a voluntary basis during the credentialing process and utilizes indirect data sources (e.g., Association of American Medical Colleges (AAMC) as needed." However, credentialing has not been a health plan responsibility for more than two years. Onsite discussion confirmed practitioner cultural, ethnic, racial, and linguistic data is provided to the health plan by the State's credentialing vendor, Gainwell, and may be submitted to the health plan by providers during the contracting/enrollment process.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Magnolia provided a copy of the Culturally and Linguistically Appropriate Services Program Description after the onsite. The program description addresses communication, language assistance, network cultural responsiveness, etc. However, page 12 of the document states, "Practitioners and offices who provide bilingual services attest to proficiency during the credentialing process." Additionally, page 14 states, "Race, ethnicity, and language proficiency is obtained through the credentialing and enrollment process as outlined in the CC.PRVR.47 policy." *Recommendation: Ensure all applicable documents appropriately state current health plan activities and remove incorrect references health plan credentialing for Medicaid providers.*
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 was reviewed. Magnolia uses CenProv as its provider enrollment system. An inter-departmental approach, including network development, operations, and provider data excellence, is used to maintain the provider enrollment data. Pega is the logic system used to load, store, and update provider information. Verification is conducted through CenProv. The digital member facing directory

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is updated every 24 hours by way of an interfacing process.
1.10 The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy CC.QI.17, Potential Quality of Care Incidents, details Magnolia's processes for identifying, investigating, and resolving potential quality of care issues. All potential quality of care issues are referred for investigation, severity levels are assigned, if appliable, and resulting actions and/or resolutions are determined. Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, provides the process for suspending or terminating a provider for quality of care/service issues.
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					Appointment access standards are appropriately documented in Policy MS.PRVR.10, Evaluation of the Accessibility of Services, the Provider Manual, and the Member Handbook. This reflects that Magnolia addressed the Corrective Action Plan from the previous EQR to revise Policy MS.PRVR.10 to include appointment access standards for all providers.
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					Policy MS.PRVR.10, Evaluation of the Accessibility of Services, states Magnolia measures appointment accessibility for primary care, behavioral health, high-volume, and high-impact providers at least annually to identify providers that do not meet the standards. This is accomplished through Random Access Audits for PCP services by Provider Relations staff. These may be

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducted electronically, by telephone, and through onsite visits over the course of the year. Additionally, Magnolia monitors results of member satisfaction survey questions related to appointment access and monitors member complaints/grievances about practitioner access. The Quality Improvement Committee (QIC) or a designated subcommittee makes recommendations to address any identified deficiencies. The 2023 Quality Management Program Evaluation indicates Magnolia conducted an after-hours telephonic survey in 2023 to evaluate PCPs, behavioral health practitioners, and non-prescribing behavioral health practitioners for after-hours access. Results of the after-hours survey were not included in the program evaluation. Also, the results of the appointment access survey in the 2023 Quality Management Program Evaluation reflected incorrect appointment access standards for all provider appointment types except PCP well care visits and PCP urgent care visits. During onsite discussion, Magnolia reported that the correct parameters were used for the actual appointment access survey. *Recommendation: Ensure that reporting of appointment access surveys reflects the correct parameters for the various appointment types.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.		X				Elements that must be included in the Provider Directory are documented in Policy MS.PRVR.19, Provider Directory. Review of the online Provider Directory confirmed all the required elements are included. The printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers. During the onsite discussion, Magnolia acknowledged this finding and stated practice names can be included in future printings of the Provider Directory. *Corrective Action: Ensure the printed Provider Directory includes all required information. Refer to the CAN Contract, Section 6 (E) and 42 C.F.R. § 438.10 (h).* Per Policy MS.PRVR.19, Provider Directory, "The Plan will make available hard copy provider directories in the State Medicaid Regional offices, in the Plan's office, WIC offices, upon member request, and other areas as directed by the Division." The policy also states the web-based Provider Directory is updated within five business days of changes via a nightly refresh from the Enterprise Data Warehouse system.
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Onsite discussion revealed Magnolia validates Provider Directory information through a variety of activities, including vendor audits of provider information, health

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						plan audits, provider outreach activities, monthly provider face-to-face meetings, etc. During the onsite, Magnolia reported they are developing a website enhancement that will include a provider demographic tool to allow providers to update their panel sizes/limitations, physical and billing address, etc.
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 each provider type. The methods Magnolia used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments using reliable software. The ISCA evaluation demonstrated that Magnolia 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					Magnolia conducts new provider orientation for all PCPs, specialists, hospitals, and ancillary providers who are not part of an existing in-network group or facility within 30 days of execution of a new provider contract or the date the provider becomes active in the network. This is documented in Policy CC.PRVR.13, Provider Orientations. The policy includes a list of topics covered in the provider orientation presentation. As noted, the health plan distributes provider tool kits via mail or electronically via email to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						all newly contracted providers, and training attendees are instructed about where to obtain additional information and resources.
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, and services provided under fee-for-service payment by DOM;	X					Member benefits and value-added services are covered in the provider orientation sessions. The Provider Manual includes a grid that lists member benefits and any related limitations. When comparing documentation of benefits in the Provider Manual and Member Handbook, a discrepancy was noted for Orthotics and Prosthetics. The Provider Manual page 22, states, "limited to children under 21 years" while the Member Handbook, page 20, states "no limit." *Recommendation: Revise the Member Handbook or Provider Manual, as applicable, to reflect the correct limitation for orthotics and prosthetics.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					Referrals are covered in the provider orientation sessions. The Provider Manual includes information that PCPs should coordinate all member healthcare services, that referrals are not required, and that providers may contact the health plan to verify

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						whether referrals and/or authorizations are required. The Provider Manual lists services that do not require PCP authorization or referrals. The Provider Manual also states that in specific circumstances, members may use a specialist as their PCP. This must be "pursuant to a treatment plan approved by Magnolia and must be made in consultation with the PCP to which the member is currently assigned, the member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Magnolia's provider network."
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					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					The Provider Manual informs providers that they are responsible for "following up with each member who is not in compliance with the EPSDT screening requirements and EPSDT services, including missed appointments. Providers are required to document the reason for noncompliance, where possible, and to document their efforts to bring the member's care into compliance with the standards."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
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	X					Providers are informed through the Provider Manual of the expectation that they will participate in quality activities. Specifically, it mentions that Magnolia

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
utilization management criteria and processes;						requires all practitioners and providers to cooperate with all Quality Improvement (QI) activities and allow Magnolia to use practitioner and/or provider performance data to ensure the success of the Quality Assessment Performance Improvement program. This includes participation in data collection initiatives such as HEDIS and other contractual or regulatory programs, as well as compliance with Magnolia's Population Health and Clinical Operations program.
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					During onsite discussion, Magnolia confirmed that ongoing provider education is not addressed in a policy. The health plan's staff reported during the discussion that ongoing provider education is accomplished through webinars to inform providers of changes and answer common questions, monthly meetings with providers, weekly e-blasts to answer common questions, and multiple conferences each year to provide ongoing education.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise an existing policy or develop a new policy to document Magnolia's processes for providing ongoing provider education.
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 CPGs and PHGs. 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.
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 CPGs and PHGs are disseminated to providers via the health plan's website, provider orientation materials, provider newsletters, and/or special mailings. The review of the list of guidelines on Magnolia's website revealed a comprehensive list of adopted guidelines along with hyperlinks to access the individual guidelines. However, multiple hyperlinks were either non-functional, resulted in "page not found" or "page has been moved" error messages, required the reader to create an account and log in to access the information, or required membership with the entity to access the information.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise the hyperlinks to the CPGs and PHGs on Magnolia's website to ensure providers can access the information.
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					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II D. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Magnolia includes the elements of required medical record documentation in Policy MS.QI.13, Medical Record Review, and in the Provider Manual.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					Magnolia monitors provider compliance with medical record documentation standards through annual medical record audits. Policy MS.QI.13, Medical Record Review, addresses the process for conducting the medical record audits and states the audits are conducted by qualified employees or contractors using the Magnolia Medical Record Audit Tool. Preliminary results are reviewed with the designated office contact person to resolve any inconsistencies or disputes. Providers are notified by mail of the results, including the overall score, areas of deficiency, and a copy of the completed audit tool, within 15 days. Scores below 90% require improvement and a follow-up audit is conducted within six months. For continued non-compliance, further action may include Chief Medical Director review, referral to the QIC, or termination from Magnolia's network. Page 3, item 13, of Policy MS.QI.13, Medical Record Review, states, "Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure all applicable documents appropriately state current health plan activities and remove incorrect references health plan credentialing for Medicaid providers. For the 2023 Medical Record Review, six practices were audited. Overall scores ranged from 99.25% to 100%. Three of the six practices audited were found to have issues related to updating the immunization record for pediatric members. The documentation indicated Magnolia will increase education to providers about this topic.
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, a NCQA certified survey vendor, was selected by Magnolia Health Plan to conduct its 2023 Provider Satisfaction Survey. A total of 111 valid surveys were received out of the total sample of 2,125, equating to a 5.2% response rate. This response rate is lower than the previous year's response rate of 7.9%. This is a low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. The net satisfaction score was 75.5% and the net loyalty score was 65.5%. Several measures increased significantly from 2022, and there were no measures that decreased significantly from 2022.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Continued efforts should be made to gather a better representation of the providers and increase education on the importance of the survey.
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 during the December 2023 and January 2024 meetings.

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

Member Services includes a review of policies, procedures, member rights and responsibilities, member education, preventive health and chronic disease management, processes for handling grievances, and member enrollment and disenrollment.

Member rights and responsibilities are documented in Policy MS.MBRS.25, Member Rights and Responsibilities. Members are informed of their rights and responsibilities in the New Member Packet, Member Handbook, and on Magnolia's website. The review confirmed member rights and responsibilities are consistently documented across materials.

Information regarding the health plan is provided to new members in the New Member Packet and sent to members within 14 days of enrollment. The packet contains 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 educational brochures.

The Member Handbook instructs members about obtaining a Provider Directory, choosing a PCP, covered benefits, second opinions, and requirements for obtaining out-of-network care. The terms urgent and emergent care are defined along with access information, pharmacy benefits and limitations, and the Preferred Drug List. The hours of operation for the Member Services Call Center are reported in member materials and are compliant with contractual requirements. Member materials also note that the Nurse Advice Line is available 24 hours per day, seven days per week.

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. Onsite discussion highlighted the website notification and Member Handbook updates specific to the Gainwell Pharmacy change.

Member materials are developed using the appropriate font and reading level 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. 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, alternate language materials, and TTY/TTD services.

Member Services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities. The Quality Management Program Evaluation indicated that all performance metrics were met throughout 2023.

In the New Member Packet and in the Member Handbook, members are informed about PCP selection and about the PCP's role as a primary source of assistance. Policy MS.ELIG.05, Disenrollment, describes the steps and points of contact for disenrollment, detailing timeframes for member requests for disenrollment and that members must direct these requests to DOM.

Grievances

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

Grievance management processes are outlined in Policy MS.MBRS.07, Member Grievance and Complaints, the Member Handbook, Provider Manual, and on the website. The definitions of grievances and complaints are clear and consistent throughout Magnolia's materials, along with the instructions for filing verbally or in writing.

Timelines for acknowledging and resolving grievances are indicated in policies and materials. Complaints are resolved within one calendar day. Grievances are acknowledged within 10 calendar days and resolved within 30 calendar days with a 14-day extension if needed and may be filed at any time. Clinically urgent grievances are resolved within 72 hours of receipt.

Grievances are logged, categorized, and maintained per contractual requirements. Summaries of complaint and grievance actions, trends, and opportunities for improvement are reported quarterly to the QIC. Constellation reviewed a random sample of grievance files for the current EQR and 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, a certified vendor, to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult and child member surveys. Surveys were fielded from February 2024 to April 2024.

For Measure Year (MY) 2023, the adult CAHPs survey had a response rate of 16.1%, which is lower than last year's rate of 19.4%. The largest improvement was in the rating of specialists and the largest decline was in the measure regarding customer service.

The MY 2023 child CAHPS survey also had a decline in the response rate to 10.1%, compared to 16.7% the previous year. The largest improvement was in the rating of personal doctors, and the largest decline occurred in the rating of specialists.

The child with chronic conditions (CCC) survey had a response rate of 9.3%, which is lower than last year's rate of 13.4%. The largest increase was for rating of specialist, and the largest decline was in coordination of care. The documentation demonstrated the assessment of barriers and interventions to address member satisfaction concerns.

Magnolia met 100% of the standards for Member Services for the current EQR. Strengths for the Member Services section are included in the table that follows.

Figure 4: Member Services Findings

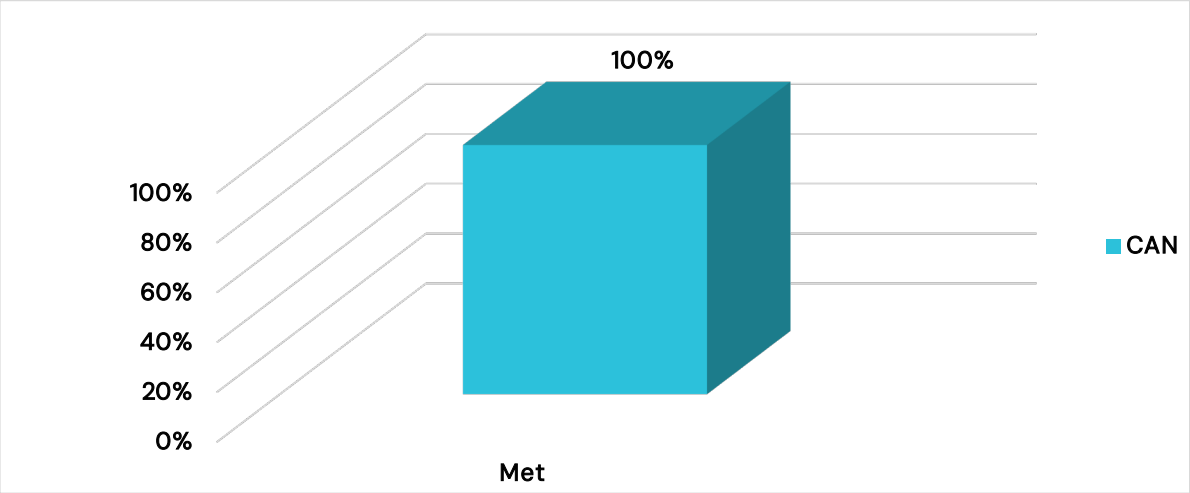


Table 12: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members are informed of their rights and responsibilities consistently and in a variety of ways for convenient review.	✓		
Magnolia notified members and offered timely assistance regarding the Gainwell Pharmacy change via the website and the Member Handbook.	✓	✓	✓
The Member Services call center performance metrics were all met throughout 2023.	✓		
The Community Connects Team has dedicated staff to provide member education about preventive health, resources, and disease management information.			✓
The sample of Magnolia's grievance files reviewed for the 2024 EQR were acknowledged and resolved in a timely manner.		✓	

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					Member rights are documented in Policy MS.MBRS.25, Member Rights and Responsibilities. The New Member Packet, Member Handbook, and the website inform members of their rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					
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;						
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
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 Policy MS.MBRS.25, Member Rights and Responsibilities. The New Member Packet, Member Handbook, and the website inform members of their responsibilities.
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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)*						
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					
1.1 Full disclosure of benefits and services included and excluded in coverage;						
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						Members are informed of the steps to access second opinions at no cost with network providers, and that

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
use of an out-of-network provider if necessary.						second opinions from out of network providers may require authorization.
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 hours of operation for the Member Services Call Center are reported in member materials and are compliant with contractual requirements. Member materials also note that the Nurse Advice Line is available 24 hours per day, seven days per week.
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;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing						Policy MS.MBRS.12, Member Notification of Plan Changes, outlines processes for notifying members of benefit and network changes.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
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;						
1.13 A description of EPSDT services;						The Member Handbook provides information about EPSDT services, benefits, programs, and resources.
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						Information is provided in the Member Handbook and website for steps to report instances of suspected fraud or abuse.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						
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					
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					
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
availability of free oral translation services for all languages.						
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					
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					Hours of operation for the Member Services Call Center are consistent in member materials. The nurse advice line operates 24 hours per day, seven days per week.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Training is provided to call center staff on the use of interactive scripts for initial welcome calls, outbound calls to new members, assisting members with PCP selection, and responding to general member calls.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					The 2023 Quality Management Program Evaluation reports that the "Health Plan Call Center Service Staff" scored the highest performance with a summary rating of 46.7%. Goals were met for each quarter.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Members are informed that they can make changes for any reason in the first 90 days of membership and may call DOM to stop membership during this period.
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					Magnolia shared that the Community Connects Team has dedicated staff to provide member education about preventive health, resources, and disease management information.
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					
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 Press Ganey, a certified vendor, to conduct the adult and child satisfaction surveys, fielded from February 2024 to April 2024.
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details the results of all adult and child surveys.
3. The CCO reports results of the member satisfaction survey to providers.	X					Magnolia emailed a news blast with member satisfaction results to providers on 11/1/2024.
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					
III G. Grievances *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 Process, the Member Handbook, Provider Manual, and the website describe processes for receiving, processing, and responding to member grievances and complaints.
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 the website appropriately define a grievance as "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing and handling a grievance;	X					Information about the steps for filing a verbal or written grievance is found in the Member Handbook and on the website.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					
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 for the period specified in the contract.	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					The sample of grievance files reviewed for the 2024 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					
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					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

Magnolia's Quality Improvement (QI) Program is comprehensive. The 2024 Quality Program Description (QI Program Description) describes a systematic approach to improving the quality and safety of clinical care and services provided to members. The program integrates quality assurance, management, and improvement into all staff roles and department functions and is overseen by the Board of Directors. Magnolia utilizes reliable methods like HEDIS, CAHPS, and CMS Core Measures to monitor and improve performance. The Chief Medical Director serves as the senior quality executive responsible for the QI Program. The Behavioral Health Medical Director is the designated practitioner responsible for the behavioral health aspects of the QI Program.

Credentialing and recredentialing are mentioned several times in the QI Program Description. Page 14 of this document specifically mentions the Credentialing Committee has the responsibility for credentialing and recredentialing physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners. However, the program description does not include Magnolia's current responsibilities related to credentialing and recredentialing since DOM implemented centralized credentialing.

The QI Program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. It also focuses on health disparity reduction and cultural competency, ensuring that services are delivered in a culturally and linguistically competent manner. The program identifies and addresses health inequities, promotes health equity, and includes targeted interventions to improve health disparities based on various demographic factors. The Health Equity and Diversity Council (HEDC) is responsible for executing strategies to improve quality and reduce costs associated with health disparities. The council provides oversight and direction for all activities related to health disparities, assesses the appropriateness of care and services delivered, and continuously enhances and improves the quality of services provided to members to promote health equity. The HEDC reviews and directs clinical, physical, behavioral health, and service operational activities to identify and address health disparities by tailoring services to remove barriers. The council also establishes goals, policies, and benchmarks for health equity initiatives; facilitates stakeholder perspectives; and ensures alignment and accountability within the health plan.

A Quality Work Plan is used as part of Magnolia's Quality Program. The work plan identifies the yearly planned activities, the individual(s) accountable for each task, specific start and completion dates, data collection methods and analysis, and includes quarterly updates. The

work plan is reviewed by the Quality Improvement Committee on a regular basis and is a fluid document that is frequently updated to document progress throughout the year.

Magnolia's Board of Directors has authority and oversight of the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors delegates the operating authority of the Quality Program to the Quality Improvement Committee (QIC). The QIC is the senior management lead committee accountable directly to the Board of Directors and reports Quality Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. The committee's structure is designed to continually promote information, reports, and improvement activity results, driven by the QI Work Plan. The QIC serves as the umbrella committee.

Members of the QIC include senior management staff, clinical staff, and network practitioners. 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. Voting members must attend 75% of scheduled meetings. In 2023, there were eight voting members who did not meet this attendance requirement. Also, line nine of the 2023 QI Work Plan included an activity to ensure the QIC had adequate representation of external providers. This activity was to ensure there was at least one behavioral health provider, and ensure there was a pediatrician, family practice provider, internal medicine provider, nurse practitioner, and specialist. The 2023 QIC minutes and the 2024 committee membership list did not include an internal medicine provider or a specialist as a member of this committee. This activity was noted as "MET" even though there was no representation of an internal medicine provider or specialist on this committee.

Magnolia monitors provider performance through profiling reports focusing on primary care physicians. Policy MS.QI.23, Provider Profiling Program, outlines the process by which Magnolia develops, implements, monitors, and distributes provider profiling reports to PCPs. This program aims to increase provider awareness of their performance and improve health outcomes for members by recognizing providers who deliver quality care. PCPs with low scores may face interventions like education, performance improvement plans, or network termination. High-performing providers may receive recognition and preferred status. Data sources for these reports include medical claims, pharmacy data immunization registries, lab values, and HEDIS measures. Monthly updates are available on dashboards showing cost, utilization data, patient engagement, emergency department reporting, quality measures, and peer comparisons.

Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, outlines Magnolia's policy and procedures for providing EPSDT services for Medicaid recipients under 21.

It details the commitment to providing comprehensive preventive health screenings and improving children's health. The policy includes guidelines for health assessments, immunizations, and necessary follow-up care. It also describes the roles of various departments, monitoring and reporting processes, and educational initiatives for employees, providers, and members. Regular audits and targeted interventions ensure compliance and continuous improvement in service delivery. Magnolia runs monthly reports to identify members needing follow-up care after an EPSDT screening. If abnormal findings are detected, the EPSDT Coordinator or QI designee monitors claims for evidence of treatment and follows up with providers and parents or guardians to ensure necessary care is provided.

Magnolia evaluates the QI Program through an annual evaluation that includes an analysis and evaluation of the overall effectiveness of the Quality Program, including progress toward influencing network-wide safe clinical practices and an evaluation of the adequacy of resources and training related to the Quality Program. The 2023 Magnolia Health Quality Management Program Evaluation was received. This program evaluation included a description of completed and ongoing studies and quality activities that address quality and safety of clinical care and quality of service. Trending of measures collected over time to assess performance and interventions implemented to address issues are also included. The findings are presented to the Quality Improvement Committee and the Board of Directors for approval annually.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

DOM has selected a set of performance measures (PMs) to evaluate the quality of care and services delivered by Magnolia to its members. Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the PMs identified by DOM to evaluate their accuracy as reported by Magnolia. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2023, through December 31, 2023.

Per the contract between the CCO and DOM, Magnolia was required to submit HEDIS data to NCQA. To ensure the HEDIS rates were accurate and reliable, DOM required the CCO to undergo an NCQA HEDIS Compliance Audit. Magnolia contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Aqurate reviewed the CCO's final audit reports, information systems compliance tools, and Interactive Data Submission System 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 2023.

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 main steps in Aqurate' s validation process include the following:

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 CCO, 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 process for Magnolia was 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 Magnolia's data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation — Documentation provided by Magnolia was used for validation of review findings. Supplementary information was provided via interviews and system demonstrations. 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.

Rate inconsistencies were found in the reported data. The responses Magnolia provided are indicative of gaps in processes established for verification and reporting of measure rate data. Inconsistencies were observed in the reported enrollment data during the validation. The HEDIS Compliance Audit Final Audit Report also identified areas of improvement in reporting enrollment information.

All relevant HEDIS performance measures and CMS Core Set measures were compared for the current review year (MY 2023) to the previous year (MY 2022), and the changes from 2022 to 2023 are reported in the tables that follow. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

Table 13: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA)	44.79%	62.05%	17.26
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	58.39%	56.20%	-2.19
Counseling for Nutrition	51.09%	44.28%	-6.81
Counseling for Physical Activity	48.66%	45.50%	-3.16
Childhood Immunization Status (CIS)			
DTaP	72.51%	71.26%	-1.25
IPV	89.05%	85.62%	-3.43
MMR	87.35%	86.90%	-0.45
HiB	84.91%	82.85%	-2.06
Hepatitis B	89.78%	83.80%	-5.98
VZV	87.35%	86.21%	-1.14
Pneumococcal Conjugate	74.45%	71.42%	-3.03
Hepatitis A	78.83%	77.77%	-1.06
Rotavirus	74.45%	71.24%	-3.21
Influenza	28.47%	19.42%	-9.05
Combination #3	67.15%	63.46%	-3.69
Combination #7	55.23%	53.04%	-2.19
Combination #10	20.68%	14.58%	-6.10
Immunizations for Adolescents (IMA)			
Meningococcal	57.66%	51.38%	-6.28
Tdap/Td	79.32%	75.30%	-4.02
HPV	25.30%	19.75%	-5.55
Combination #1	57.42%	50.82%	-6.60
Combination #2	24.33%	18.92%	-5.41
Lead Screening in Children (LSC)	65.80%	66.63%	0.83
Breast Cancer Screening (BCS)	52.23%	51.34%	-0.89
Breast Cancer Screening (BCS-E)		51.34%	--
Cervical Cancer Screening (CCS)	54.26%	47.69%	-6.57
Chlamydia Screening in Women (CHL)			
16-20 Years	49.78%	47.88%	-1.90
21-24 Years	63.74%	58.14%	-5.60
Total	51.48%	49.41%	-2.07
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
Appropriate Testing for Pharyngitis (3-17)	74.96%	82.34%	7.38
Appropriate Testing for Pharyngitis (18-64)	63.76%	73.55%	9.79
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Appropriate Testing for Pharyngitis (Total)	73.59%	81.37%	7.78
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	22.27%	24.48%	2.21
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	47.92%	47.99%	0.07
Bronchodilator	77.34%	76.42%	-0.92
Asthma Medication Ratio (AMR)			
5-11 Years	83.00%	86.69%	3.69
12-18 Years	71.14%	74.01%	2.87
19-50 Years	60.70%	66.89%	6.19
51-64 Years	56.20%	54.96%	-1.24
Total	73.21%	76.52%	3.31
Plan All-Cause Readmissions (PCR-AD)			
Observed Readmission Rate	11.02%	13.62%	2.60
Expected Readmission Rate	10.88%	11.14%	0.26
Observed/Expected (O/E) Ratio	1.0126	1.2228	0.2102
Outlier Rate	61.52%	67.13%	5.61
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	53.77%	54.50%	0.73
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	80.43%	NA	NA
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy - 21-75 years (Male)	74.90%	75.37%	0.47
Statin Adherence 80% - 21-75 years (Male)	56.54%	54.26%	-2.28
Received Statin Therapy - 40-75 years (Female)	72.98%	72.83%	-0.15
Statin Adherence 80% - 40-75 years (Female)	51.89%	51.35%	-0.54
Received Statin Therapy - Total	73.94%	74.05%	0.11
Statin Adherence 80% - Total	54.26%	52.77%	-1.49
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (18-64)	3.59%	1.78%	-1.81
Cardiac Rehabilitation - Engagement1 (18-64)	5.13%	2.37%	-2.76
Cardiac Rehabilitation - Engagement2 (18-64)	1.54%	0.59%	-0.95
Cardiac Rehabilitation - Achievement (18-64)	0.00%	0.00%	0.00
Cardiac Rehabilitation - Initiation (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement2 (65+)	NA	NA	NA
Cardiac Rehabilitation - Achievement (65+)	NA	NA	NA
Cardiac Rehabilitation - Initiation (Total)	3.55%	1.76%	-1.79
Cardiac Rehabilitation - Engagement1 (Total)	5.08%	2.35%	-2.73
Cardiac Rehabilitation - Engagement2 (Total)	1.52%	0.59%	-0.93
Cardiac Rehabilitation - Achievement (Total)	0.00%	0.00%	0.00
Effectiveness of Care: Diabetes			

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
PoorHbA1cControl	49.15%	50.85%	1.70
AdequateHbA1cControl	42.34%	42.09%	-0.25
Eye Exam for Patients With Diabetes (EED)°	63.99%	59.37%	-4.62
Blood Pressure Control for Patients With Diabetes (BPD)	57.42%	61.07%	3.65
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	17.01%	19.24%	2.23
Kidney Health Evaluation for Patients With Diabetes (65-74)	32.26%	18.60%	-13.66
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	17.10%	19.24%	2.14
Statin Therapy for Patients with Diabetes (SPD)			
Statin Therapy for Patients With Diabetes - Received Statin Therapy	62.46%	62.06%	-0.40
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	49.77%	52.36%	2.59
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (AMM)°			
Effective Acute Phase Treatment	49.53%	51.80%	2.27
Effective Continuation Phase Treatment	30.85%	31.52%	0.67
Follow-Up Care for Children Prescribed ADHD Medication (ADD)°			
Initiation Phase	55.14%	56.06%	0.92
Continuation and Maintenance (C&M) Phase	71.08%	66.92%	-4.16
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	65.34%	68.53%	3.19
6-17 years - 7-Day Follow-Up	36.49%	41.96%	5.47
18-64 years - 30-Day Follow-Up	55.51%	51.67%	-3.84
18-64 years - 7-Day Follow-Up	31.79%	32.38%	0.59
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	61.59%	62.46%	0.87
7-Day Follow-Up	34.72%	38.53%	3.81
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
6-17 years - 30-Day Follow-Up	54.49%	64.64%	10.15
6-17 years - 7-Day Follow-Up	37.82%	46.41%	8.59
18-64 years - 30-Day Follow-Up	48.06%	37.26%	-10.80
18-64 years - 7-Day Follow-Up	28.62%	23.89%	-4.73
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	50.34%	47.27%	-3.07
Total- 7-Day Follow-Up	31.89%	32.12%	0.23
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
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)	41.46%	38.34%	-3.12
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (18-64)	34.76%	27.98%	-6.78
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)	40.83%	36.27%	-4.56
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 days (Total)	33.73%	26.47%	-7.26
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)°			
30-Day Follow-Up: 13-17 Years	28.26%	20.59%	-7.67
7-Day Follow-Up: 13-17 Years	15.22%	13.24%	-1.98
30-Day Follow-Up: 18+ Years	27.72%	23.90%	-3.82
7-Day Follow-Up: 18+ Years	15.79%	14.47%	-1.32
30-Day Follow-Up: Total	27.79%	23.32%	-4.47
7-Day Follow-Up: Total	15.71%	14.25%	-1.46
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	28.66%	24.70%	-3.96
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	28.93%	24.70%	-4.23
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	69.64%	74.63%	4.99
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	74.58%	73.22%	-1.36
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	74.47%	76.79%	2.32
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	58.23%	55.43%	-2.80
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose Testing (1-11)	37.39%	34.45%	-2.94
Cholesterol Testing (1-11)	26.99%	23.10%	-3.89
Blood Glucose and Cholesterol Testing (1-11)	24.56%	20.47%	-4.09
Blood Glucose Testing (12-17)	49.32%	51.53%	2.21
Cholesterol Testing (12-17)	33.83%	32.47%	-1.36
Blood Glucose and Cholesterol Testing (12-17)	30.75%	29.90%	-0.85

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Blood Glucose Testing (Total)	44.49%	44.68%	0.19
Cholesterol Testing (Total)	31.07%	28.72%	-2.35
Blood Glucose and Cholesterol Testing (Total)	28.25%	26.12%	-2.13
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)	73.20%	73.31%	0.11
Appropriate Treatment for Upper Respiratory Infection (18-64)	58.47%	58.67%	0.20
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	71.61%	71.67%	0.06
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	50.27%	51.59%	1.32
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	41.85%	41.22%	-0.63
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	49.01%	49.99%	0.98
Use of Imaging Studies for Low Back Pain (LBP)	71.42%	70.82%	-0.60
Use of Opioids at High Dosage (HDO)	1.37%	0.98%	-0.39
Use of Opioids from Multiple Providers (UOP)			
Multiple Prescribers	13.42%	12.44%	-0.98
Multiple Pharmacies	1.03%	2.15%	1.12
Multiple Prescribers and Multiple Pharmacies	0.55%	1.06%	0.51
Risk of Continued Opioid Use (COU)			
18-64 years - >=15 Days covered	3.93%	6.16%	2.23
18-64 years - >=31 Days covered	2.62%	2.32%	-0.30
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	3.92%	6.16%	2.24
Total - >=31 Days covered	2.62%	2.32%	-0.30
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20-44 Years	83.73%	81.07%	-2.66
45-64 Years	90.28%	88.06%	-2.22
65+ Years	78.69%	72.32%	-6.37
Total	86.62%	83.89%	-2.73
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	--	18.92%	--

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Oral Evaluation, Dental Services (3-5)	--	60.52%	--
Oral Evaluation, Dental Services (6-14)	--	62.75%	--
Oral Evaluation, Dental Services (15-20)	--	45.77%	--
Oral Evaluation, Dental Services (Total)	--	52.50%	--
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	--	10.06%	--
Topical Fluoride for Children (3-4)	--	19.62%	--
Topical Fluoride for Children (Total)	--	14.56%	--
Initiation and Engagement of AOD Dependence Treatment (IET)°			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	81.25%	65.96%	-15.29
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	6.25%	0.00%	-6.25
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	63.14%	65.96%	2.82
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	5.51%	4.26%	-1.25
Total: Initiation of AOD Treatment: 13-17 Years	66.55%	66.17%	-0.38
Total: Engagement of AOD Treatment: 13-17 Years	5.46%	3.56%	-1.90
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	44.83%	42.93%	-1.90
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	7.00%	3.26%	-3.74
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	45.50%	36.54%	-8.96
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	16.22%	14.29%	-1.93
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	41.30%	42.83%	1.53
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.11%	4.85%	-3.26
Total: Initiation of AOD Treatment: 18+ Years	43.05%	41.82%	-1.23
Total: Engagement of AOD Treatment: 18+ Years	8.76%	5.93%	-2.83
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	47.47%	44.67%	-2.80
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7.07%	3.00%	-4.07
Opioid abuse or dependence:	46.75%	37.54%	-9.21

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Initiation of AOD Treatment: Total			
Opioid abuse or dependence: Engagement of AOD Treatment: Total	15.58%	13.92%	-1.66
Other drug abuse or dependence: Initiation of AOD Treatment: Total	45.66%	48.08%	2.42
Other drug abuse or dependence: Engagement of AOD Treatment: Total	7.57%	4.71%	-2.86
Total: Initiation of AOD Treatment: Total	46.36%	45.63%	-0.73
Total: Engagement of AOD Treatment: Total	8.31%	5.55%	-2.76
Prenatal and Postpartum Care (PPC)◊			
Timeliness of Prenatal Care	95.86%	92.46%	-3.40
Postpartum Care	70.32%	75.18%	4.86
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1-11 years	57.11%	58.94%	1.83
12-17 years	65.46%	63.06%	-2.40
Total	62.11%	61.46%	-0.65
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	57.39%	58.08%	0.69
15 Months-30 Months	65.35%	70.23%	4.88
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	45.44%	46.15%	0.71
12-17 Years	38.53%	40.67%	2.14
18-21 Years	20.77%	21.06%	0.29
Total	40.82%	41.92%	1.10

NA: Denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR: Rate was not reported.
NQ: Not Required
◊ indicates that the measure has a "Trend with Caution" guidance note from NCQA for MY 2023.

As shown in the preceding table, the following measures showed an improvement:

- The Adult BMI Assessment (ABA) measure improved by over 17 percentage points.
- The Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure increased by 10.15 percentage points for the 6-17 years - 30-Day Follow-Up indicator.

There were two measures that showed a substantial decrease in the rate. Those were:

- The Kidney Health Evaluation for Patients with Diabetes (KED) measure decreased by over 13 percentage points for the ages 65-74 indicator.
- The Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure decreased by 10.80 percentage points for the 18-64 years - 30-Day Follow-Up indicator.

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 2023 and the previous year (MY 2022). The change from 2022 to 2023 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 14: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2022 CAN Rate	MY 2023 CAN Rates	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
Colorectal Cancer Screening (COL-AD)◊			
Ages 46 - 50	--	24.68%	--
Ages 50-64	48.57%	--	--
Ages 51- 65	--	47.91%	--
Ages 65-75	39.64%	--	--
Ages 66 - 75	--	35.71%	--
Total	43.92%	42.82%	-1.10
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.61%	0.64%	0.03
Ages 65+	3.86%	3.63%	-0.23
Total	0.64%	0.67%	0.03
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception – 3 days	11.17%	12.66%	1.49
Most or moderately effective contraception – 90 days	40.70%	51.64%	10.94
LARC - 3 Days	0.46%	0.61%	0.15
LARC - 90 Days Reported	7.37%	11.35%	3.98
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception rate	23.21%	24.69%	1.48
LARC rate	2.29%	2.92%	0.63
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	25.52	27.16	1.64
Ages 65+	NA	NA	NA
Total	25.46	27.07	1.61
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	59.71	57.01	-2.7
Ages 65+	225.56	106.72	-118.84
Total	60.72	57.43	-3.29
HEART FAILURE ADMISSION RATE (PQI-08)			

Measure	MY 2022 CAN Rate	MY 2023 CAN Rates	Change
Ages 18 - 64	51.24	45.82	-5.42
Ages 65+	75.19	0	-75.19
Total	51.30	45.66	-5.64
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	1.03	1.87	0.84
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	29.12%	39.30%	10.18
Ages 65+	NA	NA	NA
Total	29.02%	38.94%	9.92
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)			
Ages 18 - 64	--	73.20%	--
Ages 65+	--	75.00%	--
Total	--	73.21%	--
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	1.33%	1.01%	-0.32
Ages 65+	NA	NA	NA
Total	1.33%	1.01%	-0.32
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	3.20%	3.24%	0.04
Ages 65+	NA	NA	NA
Total	3.20%	3.22%	0.02
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	40.16%	45.78%	5.62
Prescription for Buprenorphine	36.77%	40.25%	3.48
Prescription for Oral Naltrexone	0.91%	0.97%	0.06
Prescription for Long-acting, injectable naltrexone	0.13%	0.14%	0.01
Prescription for Methadone	2.74%	4.98%	2.24
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	--	NA	--
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	--	NA	--
Discussed or Recommended Cessation Medications: Ages 18 to 64	--	NA	--
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	--	NA	--
Percentage of Current Smokers and Tobacco Users: Age 65 and Older	--	NA	--
Advising Users to Quit: Age 65 and Older	--	NA	--
Discussing Cessation Medications: Age 65 and Older	--	NA	--
Discussing Cessation Strategies: Age 65 and Older	--	NA	--
Percentage of Current Smokers and Tobacco Users: Total	--	NA	--
Advising Users to Quit: Total	--	NA	--
Discussing Cessation Medications: Total	--	NA	--

Measure	MY 2022 CAN Rate	MY 2023 CAN Rates	Change
Discussing Cessation Strategies: Total	--	NA	--
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	--	NA	--
Child Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	1.21%	1.58%	0.37
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	5.19%	6.33%	1.14
Age 2 Screening	5.72%	6.61%	0.89
Age 3 Screening	5.46%	4.95%	-0.51
Total Screening	5.41%	6.06%	0.65
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	1.42%	1.67%	0.25
Most or moderately effective contraception – 90 days	44.50%	57.62%	13.12
LARC - 3 Days	0.53%	0.48%	-0.05
LARC - 90 Days Reported	10.11%	15.95%	5.84
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	28.32%	28.66%	0.34
LARC Rate	2.29%	2.21%	-0.08
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	54.40%	51.56%	-2.84
Numerator 2 All Four Molars Sealed	37.76%	35.41%	-2.35
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.79%	0.77%	-0.02
Ages 1-2	22.74%	21.89%	-0.85
Ages 3-5	58.72%	57.69%	-1.03
Ages 6-7	64.64%	63.32%	-1.32
Ages 8-9	64.49%	63.51%	-0.98
Ages 10-11	61.41%	62.12%	0.71
Ages 12-14	55.92%	56.85%	0.93
Ages 15-18	46.60%	45.81%	-0.79
Ages 19-20	27.74%	27.24%	-0.50
Total Ages <1-20	50.85%	49.66%	-1.19
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	11.81%	11.42%	-0.39
Ages 3-5	27.51%	27.25%	-0.26
Ages 6-7	31.44%	31.40%	-0.04

Measure	MY 2022 CAN Rate	MY 2023 CAN Rates	Change
Ages 8-9	31.31%	30.69%	-0.62
Ages 10-11	29.16%	29.29%	0.13
Ages 12-14	25.65%	25.91%	0.26
Ages 15-18	17.83%	18.22%	0.39
Ages 19-20	9.27%	7.39%	-1.88
Total Ages 1-20	24.15%	23.87%	-0.28
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	6.31%	6.06%	-0.25
Ages 3-5	25.24%	25.56%	0.32
Ages 6-7	30.75%	30.62%	-0.13
Ages 8-9	30.92%	30.16%	-0.76
Ages 10-11	28.98%	28.94%	-0.04
Ages 12-14	25.44%	25.33%	-0.11
Ages 15-18	17.65%	17.81%	0.16
Ages 19-20	9.07%	7.06%	-2.01
Total Ages 1-20	23.08%	22.70%	-0.38
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	4.01%	4.02%	0.01
Ages 3-5	0.43%	0.42%	-0.01
Ages 6-7	0.00%	0.01%	0.01
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	0.44%	0.47%	0.03

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.
◊ indicates that the measure has a "Trend with Caution" guidance note from NCQA for MY 2023.

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

- The Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD) measure improved by over 17 percentage points for the most or moderately effective contraception-90 days indicator.
- The HIV Viral Load Suppression measure (HVL - AD) improved by over 10 percentage points for the ages 18-64 indicator.

- The Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH) measure improved by over 13 percentage points for the most or moderately effective contraception-90 days indicator.

A substantial decrease in the rate was noted in two measures. Those measures were:

- The Chronic Obstructive Pulmonary Disease (COPD) OR Asthma in Older Adults Admission Rate (PQI-05) measure decreased by 118.84 per 100,000 member months for the Ages 65+ indicator.
- The Heart Failure Admission Rate (PQI-08) measure decreased by 75.19 per 100,000 member months for the Ages 65+ indicator.

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

For this review, Magnolia submitted three PIPs. Topics for those PIPs included Reducing Preterm Births, Sickle Cell Disease, and Asthma/COPD. Magnolia indicated they were in the process of working on a fourth PIP regarding Follow-up After Hospitalization for Mental Illness. The three PIPs validated scored in the "High Confidence in Reported Results" range as noted in the tables below. A summary of each PIP's status and interventions is also included.

Table 15: 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 indicator goal rate for this PIP was 11.4% and the baseline rate was 14.47%. In the last two remeasurements the rate increased from 15.05% to 15.44%, which is not a substantial increase. However, this increase reflects a lack of improvement, as the goal is to reduce the preterm birth rate.	
Previous Validation Score	Current Validation Score

Reducing Preterm Births	
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Member outreach on pregnancy related topics. • Completing Notification of Pregnancy as applicable. • Enrolling member in the Start Smart for Baby program. • Home blood pressure monitoring program. • Nutritional status assessments. • Refer to Care Management for continuous follow-up. • Medical record review for monitoring and tracking. • Member and provider education on the clinical practice guidelines.	

Table 16: 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
74/75=99% High Confidence in Reported Results	80/80=100% 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 to all members who received letters to provide education and to address any barriers/concerns. • Texting campaigns to encourage medication refill reminders.	

Table 17: 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 improved from 71.14% to 74.01%; spirometry test improved from 22.27% to 24.48%.	
Previous Validation Score	Current Validation Score

Asthma/COPD	
74/75=99% High Confidence in Reported Results	80/80=100% 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 MY 2023 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 provided Magnolia with a recommendation for the Reducing Preterm Births PIP as noted in *Table 18: Performance Improvement Project Recommendations*.

Table 18: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Reducing Preterm Births PIP	Was there any documented, quantitative improvement in processes or outcomes of care?	In the last two remeasurements the rate increased from 15.05% to 15.44%, which is not a substantial increase, but lower is better so this reflects a lack of improvement.	Determine if additional interventions may assist in reducing preterm births; enhance member education on assessing for signs of pre-eclampsia

For the 2024 EQR of Magnolia, all standards received a "Met" score in the Quality Improvement section of the review as noted in the figure that follows. Strengths, weaknesses, and recommendations are noted in the tables that follow.

Figure 5: Quality Improvement Findings

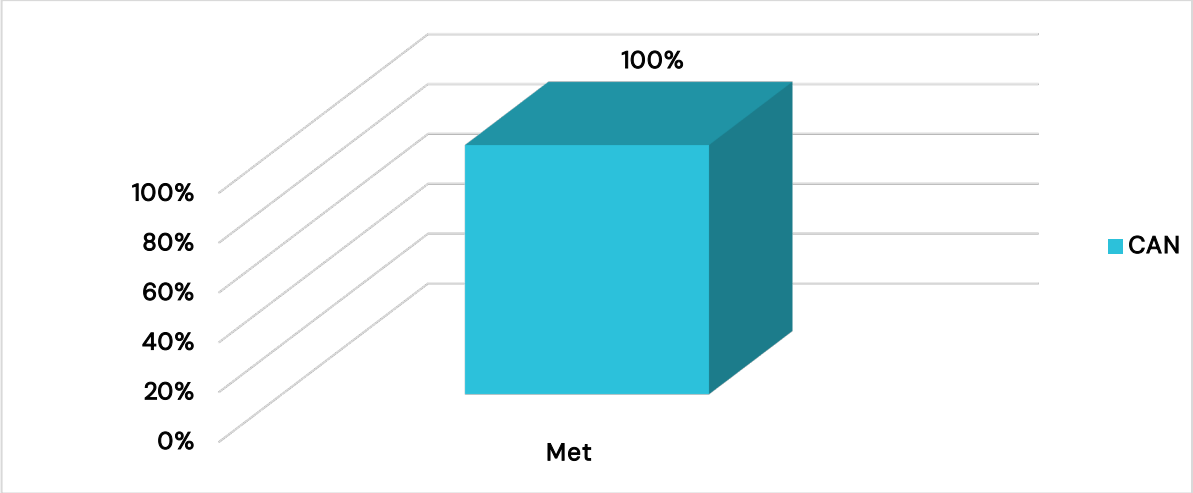


Table 19: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The Quality Program addresses a wide range of areas including access to care, quality of care, preventive care, health disparity reduction, and population health management.	✓		
Magnolia uses a data driven approach to monitor performance and measure effectiveness of quality initiatives.	✓		
The validation of the performance improvement projects found the projects meet the validation requirements and scored in the High Confidence range.	✓		
Magnolia's HEDIS auditor found that the CCO was fully compliant with all Information Systems Standards and determined that Magnolia submitted valid and reportable rates for all HEDIS measures in scope of the audit.	✓		
There were no concerns with Magnolia's data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Magnolia followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.	✓		
The following HEDIS and CMS Core Set MY 2023 measure rates were strengths for Magnolia since their rates had a greater than 10 percentage point improvement: • The Adult BMI Assessment (ABA) measure improved by over 17 percentage points. • The Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD) measure improved by over 17 percentage points for the most or moderately effective contraception-90 days indicator. • The Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure increased by 10.15 percentage points for the 6-17 years - 30-Day Follow-Up indicator. • The HIV Viral Load Suppression measure (HVL - AD) improved by over 10 percentage points for the ages 18-64 indicator.	✓		

Strengths	Quality	Timeliness	Access to Care
• The Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH) measure improved by over 13 percentage points for the most or moderately effective contraception-90 days indicator.			

Table 20: Quality Improvement Weaknesses, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The QI Program Description does not include Magnolia's current responsibilities related to credentialing and recredentialing since DOM implemented centralized credentialing	*Recommendation: Update the QI Program Description to include Magnolia's current responsibilities related to credentialing and recredentialing.*	✓		
According to the Quality Improvement Committee Charter, voting members must attend 75% of scheduled meetings. In 2023 there were eight voting members who did not meet this attendance requirement.	*Recommendation: Committee members who don't meet the attendance requirements for the Quality Improvement Committee should be replaced.*	✓		
Line nine of the 2023 QI Work Plan included an activity to ensure the Quality Improvement Committee had adequate representation of external providers. This activity was to ensure there was at least one behavioral health provider, and ensure there was a pediatrician, family practice provider, internal medicine provider, nurse practitioner, and specialist. The 2023 QIC minutes and the 2024 committee membership list did not include an internal medicine provider or a specialist.	*Recommendation: Add a network provider who specializes in internal medicine and a specialist to ensure the Quality Improvement Committee has adequate representation as noted in the QI Work Plan.*	✓		
For the Reducing Preterm Births PIP, in the last two remeasurements the rate increased from 15.05% to 15.44%, which is not a substantial increase, but lower is better so this reflects a lack of improvement.	*Recommendation: Determine if additional interventions may assist in reducing preterm births; enhance member education on assessing for signs of pre-eclampsia.*	✓		
The following HEDIS and CMS Core Set MY 2023 measure rates were determined to be areas of opportunities for Magnolia since their rates had a greater than 10 percentage point decline:	*Recommendation: Seek opportunities to improve the Kidney Health Evaluation for Patients with Diabetes, Follow-up After Emergency Department Visit for Mental Illness, Chronic Obstructive Pulmonary*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
• The Kidney Health Evaluation for Patients With Diabetes (KED) measure decreased by over 13 percentage points for the ages 65-74 indicator. • The Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure decreased by 10.80 percentage points for the 18-64 years - 30-Day Follow-Up indicator. • The Chronic Obstructive Pulmonary Disease (COPD) OR Asthma In Older Adults Admission Rate (PQI-05) measure decreased by 118.84 per 100,000 member months for the Ages 65+ indicator. • The Heart Failure Admission Rate (PQI-08) measure decreased by 75.19 per 100,000 member months for the Ages 65+ indicator.	*Disease or Asthma, and the Heart Failure Admission Rate measures.*			
Rate inconsistencies were found in the reported measure data. The responses Magnolia provided are indicative of gaps in processes established for verification and reporting of measure rate data.	*Recommendation: Improve processes for rate reporting, validation, and trending to identify measure rate reporting concerns.*	✓		
Inconsistencies were observed in the reported enrollment data during the Performance Measure Validation. The HEDIS Compliance Audit Final Audit Report also identified areas of improvement in reporting enrollment information.	*Recommendation: Improve processes for maintaining and reporting accurate enrollment counts for measure rate reporting.*	✓		

QUALITY IMPROVEMENT

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's Quality Improvement Program is comprehensive. The 2024 Quality Program Description describes a systematic approach to improving the quality and safety of clinical care and services provided to members. The program integrates quality assurance, management, and improvement into all staff roles and department functions and is overseen by the Board of Directors. Magnolia utilizes reliable methods like HEDIS, CAHPS, and CMS Core Measures to monitor and improve performance. The Chief Medical Director serves as the senior quality executive responsible for the QI Program. The Behavioral Health Medical Director is the designated practitioner responsible for the behavioral health aspects of the QI Program. Credentialing and recredentialing are mentioned several times in the QI Program Description. Page 14 of this document specifically mentions the Credentialing Committee has the responsibility for credentialing and recredentialing physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners. The program description does not include Magnolia's current responsibilities related to credentialing and recredentialing since DOM implemented centralized credentialing.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the QI Program Description to include Magnolia's current responsibilities related to credentialing and recredentialing.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. It also focuses on health disparity reduction and cultural competency, ensuring that services are delivered in a culturally and linguistically competent manner. The program identifies and addresses health inequities, promotes health equity, and includes targeted interventions to improve health disparities based on various demographic factors. The HEDC is responsible for executing strategies to improve quality and reduce costs associated with health disparities. The council provides oversight and direction for all activities related to health disparities, assesses the appropriateness of care and services delivered, and continuously enhances and improves the quality of services provided to members to promote health equity. The HEDC reviews and directs clinical, physical, behavioral health, and service operational activities to identify and address health disparities by tailoring services to remove barriers. The council also establishes goals, policies, and benchmarks for health equity initiatives, facilitates stakeholder perspectives, and ensures alignment and accountability within the health plan.
3. The scope of the QI program includes investigation of trends noted through	X					Magnolia monitors utilization patterns by performing assessments of utilization data to identify potential

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
utilization data collection and analysis that demonstrate potential health care delivery problems.						over- and under-utilization issues or practices. This includes using various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services. Additionally, the Utilization Management Committee oversees the appropriateness of care and guards against over and under-utilization of health care services provided to members.
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					A Quality Work Plan is used as part of Magnolia's Quality Program. The work plan identifies the yearly planned activities, the individual(s) accountable for each task, specific start and completion dates, data collection methods and analysis, and includes quarterly updates. The work plan is reviewed by the Quality Improvement Committee on a regular basis and is a fluid document that is frequently updated to document progress throughout the year. For this EQR, Magnolia provided the 2023 and 2024 work plans.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia's Board of Directors has authority and oversight of the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors delegates the operating authority of the Quality Program to the Quality Improvement Committee. The Quality Improvement Committee is the senior management lead committee accountable directly to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Board of Directors and reports Quality Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. The committee's structure is designed to continually promote information, reports, and improvement activity results, driven by the QI Work Plan. The Quality Improvement Committee serves as the umbrella committee.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Members of the QIC include senior management staff, clinical staff, and network practitioners. 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. Voting members must attend 75% of scheduled meetings. In 2023 there were eight voting members who did not meet this attendance requirement. Also, line nine of the 2023 QI Work Plan included an activity to ensure the QIC had adequate representation of external providers. This activity was to ensure there was at least one behavioral health provider, and ensure there was a pediatrician, family practice provider, internal medicine provider, nurse practitioner, and specialist. The 2023 QIC minutes and the 2024 committee membership list did not include an internal medicine provider or a specialist as a member of this committee. This activity was noted as "MET" even though there was no representation of an internal medicine provider or specialist on this committee.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Committee members who do not meet the attendance requirements for the Quality Improvement Committee should be replaced. Also, add a network provider who specializes in internal medicine and a specialist to ensure the Quality Improvement Committee has adequate representation as noted in the QI Work Plan.
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are drafted and distributed to committee members prior to the meetings. Handouts or meeting packets are emailed, or hard copies are mailed to network physician committee members. Meeting minutes provided with the desk materials demonstrated minutes are recorded and reviewed for each meeting.
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 Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. Magnolia met all the requirements for the validation.
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 three PIPs. Topics for those PIPs included Reducing Preterm Births, Sickle Cell Disease, and Asthma/COPD. Magnolia indicated they were in the process of working on a fourth PIP

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						regarding follow-up after hospitalization for mental illness.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					The three PIPs validated scored in the "High Confidence in Reported Results" range. For the Reducing Preterm Births PIP, in the last two remeasurements the rate increased from 15.05% to 15.44%, which is not a substantial increase, but lower is better so this reflects a lack of improvement. *Recommendation: Determine if additional interventions may assist in reducing preterm births; enhance member education on assessing for signs of pre-eclampsia.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Magnolia monitors provider performance through profiling reports focusing on PCPs. Policy MS.QI.23, Provider Profiling Program, outlines the process by which Magnolia develops, implements, monitors, and distributes provider profiling reports to PCPs. This program aims to increase provider awareness of their performance and improve health outcomes for members by recognizing providers who deliver quality care. PCPs with low scores may face interventions like education, performance improvement plans, or network termination. High-performing providers may receive recognition and preferred status. Data sources for these reports include medical claims, pharmacy data immunization registries, lab values, and HEDIS

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						measures. Monthly updates are available on dashboards showing cost, utilization data, patient engagement, emergency department reporting, quality measures, and peer comparisons.
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. Annually, Magnolia monitors practitioner adherence to these guidelines through review of HEDIS measures. For 2023 Diabetes Care, Prenatal Care, ADHD, and Depression were chosen for monitoring.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						Policy MS.QI.20, Early and Periodic Screening, Diagnostic & Treatment (EPSDT) Service, outlines Magnolia's policy and procedures for providing EPSDT services for Medicaid recipients under 21. It details the commitment to providing comprehensive preventive health screenings and improving children's health. The policy includes guidelines for health assessments, immunizations, and necessary follow-up care. It also describes the roles of various departments, monitoring and reporting processes, and educational initiatives for employees, providers, and members. Regular audits and targeted interventions ensure compliance and continuous improvement in service delivery. Magnolia runs monthly reports to identify members needing follow-up care after an EPSDT screening. If abnormal findings are detected, the EPSDT Coordinator or QI designee monitors claims for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						evidence of treatment and follows up with providers and parents or guardians to ensure necessary care is provided.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
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)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Magnolia evaluates the QI Program through an annual evaluation that includes an analysis and evaluation of the overall effectiveness of the Quality Program, including progress toward influencing network-wide safe clinical practices and an evaluation of the adequacy of resources and training related to the Quality Program. The 2023 Magnolia Health Quality Management Program Evaluation was received. This program evaluation included a description of completed and ongoing studies and quality activities that address quality and safety of clinical care and quality of service. Trending of measures collected over time to assess performance and interventions implemented to address issues are also included. The findings are presented to the Quality Improvement Committee and the Board of Directors for approval annually.
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)

Information about Magnolia's Utilization Management (UM) Program is included in the UM Program Description 2024 as well as in numerous policies and procedures. The scope and goals of the UM Program are outlined and a detailed description of roles and qualifications for the UM leadership staff positions is provided.

Authority, oversight, and lines of responsibility of the UM Program are clearly identified within the policies and procedures. Policy CC. UM.01, Program Description, states that the Chief Medical Director has operational responsibility for and provides support to Magnolia's UM Program.

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

The UM process encompasses the following program components: 24-hour nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning, and care coordination. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, scheduled inpatient services, or emergent/urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting provider and member (when applicable) have been notified of the determination.

Appropriately licensed, qualified staff supervise the UM process and render all medical necessity decisions, as referenced in Policy CC.UM.04, Appropriate UM Professionals. A physician or other appropriately licensed health care professional issues all medical necessity denials of healthcare services. Reviewers employed by or under contract to perform utilization review are appropriately qualified, trained, and hold current professional licensure. Appropriately trained reviewers conduct service authorization requests using InterQual criteria or other established guidelines. There are mechanisms in place for prior authorization and appeals, including expedited appeals.

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify Magnolia of a service request and for making UM decisions and subsequently notifying the member and provider. At the time of an adverse benefit determination, members and providers are notified verbally and/or in writing of the availability of an appropriate practitioner reviewer to discuss the adverse benefit determination, and how to contact a reviewer for specific cases.

Constellation's review of sample approval and denial files found that the criteria and procedures for the evaluation of medical necessity of services for members were applied consistently.

Appeals

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

Magnolia describes processes for handling verbal and written appeals in Policy MS.UM08, Appeal of UM Decisions, the Member Handbook, and the UM Program Description. The term "appeal" is defined in policy, the Member Handbook, Provider Manual, UM Program Description, and health plan website as a request to review an adverse benefit determination. Timelines for the acknowledgement and resolution of standard and expedited appeals are indicated in member and provider materials.

The review of a sample of appeal files found that all were processed in a timely manner and reflected that an appropriate physician made the appeal determinations.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

Various policies outline the purpose, scope, and goals of the Care Management Program. Members are referred for care management services through various referral sources such Disease Management Health Coaches, community agencies, health care providers, pharmacy, hospital staff, emergency department utilization reports, self-referrals, and predictive modeling software. Once a member is identified as a potential candidate for care management services, a referral is initiated within 30 days to conduct an initial assessment that is completed by a qualified professional.

Once a treatment plan is completed, care management activities are provided to members based upon their identified needs and risk level assignment. Magnolia also offers disease management programs to address specific health related needs to members. For example, Puff Free Pregnancy is a smoking cessation program to promote a healthy pregnancy for mothers. Also, Magnolia's health prevention/wellness program, My Health Pays, is a member incentive program that promotes personal healthcare engagement by offering financial incentives for members to participate in wellness visits. Transitional care management services are also provided to manage transitional care for members across healthcare settings. Based upon review of the sample care management files, care management interventions were provided to members based upon their assigned risk level and identified needs.

As noted in *Figure 6*, 100% of the Utilization Management standards were scored as "Met." Strengths for the Utilization Management section are included in the table that follows.

Figure 6: Utilization Management Findings

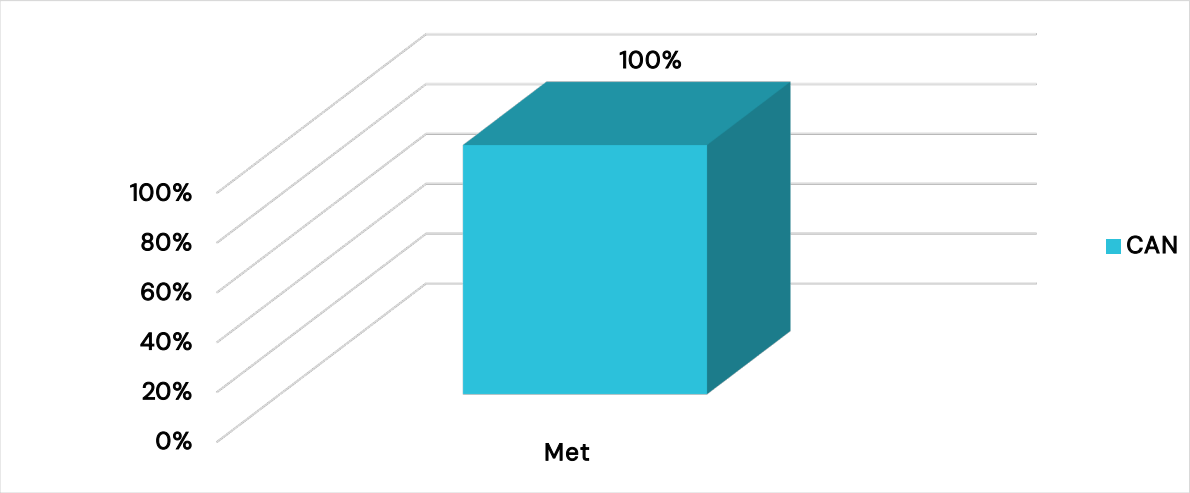


Table 21: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
The turnaround timeliness measures for non-urgent pre-service, urgent pre-service, outpatient non-urgent preservice, outpatient urgent pre-service, and post service reviews exceeded their performance goals of 98% during 2023.		✓	
Review of a sample of denial files determined all were processed timely and reviewed by appropriate health care professionals. The rationale for denial was clearly stated and communicated to members and providers within required timeframes.		✓	
My Health Pays is a member incentive program that promotes personal healthcare engagement by offering financial incentives for members to participate in wellness visits.	✓		
Puff Free Pregnancy is a smoking cessation program to promote a healthy pregnancy for mothers.	✓		
Constellation reviewed a sample of appeal files and found that all were acknowledged and resolved in a timely manner and reflected appropriately credentialed reviewers.		✓	

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 Utilization Management Program Description, Policy ID CC.UM.01, details the structure and function of the UM program.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					The UM Program Description details the authority, oversight, and operational responsibility for Magnolia's UM Program.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Magnolia follows written clinical support criteria to evaluate medical necessity to ensure consistency in UM decisions.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.
1.5 Consideration of new technology;	X					Magnolia evaluates the inclusion of new technology and the new application of existing technology for coverage determinations.
1.6 The appeal process, including a mechanism for expedited appeal;	X					A member or an authorized representative of a member acting on their behalf may appeal an adverse decision regarding their care and service. An expedited appeal is available under certain circumstances, including urgent care requests.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					All individuals involved in UM decision making sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affect subsequent claim activity.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The Chief Medical Director has operational oversight for and provides support to the UM Program. Additionally, appropriate specialists are involved in the implementation, monitoring, and directing of specialty health and service aspects of the UM Program.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Through the Quality Committee, appropriate providers are involved in developing, adopting, and reviewing criteria.
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 § 457. 1228*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Per Policy CC.UM.02, Clinical Decision Criteria and Application, Magnolia utilizes medical necessity criteria as an objective screening guide. The criteria are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with the currently accepted medical and/or behavioral health care practices, taking into consideration individual member needs and characteristics at the time of the request.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					At least annually, the Vice President of Population Health and Clinical Operations and Vice President of Medical Affairs, in conjunction with the Organization and the Clinical Criteria Team, initiate and conduct inter-rater reliability testing to assess the consistency with which clinical reviewers apply clinical criteria decision-making tools.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Magnolia's website, Provider Manual, and Member Handbook all reference the most current version of the Preferred Drug List.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Emergency and post-stabilization services do not require prior authorization and can be received outside of the Magnolia network.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Utilization management standards/criteria are available to providers.	X					Providers are notified of UM criteria during their initial orientation. Criteria and standards are listed in the Provider Manual, on the Plan's website, and in provider newsletters.
8. Utilization management decisions are made by appropriately trained reviewers.	X					The UM Program Description explains the two levels of UM medical necessity review that are available for all authorization requests. Level I review is conducted on covered medical benefits by a care manager who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. Level II review is conducted on a case-by-case basis by an appropriate provider with a current license to practice without restriction, or other healthcare professional as appropriate.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					The sample of approval files reviewed demonstrated that Magnolia's utilization decisions met the contract standards for timeliness and notification requirements. 100% of the files reviewed exhibited consistency with the approval process, including notification to the member and provider. Additional information was requested and considered when it was determined necessary to make appropriate decisions.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
pertinent information prior to making the decision to deny services.						
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					For the sample of denial files reviewed, determinations were based on medical necessity and were made by an appropriate physician specialist.
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.	X					The review of the sample denial files reflected decisions were communicated timely to both provider and member and included the rationale for the denial. Information regarding appeals was provided to the provider and member.
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					Policy MS.UM.08, Appeal of UM Decisions, the Member Handbook, and the 2024 Magnolia Health Utilization Management Program Description describe Magnolia's processes for responding to members' requests to reconsider a decision made about their service(s).
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeal terminology is defined in policy, the Member Handbook, Provider Manual, UM Program Description, and on the health plan website as a request to review an adverse benefit determination.
1.2 The procedure for filing an appeal;	X					Steps for filing verbal and written appeals are clearly indicated in member and provider materials, along with phone or electronic submission information.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					Standard appeals are acknowledged in writing within 10 calendar days of the receipt of a request for an appeal and resolved within 30 calendar days.
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					
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
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 MS.CM.01, Care Management Program and Program Description, outlines the purpose, scope, and goals of the Care Management Program.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					As outlined in Policy MS.CM.01, Care Management Program and Program Description, Policy CC.CM.02, Care Coordination Care Management Service, and Policy MS.PHARM.17, Case Management Referral Process, members are referred for care management services through various referral sources such Disease Management Health Coaches, community agencies, health care providers, pharmacy, hospital staff, emergency department utilization reports, self-referrals, and predictive modeling software.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					As outlined in Policy MS.CM.01, Care Management Program and Program Description, and Policy CC.CM.02, Care Coordination Care Management Service, once a member is identified as a potential candidate for care management services, a referral is initiated within 30 days to conduct an initial assessment.
4. The detailed health risk assessment includes all required elements:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Identification of the severity of the member's conditions/disease state;	X					As outlined in Policy MS.CM.01, Care Management Program and Program Description, and Policy CC.CM.02, Care Coordination Care Management Service, the member's clinical history is assessed.
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					A member's demographic information is obtained during a health risk assessment as outlined in Policy CC.CM.02, Care Coordination Care Management Service.
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					Constellation's review of the sample of care management files found that the health risk assessment was completed by a qualified professional and a treatment plan was completed according to contractual requirements.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Ongoing monitoring is conducted through Impact Pro, a predictive modeling system that identifies any changes in the member's needs. The member's risk level is updated accordingly. Also, reassessments are conducted yearly to assess any updated needs for members as outlined in Policy CC.CM.02, Care Coordination Care Management Service.
7. The CCO utilizes care management techniques to ensure comprehensive,	X					As described in various policies and in the Member Handbook, Magnolia offers an integrated approach in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
coordinated care for all members through the following minimum functions:						providing care management services to ensure whole person-centered care. If a member's primary diagnosis is a behavioral health condition, a behavioral health care manager is assigned as primary point of contact. If the member's primary diagnosis is a medical condition, a physical health care manager is the primary point of contact. Both disciplines work collaboratively as needed to address the member's care needs. Once the treatment plan is developed, care coordination activities, such as member education, discharge planning, coordination to community resources, appointment scheduling, etc., are provided. Frequency and content of services provided are based upon the member's assigned risk level and all care management activities are documented in a centralized documentation system.
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 follow-up						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 are undergoing an active course of						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 care management activities that are provided to Mississippi members that are assigned to the high risk level. Based upon the file review, members assigned to the medium and high risk levels were provided appropriate care management interventions based upon their assigned risk level.
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					As outlined in various policies and program descriptions, Magnolia offers disease management programs to address specific health related needs. The various disease management programs that are offered entail cardiac, diabetes, asthma, lifestyle management, and other health and wellness programs. Members are identified for these programs through self-referral, claims data, staff referral, etc. Magnolia shared during onsite discussion that if a member has identified disease management needs, the care management team works collaboratively with the disease management team to ensure that member is linked to the appropriate service. Magnolia shared information about their current health prevention/wellness program, My Health Pays, which is a member incentive program that promotes personal healthcare engagement by offering financial incentives for members to participate in wellness visits. The Puff Free Pregnancy program, a smoking cessation program to promote a healthy pregnancy for mothers, is also available.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Policy MS.CM.99, Transitional Care Management Process, and Policy MS.UM.24, Continuity and Coordination of Care, provide a descriptive overview of the process and guidelines of managing transitional care for members across healthcare settings.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					As outlined in Policy MS.CM.99, Transitional Care Management Process, and Policy MS.CM.1.02, Integrated Care Team Co-located and Field Staff Guidelines and Responsibilities, the transitional care management team is comprised of a fully integrated group of staff such as Registered Nurse Care Managers, Social Service Specialists, Medical Directors, Program Coordinators, Behavioral Health Staff, etc. to provide support for members' transition of care within their home or community setting.
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					The Quality Committee coordinates annual review and revision of the UM Program Description, Work Plan, and the annual UM Program Evaluation.

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 22: Delegated Entities and Services*.

Table 22: Delegated Entities and Services

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

According to Policy MS.QI.14, Oversight of Delegated Vendor Services, a pre-delegation review is conducted prior to the activation of the delegation agreement. This review includes an evaluation of the entity's program, associated policies and procedures, staffing capabilities, and performance record to ensure compliance with Magnolia, State, NCQA, HIPAA, and other applicable regulatory standards. Magnolia monitors performance through routine reporting, oversight meetings, and annual evaluations to ensure compliance with standards. Corrective action plans are required for any deficiencies identified. Severe or unresolved deficiencies may lead to the revocation of the delegation agreement.

A mutually agreed upon written document, signed by both parties, is required for delegation. This agreement outlines the responsibilities, regulatory requirements, quality improvement activities, reporting frequency, performance evaluation processes, and consequences for non-compliance.

Magnolia maintains accountability for all activities conducted by third-party entities. Ongoing monitoring is conducted and reported to the appropriate committee at least quarterly. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

As noted in *Figure 7*, all standards in the Delegation section were scored as "Met." Delegation strengths are noted in the table that follows.

Figure 7: Delegation Findings

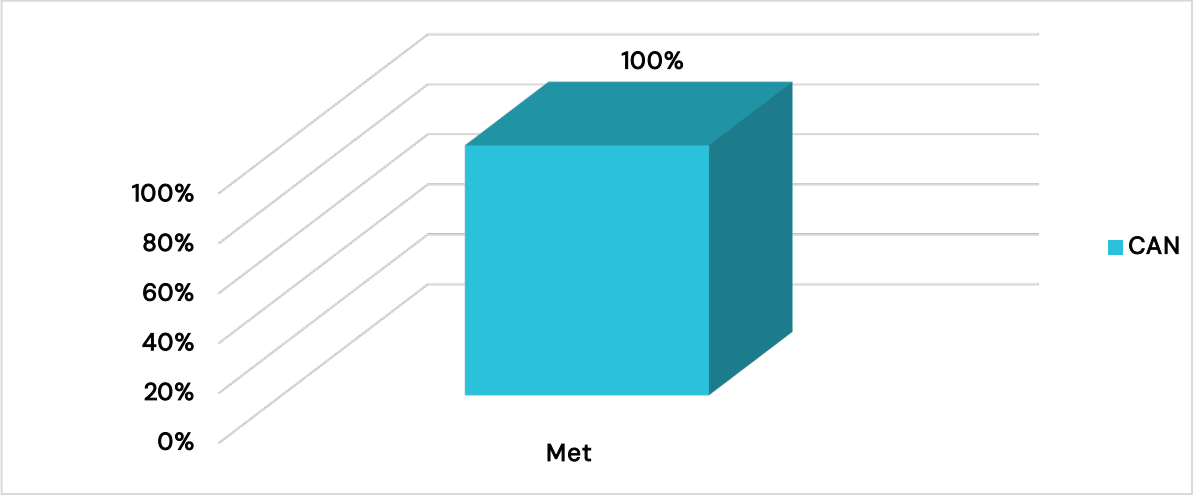


Table 23: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Magnolia's delegation oversight program includes a thorough pre-delegation review, ongoing monitoring, and annual evaluations to ensure that delegated entities meet Magnolia's standards and regulatory requirements.	✓		
The Delegation Oversight Program has a structured approach for identifying deficiencies and implementing corrective actions through Corrective Action Plans. This proactive approach helps in addressing issues promptly and improving the performance of delegated entities.	✓		

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 established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Magnolia delegates certain activities to entities but retains ultimate accountability. According to Policy MS.QI.14, Oversight of Delegated Vendor Services, delegated activities may include quality data collection, analysis, improvement activities, prior authorization, disease management, credentialing, network management, and claims payment. A pre-delegation review is conducted prior to the activation of the delegation agreement. This review includes evaluating the entity's program, associated policies and procedures, staffing capabilities, and performance record to ensure compliance with Magnolia, State, NCQA, HIPAA, and other applicable regulatory standards. Magnolia monitors performance through routine reporting, oversight meetings, and annual evaluations to ensure compliance with standards. Corrective action plans are required for any deficiencies identified. Severe or unresolved deficiencies may lead to the revocation of the delegation agreement.
2. 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					A mutually agreed upon written document, signed by both parties, is required for delegation. This agreement outlines the responsibilities, regulatory requirements, quality improvement activities, reporting frequency, performance evaluation processes, and consequences for non-compliance.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. 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					Magnolia maintains accountability for all activities conducted by third-party entities. Ongoing monitoring is conducted and reported to the appropriate committee at least quarterly. An annual delegation oversight audit is conducted, and findings are reviewed to determine the continuation of the delegation. If the delegated entity's' performance is found below standards, a corrective action plan is issued. For this EQR Magnolia reported delegation agreements with six subcontractors. The delegated services include dental services, non-emergent transportation, utilization management, vision services, and pharmacy services. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Assessment of Corrective Action Plans from Previous EQR

Attachment 1: Initial Notice and Materials Requested for Desk Review

June 3, 2024

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 2024 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN (MSCAN) Program and will be conducted by Constellation Quality Health, formerly The Carolinas Center for Medical Excellence.

The methodology used 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 Constellation Quality Health) 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 November 6, 2024, and November 7, 2024, 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 Constellation Quality Health no later than July 3, 2024.

Please upload all the desk materials electronically to Constellation Quality Health 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, Constellation Quality Health 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 Constellation Quality Health 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

MississippiCAN 2024 External Quality Review

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 positions 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. Please include all of the following:
    a. A list of all contracted providers. This list should be submitted as an excel spreadsheet and include county, specialty, panel limitations, and a description of any codes used in the spreadsheet.
    b. Geographic access assessments
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios
    f. Analysis of in-network and out-of-network utilization data
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 2023 and 2024.

11. The most recent reports that summarize 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 all committee meetings 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. Please indicate which members are voting members and include committee charters if available.
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 2023 and 2024 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 2023 through June 2024. 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 2023 to June 2024. 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 2023 through June 2024.
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.
    a. Copies of the EPSDT tracking reports and follow-up activities from August 2023 through June 2024.
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 with updated data for MY 2023. *(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 2023 through June 2024.

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 2023 (MY 2023) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2023 [1]NCQA 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 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 2023.
c.	HEDIS MY 2023 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 2023. NOTE: Constellation understands CCOs may not receive the FARs from the HEDIS auditors until 7/15/24. Please submit this item by 7/17/24.
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℠, 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, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health's portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. Constellation Quality Health 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	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health portal, folder 36 g) a

Folder	Requested Document	Description
	the HEDIS measures	list of the first 100 numerator compliant records and exclusions/valid data errors that are identified through medical record review. Constellation Quality Health will select a random sample to conduct the medical record review validation.
h.	Rate Reporting template populated with data for non-HEDIS measure rates	Constellation Quality Health 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 2023 through June 2024. 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 2023 through June 2024, 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 Constellation Quality Health.

These materials:

- should be organized and uploaded to the secure Constellation Quality Health 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 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied
2. A copy of the 2024 Annual Delegation audit for Envolve Dental
3. Copies of the 2023 and 2024 Joint Oversight Committee meeting minutes
4. Copies of the 2023 vendor dashboards for the Envolve Dental, Envolve Vision, MTM, Evolent (NIA), Turning Point, and Cenetene Pharmacy
5. The updated version of the 2023 QI Program Evaluation
6. A copy of policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines
7. A sample copy of the Provider Profile results used to measure provider performance
8. A screenshot of the Provider Analytic dashboard
9. Departmental trainings related to CC.UM.O2, Clinical Decision Criteria and Application

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
- PM Validation CAN
- PIP Validation CAN
- Network Adequacy Validation CAN

EQR Survey Validation Worksheet

Plan Name	Magnolia Health
Survey Validated	CAHPS MEMBER SATISFACTION – ADULT
Validation Period	2023
Review Performed	2024

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 MY2023
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 MY2023
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 MY2023

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 MY2023
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 MY2023

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 MY2023
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 MY2023
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 MY2023
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 MY2023
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 MY2023

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 MY2023
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 MY2023

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 MY2023.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. Documentation: Press Ganey Adult CAHPS Report MY2023
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 MY2023

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 MY2023
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. Documentation: Press Ganey Adult CAHPS Report MY2023
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 MY2023

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 MY2023

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The adult CAHPs survey had a response rate of 16.1% which is lower than last year's rate of 19.4%. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. Documentation: Press Ganey Adult CAHPS Report MY2023
7.3	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 MY2023
7.4	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 MY2023

EQR Survey Validation Worksheet

Plan Name	Magnolia Health
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2023
Review Performed	2024

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 Report MY2023
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 Report MY2023
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 Report MY2023

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 Report MY2023
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 Report MY2023

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 Report MY2023
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 Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. Documentation: Press Ganey Child Report MY2023
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 Report MY2023
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 Report MY2023

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 Report MY2023
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 Report MY2023

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,	**MET**	The quality plan is documented. *Documentation:* Press Ganey Child Report MY2023.

Survey Element		Element Met / Not Met	Comments and Documentation
	coding, editing, and entering of data, procedures for missing data, and data that fails edits		
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child Report MY2023
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 Report MY2023

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 Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child Report MY2023

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 Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child Medicaid response rate was 10.1% which is a slight decline from the previous year's rate of 16.7%. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child Report MY2023

Results Elements		Validation Comments and Conclusions
7.3	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 Report MY2023
7.4	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 Report MY2023

EQR Survey Validation Worksheet

Plan Name	Magnolia Health
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD WITH CCC
Validation Period	2023
Review Performed	2024

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. Documentation: Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child with CCC response rate was 9.3% which is a slight decline from the previous year's rate of 13.4%. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
7.3	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 with CCC CAHPS Report MY2023
7.4	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 with CCC CAHPS Report MY2023

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2024**
Review Performed:	**11/6/2024**

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	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	for members who received the services outside the MCO/PIHP's network) are complete and accurate.		
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:	**ALL ADULT AND CHILD CMS CORE MEASURES – CAN**
Reporting Year:	**2024**
Review Performed:	**11/6/2024**

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 Health**
Name of PIP:	**Reducing Preterm Births for Pregnant Mothers with HTN/Pre-eclampsia**
Reporting Year:	**2023**
Review Performed:	**2024**

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**	Magnolia Health data shows the overall preterm birth rate increased from 2017 to 2019 and then fell to 14.47% in 2020. The most common diagnosis for preterm births from 2018 to 2020 was Hypertension/Pre-Eclampsia.
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 addresses 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 includes 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)**	**N/A**	Administrative data used; no sampling included.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**N/A**	Administrative data used; no sampling included.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Administrative data used; no sampling included.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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.
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 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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 provide 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 are 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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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%; in the last two remeasurements the rate increased from 15.05% to 15.44%, which is not a substantial increase, but lower is better so this reflects a lack of improvement. **Recommendation**: *Determine if additional interventions may assist in reducing preterm births; enhance member education on assessing for signs of pre-eclampsia.*
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**	Improvement in primary indicator did not occur.
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	0
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 Health
Name of PIP:	Respiratory Illness: AMR and Spirometry Testing
Reporting Year:	2023
Review Performed:	2024

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**	Approximately 10.4% of Mississippi children ages 0-17 currently have asthma. Asthma-related ED visits and hospitalization are an indication of poorly controlled asthma and most of these visits are preventable through appropriate medication use.
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 addresses 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 includes 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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure are clearly defined.
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 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**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 provide 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 are 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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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)**	**MET**	AMR rate improved from 71.14% to 74.01%; Spirometry testing improved from 22.27% to 24.48%.
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 was demonstrated across all indicators and appears to be related to the system, provider, and member-focused interventions.
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	NA	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 Health**
Name of PIP:	**Sickle Cell Disease**
Reporting Year:	**2023**
Review Performed:	**2024**

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, only 37.5% 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 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 addresses 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 includes 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 measures 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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 provide 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 are 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		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate of members with SCD that remain compliant to medication during their

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
		treatment period improved from 25.87% to 30.53%. The goal is 47%.
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 was not demonstrated across all indicators.
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 as final rate not sustained over time.

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	NA	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 Network Adequacy Validation Worksheet

Plan Name:	**Magnolia CAN**
Reporting Year:	**2023**
Review Performed:	**2024**

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)**	**N/A**	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.
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.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
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 were used 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 Magnolia.

ACTIVITY 4: PERFORM OVERALL VALIDATION OF AND REPORTING OF RESULTS

Step	Possible Score	Score
Step 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
1.7	1	1
1.8	NA	NA
1.9	5	5
Step 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
Step 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	**99**	**99**

Project Score	99
Project Possible Score	99
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.*

Attachment 4: Assessment of Corrective Action Plans from Previous EQR

Constellation Quality Health

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

Magnolia Health Plan 2023 Corrective Action Plan

2023 EQR Findings	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
I A. Compliance/Program Integrity			
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.			
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:	Magnolia will continue to work with voting members to schedule the compliance meetings and will ensure that proxies are properly documented.	✓	

2023 EQR Findings	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
• 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 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.*			
7. The CCO implements and maintains a Pharmacy Lock-In Program.			
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 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.	Policy MS.PHAR.15, Pharmacy Lock-In Program, has been updated to include the following language under the Lock-In Process Section 3 (b): "Emergency supplies are limited to a seventy-two (72) hour supply of medication."	✓	

2023 EQR Findings	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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			
II A. Adequacy of the Provider Network			
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: 1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.			
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 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.*	Policy MS.CONT.01, Provider Network, is Magnolia's policy specific to Medicaid provider network requirements under the MississippiCAN contract, and this policy has been updated with the table of geo access requirements from the contract.	✓	
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.			

2023 EQR Findings	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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 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, Section 7 (B) 2, Table 7.*	Policy MS.PRVR.10 has been updated to include specialist.	✓	
Utilization Management			
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: 1.3 Guidelines/standards to be used in making utilization management decisions;			
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.*	The UM Program Description has been updated add "the Health Plan does allow for delegation of UM activities to vendors and oversight of such vendors is performed in accordance with CC.COMP.60 in the Delegation Section." The updated redline version has been updated.	✓	