Constellation Quality Health

# Mississippi External Quality Review

## Annual Comprehensive Technical Report

## Contract Year 2024 – 2025

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Prepared on behalf of the Mississippi Division of Medicaid

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# EXECUTIVE SUMMARY

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

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

The goals and objectives of the review were to:

- Determine whether the CCOs were in compliance with service delivery as mandated in Federal Regulations and in the CCO contracts with DOM.
- Assess the degree to which the health plans addressed deficiencies identified during the previous EQR and provide feedback for potential areas of continued improvement.

The purpose of the EQRs is to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and quality of health care services. This was accomplished by conducting the following activities for the CAN and CHIP Programs: validation of performance improvement projects (PIPs), performance measures (PMs), surveys, and network adequacy; assessment of compliance with state and federal regulations; and access studies for each health plan. Constellation also conducted a Behavioral Health Member Satisfaction Survey for each of the CCOs. This report is a compilation of the activities conducted in the 2024-2025 review cycle for the CAN and CHIP Programs for each CCO.

## Overall Findings for Mandatory EQR Activities

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 provider credentialing and recredentialing, and an assessment of CCO compliance with Provider Selection *(§ 438.214, § 457.1233)* is not included in this report.

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

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

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

## Administration

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

The CCOs develop, implement, and routinely review policies and procedures to guide staff and ensure compliance with laws, regulations, and contractual requirements. Staff can access policies and procedures through policy management platforms, intranet sites, and/or SharePoint sites.

Staffing is sufficient to ensure the CCOs can conduct all required functions and provide the required services to members. Recruitment efforts were in place to fill any vacancies.

The CCOs' Compliance Plans and Fraud, Waste, and Abuse (FWA) Plans address processes for ensuring compliance with laws, regulations, and contractual requirements, and for preventing, detecting, and responding to FWA. Policies and procedures provide detailed information to guide staff about compliance and FWA. Codes of Conduct define expectations for business conduct.

Compliance Committees assist in developing and implementing the Compliance Programs. Issues found for Molina were related to the documentation of the committee's name, meeting frequency, the committee's chairperson, and committee membership. All employees are required to complete Compliance Program training at the time of employment and annually. Additionally, members of the Board of Directors, subcontractors, vendors, and/or suppliers must complete annual compliance training. The health plans provide options for staff to ask questions and to discuss or report concerns confidentially and anonymously. Reporting options include telephone hotlines, online reporting systems, etc.

Each of the health plans has a Pharmacy Lock-in Program to assist members who have a pattern of abuse of the pharmacy benefits. No issues with this program were identified for Magnolia and Molina. United's policy defining the Pharmacy Lock-in Program's processes and requirements was not Mississippi-specific and did not address the required 72-hour emergency supply of medication.

Policies, program descriptions, training programs, compliance plans, codes of conduct, etc. address the expectation that staff maintain the security and confidentiality of protected health information.

Review and assessment of Information Systems Capabilities Assessment documentation and related policies and procedures indicated each organization's information systems infrastructure was capable of meeting contractual requirements. All the CCOs met or exceeded timelines for clean claims payment as required by the State. The 2024 EQRs found that systems and processes are appropriately maintained and updated in accordance with policies that prioritize data security and system resilience. Disaster Recovery plans are tested and updated annually to identify risks and protect system data.

## Provider Services

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

The CCOs' policies describe processes for initial provider orientation, but only two of the plans address ongoing provider education in policy. Provider Manuals and websites are additional resources for providers. However, there were issues noted in the Provider Manual

documentation for each CCO. These issues were related to documentation of member benefit limitations, self-referrals, accessing the EPSDT schedule, medical record retention requirements, and the required non-exclusivity statement.

The CCOs educate providers about medical record documentation requirements, evaluate provider compliance with the requirements, and work with providers who do not demonstrate compliance with the requirements. The CCOs also educate providers about clinical practice and preventive health guidelines. It was found that Molina's CHIP website did not list all the guidelines that had been adopted. Magnolia and Molina's websites included incorrect hyperlinks to the guidelines and/or hyperlinks which required an account/membership to access the information. Molina inconsistently documented the frequency of guideline review.

The CCOs' provider networks were found to be adequate and met the validation requirements listed in the Centers for Medicare and Medicaid Services (CMS) "*Protocol 4. Validation of Network Adequacy*." The CCOs have appropriate processes to classify, store, and update provider enrollment data. The CCOs correctly document geographic access standards for all provider types in policies and generate quarterly geographic access reports, but Magnolia's geographic access mapping used incorrect parameters for dental providers. United and Magnolia have appropriately documented appointment access standards for all provider types, but Molina erroneously documented the standards for behavioral health/substance use disorder appointments. The CCOs assess provider compliance with appointment access standards through routine call studies. There were no issues noted for Molina and United, but Magnolia's documentation reflected the use of incorrect appointment access standards for most provider appointment types and lacked the results of the after-hours telephonic survey. The CCOs also consider member satisfaction survey results, complaints, grievances, and out of network requests when assessing network adequacy. Each CCO has established a cultural competency program to ensure networks can adequately serve members with special needs. Cultural competency resources are available on plan websites.

The printed and online Provider Directories were reviewed and revealed no issues for Molina and United. Magnolia's online Provider Directory included the required elements, but the printed Provider Directory did not include the group affiliation for individual providers. The CCOs validate Provider Directory information through a variety of activities.

Constellation conducted and considered the results of Telephone Access Studies and Provider Directory Validations for each CCO. The most recent survey results found the successful contact rates ranged from 24% to 55%, Provider Directory accuracy rates ranged from 48% to 74%, routine appointment compliance rates ranged from 19% to 68%, and urgent appointment compliance rates ranged from 0% to 45%.

Constellation conducted validation reviews of the CCOs' provider satisfaction surveys using the "*Administration or Validation of Quality of Care Surveys*" protocol developed by the CMS. There were low response rates for each of the CCOs, ranging from 1.1% to 7.7%. These low response rates may produce results that may not reflect the full population of providers and should be interpreted with caution.

The 2024 EQRs revealed that references to credentialing and recredentialing activities remained in various documents for Magnolia and Molina, despite that the CCOs have not conducted credentialing and recredentialing activities for more than two years.

### 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 are informed of their rights and responsibilities in policies, Member Handbooks, welcome packets, and the CCOs' websites. Additional educational and outreach methods used include newsletters and various mailings.

Members are provided with information about health plan processes, covered benefits, applicable copays, programs, and services in new member packets, Member Handbooks, newsletters, websites, etc. Written notification is provided to members regarding changes in benefits and services 30 days prior to the effective date. For Molina, discrepancies were noted in documentation of CAN member benefits when comparing the CAN Member Handbook to Molina's website.

Member materials are developed in a manner to ensure they are easily understood and are available in alternate font sizes, languages, and formats as needed. Each health plan provides free translation and interpreter services to members.

Call Center assistance, hours of operation, and member support information is included in member and provider materials and on each CCO's website. Call Center personnel are trained to incorporate interactive scripts, which are reviewed annually. Targets for call center performance/call metrics are defined by DOM and analyzed by each CCO. Member Services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities.

Preventive health programs and resources are detailed in each CCO's policies, with information provided to members in the Member Handbooks, newsletters, mailings, the website, and telephone/text alerts. Health fairs, mobile/RV units, and other community events are coordinated to enhance member education.

Each CCO informs members of processes for enrollment and disenrollment and about circumstances under which they may request disenrollment or under which they may be involuntarily disenrolled. Members are instructed to contact DOM in writing or by telephone to request disenrollment and/or a change in health plan.

Grievance processes are described in policies for each health plan. Applicable terms are defined in Member Handbooks, Provider Manuals, and websites, along with associated timeframes for resolving or extending grievances. Constellation reviewed a random sample of grievance files for each CCO and found that all were acknowledged and resolved timely in accordance with policy and contractual guidelines. Grievances are logged and categorized by each health plan with trends reported internally each quarter to assess quality improvement opportunities.

As contractually required, the health plans conducted the Adult, Child, and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. Using the protocol developed by CMS *(Protocol 6: Administration or Validation of Quality of Care Surveys)*, Constellation validated the surveys to ensure that the results were reliable and valid. Validation results found all health plans met the overall validation criteria, demonstrating adherence to methodological standards and reliability in reporting. However, all plans reported survey response rates significantly below the National Committee for Quality Assurance (NCQA) target, which may introduce bias into the generalizability of the findings. Response rates across plans ranged from 9.2% to 16.1%, with most showing declines compared to the previous year, except for Molina CAN Adult. Child surveys secured the lowest response rates, with multiple plans reporting rates below 10%.

## Quality Improvement

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

The health plans are required by contract to establish and implement an ongoing comprehensive quality assessment and performance improvement program. Both the *CAN Contract* and *CHIP Contract* require the health plans to have a written description of the Quality Improvement (QI) Program that focuses on health outcomes and includes detailed objectives, program structure, accountabilities, details regarding the scope for the QI Program, and an annual program evaluation. To demonstrate compliance with this requirement, each health plan submitted their QI Program Descriptions. Molina and Magnolia's 2024 QI Program Descriptions were not updated to describe the health plans' responsibilities, if any, related to centralized credentialing that was implemented by DOM in 2022.

As required by contract, the health plans must make information about the QI Program and a report on meeting its goals available annually to its members and practitioners. Information

regarding the QI Programs was found in the Provider Manuals, Member Handbooks, and on the health plans' websites. United requires members to send in a written request for additional information regarding the QI Program.

A Quality Work Plan is used as part of each health plan's QI Program. The Work Plans identified the yearly planned activities, the individual(s) accountable for each task, specific start and completion dates, data collection methods and analysis, and included quarterly updates. Constellation received copies of the 2023 and 2024 QI Work Plans from each health plan and found all requirements were met.

A committee appointed by the health plans Board of Directors is responsible for overseeing the QI Program. Members of the QI committees included senior management staff, clinical staff, and network practitioners.

The health plans monitor and provide direct feedback regarding provider performance via profiling reports, gaps in care reports, and information shared during office visits. Early and Periodic Screening, Diagnosis, and Treatment services and Well-Baby, Well-Child, and Immunization services are tracked, and outreach and education are provided to inform eligible members and providers of the importance of preventive care and how to access services. Members who receive an abnormal finding during their screenings are identified, and the member is contacted regarding the need for follow-up.

At least annually, the health plans conduct an evaluation to assess various aspects of the QI Program, such as access to care, specialist appointment availability, medical records for providers, network adequacy, member satisfaction, prevention activities, quality improvement projects, and monitoring for disparities. Copies of the 2023 QI Program Evaluations were provided for review. Each QI Program Evaluation included the analysis, trends, changes in those trends, and any barriers impacting results. The findings are reported to the appropriate committees and the Board of Directors.

**Performance Measure Validation:** Constellation conducted a validation review of the HEDIS®, CMS Adult and CMS Child Core Set measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. For the validation process, Constellation applies the three activities for each CCO to support the auditing process per *42 CFR §438.330 (c)* and *§457.1240 (b)*. To evaluate the accuracy of the Performance Measures (PMs) reported, Constellation contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA Licensed Organization certified to conduct HEDIS Compliance audits, to conduct a validation review. PM 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. All relevant HEDIS PMs for the CAN and CHIP populations were compared for the current review year (MY 2023) to the previous year (MY 2022). The tables

that follow highlight the HEDIS and Adult and Child Core Set measures with substantial increases or decreases. Rates shown in green indicate a substantial improvement (>10%), and the rates shown in red indicate a substantial decline (>10%). All the rates reported by the CCOs, the statewide averages, and a comparison of the current rate (MY 2023) to the previous reported rate are included in the Quality Improvement section of this report.

**Table 1: CAN HEDIS Measures with Substantial Changes in Rates**

| Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates |
|---|---|---|---|
| Substantial Increase in Rate (>10% improvement) | | | |
| Adult BMI Assessment (ABA) | 62.05% | 55.60% | 66.11% |
| Appropriate Testing for Children with Pharyngitis (CWP) | | | |
| *Appropriate Testing for Pharyngitis (18-64)* | 73.55% | 75.05% | 73.14% |
| Statin Therapy for Patients with Cardiovascular Disease (SPC) | | | |
| *Statin Adherence 80% - 21-75 years (Male)* | 54.26% | 65.93% | 57.45% |
| *Statin Adherence 80% - 40-75 years (Female)* | 51.35% | 56.79% | 52.92% |
| *Statin Adherence 80% - Total* | 52.77% | 61.63% | 55.29% |
| Hemoglobin A1c Control for Patients With Diabetes (HBD) | | | |
| *Poor HbA1c Control* ∞ | 50.85% | 45.74% | 41.36% |
| *Adequate HbA1c Control* | 42.09% | 47.20% | 50.12% |
| Blood Pressure Control for Patients With Diabetes (BPD) | 61.07% | 62.04% | 58.39% |
| Statin Therapy for Patients with Diabetes (SPD) | | | |
| *Statin Adherence 80%* | 52.36% | 60.81% | 52.88% |
| Follow-Up Care for Children Prescribed ADHD Medication (ADD) ◊ | | | |
| *Initiation Phase* | 56.06% | 46.63% | 51.77% |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | | | |
| *6-17 years - 30-Day Follow-Up* | 64.64% | 55.13% | 61.21% |
| Initiation and Engagement of AOD Dependence Treatment (IET) | | | |
| *Total: Initiation of AOD Treatment: 13-17 Years* | 66.17% | 68.87% | 62.08% |
| Substantial Decrease in Rate (>10% decrease) | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | | | |
| *Counseling for Nutrition* | 44.28% | 47.45% | 32.36% |
| *Counseling for Physical Activity* | 45.50% | 44.04% | 30.41% |
| Kidney Health Evaluation for Patients With Diabetes (KED) | | | |
| *65-74 Years* | 18.60% | NA | NA |

| Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates |
|---|---|---|---|
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | | | |
| *18-64 years - 30-Day Follow-Up* | 37.26% | 37.23% | 38.08% |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) ◊ | | | |
| *30-Day Follow-Up: 13-17 Years* | 20.59% | NA | 16.13% |
| *7-Day Follow-Up: 13-17 Years* | 13.24% | NA | 6.45% |
| Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) | 76.79% | NA | 66.67% |
| Initiation and Engagement of AOD Dependence Treatment (IET) | | | |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years* | 65.96% | NA | 67.35% |

*NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*◊: The measure has a "Trend with Caution" guidance notes from NCQA for MY 2023.*

### Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

| Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates |
|---|---|---|
| Substantial Increase in Rate (>10% improvement) | | |
| Immunizations for Adolescents (IMA) | | |
| *Tdap/Td* | 89.54% | 82.97% |
| Appropriate Treatment for Upper Respiratory Infection (URI) | | |
| *18-64 Years* | 65.26% | 59.24% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | | |
| *1-11 Years* | NA | 57.14% |
| Substantial Decrease in Rate (>10% decrease) | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | | |
| *Counseling for Nutrition* | 41.36% | 36.98% |
| *Counseling for Physical Activity* | 41.85% | 33.58% |
| Asthma Medication Ratio (AMR) | | |
| *5-11 Years* | 75.53% | 89.09% |
| *Total* | 73.91% | 86.26% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | | |
| *12-17 Years* | 54.72% | 63.00% |

*NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*◊: The measure has a "Trend with Caution" guidance notes from NCQA for MY 2023.*

### Table 3: CAN Adult and Child Core Set Measure Rates with Substantial Changes in Rates

| Measure/Data Element | Magnolia MY 2023 CAN Rates | Molina MY 2023 CAN Rates | United MY 2023 CAN Rates |
|---|---|---|---|
| Substantial Increase in Rate (>10% improvement) | | | |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD) | | | |
| *Most or Moderately Effective Contraception – 90 days* | 51.64% | 59.46% | 54.29% |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) ∞ | | | |
| *Ages 40 - 64* | 57.01 | 41.63 | 63.35 |
| *Ages 65+* | 106.72 | 0.00 | 0.00 |
| *Total* | 57.43 | 41.55 | 63.03 |
| HEART FAILURE ADMISSION RATE (PQI-08) ∞ | | | |
| *Ages 65+* | 0.00 | 0.00 | 216.45 |
| HIV VIRAL LOAD SUPPRESSION (HVL - AD) | | | |
| *Ages 18 - 64* | 39.30% | 8.94% | 22.25% |
| USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD) | | | |
| *Overall* | 45.78% | 61.19% | 38.94% |
| *Prescription for Buprenorphine* | 40.25% | 56.16% | 37.55% |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH) | | | |
| *Most or Moderately Effective Contraception – 90 days* | 57.62% | 50.87% | 62.66% |
| Substantial Decrease in Rate (>10% decrease) | | | |
| HEART FAILURE ADMISSION RATE (PQI-08) ∞ | | | |
| *Ages 65+* | 0.00 | 0.00 | 216.45 |
| HIV VIRAL LOAD SUPPRESSION (HVL - AD) | | | |
| *Ages 18 - 64* | 39.30% | 8.94% | 22.25% |
| *Total* | 38.94% | 8.80% | 22.03% |

*∞: Lower rate indicates better performance*

### Table 4: CHIP Non-HEDIS Measures with Substantial Changes in Rates

| Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates |
|---|---|---|
| Substantial Increase in Rate (>10% improvement) | | |
| SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH) | | |
| *Numerator 1 At Least One Sealant* | 38.21% | 45.04% |
| Substantial Decrease in Rate (>10% decrease) | | |

| Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates |
|---|---|---|
| DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) ∞ | | |
| *Ages 18 - 64* | 67.53 | 0.00 |
| *Total* | 67.53 | 0.00 |

*∞: Lower rate indicates better performance*

**Performance Improvement Project Validation:** Each CCO is required to submit PIPs to Constellation for validation annually. Constellation validates and scores the submitted projects using the CMS protocol to evaluate the validity and confidence in the results of each project. For the 2024/2025 EQRs, the CCOs submitted 21 projects, which were validated. Validation results for each project are displayed in the tables that follow. Interventions and project performance over time are included in the Quality Improvement section of this report.

**Table 5: CAN Performance Improvement Projects Submitted for Validation**

| Project | Validation Score | Project Status |
|---|---|---|
| **Magnolia** | | |
| Reducing Preterm Births | 74/75=99% High Confidence in Reported Results | The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with hypertension/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. |
| Sickle Cell Disease Outcomes | 80/80=100% High Confidence in Reported Results | 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 who remain compliant with the medication during their treatment period. The baseline rate was 37.5%, decreasing to 30.5% 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. |
| Adult and Child Respiratory Disease | 80/80=100% High Confidence in Reported Results | The Adult and Child Respiratory PIP focuses on the percentage of members 12 to 18 years of age with persistent asthma and the spirometry test for members 40 and older with chronic obstructive pulmonary disease (COPD). This indicator uses the HEDIS measure, AMR. The AMR rate improved from 71.14% to 74.01%, and the spirometry test improved from 22.27% to 24.48%. |
| **Molina** | | |

| Project | Validation Score | Project Status |
|---|---|---|
| Asthma Medication Ratio | 80/80=100% High Confidence in Reported Results | The aim for the Asthma PIP is to increase the compliance rate of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The Asthma PIP focused on the AMR HEDIS rate for ages 5 to 64. Quarterly data showed an increase from 64.69% in Q4 2023 to 84.80% in Q1 2024, with a goal of 72.89%. |
| Pharmacotherapy Management of COPD Exacerbation | 80/80=100% High Confidence in Reported Results | The COPD PIP uses the systemic corticosteroid HEDIS measure and the bronchodilator HEDIS measure. For Q4 2023 to Q1 2024, there was an increase from 57.89% to 62.07% for the corticosteroid measure, with a goal of 53.43%, and a non-significant decline from 77.19% to 75.89% for the bronchodilators, with a goal of 81.8%. |
| Follow-up After Hospitalization for Mental Illness | 74/75=99% High Confidence in Reported Results | This PIP assesses 7- and 30- day follow up for members hospitalized for treatment of mental illness. For the 30-day follow-up, the rate reduced from 52.05% to 27.53%, with a goal of 50%. The 7-day rate declined from 31.10% to 19.66%, with a goal of 28.32%. |
| Prenatal and Postpartum Care | 74/75=99% High Confidence in Reported Results | This PIP examines the rate of deliveries that received prenatal care within the first trimester and postpartum care visits within 84 days of delivery. For prenatal visits, the rate increased from 87.03% to 89.36%, with a goal of 93.6%. For postpartum visits, the rate declined from 51.11% to 35.41%, with a goal of 74.30%. |
| Sickle Cell Disease | 74/75=99% High Confidence in Reported Results | This PIP focuses on the percentage of members with Sickle Cell Disease who are enrolled in case management. The rate declined from 9.47% to 8.25%, with a goal of 15.9%. |
| Obesity | 74/75=99% High Confidence in Reported Results | This PIP utilizes the BMI percentile documentation, counseling for nutrition, and counseling for physical activity HEDIS measures. For BMI percentile documentation, rates declined from 27.72% to 14.01%, with a goal of 61.31%. The counseling for nutrition declined 15.69% to 7.46%, with a goal of 52.31%. The counseling for physical activity measure declined 15.61% to 7.30%, with a goal of 57.42%. |
| **United** | | |
| Reducing 30-Day Psychiatric Inpatient Readmission Rates | 74/75=99% High Confidence in Reported Results | The Behavioral Health (BH) Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The readmission rate slightly increased from baseline 18% to 18.7% in 2022, and then, the final rate slightly increased to 18.8%. |
| Improving Pregnancy Outcomes | 94/95=99% | The goal of the Improved Pregnancy Outcomes PIP is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of |

| Project | Validation Score | Project Status |
|---|---|---|
| | High Confidence in Reported Results | enrollment. The DOM goal rate was 94.92% for the HEDIS Timeliness of Prenatal Care rate. The baseline rate was 92.21%, and the remeasurement number four rate was 92.94%, which was a decline from the previous year's hybrid rate of 96.84%. |
| Respiratory Illness Management | 74/75=99%<br>High Confidence in Reported Results | Respiratory Illness Management examines the appropriate medications (bronchodilators or systemic corticosteroids) for members with COPD exacerbation based on HEDIS measures, as well as the asthma medication ratio HEDIS measures. For bronchodilators, the baseline was 74.96%, increasing to 80.77% at remeasurement four in 2023, an increase from the 2022 rate of 78.40%. Corticosteroids improved from 42.24% at baseline to 46.15% in 2023, a decline from 50.76% in 2022. The AMR baseline was 70.7% and increased to 74.01% in 2023, a decline from 75.79% in 2022. |
| Sickle Cell Disease Management Decreasing ER Utilization | 80/80=100%<br>High Confidence in Reported Results | The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members 5 to 64 years of age who were identified as persistent super users of emergency room services for Sickle Cell Disease complications. The baseline rate of 36.28% declined to 24.78% in 2023. |

**Table 6: CHIP Performance Improvement Projects Submitted for Validation**

| Project | Validation Score | Project Status |
|---|---|---|
| **Molina** | | |
| Asthma Medication Ratio | 85/85=100%<br>High Confidence in Reported Results | The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. Quarterly rates show an improvement from 75.84% in Q4 2023 to 80.70% in Q1 2024, with the goal rate being 72.89%. The rate has been above the goal rate for several measurement periods. |
| Follow-up After Hospitalization for Mental Illness | 74/75=99%<br>High Confidence in Reported Results | The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate for 6- to 17-year-olds declined from 55% in Q4 2023 to 37.5% in Q1 2024, with a goal of 50%. For the 7-day rate, the rate declined from 32% in Q4 2023 to 25% in Q1 2024, with a goal of 28.32%. |
| Obesity | 74/75=99%<br>High Confidence in Reported Results | The Obesity PIP aims to increase the percentage of CHIP members who had an outpatient visit with their primary care provider (PCP) or OB/GYN that includes weight assessment counseling. The BMI documentation rate declined from 24.49% to 11.06%, with a goal of 61.31%. The nutrition counseling rate also declined from 16.23% to 6.40%, with a goal of 52.31%. Counseling for physical activity declined from 15.62% to 6.0%, with a goal of 57.42%. |

| Project | Validation Score | Project Status |
|---|---|---|
| Well Care/Well Child | 79/80= 99%<br>High Confidence in Reported Results | The aim for the Well Care/Well Child PIP is to increase the number of CHIP members who receive at least six or more well care/well child visits during the first 0 to 15 months of life. Rates were 69.03% in Q4 2023 and reduced to 63.16% in Q1 2024. The goal rate is 56.13% so the rate is still above the goal rate. |
| **United** | | |
| Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV) | 75/75=100%<br>High Confidence in Reported Results | The Adolescent Well Child Visits (AWC)/Child and Adolescent Well Care Visits (WCV) PIP goal is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year. The WCV showed the rate for 12- to 17-year-olds increased to 41.12% from 39.96% in 2022; the 18- to 21-year-old rate increased to 25.03% in 2023 from 24.93% in 2022 for the administrative rates. Hybrid rates were also presented for the total (12 to 21 years of age) for all measurement periods. |
| Follow Up After Hospitalization for Mental Illness | 74/75 = 99%<br>High Confidence in Reported Results | The goal for the Follow-Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7-day and 30-day follow-up visits. This PIP report showed that the 30-day follow up rate declined from 67.48% in 2022 to 63.21% in 2023, which represented a decline from the previous two years. The 7-day follow up rate declined from 41.1% in 2022 to 36.79% in 2023. |
| Reducing Adolescent and Childhood Obesity | 94/95=100%<br>Hight Confidence in Reported Results | The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: BMI percentile, counseling for nutrition, and counseling for physical activity. Rates were computed using hybrid methodology. BMI percentile documentation declined from 72.28% in 2022 and to 66.67% in 2023. Counseling on nutrition declined from 47.93% in 2022 to 36.98% in 2023. Counseling for physical activity declined from 48.66% in 2022 to 33.58% in 2023. |
| Getting Needed Care CAHPS | 94/95=100%<br>High Confidence in Reported Results | For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. The rate declined from 87%, with the final rate of 84.7%. Overall, the rate improved from the baseline rate of 80.92%. |

## Utilization Management

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

The health plans have developed Utilization Management (UM) Program Descriptions, related policies and procedures that define the structure and components of the UM Program and the lines of responsibility and accountability.

All three programs emphasize the importance of clinical oversight, timely decisions, and clear communication of determinations, with structured appeal processes in place. Appropriate clinical staff conduct reviews of service authorization requests using approved clinical guidelines. All three plans consistently met the standard for timeliness guidelines. Regular reviews ensure that guidelines are followed consistently, though minor issues, such as appeal instructions, were noted in United's CAN and CHIP files.

Each Mississippi health plan describes processes for filing and managing verbal and written member appeals in policies, member and provider materials, UM Program Descriptions, and their websites. Appeal terminology is defined, along with steps for filing by the member, a legal guardian, authorized representative, or service provider. Timeframes associated with standard and expedited appeals are clearly documented for appeal acknowledgment, resolution, and extension for each health plan.

Appeals are logged, categorized, and analyzed for trends and quality improvement opportunities. For the sample appeal files reviewed for the 2024 EQR, Magnolia and Molina CAN and CHIP files were addressed in a timely manner and reflected that appropriately credentialed reviewers made the appeal determinations. One United CAN resolution letter was addressed to the provider rather than the member, and two United CAN files were not resolved within the required timeframe.

The health plans offer Care Management, Disease Management, and Population Health Management programs in accordance with the requirements outlined in the CAN and CHIP contracts. Various resources are utilized to identify potential candidates for care management services. Once a member is referred, health plans deliver care management services tailored to the member's assessed needs and risk level. Additionally, each health plan provides care transition services, coordinated by an interdisciplinary team, to ensure smooth transitions for members between home and community settings. Specialized services are also offered to address the unique health needs of members and to promote their active engagement in their care. Care management sample files indicated that care management activities were conducted appropriately.

## Delegation

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

The delegation review includes the health plans policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. Constellation

requested a list of delegated entities, the services delegated, and a copy of the oversight monitoring.

The health plans conduct a pre-delegation review prior to the activation of a 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 all requirements. Performance is monitored through routine reporting, oversight meetings, and annual evaluations to ensure continued 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 pre-delegation audits, routine reporting, and annual monitoring were provided for all health plans except United. There was no documentation of the annual audits conducted by United.

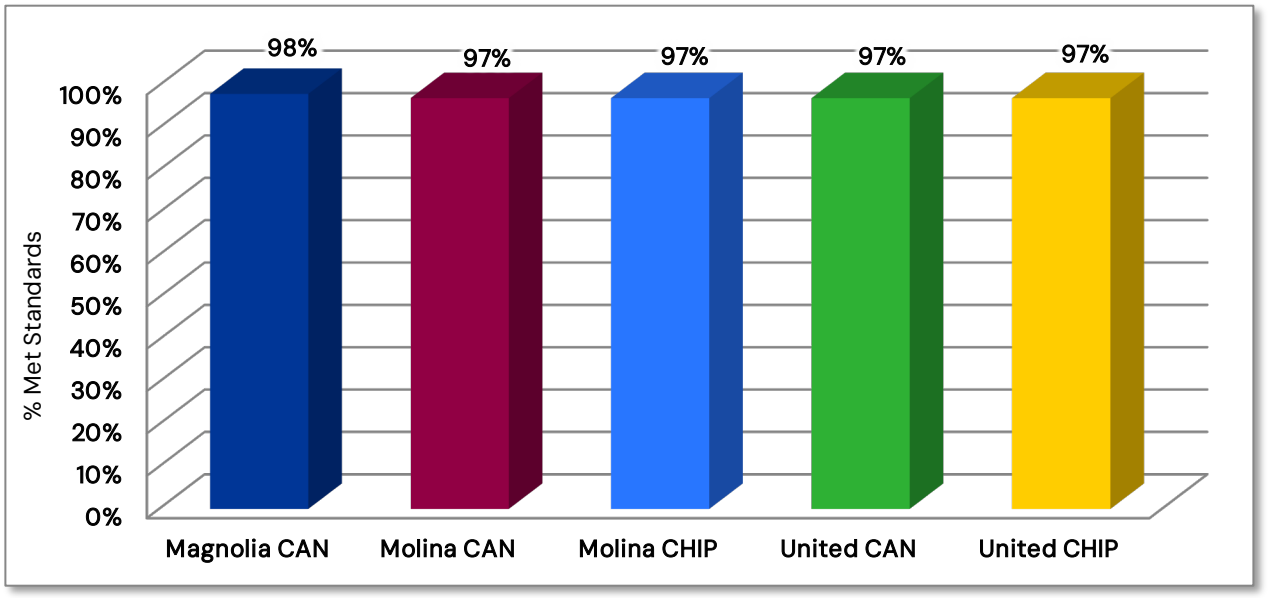
## Corrective Action Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. Technical assistance is provided to each health plan until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which each health plan implemented the actions to address deficiencies identified during the previous EQR. Findings of the EQRs confirmed all the health plans corrected the deficiencies identified during the previous EQRs. The complete CAP report for each health plan is included in *Attachment 1* of this report.

## Conclusions

For the 2024 EQRs, the CCOs met most of the requirements set forth in *42 CFR Part 438 Subpart D,* the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*, and the requirements of the *DOM Contracts*. The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2024 EQRs.

Figure 1: Percentage of Met Standards




*Scores were rounded to the nearest whole number.*

The following tables provide an overall snapshot of the CCOs' CAN and CHIP compliance scores specific to each of the Part 438 *Subpart D* and QAPI standards.

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

| Category | Magnolia CAN 2024 | Molina CAN 2024 | Molina CHIP 2024 | United CAN 2024 | United CHIP 2024 |
|---|---|---|---|---|---|
| Availability of Services *(§ 438.206, § 457.1230)* Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)* | 87% | 93% | 93% | 100% | 100% |
| Coordination and Continuity of Care *(§ 438.208, § 457.1230)* | 100% | 100% | 100% | 100% | 100% |
| Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* | 100% | 100% | 100% | 100% | 92% |
| Confidentiality *(§ 438.224)* | 100% | 100% | 100% | 100% | 100% |
| Grievance and Appeal Systems *(§ 438.228, § 457.1260)* | 100% | 100% | 100% | 100% | 100% |
| Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)* | 100% | 100% | 100% | 67% | 67% |
| Practice Guidelines *(§ 438.236, § 457.1233)* | 89% | 89% | 71% | 100% | 100% |
| Health Information Systems *(§ 438.242, § 457.1233)* | 100% | 100% | 100% | 100% | 100% |

| Category | Magnolia CAN 2024 | Molina CAN 2024 | Molina CHIP 2024 | United CAN 2024 | United CHIP 2024 |
|---|---|---|---|---|---|
| Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)* | 100% | 95% | 95% | 100% | 100% |
| Disenrollment Requirements and Limitations *(§ 438.56)* | 100% | 100% | 100% | 100% | 100% |
| Enrollee Rights Requirements *(§ 438.100)* | 100% | 100% | 100% | 100% | 100% |
| Emergency and Post Stabilization Service *(§ 438.114)* | 100% | 100% | 100% | 100% | 100% |

Score = 100% Score < 100%

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

## Overall Recommendations and Opportunities for Improvements

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 8: Evaluation of Quality, Timeliness, and Access to Care**

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| **Administration** | | | |
| Policies and procedures are developed to guide staff in day-to-day business operations, reviewed at least annually, and accessible to staff. | ✓ | | |
| Staffing is sufficient for CCO's to conduct required activities and provide all required services to members. | ✓ | | |
| Compliance Plans, FWA Plans, Codes of Conduct, and policies define expectations and processes for ensuring compliance with laws, regulations, and accreditation standards, processes for preventing, detecting, responding to alleged or suspected FWA, and expectations for appropriate business conduct. | ✓ | | |
| Employees are required to complete compliance training at employment and then annually. | ✓ | ✓ | |
| The health plans maintain open lines of communication and provide options for employees to ask compliance questions and to discuss or report concerns confidentially and anonymously. | ✓ | | |
| The health plans conduct internal auditing and monitoring activities to identify potential areas of risk and to maintain the integrity of health plan operations. | ✓ | | |
| All CCOs performed sufficient regular risk assessments and had appropriate disaster recovery processes to identify potential risks to infrastructure and to aid in implementation of preventative measures. | ✓ | | |

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| All CCOs have the capabilities to perform Medicaid claims and encounter data processing as required by DOM. | ✓ | | |
| **Provider Services** | | | |
| Policies and procedures define processes for initial provider orientation and education. | ✓ | | |
| The health plans conduct ongoing provider education activities through a variety of forums, including webinars, in-office provider meetings, e-blasts, workshops and conferences, newsletters, etc. | ✓ | | |
| The CCOs educate providers about medical record documentation standards and assess provider compliance with those standards through routine medical record audits. | ✓ | | |
| Each of the CCOs adopts preventive health and clinical practice guidelines to guide healthcare decision making and to improve member outcomes. | ✓ | | ✓ |
| The provider satisfaction surveys cover multiple critical areas (i.e., finance, utilization management, provider relations, pharmacy, and call center service), ensuring a well-rounded assessment of provider satisfaction. The surveys use a mixed-mode methodology for data collection, which increases the likelihood of higher response rates and diverse input from different provider demographics. | ✓ | | |
| The provider satisfaction survey collects provider demographics, years in practice, and insurance participation, which aids in targeted analysis and improvement efforts. | ✓ | | |
| Health plan systems refresh provider information daily or multiple times per week. | ✓ | | ✓ |
| Structured and automated data management systems help streamline provider enrollment, credentialing, and claims processing. | ✓ | | |
| Each health plan has established processes to notify providers when members are assigned to their panels and to monitor providers' panel statuses to ensure appropriate access for members. Providers can verify member enrollment in a variety of ways. | ✓ | | ✓ |
| All the health plans correctly document geographic access standards for PCPs, specialists, and other provider types in policies. | ✓ | | ✓ |
| Geographic access studies are conducted to determine the geographic adequacy of the health plans' networks, and provider compliance with appointment access standards is assessed through secret shopper call studies. | ✓ | | ✓ |
| Member satisfaction, complaint, and grievance data are considered when assessing network adequacy. | ✓ | | ✓ |
| The health plans take action to address any identified network gaps. | ✓ | | |
| Cultural competency programs are in place to ensure health plan networks can serve members with diverse cultural and language needs, accessibility considerations, and other special needs. | | | ✓ |
| Molina and United's online and printed Provider Directories include all required elements. | | | ✓ |
| **Member Services** | | | |
| Each CCO informs members of their rights and responsibilities in a variety of formats, including welcome information, member and provider materials, and websites. | ✓ | | ✓ |
| The sample grievance files reviewed reflected that all were acknowledged and resolved timely in accordance with policy and contractual guidelines. | ✓ | ✓ | |
| Members are informed of preventive health and disease management resources through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, health fairs, and other health promotion events. | | | ✓ |

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Member satisfaction surveys had a well-documented purpose, clear study objectives, and a defined audience, ensuring alignment with intended goals and stakeholders, which helps maintain focus and enhances the credibility of the findings. | ✓ | | |
| The member satisfaction survey instruments were rigorously tested for both validity and reliability, confirming that they accurately measure what is intended and produce consistent results over time. | ✓ | | |
| The member satisfaction surveys followed a structured analysis plan using appropriate statistical methods, and all conclusions were supported by the data. The final report provided a thorough overview of the survey's purpose, implementation, and key findings, enhancing transparency and usability for decision-making. | ✓ | | |
| **Quality Improvement** | | | |
| The QI Programs were structured and comprehensive with well-defined committees. | ✓ | | |
| Each QI Program covers a wide range of health care aspects, including physical, behavioral, and oral health, ensuring that members receive holistic and integrated care across the entire health care continuum. | ✓ | | |
| Utilization data from various sources is used for quality monitoring. | ✓ | | |
| The QI Programs place a strong emphasis on health equity, addressing health and care inequalities, and ensuring culturally and linguistically appropriate services. This is crucial for reducing disparities and improving health outcomes for diverse populations. | ✓ | | |
| The CCOs were fully compliant with all information systems standards and HEDIS determination standards for the CAN and CHIP HEDIS performance measures. | ✓ | | |
| Based on the validation of performance measure rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. | ✓ | | |
| The CCOs improved or remained consistent overall with MY 2023 rates. | ✓ | | |
| The performance improvement projects received scores within the high confidence in reported results range across all health plans, with most validation scores ranging between 99% and 100%. | ✓ | | |
| Comprehensive intervention strategies were implemented across multiple PIPs. Plans deployed outreach initiatives, provider education programs, case management services, and technology-driven interventions, such as telehealth campaigns, text reminders, and pharmacy outreach programs. | ✓ | | |
| **Utilization Management** | | | |
| The sample approval and denial files indicated reviews were completed in a timely manner according to contractual standards for all health plans. Criteria and procedures for the evaluation of medical necessity of services were applied consistently. | | ✓ | ✓ |
| Each Mississippi health plan describes processes for filing and managing verbal and written member appeals in policies, member and provider materials, UM Program Descriptions, and their websites. | ✓ | | ✓ |
| Timeframes associated with standard and expedited appeals are clearly documented for appeal acknowledgment, resolution, and extension for each health plan. | ✓ | | ✓ |
| For the sample of appeal files reviewed for the 2024 EQR, Magnolia and Molina CAN and CHIP files were addressed in a timely manner and reflected that appropriately credentialed reviewers made the appeal determinations. | | ✓ | |

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Each health plan has specialized programs to address members' specific needs and promote member engagement. | ✓ | | ✓ |
| **Delegation** | | | |
| The health plans' delegation oversight program includes a thorough pre-delegation review, ongoing monitoring, and annual evaluations to ensure that delegated entities meet standards and regulatory requirements. | ✓ | | ✓ |
| The Delegation Oversight Programs had a structured approach for identifying deficiencies and implementing corrective actions through a Corrective Action Plan. This proactive approach helps in addressing issues promptly and improving the performance of delegated entities. | ✓ | | |
| Each health plan mandates that all third-party entities enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights. | ✓ | | |

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| **Administration** | | | | |
| For Molina, issues were found related to the documentation of the Compliance Committee's name, meeting frequency, chairperson, and committee membership. | *Ensure health plan documentation reflects correct and consistent information about the Compliance Committee.* | ✓ | | |
| United's policy that defined the Pharmacy Lock-in Program processes and requirements was a corporate policy that did not include Mississippi-specific requirements and did not address the provision of a 72-hour emergency supply of medication. | *Ensure policies and procedures include information that is specific to Mississippi contractual requirements and processes.* | ✓ | | ✓ |
| **Provider Services** | | | | |
| Two of the three health plans do not address ongoing provider education processes in policy. | *Ensure health plan policies describe activities and processes for ongoing provider education.* | ✓ | | |
| Issues were noted in the Provider Manual documentation related to documentation of member benefit limitations (Magnolia), member self-referrals for behavioral health services (Molina), accessing the EPSDT schedule (United), medical record retention requirements (United), and the required non-exclusivity statement (Molina and United). | *Ensure Provider Manuals include complete and correct contractually required information.* | ✓ | | ✓ |
| Molina's documentation of the frequency of review of clinical practice and preventive health guidelines was inconsistent across documentation. | *Ensure documentation consistently and correctly defines the frequency of review for clinical practice and preventive health guidelines.* | ✓ | | |

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| Molina's CHIP website did not include all adopted clinical practice guidelines. Both Magnolia and Molina's websites included non-functional hyperlinks to some guidelines. | *Ensure health plan websites include all adopted guidelines and that hyperlinks to the guidelines are functional.* | ✓ | | ✓ |
| Despite the mixed-method approach for the provider satisfaction survey, the response rates remain low (7.7% overall), limiting the generalizability and statistical power of findings. | *Continued efforts should be made to gather a better representation of providers and increase education on the importance of the survey, particularly considering the low response rates, such as personalized outreach and education on the impact of the survey.* | ✓ | | |
| Health plans depend on providers to submit changes for contact details, panel status, and availability, which can lead to outdated information in provider directories and create challenges in maintaining accuracy for members. | *Continue routine audits to ensure accuracy in provider directories.* | ✓ | | ✓ |
| Provider phone numbers and office hours are not routinely validated, increasing the risk of inconsistencies in directories and administrative inefficiencies. | *Consider a centralized system to track providers and maintain updated contact information.* | ✓ | | ✓ |
| For Magnolia, the Envolve Dental Network Analysis dated October 1, 2024, used incorrect geographic access parameters for general/pediatric dentists and dental specialists. | *Ensure correct parameters are used to evaluate geographic access to network providers.* | ✓ | | ✓ |
| For Molina, incorrect documentation of the timeframe for post-discharge appointments with behavioral health/substance use disorder providers. | *Ensure policies and other documents list the correct appointment scheduling timeframes for all provider types.* | | ✓ | ✓ |
| Magnolia's printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers. | *Ensure Provider Directories include all required elements.* | ✓ | | ✓ |
| Magnolia and Molina policies and other documents continue to include references to credentialing and recredentialing activities, which have not been health plan responsibilities for more than two years. | *Remove references to health plan credentialing and recredentialing activities from all applicable documentation.* | ✓ | | |
| **Member Services** | | | | |
| For one health plan, discrepancies in documentation of member benefits were identified in the CAN and CHIP Member Handbooks and/or websites. | *Ensure Member Handbooks and health plan websites correctly and consistently document member benefits.* | | | ✓ |
| The member satisfaction surveys for each CCO had low response rates which may introduce bias in the generalizability of the findings, limiting the ability to draw fully representative conclusions. | *Continue efforts to increase survey participation by using multiple contact methods, such as mail, email, text reminders, and phone follow-ups, to engage members through their preferred* | ✓ | | |

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| | *communication channels. Educate members and communicate the importance and impact of the survey through personalized messaging that explains how member feedback leads to improvements in healthcare services.* | | | |
| **Quality Management** | | | | |
| United requires its members to submit in writing their request for information regarding the QI Program. | *Include information in the Member Handbook regarding the QI Program and provide a phone number for members to call instead of requiring them to submit a written request for additional information.* | ✓ | | |
| Some of the QI Program Descriptions contained incorrect information regarding the health plan's credentialing and recredentialing responsibilities. | *Update Program Descriptions and include the health plans' responsibilities related to DOM's centralized credentialing process.* | ✓ | | |
| 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. | *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 for Magnolia. The HEDIS Compliance Audit Final Audit Report also identified areas of improvement in reporting enrollment information. | *Improve processes for maintaining and reporting accurate enrollment counts for measure rate reporting.* | ✓ | | |
| While Molina seems to have experienced improvements in measure rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years. | *Improve processes for rate validation and trending to identify measure reporting concerns.* | ✓ | | |
| Several PIP performance measures did not show consistent improvement over time, with some indicators stagnating or declining despite continued interventions. | *Reassess interventions using data-driven evaluations to refine strategies and improve outcomes.* | ✓ | | |
| Low adherence rates were noted for certain chronic condition management PIP measures, particularly in asthma/COPD, obesity management, and sickle cell disease interventions. | *Enhance patient engagement with personalized outreach and targeted reminders and strengthen provider collaboration to improve health outcomes in PIPs.* | ✓ | | |
| **Utilization Management** | | | | |
| United's Provider Manual incorrectly listed Optum Rx as the Pharmacy Benefit Manager. | *Ensure all provider materials include correct information about the current Pharmacy Benefit Manager.* | ✓ | | ✓ |

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| United and Molina's CAN and CHIP Adverse Benefit Determination letters and UHC's policy incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. Also, an additional UHC policy and UHC's website included incorrect information stating that a written request is required when a verbal request is submitted. This is no longer a contractual requirement. | *Ensure adverse benefit determination notices, policies, and websites include correct information about appeal filing processes and requirements.* | | | ✓ |
| Molina's CAN and CHIP Member Handbooks do not address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. | *Ensure Member Handbooks address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf.* | | | ✓ |
| **Delegation** | | | | |
| There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation as required by the *DOM CAN Contract, Section 15* and *CHIP Contract, Section 14.* | *Conduct a formal annual audit of all subcontractors and include the results of this oversight monitoring in the Annual Quality Management Program Evaluation as required by the DOM CAN Contract, Section 15 and CHIP Contract, Section 14.* | ✓ | | |

## Assessment of DOM's Quality Strategy

The Division of Medicaid mandates that CCOs achieve NCQA accreditation, adhere to state-designated PIP topics, and comply with priority-based quality monitoring requirements. This reflects the State's commitment to enhanced oversight, accountability, and continuous quality improvement in managed care. Constellation recommends that DOM continue utilizing key assessment tools, including annual network adequacy reviews, HEDIS audits, and PIP validation to measure the success of its Quality Strategy in overseeing integrated physical and behavioral health services across health plans.

The 2024-2025 EQR results highlight health plan strengths, weaknesses, and recommendations, demonstrating the effectiveness of DOM's strategy in ensuring plan compliance, enhancing quality of care, and aligning healthcare goals with priority initiatives. The Quality Strategy establishes clear goals and standards that align with CMS priority areas, serving as a framework for system-wide improvements. Based on these objectives, Constellation has developed targeted recommendations to support CCOs in fulfilling the Quality Strategy's goals. These recommendations are detailed in *Table 9: DOM Quality Strategy Goals*.

Table 9: DOM Quality Strategy Goals

| DOM Quality Strategy Goal | Recommendation |
|---|---|
| Make Care Affordable | • Address avoidable emergency department utilization by improving timely follow-ups after hospital visits and ensuring better medication adherence for chronic conditions like asthma and sickle cell disease.<br>• Expand value-based payment models that encourage early prenatal care and preventive services to reduce high-cost hospital admissions. |
| Work with Communities to Promote Best Practices of Healthy Living | • Strengthen community-based education on asthma, obesity, and sickle cell disease as PIPs show low adherence rates to recommended treatments despite outreach efforts.<br>• Expand population-specific education initiatives, such as school-based asthma programs and outreach campaigns for obesity prevention. |
| Promote Effective Prevention & Treatment of Chronic Disease | • Improve medication adherence for chronic conditions like sickle cell disease, asthma, and COPD through targeted case management, pharmacy-led education, and refill reminders.<br>• Increase postpartum and prenatal care engagement by reinforcing provider education and automating appointment reminders for high-risk patients. |
| Make Care Safer by Reducing Harm in the Delivery of Care | • Reduce medication non-adherence and treatment delays by implementing pharmacist-led outreach, text reminders for refills, and provider education.<br>• Improve maternal health outcomes by strengthening early prenatal enrollment efforts and postpartum follow-ups, as PIPs show that preterm birth rates have increased despite interventions. |
| Strengthen Person & Family Engagement as Partners in Care | • Increase follow-up rates for mental health and maternity patients by expanding case management efforts and direct patient outreach, as several PIPs reported lower-than-expected post-hospitalization follow-up rates.<br>• Implement more proactive outreach strategies, such as text and call reminders, incentives for preventive care, and educational materials tailored to high-risk populations. |
| Promote Effective Communication & Coordination of Care | • Improve provider collaboration and case management services, particularly in chronic disease and mental health follow-ups, where interventions have not consistently improved adherence.<br>• Ensure data-driven decision-making by analyzing utilization trends and PIP performance metrics to refine intervention strategies based on what has been most effective. |

## Optional EQR Activities

DOM requested that Constellation conduct a Behavioral Health Member Satisfaction Survey for each of the CCOs.

### Behavioral Health Member Satisfaction Survey

Constellation contracted with DataStat, Inc., an NCQA Certified CAHPS Survey Vendor, to conduct an Experience of Care and Behavioral Health Outcomes (ECHO) Survey, developed by the Agency for Healthcare Research and Quality (AHRQ), to learn about the experiences of adult and child members who have received counseling or treatment from a provider. The survey addresses key topics such as access to counseling and treatment, provider communication, plan information, and overall rating of counseling and treatment received. For MississippiCAN, attempts were made to survey 2,250 adult enrollee households and 2,250 child enrollee households. For CHIP, attempts were made to survey 1,500 enrollee households. The surveys for both MississippiCAN and CHIP were conducted by mail from October 31, 2024, through February 20, 2025, using a standardized survey procedure and questionnaire. See *Attachment 2* for a summary of the 2024 Behavioral Health Member Satisfaction Surveys.

## BACKGROUND

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

In addition to the mandatory activities, Constellation conducts a behavioral health member satisfaction survey.

After completing the annual review of the required EQR activities for each health plan, Constellation submits a detailed technical report to DOM and the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addressed the corrective actions from the previous year's review, if applicable. Constellation prepares an annual comprehensive technical report for the State, which is a compilation of the individual annual review findings. The comprehensive technical report for contract year 2024 through 2025 contains data regarding results of the EQRs conducted for the CAN and CHIP Programs for United and Molina and the CAN Program for Magnolia.

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

## METHODOLOGY

The process Constellation uses for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and virtual onsite visits for plan. The following table displays the dates of the EQRs conducted for each health plan.

**Table 10: External Quality Review Dates**

| Health Plan | Annual EQR Initiated | Onsite Conducted | Report Submitted to DOM |
|---|---|---|---|
| Magnolia Health Plan CAN | 6/3/24 | 10/9/24 – 10/10/24 | 12/12/24 |
| Molina Healthcare CAN<br>Molina Healthcare CHIP | 6/3/24 | 11/6/24 – 11/7/24 | 11/25/24 |

| Health Plan | Annual EQR Initiated | Onsite Conducted | Report Submitted to DOM |
|---|---|---|---|
| UnitedHealthcare CAN<br>UnitedHealthcare CHIP | 6/3/24 | 9/4/24 – 9/5/24 | 10/15/24 |

After completing each annual review, Constellation submits a detailed technical report to DOM and the health plan (covered in the preceding section titled, Background). For a health plan not meeting requirements, Constellation requires the plan to submit a Corrective Action Plan for each standard identified as not fully met. Constellation provides technical assistance to each health plan until all deficiencies are corrected. Following the initial acceptance of the CAP items, quarterly CAP reviews are completed to evaluate whether the health plan has fully implemented the corrective action items.

## FINDINGS

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

### A. Administration

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

The review of the Administration section focuses on policy development, review, and management; CCO staffing; information management systems and processes; compliance; program integrity; and confidentiality.

The CCOs develop and implement policies and procedures to guide staff and ensure compliance with laws, regulations, and contractual requirements. All policies and procedures are reviewed at least annually and updated as needed. Policies and procedures are housed in policy management platforms, intranet sites, and/or SharePoint sites for staff access, and staff are educated in various ways about new and revised policies.

The review of the Organizational Charts and onsite discussions indicated overall staffing is sufficient to ensure that all required services are provided to members. Magnolia had one staff position in recruitment. Molina's Chief Financial Officer position was vacant, but the Regional Chief Financial Officer assumed those duties while recruiting a replacement, and a Medical Director position was vacant but in recruitment. For United, the Chief Executive Officer position was filled on an interim basis by a regional Chief Executive Officer.

Each CCO has written Compliance Plans and Fraud, Waste, and Abuse (FWA) Plans which address processes for ensuring compliance with laws, regulations, and contractual requirements, and for preventing, detecting, and responding to FWA. Magnolia and United have developed state-specific addenda to corporate FWA Plans. In addition, policies and procedures provide detailed information to guide staff about compliance and FWA. Written Codes of Conduct are in place to provide staff with information and expectations for appropriate and ethical business conduct.

Each CCO has a Compliance Committee which assists in developing and implementing the CCOs' Compliance Programs. Committee charters describe the purpose, objectives, membership, functions, responsibilities, etc. of the committees. For Molina, issues were found related to the documentation of the committee's name, meeting frequency, chairperson, and membership. However, Molina staff explained that two previous Compliance Committees, the Compliance Committee of the Board of Directors and the Management Level Compliance Committee, were recently consolidated. All the CCOs' committees meet quarterly.

The CCOs require employees to complete Compliance Program training, which includes training about FWA and appropriate business conduct, at the time of employment and then annually. The health plans also require members of the Board of Directors, subcontractors, vendors, and/or suppliers to complete the Compliance Training annually. Employees are educated about the potential consequences of inappropriate business conduct and FWA activities. The health plans maintain open lines of communication and provide various avenues for employees and others to ask compliance questions and to discuss or report concerns confidentially and anonymously. In addition to direct reporting to managers, health plan leadership, etc., staff may report compliance issues and FWA through telephonic hotlines, online reporting systems, etc. The health plans prohibit intimidation and retaliation against those who make reports of suspected misconduct and FWA.

The health plans conduct internal auditing and monitoring activities to identify potential areas of risk and to maintain the integrity of health plan operations. These activities include annual risk assessments, monitoring of Compliance Program implementation and reporting, periodic compliance audits, desk audits, etc.

Each of the health plans has a Pharmacy Lock-in Program to assist members who have a pattern of abuse of the pharmacy benefits. Members in the program are restricted to one pharmacy for all pharmacy benefits. For Magnolia and Molina, there were no issues identified with this program. For United, the policy defining the program's processes and requirements was a corporate policy that did not include Mississippi-specific requirements and did not address the provision of a 72-hour emergency supply of medication, as required by the *CAN Contract, Section 11 (F) (3)*.

Policies, program descriptions, training programs, Compliance Plans, Codes of Conduct, etc. address the expectation that staff maintain the security and confidentiality of protected health information.

### Information Systems Capabilities Assessment

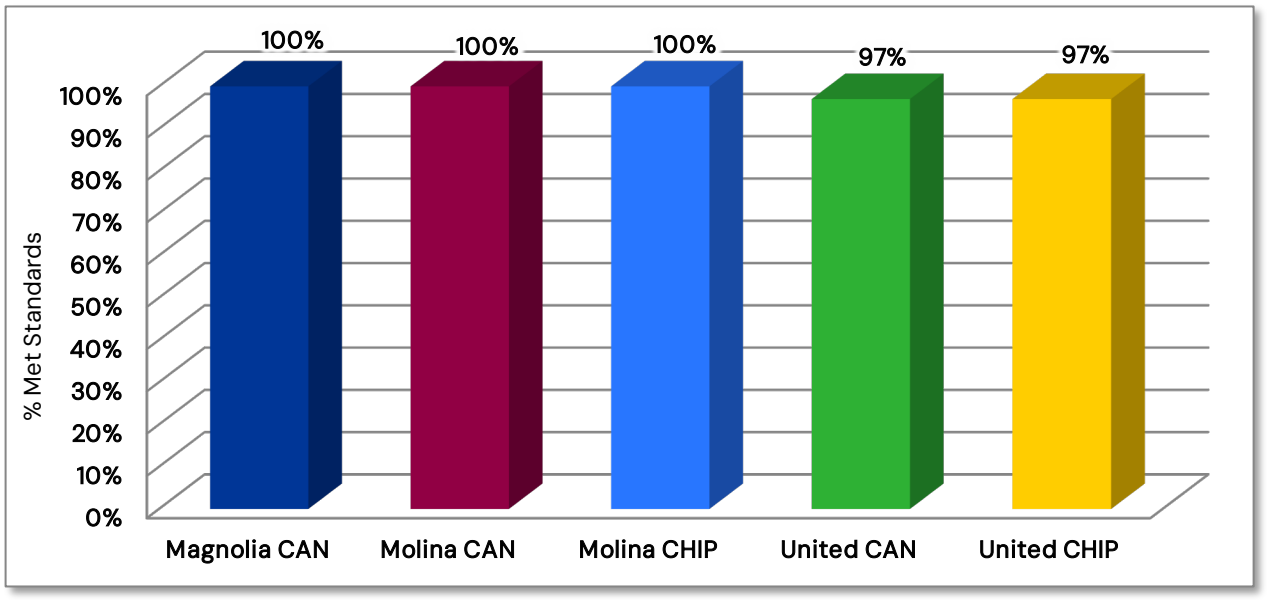
*42 CFR § 438.242, 42 CFR § 457.1233 (d)*

Review and assessment of each CCO's Information Systems Capabilities Assessment documentation and related policies and procedures indicated each organization's information systems infrastructure was capable of meeting contractual requirements. It was noted that all CCOs met or exceeded timelines required by the State specific to clean claims. The 2024 EQRs found that systems and processes are appropriately maintained and updated in accordance with policies that prioritize data security and system resilience. Disaster Recovery plans are tested and updated annually to identify risks and protect system data.

The reviews of the Administration section for each of the health plans confirmed that the CCOs appropriately addressed and implemented the Corrective Action Plans to address all Administration deficiencies identified in the 2023 EQRs. Refer to *Attachment 1* for full details of the previous findings and the CCOs' responses to the findings.

*Figure 2: Administration Findings* displays the percentage of "Met" scores for each health plan for the Administration section.

Figure 2: Administration Findings




*Scores were rounded to the nearest whole number.*

*Tables 11* and *12* display the strengths, weaknesses, and recommendations for the Administration section.

Table 11: Administration Strengths

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Policies and procedures are developed to guide staff in day-to-day business operations, are reviewed at least annually, and accessible to staff. | ✓ | | |
| Staffing is sufficient for CCOs to conduct the required activities and provide all the required services to members. | ✓ | | |
| Compliance Plans, FWA Plans, Codes of Conduct, and policies define expectations and processes for ensuring compliance with laws, regulations, and accreditation standards, processes for preventing, detecting, responding to alleged or suspected FWA, and expectations for appropriate business conduct. | ✓ | | |
| Employees are required to complete compliance training at employment and then annually. | ✓ | ✓ | |
| The health plans maintain open lines of communication and provide options for employees to ask compliance questions and to discuss or report concerns confidentially and anonymously. | ✓ | | |
| The health plans conduct internal auditing and monitoring activities to identify potential areas of risk and to maintain the integrity of health plan operations. | ✓ | | |
| All CCOs performed sufficient regular risk assessments and had appropriate disaster recovery processes to identify potential risks to infrastructure and to aid in implementation of preventative measures. | ✓ | | |

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| All CCOs have the capabilities to perform Medicaid claims and encounter data processing as required by DOM. | ✓ | | |

**Table 12: Administration Weaknesses and Recommendations**

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| For Molina, issues were found related to the documentation of the Compliance Committee's name, meeting frequency, chairperson, and committee membership. | *Ensure health plan documentation reflects correct and consistent information about the Compliance Committee.* | ✓ | | |
| United's policy that defined the Pharmacy Lock-in Program processes and requirements was a corporate policy that did not include Mississippi-specific requirements and did not address the provision of a 72-hour emergency supply of medication. | *Ensure policies and procedures include information that is specific to Mississippi contractual requirements and processes.* | ✓ | | ✓ |

An overview of the scores for the Administration section is illustrated in *Table 13: Administration Comparative Data*.

**Table 13: Administration Comparative Data**

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| General Approach to Policies and Procedures | | | | | |
| The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly | Met | Met | Met | Met | Met |
| Organizational Chart / Staffing | | | | | |
| The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:<br>Chief Executive Officer | Met | Met | Met | Met | Met |
| Chief Operating Officer | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Chief Financial Officer | Met | Met | Met | Met | Met |
| Chief Information Officer | Met | Met | Met | Met | Met |
| Information Systems personnel | Met | Met | Met | Met | Met |
| Claims Administrator | Met | Met | Met | Met | Met |
| Provider Services Manager | Met | Met | Met | Met | Met |
| Provider contracting and education | Met | Met | Met | Met | Met |
| Member Services Manager | Met | Met | Met | Met | Met |
| Member services and education | Met | Met | Met | Met | Met |
| CAN: Complaint/Grievance Coordinator<br>CHIP: Grievance and Appeals Coordinator | Met | Met | Met | Met | Met |
| Utilization Management Coordinator | Met | Met | Met | Met | Met |
| Medical/Care Management Staff | Met | Met | Met | Met | Met |
| Quality Management Director | Met | Met | Met | Met | Met |
| CAN: Marketing, member communication, and/or public relations staff<br>CHIP: Marketing and/or Public Relations | Met | Met | Met | Met | Met |
| Medical Director | Met | Met | Met | Met | Met |
| Compliance Officer | Met | Met | Met | Met | Met |
| Operational relationships of CCO staff are clearly delineated | Met | Met | Met | Met | Met |
| Information Management Systems<br>*42 CFR § 438.242, 42 CFR § 457.1233 (d)* | | | | | |
| The CCO processes provider claims in an accurate and timely fashion | Met | Met | Met | Met | Met |
| The CCO tracks enrollment and demographic data and links it to the provider base | Met | Met | Met | Met | Met |
| The CCO information management system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities | Met | Met | Met | Met | Met |
| The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented | Met | Met | Met | Met | Met |
| Compliance/Program Integrity | | | | | |
| The CCO has a Compliance Plan to guard against fraud, waste and abuse | Met | Met | Met | Met | Met |
| The Compliance Plan and/or policies and procedures address requirements | Met | Met | Met | Met | Met |
| The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities | Met | Met | Met ↑ | Met ↑ | Met ↑ |
| The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The CCO's policies and procedures define how investigations of all reported incidents are conducted | Met | Met | Met | Met | Met |
| The CCO has processes in place for provider payment suspensions and recoupments of overpayments | Met | Met | Met | Met | Met |
| The CCO implements and maintains a Pharmacy Lock-In Program | Met | Met | Met ↑ | Partially Met ↓ | Partially Met ↓ |
| Confidentiality *42 CFR § 438.224* | | | | | |
| The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy | Met | Met | Met | Met | Met |

## B. Provider Services

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

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

### Provider Education

*42 CFR § 438.414, 42 CFR § 457.1260*

Each health plan has policies that describe processes for initial provider orientation and education, which includes information the providers need to understand health plan processes and requirements so that they may function effectively within the CCO's network. Provider orientation is conducted within 30 days of the execution of a new provider contract or the date the provider becomes active in the network. Provider Manuals and health plan websites reinforce the orientation and are comprehensive resources for providers. Issues were noted in the Provider Manual documentation related to documentation of:

- Member benefit limitations (Magnolia)
- Member self-referrals for behavioral health services (Molina)
- Accessing the EPSDT schedule (United)
- Medical record retention requirements (United)
- The required non-exclusivity statement (Molina and United)

The CCOs conduct ongoing provider education to update providers about program changes and additions, process changes, member benefits, etc. It was noted that Magnolia and United do not address ongoing provider education and updates in any policy.

The CCOs educate providers about medical record documentation requirements and evaluate provider compliance with the standards through medical record audits. The health plans re-educate and/or implement corrective action plans with providers who do not achieve the threshold score on the initial audit and reaudit the providers to gauge any improvement. Additional actions may be taken for continued deficiencies.

### Practice Guidelines

*§ 438.236, § 457.1233*

United, Magnolia, and Molina adopt evidence-based clinical practice and preventive health guidelines that are specific to membership demographics and health care needs. The CCOs educate providers about the guidelines through provider orientation, on CCO websites, Provider Manuals, newsletters, special mailings, and faxes. Providers may access the guidelines on the CCOs' websites, and the CCOs make printed copies available upon request. Molina staff confirmed that the adopted guidelines are identical for CAN and CHIP, but discrepancies were noted in the guidelines listed on the CAN and CHIP websites. Magnolia and Molina's websites included hyperlinks to access individual guidelines that were non-functional, resulted in error messages, required the reader to create an account and log in to access the information, and/or required membership with the entity to access the information. The health plans review the adopted guidelines at least annually. However, for Molina, numerous discrepancies were noted in the frequency of guideline review when comparing applicable policies, the CAN and CHIP Provider Manuals, and the Quality Improvement Program Description.

### Provider Satisfaction Survey Validation

Constellation conducted validation reviews of the CCOs' provider satisfaction surveys using the protocol developed by the CMS titled, "*Protocol 6: Administration or Validation of Quality of Care Surveys.*" The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol includes seven activities:

1. Review survey purpose(s), objective(s), and intended use.
2. Assess the reliability and validity of the survey instrument.
3. Review the sampling plan.
4. Assess the adequacy of the response rate.
5. Review survey implementation.
6. Review survey data analysis and findings/conclusions.
7. Document evaluation of the survey.

It was noted that each response rate was low. The low response rates may not reflect the population of each of the CCOs' network providers. Constellation recommended the CCOs continue their efforts to gather a better representation of providers and increase education on the importance of the survey. The table below offers the results of the Provider Satisfaction Survey validations for each of the CCOs.

**Table 14: Provider Satisfaction Survey Validation Results**

| Section | Reason | Recommendation |
|---|---|---|
| Do the survey findings have any limitations or problems with generalization of the results? | **Magnolia CAN:** 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. | Continued efforts should be made to gather a better representation of the providers and increase education on the importance of the survey. |
| | **Molina CAN and CHIP:** Of the 1,500 providers in the random sample, the response rate was 7.7%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. | |
| | **United CAN and CHIP:** Of the 2,524 sampled providers, only 30 responded, creating a response rate of 1.1%, which is a very slight increase over last year's rate of 1.0%. This is a very low response rate and may not reflect the population of providers | |

## 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 the CCOs' provider networks following the CMS protocol titled, *"Protocol 4: Validation of Network Adequacy."* This protocol validates the health plans' provider networks to determine if the CCOs are meeting network standards defined by the State. To conduct this validation, Constellation requested and reviewed the following for each CCO:

- 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, and 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.
- Sample of a provider contract.

Desk reviews of these documents were conducted to assess network adequacy. An overview of the results for each activity conducted to assess network adequacy is found below.

### *Provider Network File Questionnaire*

The purpose of this Provider Network File Questionnaire (PNFQ) is to learn more about each CCO's methods for classifying, storing, and updating provider enrollment data. Constellation reviewed the information submitted by each health plan to determine if adequate procedures and processes are in place to maintain an accurate provider file directory. A summary of the findings is displayed in *Table 15*.

**Table 15: Overview of Provider Network File Questionnaire Findings**

| Domain | Magnolia CAN | Molina CAN and CHIP | United CAN and CHIP |
|---|---|---|---|
| Data Management System | Magnolia uses CenProv as its provider enrollment system, with provider data submitted through rosters, single-case enrollments, and changes. | Molina uses QNXT as its primary provider data management system, with updates processed daily based on provider requests and credentialing information from Gainwell. The Provider Data Management team undergoes three weeks of training to ensure proper handling of enrollment data. | United uses Network Database and CSP Facets as its primary provider enrollment systems, with provider data updated daily from the MississippiCAN Provider Enrollment File. Data is maintained within United's systems and updated through SQL and SSIS processes, ensuring compliance with state requirements. |
| Data Verification | Provider data verification follows workflow documents for updates to taxonomy codes, credentialing, and provider status, with changes completed within a 10-day turnaround time. | Provider updates, including taxonomy codes, credentialing status, and contact details, are verified before entry into QNXT, with credentialing data cross-checked against daily updates from Gainwell. Changes are processed on an ad hoc basis through a Provider Update Form, and panel capacity is set at 2,500 members per provider. | Provider data verification relies on the Mississippi daily PEF file for credentialing and active/inactive status, while other updates, such as taxonomy codes and provider contact information, are managed through the provider portal. Providers can modify their panel capacity through multiple channels, including written requests, the United provider portal, or My Practice Profile, with a |

| Domain | Magnolia CAN | Molina CAN and CHIP | United CAN and CHIP |
|---|---|---|---|
| | | | default maximum panel size of 2,000 members. |
| Updates to Provider Directories | The Find-A-Provider online directory is updated every 24 hours through an automated interface with Portico. | The Provider Directory updates nightly based on QNXT data. | The Provider Directory is updated bi-weekly for paper directories and five times a week for the online directory, with certain provider information reflecting changes within six hours. Directory updates are automated based on system changes. |
| Geographic Access Reporting | Geographic access reporting is conducted quarterly using Quest Analytics for PCPs, Behavioral Health providers, and OB/GYNs. | Geographic access reporting is conducted quarterly using Quest Analytics for PCPs, Behavioral Health providers, and OB/GYNs. | Geographic access reporting is conducted quarterly using Quest Analytics for PCPs, Behavioral Health providers, and OB/GYNs. |

### *Availability of Services*

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

All the health plans correctly document geographic access standards for PCPs, specialists, and other provider types in policies. The CCOs generate quarterly geographic access reports to evaluate the geographic adequacy of their networks. Magnolia's Geo Access Mapping reflected the use of incorrect parameters to assess geographic access for dental providers. The CCOs also consider other factors related to geographic access, such as member satisfaction survey results, complaints, grievances, and out of network requests, when determining network adequacy. Processes are in place to address any identified geographic access gaps.

Both Magnolia and United appropriately document appointment access standards for all provider types. For Molina, incorrect behavioral health/substance use disorder appointment access standards were noted in several documents. Additionally, Molina's policy incorrectly states the goal for provider compliance with standards for post-discharge behavioral health appointments. The health plans educate providers about appointment access standards and assess provider compliance through routine call studies. For Magnolia, the 2023 Quality Management Program Evaluation included the call study results but reflected that incorrect appointment access standards were used for most provider appointment types. Magnolia reported that the documentation was erroneous and that the correct parameters were used for the actual appointment access survey. Additionally, the 2023 Quality Management Program

Evaluation referenced a 2023 after-hours telephonic survey but did not include the results of this activity. The CCOs also evaluate appointment scheduling compliance by monitoring member satisfaction survey results and member complaints/grievances.

Both the online and printed Provider Directories for Molina and United included all required elements. Magnolia's online Provider Directory included all required elements; however, the printed (PDF) Provider Directory did not include the group affiliation for individual providers as contractually required. The CCOs validate Provider Directory information through a variety of activities, including vendor audits of provider information, health plan audits and quality reviews, provider outreach activities, in-person provider meetings, etc. Of note, Magnolia reported they are developing a website enhancement that will allow providers to update their panel sizes/limitations, physical and billing address, etc.

To ensure their provider networks can meet the needs of members with hearing or vision impairment, foreign language or cultural requirements, complex medical needs, and accessibility considerations, the CCOs routinely assess member/practitioner race, ethnicity, and languages, monitor member satisfaction with the network, conduct disparity assessments, produce cultural competency plans, and include cultural competency resources on plan websites.

### *Provider Access Study and Provider Directory Validation*

In addition to the activities documented above, Constellation conducted and considered the results of Telephone Access Studies and Provider Directory Validations for each CCO to determine if provider contact information was accurate and assess appointment availability. The methodology involved two phases:

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

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

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

**Magnolia CAN Summary:** The overall successful contact rate for Q1 2025 was 55%. This represents an increase from the successful contact rate of 32% in Q3 2024. However, the successful contact rate remains below the goal rate of 95%. The routine appointment compliance rate was 60%, and the urgent appointment compliance rate was 45%. From Q3 2024 to Q1 2025, the routine appointment availability rate declined, but the urgent

appointment availability rate improved. The Provider Directory Validation showed an accuracy rate of 62% (a 10% decline from the previous study rate of 72%).

**Molina CAN and CHIP Summary:** For Molina, the successful contact rates for Q4 2024 were 27% for CAN and 24% for CHIP. The successful contact rates for CY 2024 Q2 were 52% for CAN and 34% for CHIP. The CAN Program showed a 25% decrease in the successful contact rate, and the CHIP Program showed a 10% decrease in the successful contact rate. Both programs remain below the goal rate of 95% for successful contacts. For CAN in Q4 2024, the routine appointment compliance rate was 65%, and the urgent appointment compliance rate was 30%. For CHIP, the routine appointment compliance rate was 19%, and the urgent appointment compliance rate was 0%. For CAN, the routine and urgent appointment compliance rates improved from the previous study, but for CHIP, the routine and urgent appointment compliance rates declined from the previous study. The Provider Directory Validation for CAN showed an accuracy rate of 48%, a 41% decline from the previous study's rate of 89%. For CHIP, the Provider Directory Validation showed an accuracy rate of 74%, a 12% improvement from the previous study rate of 62%. The successful contacts declined for CAN and CHIP. Provider directory accuracy rates declined for Molina CAN but improved for CHIP.

**United CAN and CHIP Summary:** The successful contact rates for Q1 2025 were 52% for CAN and 51% for CHIP. The overall successful contact rates for Q3 2024 were 46% for CAN and 39% for CHIP. The CAN Program showed a 6% improvement in the successful contact rate, and the CHIP Program showed a 12% improvement in the successful contact rate. Both programs, however, remain below the goal rate of 95% for successful contacts.

For CAN Q1 2025, the routine appointment compliance rate was 51%, which was a decline from the previous study's rate of 84%, and the urgent appointment compliance rate was 24%, which was also a decline from the previous rate of 32%. For CHIP, the routine appointment compliance rate declined to 68% from 74% in the previous study, and the urgent appointment compliance rate improved to 21% from 15% in the previous study.

The Provider Directory Validation for CAN showed an accuracy rate of 72% (a 31% improvement from the previous study's rate of 41%). For CHIP, the Provider Directory Validation showed an accuracy rate of 48% (an 11% increase from the previous rate of 37%).

*Table 16* provides an overview of the findings of the most recent studies.

**Table 16: Overview of Call Study/Provider Directory Findings**

| | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Successful Contact Rates | 55% (53 of 96) | 27% (27 of 100) | 24% (23 of 96) | 52% (46 of 93) | 51% (46 of 90) |

| | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Provider Directory Accuracy Rates | 62% (33 of 53) | 48% (13 of 27) | 74% (17 of 23) | 72% (33 of 46) | 46% (21 of 46) |
| Routine Appointment Availability | 60% (28 of 47) | 65% (13 of 20) | 19% (3 of 16) | 51% (19 of 37) | 68% (26 of 38) |
| Urgent Appointment Availability | 45% (21 of 47) | 30% (6 of 20) | 0% (0 of 16) | 24% (9 of 37) | 21% (8 of 38) |

Overall, the results of the most recent Provider Access and Provider Directory Validation studies demonstrated the following trends (as illustrated in *Table 17*):

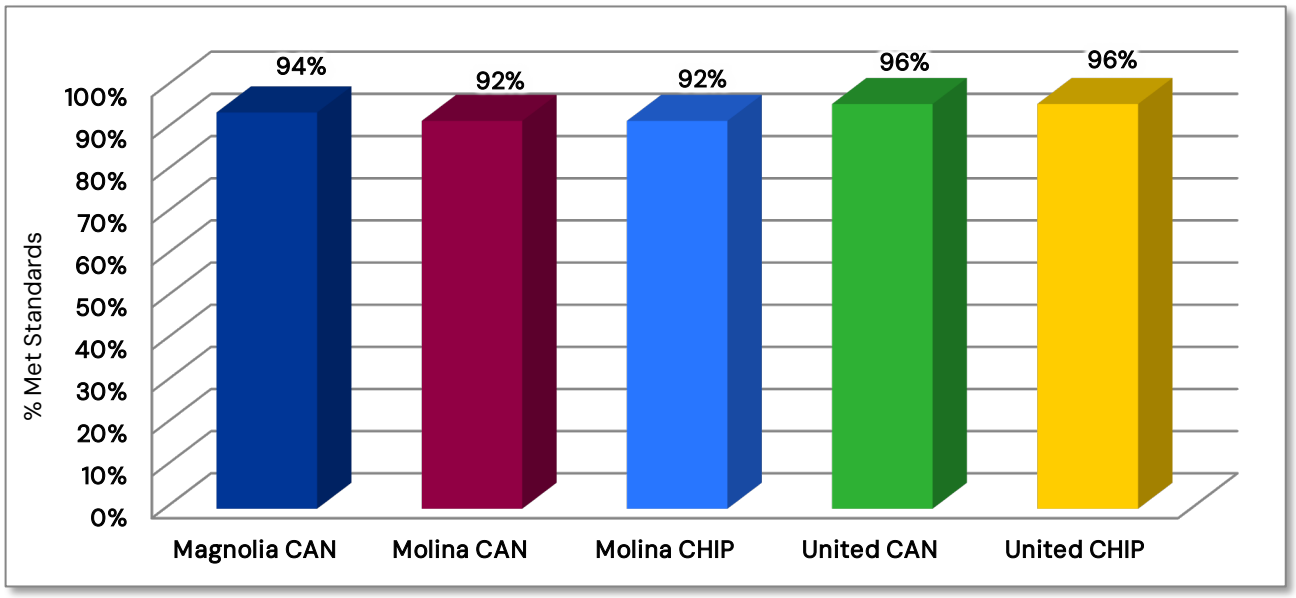
- Successful Contact Rates improved for Magnolia CAN, United CAN, and United CHIP, but declined for Molina CAN and Molina CHIP.
- Provider Directory Validation Accuracy improved for Molina CHIP, United CAN, and United CHIP, but declined for Magnolia CAN and Molina CAN.
- Routine Appointment Availability improved for Molina CAN but declined for Magnolia CAN, Molina CHIP, United CAN, and United CHIP.
- Urgent Appointment Availability improved for Magnolia CAN, Molina CAN, and United CHIP, but declined for Molina CHIP and United CAN.

**Table 17: Overview of Trends in Outcomes Current Compared to Previous Study**

| | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Successful Contact Rates | 55% ↑ | 27% ↓ | 24% ↓ | 52% ↑ | 51% ↑ |
| Provider Directory Accuracy Rates | 62% ↓ | 48% ↓ | 74% ↑ | 72% ↑ | 46% ↑ |
| Routine Appointment Availability | 60% ↓ | 65% ↑ | 19% ↓ | 51% ↓ | 68% ↓ |
| Urgent Appointment Availability | 45% ↑ | 30% ↑ | 0% ↓ | 24% ↓ | 21% ↑ |

*Figure 3: Provider Services Findings* displays the percentage of "Met" scores for each health plan for the Provider Services section.

Figure 3: Provider Services Findings




*Scores were rounded to the nearest whole number.*

*Tables 18* and *19* display the strengths, weaknesses, and recommendations for the Provider Services section.

Table 18: Provider Services Strengths

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Policies and procedures define processes for initial provider orientation and education. | ✓ | | |
| The health plans conduct ongoing provider education activities through a variety of forums, including webinars, in-office provider meetings, e-blasts, workshops and conferences, newsletters, etc. | ✓ | | |
| The CCOs educate providers about medical record documentation standards and assess provider compliance with those standards through routine medical record audits. | ✓ | | |
| Each of the CCOs adopts preventive health and clinical practice guidelines to guide healthcare decision making and to improve member outcomes. | ✓ | | ✓ |
| The provider satisfaction surveys cover multiple critical areas (i.e., finance, utilization management, provider relations, pharmacy, and call center service), ensuring a well-rounded assessment of provider satisfaction. The surveys use a mixed-mode methodology for data collection, which increases the likelihood of higher response rates and diverse input from different provider demographics. | ✓ | | |
| The provider satisfaction survey collects provider demographics, years in practice, and insurance participation, which aids in targeted analysis and improvement efforts. | ✓ | | |
| Health plan systems refresh provider information daily or multiple times per week | ✓ | | ✓ |

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Structured and automated data management systems help streamline provider enrollment, credentialing, and claims processing. | ✓ | | |
| Each health plan has established processes to notify providers when members are assigned to their panels and to monitor providers' panel statuses to ensure appropriate access for members. Providers can verify member enrollment in a variety of ways. | ✓ | | ✓ |
| All the health plans correctly document geographic access standards for primary care providers, specialists, and other provider types in policies. | ✓ | | ✓ |
| Geographic access studies are conducted to determine the geographic adequacy of the health plans' networks, and provider compliance with appointment access standards is assessed through secret shopper call studies. | ✓ | | ✓ |
| Member satisfaction, complaint, and grievance data are considered when assessing network adequacy. | ✓ | | ✓ |
| The health plans take action to address any identified network gaps. | ✓ | | |
| Cultural competency programs are in place to ensure health plan networks can serve members with diverse cultural and language needs, accessibility considerations, and other special needs. | | | ✓ |
| Molina and United's online and printed Provider Directories include all required elements. | | | ✓ |

**Table 19: Provider Services Weaknesses and Recommendations**

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| Two of the three health plans do not address ongoing provider education processes in policy. | *Ensure health plan policies describe activities and processes for ongoing provider education.* | ✓ | | |
| Issues were noted in the Provider Manual documentation related to documentation of member benefit limitations (Magnolia), member self-referrals for behavioral health services (Molina), accessing the EPSDT schedule (United), medical record retention requirements (United), and the required non-exclusivity statement (Molina and United). | *Ensure Provider Manuals include complete and correct contractually required information.* | ✓ | | ✓ |
| Molina's documentation of the frequency of review of clinical practice and preventive health guidelines was inconsistent across documentation. | *Ensure documentation consistently and correctly defines the frequency of review for clinical practice and preventive health guidelines.* | ✓ | | |

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| Molina's CHIP website did not include all adopted clinical practice guidelines. Both Magnolia and Molina's websites included non-functional hyperlinks to some guidelines. | *Ensure health plan websites include all adopted guidelines and that hyperlinks to the guidelines are functional.* | ✓ | | ✓ |
| Despite the mixed-method approach for the provider satisfaction survey, the response rates remain low (7.7% overall), limiting the generalizability and statistical power of findings. | *Continued efforts should be made to gather a better representation of providers and increase education on the importance of the survey, particularly considering the low response rates, such as personalized outreach and education on the impact of the survey.* | ✓ | | |
| Health plans depend on providers to submit changes for contact details, panel status, and availability, which can lead to outdated information in provider directories and create challenges in maintaining accuracy for members. | *Continue routine audits to ensure accuracy in provider directories.* | ✓ | | ✓ |
| Provider phone numbers and office hours are not routinely validated, increasing the risk of inconsistencies in directories and administrative inefficiencies. | *Consider a centralized system to track providers and maintain updated contact information.* | ✓ | | ✓ |
| For Magnolia, the Envolve Dental Network Analysis dated October 1, 2024, used incorrect geographic access parameters for general/pediatric dentists and dental specialists. | *Ensure correct parameters are used to evaluate geographic access to network providers.* | ✓ | | ✓ |
| For Molina, documentation of the timeframe for post-discharge appointments with behavioral health/substance use disorder providers was incorrect. | *Ensure policies and other documents list the correct appointment scheduling timeframes for all provider types.* | | ✓ | ✓ |
| Magnolia's printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers. | *Ensure Provider Directories include all required elements.* | ✓ | | ✓ |
| Magnolia and Molina policies and other documents continue to include references to credentialing and recredentialing activities, which have not been health plan responsibilities for more than two years. | *Remove references to health plan credentialing and recredentialing activities from all applicable documentation.* | ✓ | | |

*Table 20: Provider Services Comparative Data* displays the CCOs' scores for the standards reviewed during the 2024 EQRs.

**Table 20: Comparative Data Provider Services**

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Adequacy of the Provider Network<br>*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)* | | | | | |
| The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:<br>The CCO has policies and procedures for notifying primary care providers of the members assigned | Met | Met | Met | Met | Met |
| The CCO has policies and procedures to ensure out-of-network providers can verify enrollment | Met | Met | Met | Met | Met |
| The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients | Met | Met | Met | Met | Met |
| Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties | Met | Met | Met | Met | Met |
| Members have access to specialty consultation from network providers located within the contract specified geographic access standards | Partially Met ↓ | Met | Met ↑ | Met | Met |
| The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly | Met | Met | Met | Met | Met |
| Providers are available who can serve members with special needs, foreign language/cultural requirements, complex medical needs, and accessibility considerations | Met | Met | Met | Met | Met |
| The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand | Met | Met | Met | Met | Met |
| The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy | Met | Met | Met | Met | Met |
| The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues | Met | Met | Met | Met | Met |
| The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements | Met | Partially Met ↓ | Partially Met | Met ↑ | Met ↑ |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards | Met | Met | Met | Met ↑ | Met ↑ |
| The CCO regularly maintains and makes available a Provider Directory that that includes all required elements | Partially Met ↓ | Met | Met | Met | Met |
| The CCO conducts appropriate activities to validate Provider Directory information | Met | Met | Met | Met | Met |
| The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "*Validation of Network Adequacy*" | Met | Met | Met | Met | Met |
| Provider Education<br>*42 CFR § 438.414, 42 CFR § 457.1260* | | | | | |
| The CCO formulates and acts within policies and procedures related to initial education of providers | Met | Met | Met | Met | Met |
| Initial provider education includes:<br>A description of the Care Management system and protocols | Met | Met | Met | Met | Met |
| Billing and reimbursement practices | Met | Met | Met | Met | Met |
| CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM<br>CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums | Met | Met | Met | Met ↑ | Met ↑ |
| Procedure for referral to a specialist including standing referrals and specialists as PCPs | Met | Partially Met ↓ | Partially Met ↓ | Met | Met |
| Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments | Met | Met | Met | Met | Met |
| CAN: Recommended standards of care including EPSDT screening requirements and services<br>CHIP: Recommended standards of care including Well-Baby and Well-Child screenings and services | Met | Met | Met | Met | Met |
| CAN: Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services<br>CHIP: Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Medical record handling, availability, retention, and confidentiality | Met ↑ | Met | Met | Partially Met ↓ | Partially Met ↓ |
| Provider and member complaint, grievance, and appeal procedures including provider disputes | Met | Met | Met | Met | Met |
| Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete | Met | Met | Met | Met | Met |
| Prior authorization requirements including the definition of medically necessary | Met | Met | Met | Met | Met |
| A description of the role of a PCP and the reassignment of a member to another PCP | Met ↑ | Met ↑ | Met | Met | Met |
| The process for communicating the provider's limitations on panel size to the CCO | Met | Met | Met | Met | Met |
| Medical record documentation requirements | Met | Met | Met | Met | Met |
| Information regarding available translation services and how to access those services | Met | Met | Met | Met | Met |
| Provider performance expectations including quality and utilization management criteria and processes | Met | Met | Met | Met | Met |
| A description of the provider web portal | Met | Met | Met | Met | Met |
| A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business | Met | Not Met ↓ | Met | Not Met ↓ | Not Met ↓ |
| The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures | Met | Met | Met | Met | Met |
| Preventive Health and Clinical Practice Guidelines<br>*42 CFR § 438.236, 42 CFR § 457.1233(a)* | | | | | |
| 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 | Met | Partially Met ↓ | Partially Met ↓ | Met | Met |
| The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members | Partially Met ↓ | Met | Partially Met ↓ | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The preventive health guidelines include, at a minimum, the following if relevant to member demographics:<br>CAN: Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services<br>CHIP: Pediatric and Adolescent preventive care with a focus on Well-Baby and Well-Child services | Met | Met | Met | Met | Met |
| Recommended childhood immunizations | Met | Met | Met | Met | Met |
| Pregnancy care | Met | Met | Met | Met | Met |
| Adult screening recommendations at specified intervals | Met | Met | N/A | Met | N/A |
| Elderly screening recommendations at specified intervals | Met | Met | N/A | Met | N/A |
| Recommendations specific to member high-risk groups | Met | Met | Met | Met | Met |
| Behavioral health | Met | Met | Met | Met | Met |
| Practitioner Medical Records | | | | | |
| The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians | Met | Met | Met | Met | Met |
| The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers | Met | Met | Met | Met | Met |
| Provider Satisfaction Survey | | | | | |
| A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol | Met | Met | Met | Met | Met |
| The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems | Met | Met | Met | Met | Met |
| The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified | Met | Met | Met | Met | Met |

*Standards marked as N/A are not applicable for Mississippi CHIP reviews.*

## C. Member Services

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

The Member Services review covers member rights and responsibilities, member education, call center activities, enrollment and disenrollment, the member satisfaction survey, grievances, and requests for practitioner changes.

### Member Rights and Responsibilities

*42 CFR § 438.100, 42 CFR § 457.1220*

Members are informed of their rights and responsibilities in policies, Member Handbooks, welcome packets, and the CCOs' websites. Additional educational and outreach methods include newsletters and various mailings throughout the year. Magnolia describes member rights and responsibilities in Policy MS.MBRS.25, Member Rights and Responsibilities. Molina documents member rights and responsibilities in Policy MHMS-ME-003, Member Rights and Responsibilities. United provides information about member rights and responsibilities in new member materials and the CAN and CHIP Member Handbooks. The Provider Manual details member rights and responsibilities, which may be viewed on the website.

### Member CCO Program Education

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

Education about health plan processes, covered benefits, applicable copays, programs, and services is provided to members in new member packets, Member Handbooks, newsletters, websites, etc. Written notification is provided to members regarding changes in benefits and services 30 days prior to the effective date. For Molina, discrepancies were noted in documentation of CAN member benefits when comparing the CAN Member Handbook to Molina's website. Those discrepancies were related to vision services, genetic testing, and non-emergency transportation. There were also discrepancies noted when comparing the CHIP Member Handbook and Molina's website. Those discrepancies included prior authorization requirements for ambulatory surgery, covered services for substance abuse, coverage for disease management, emergency transportation services, and prior authorization for radiology services.

Member materials are developed in a manner to ensure they are easily understood and are available in alternate font sizes, languages, and formats as needed. Each health plan provides free translation and interpreter services to members. Members may request a copy of the Member Handbook and Provider Directory annually.

Call Center assistance, hours of operation, and member support information is included in member and provider materials and each CCO website. Call Center personnel are trained to incorporate interactive scripts which are reviewed annually. Targets for call center

performance/call metrics are defined by DOM and analyzed by each CCO. Member Services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities.

### Preventive Health and Chronic Disease Management Education

Information about preventive health programs and resources is provided in policy, the Member Handbooks, newsletters, mailings, the website, and telephone/text alerts. Health fairs, mobile/RV units, and other community events are coordinated to enhance member education. Molina trains Contact Center staff to inform members about available resources and recommended services. United also educates members about population health activities and recommendations through member newsletters, mailings, automated and live calls, e-mails, text messages, and events such as health fairs and other health promotion events. Members that are engaged with care managers are informed of services offered through the program in which they are enrolled.

### Member Enrollment and Disenrollment

*42 CFR § 438.56*

Each CCO informs members of processes for enrollment and disenrollment and about circumstances under which they may request disenrollment or under which they may be involuntarily disenrolled. Members are instructed to contact DOM in writing or by telephone to request disenrollment and/or a change in health plan. Magnolia's policy MS.ELIG.05, Disenrollment, describes the steps and points of contact for disenrollment and details timeframes for members to request disenrollment, with members directing these requests to DOM. Policy MHI-EA-309.1, Disenrollment Processes, details the steps taken by Molina's Enrollment Department to manage member disenrollment requests.

### Grievances

*42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR P 457.1260*

Grievance processes are outlined in policies for each health plan. Applicable terms are defined in Member Handbooks, Provider Manuals, and websites, along with associated timeframes for resolving or extending grievances. Magnolia's grievance management processes are outlined in Policy MS.MBRS.07, Member Grievance and Complaints. Molina provides information about filing and processing verbal and written grievances in Policy MHMS-MRT-01, Member Complaints and Grievances. Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, includes details of United's grievance processes.

A sample of each CCO's grievance files was reviewed and findings showed all grievances were acknowledged and resolved timely in accordance with policy and contractual

guidelines. Grievances are logged and categorized by each health plan with trends reported internally each quarter to assess quality improvement opportunities.

## Member Satisfaction Survey Validation

As contractually required, the health plans conducted the Adult, Child, and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Using the protocol developed by CMS, *Protocol 6: Administration or Validation of Quality of Care Surveys*, Constellation validated to ensure that the results of the surveys were reliable and valid. The results found all health plans met the overall validation criteria, demonstrating adherence to methodological standards and reliability in reporting. However, all plans reported survey response rates significantly below the NCQA target, which may introduce bias into the generalizability of the findings. Response rates across plans ranged from 9.2% to 16.1%, with most showing declines compared to the previous year, except for Molina CAN Adult. The lowest response rates were seen in child surveys, with multiple plans reporting rates below 10%.

*Table 21: Member Satisfaction Survey Validation Results* provides information about the areas that need improvement along with related recommendations.

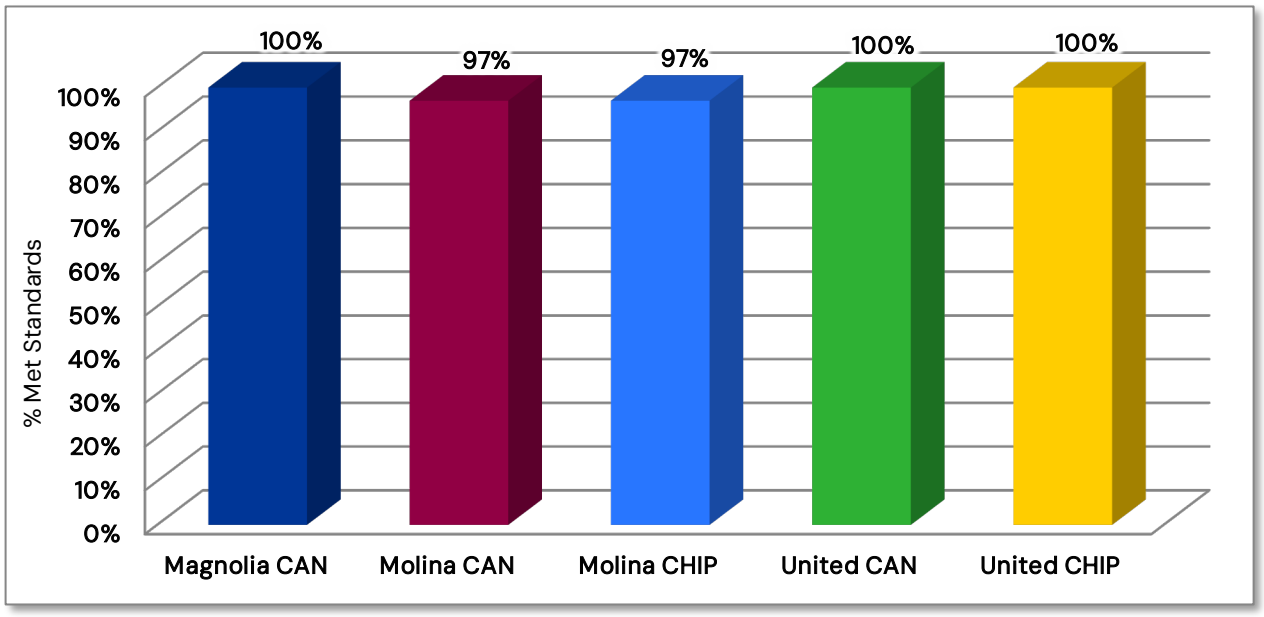
**Table 21: Member Satisfaction Survey Validation Results**

| Section | CAHPS Survey Version | Reason | Recommendation |
|---|---|---|---|
| **Magnolia** | | | |
| Do the survey findings have any limitations or problems with generalization of the results? | 5.1 H MY 2023 Adult | The response rate was 16.1%, which is lower than last year's rate of 19.4%. Additionally, this response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey. |
| | 5.1 H MY 2023 Child | The 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 and may introduce bias into the generalizability of the findings. | |
| | 5.1 H MY 2023 Child CCC | The 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 and may introduce bias into the generalizability of the findings. | |
| **Molina CAN** | | | |
| Do the survey findings have any limitations or | 5.1 H MY 2022 Adult | The response rate was 13.0%, which is an improvement over the previous year's response rate of 10.8%. This response rate, | Continue efforts to increase survey participation by using |

| Section | CAHPS Survey Version | Reason | Recommendation |
|---|---|---|---|
| problems with generalization of the results? | | however, is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | multiple contact methods. Educate members and communicate the importance and impact of the survey. |
| | 5.1 H MY 2022 Child | The response rate was 9.2%. This response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | |
| **Molina CHIP** | | | |
| Do the survey findings have any limitations or problems with generalization of the results? | 5.1 H MY 2022 Child | The response rate was 11.2%, which is a slight decline from the previous year's rate of 11.9%. This response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey. |
| **United CAN** | | | |
| Do the survey findings have any limitations or problems with generalization of the results? | 5.1 H MY 2023 Adult | The response rate was 14.7%, which is a decline from the previous year's rate of 16.1%. Additionally, this response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey. |
| | 5.1 H MY 2023 Child CCC | response rate was 10.2%, which is a slight decline from the previous year's rate of 10.8%. Additionally, this response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | |
| **United CHIP** | | | |
| Do the survey findings have any limitations or problems with generalization of the results? | 5.1 H MY 2023 Child CCC | The response rate was 12%, which is a decline from the previous year's rate. Additionally, this response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. | Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey. |

*Figure 4: Member Services Findings* displays the percentage of "Met" scores for each health plan for the Member Services section.

Figure 4: Member Services Findings




*Scores were rounded to the nearest whole number*

Strengths, weaknesses, and recommendations for the Member Services section of the review are found in *Table 22* and *Table 23*.

Table 22: Member Services Strengths

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Each CCO informs members of their rights and responsibilities in a variety of formats, including welcome information, member and provider materials, and websites. | ✓ | | |
| The review of sample grievance files for each CCO found that all were acknowledged and resolved timely in accordance with policy and contractual guidelines. | | ✓ | |
| Members are informed of preventive health and disease management resources through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, health fairs, and other health promotion events. | | | ✓ |
| Member satisfaction surveys had a well-documented purpose, clear study objectives, and a defined audience, ensuring alignment with their intended goals and stakeholders, which clarity helps maintain focus and enhances the credibility of the findings. | ✓ | | |
| The member satisfaction survey instruments were rigorously tested for both validity and reliability, confirming that they accurately measure what is intended and produce consistent results over time. | ✓ | | |
| The member satisfaction surveys followed a structured analysis plan using appropriate statistical methods, and all conclusions were supported by the data. The final report provided a thorough overview of the survey's purpose, implementation, and key findings, enhancing transparency and usability for decision-making. | ✓ | | |

**Table 23: Member Services Weaknesses and Recommendations**

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| For one health plan, discrepancies in documentation of member benefits were identified in the CAN and CHIP Member Handbooks and/or health plan websites. | *Ensure Member Handbooks and health plan websites correctly and consistently document member benefits.* | | | ✓ |
| The member satisfaction surveys for each CCO had low response rates which may introduce bias in the generalizability of the findings, limiting the ability to draw fully representative conclusions. | *Continue efforts to increase survey participation by using multiple contact methods, such as mail, email, text reminders, and phone follow-ups, to engage members through their preferred communication channels. Educate members and communicate the importance and impact of the survey through personalized messaging that explains how member feedback leads to improvements in healthcare services.* | ✓ | | |

An overview of the scores for the Member Services section is illustrated in *Table 24: Member Services Comparative Data*.

**Table 24: Member Services Comparative Data**

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Member Rights and Responsibilities<br>*42 CFR § 438.100, 42 CFR § 457.1220* | | | | | |
| The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities | Met | Met | Met | Met | Met |
| All member rights included | Met | Met | Met | Met | Met |
| All member responsibilities included | Met | Met | Met | Met ↑ | Met ↑ |
| Member CCO Program Education<br>*42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)* | | | | | |
| Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled | Met | Partially Met ↓ | Partially Met ↓ | Met ↑ | Met ↑ |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network | Met | Met | Met | Met ↑ | Met ↑ |
| Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract | Met | Met | Met | Met | Met |
| The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages | Met | Met | Met | Met | Met |
| Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed | Met | Met | Met | Met | Met |
| CAN: Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members | Met | Met | N/A | Met | N/A |
| Call Center | | | | | |
| The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals | Met | Met | Met | Met ↑ | Met ↑ |
| Call Center scripts are in-place and staff receive training as required by the contract | Met | Met | Met | Met | Met |
| Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee | Met | Met | Met | Met | Met |
| Member Enrollment and Disenrollment<br>*42 CFR § 438.56* | | | | | |
| The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed | Met | Met | Met | Met | Met |
| Member disenrollment is conducted in a manner consistent with contract requirements | Met | Met | Met | Met | Met |
| Preventive Health and Chronic Disease Management Education | | | | | |
| The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits | Met | Met | Met | Met | Met |
| The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| participation of pregnant members in recommended care, including participation in the WIC program | | | | | |
| CAN: The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits<br>CHIP: The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits | Met | Met | Met | Met | Met |
| The CCO provides educational opportunities to members regarding health risk factors and wellness promotion | Met | Met | Met | Met | Met |
| Member Satisfaction Survey | | | | | |
| The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol | Met | Met | Met | Met | Met |
| The CCO analyzes data obtained from the member satisfaction survey to identify quality problems | Met | Met | Met | Met | Met |
| The CCO reports results of the member satisfaction survey to providers | Met | Met | Met | Met | Met |
| 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 | Met | Met | Met | Met | Met |
| Grievances<br>*42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | | |
| The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: | Met | Met | Met | Met | Met |
| Definition of a grievance and who may file a grievance | Met | Met | Met | Met | Met |
| The procedure for filing and handling a grievance | Met | Met | Met | Met | Met |
| Timeliness guidelines for resolution of grievances as specified in the contract | Met | Met | Met | Met | Met |
| Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process | Met | Met | Met | Met | Met |
| Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The CCO applies the grievance policy and procedure as formulated | Met | Met | Met | Met ↑ | Met ↑ |
| Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee | Met | Met | Met | Met | Met |
| Grievances are managed in accordance with CCO confidentiality policies and procedures | Met | Met | Met | Met | Met |
| Practitioner Changes | | | | | |
| The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction | Met | Met | Met | Met | Met |
| Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee | Met | Met | Met | Met | Met |

## D. Quality Improvement

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

The health plans are required by contract to establish and implement an ongoing comprehensive quality assessment and performance improvement program. Both the *CAN Contract* and *CHIP Contract* require the health plans to have a written description of the Quality Improvement (QI) Program that focuses on health outcomes and includes detailed objectives, program structure and scope, accountabilities, and an annual Program Evaluation. To demonstrate compliance with this requirement, each health plan submitted their QI Program Descriptions. Molina and Magnolia's 2024 QI Program Descriptions were not updated to describe the health plans' responsibilities, if any, related to centralized credentialing, which was implemented by DOM in 2022. Molina's QI Program Descriptions incorrectly indicated that the health plan maintains a comprehensive and detailed credentialing and recredentialing program.

As required by contract, the health plans must make available information about the QI Program and a report on meeting its goal annually to its members and practitioners. Information regarding the QI Programs was found in the Provider Manuals, Member Handbooks and on the health plans websites. United requires a member to send their request for additional information regarding the QI Program in writing.

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

Constellation received copies of the 2023 and 2024 QI Work Plans from each health plan and found all requirements were met.

Responsibility for the QI Programs is overseen by a committee appointed by the Board of Directors for each health plan. United's Quality Management Committee (QMC) is responsible for the implementation, coordination, and integration of all activities; providing program direction; and reviewing and approving various QI Program documents. The QMC is chaired by the Chief Medical Officer (CMO). The Provider Advisory Committee evaluates and reviews clinical indicators, guidelines, quality of care complaints, appeals, grievances, inpatient quality issues, provider satisfaction survey results, and compliance with regulatory requirements. United's CMO also chairs this committee and network providers specializing in obstetrics/gynecology, internal medicine, psychiatry, dentistry, pediatrics, and family medicine are included as voting members.

Molina has established the Quality Improvement and Health Equity Transformation Committee that is responsible for the implementation and ongoing examination of the QI Program. Through subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes, and evaluates the progress and results of all QI activities, institutes needed action, and ensures follow up. This committee is co-chaired by the CMO and the Quality Lead, with members from various leadership roles within the health plan. This committee also includes external network physicians specializing in pediatrics, internal medicine, and psychiatry.

Magnolia's Board of Directors delegated the operating authority of the QI Program to the Quality Improvement Committee. This committee serves as the umbrella committee for the organization. Committee members include senior management staff, clinical staff, and network practitioners. Network providers specializing in pediatrics, family medicine, and psychiatry act as voting members of Magnolia's Quality Improvement Committee.

The health plans monitor and provide direct feedback regarding provider performance via profiling reports, gaps in care reports, and information shared during office visits. Early and Periodic Screening, Diagnosis, and Treatment services and Well-Baby, Well-Child, and Immunization services are tracked, and outreach and education are provided to inform eligible members and providers of the importance of preventive care and how to access services. Members who receive abnormal findings during their screenings are identified, and the members are contacted regarding the need for follow-up.

At least annually, the health plans conduct an evaluation to assess various aspects of the QI Program such as access to care, specialist appointment availability, medical records for providers, network adequacy, member satisfaction, prevention activities, quality improvement projects, and disparities monitoring. Copies of the 2023 QI Program Evaluations were provided for review. Each Program Evaluation included the analysis, trends, changes in those trends, and

any barriers impacting the results. The findings are reported to the appropriate committees and the Board of Directors.

## Performance Measure Validation

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

Constellation conducted a validation review of the Healthcare Effectiveness Data Informational Set (HEDIS®), CMS Adult and CMS Child Core Set measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. Constellation contracts with Aqurate Health Data Management, Inc. (Aqurate) to conduct a validation review of the PMs identified by DOM to evaluate their accuracy as reported by the CCOs for the CAN and CHIP populations. Aqurate applies the three activities for each CCO to support the auditing process per *42 CFR §438.330 (c)* and *§457.1240 (b)*. PM validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS measures and the CMS Adult and Child Core Set measures when calculating the PM rates.

## Performance Measure Validation Documentation Requested

Per the contract between the CCOs and DOM, the CCOs were required to submit HEDIS data to NCQA. To ensure the HEDIS rates were accurate and reliable, DOM required the CCO to undergo an NCQA HEDIS Compliance Audit. Magnolia, Molina, and United contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Each CCO was required to submit the Completed NCQA Record of Administration, Data Management, and Processes (Roadmap) from the MY 2023 HEDIS Compliance Audit, associated supplemental documentation, NCQA and Interactive Data Submission System (IDSS) files, the 2023 HEDIS Compliance Audit Final Audit Reports (FARs), and the Adult and Child Core Set measure rates reported using only administrative data.

Aqurate also requested the NCQA certification for the certified measure code used to generate each of the HEDIS measures, source code review-related documents for measures not produced using NCQA certified code, the numerator positive case listings for the HEDIS and non-HEDIS measures, and the list of numerator compliant records and exclusions identified via medical record review. Additional follow-up items were requested based on the findings from the desk review and the virtual audit review.

## Performance Measure Validation Process

The following activities were conducted for the PM Validation for the CCOs.

**Review of Data Management Processes to include:**

- The health plan's measurement policies and procedures.

- The table and field definitions to ensure the correct data is being used to calculate the selected measures.
- The health plan's standard code mapping used in the calculation of measures.
- A review of the health plan's policies and procedures for safeguarding confidential information.
- Compliance with HEDIS technical specifications for calculating and reporting PMs per certified auditor report.

**Algorithmic compliance evaluation is completed that includes:**

- Complete source code and programming logic review that details the calculation of the numerator and denominator for the measure, including all intermediate data merges and data staging that are used to calculate the measure.
- Verification that all the correct clinical codes defined in the measure specification are used appropriately to calculate the measure.
- Verification that age groups and other measure stratification groups are correctly programmed as defined by the measure specification.

Aqurate reviewed the CCO's final audit reports, information systems compliance tools, and IDSS files approved by the NCQA-licensed organizations. 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 reviews several aspects crucial to the calculation of PM data: data integration, data control, and documentation of PM calculations. The main steps in the validation process include:

- **Data Integration —** The steps used to combine various data sources, including claims and encounter data, eligibility data, and other administrative data, must be carefully controlled and validated. Aqurate validated the data integration process used by the CCOs, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.
- **Data Control —** The CCOs' organizational infrastructure must support all necessary information systems and quality assurance practices, and backup procedures need to ensure timely and accurate processing of data and provide data protection in the event of a disaster.
- **Performance Measure Documentation —** Documentation provided by the CCOs was used for validation of review findings. Supplementary information was provided via interviews and system demonstrations. Aqurate reviewed all related documentation, such as the completed

HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation.

CMS Scoring worksheets were used to score each measure. The final scoring was used to determine if the plan was Fully Compliant. *Table 25: Performance Measure Validation Rating* provides an overview of the validation score definitions.

**Table 25: Performance Measure Validation Rating**

| 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. |

## Performance Measure Validation Results

The Performance Measure (PM) Validation found that all the health plans were fully compliant with all HEDIS and CMS Adult and CMS Child Core Set measures, as shown in *Table 26: Performance Measure Validation Rating,* and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

**Table 26: Performance Measure Validation Rating**

| CCO | Performance Measure Validation Rating |
|---|---|
| Magnolia CAN | Fully Compliant |
| Molina CAN | Fully Compliant |
| Molina CHIP | Fully Compliant |
| United CAN | Fully Compliant |
| United CHIP | Fully Compliant |

## HEDIS Performance Measure Validation – CAN Program

All relevant HEDIS PMs for the current measure year (MY 2023) and the change from the current to previous year are reported in *Table 27: HEDIS Performance Measure* Results. Rates shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%).

The arrows indicate a change in the rate from the previous measure year. For example, an arrow pointing up (↑) indicates an improvement in the rate and a down arrow (↓) indicates the rate was lower than the previous measure year. For rates where an arrow is not displayed, there was no change in the reported rate.

**Table 27: HEDIS® Performance Measure Data for CAN Programs**

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| Effectiveness of Care: Prevention and Screening | | | | |
| Adult BMI Assessment (ABA) | 62.05 ↑ | 55.60% ↑ | 66.11% ↑ | 62.68% |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | | | | |
| *BMI Percentile* | 56.20% ↓ | 56.69% ↑ | 68.37% ↓ | 60.42% |
| *Counseling for Nutrition* | 44.28% ↓ | 47.45% ↑ | 32.36% ↓ | 41.36% |
| *Counseling for Physical Activity* | 45.50% ↓ | 44.04% ↑ | 30.41% ↓ | 39.98% |
| Childhood Immunization Status (CIS) | | | | |
| *DTaP* | 71.29% ↓ | 69.34% ↓ | 77.86% ↑ | 72.83% |
| *IPV* | 85.40% ↓ | 85.40% ↓ | 90.75% ↓ | 87.19% |
| *MMR* | 85.89% ↓ | 85.64% ↓ | 89.29% ↓ | 86.94% |
| *HiB* | 81.27% ↓ | 82.97% ↓ | 87.10% ↓ | 83.78% |
| *Hepatitis B* | 87.10% ↓ | 88.81% ↓ | 92.94% ↓ | 89.62% |
| *VZV* | 85.40% ↓ | 85.16% ↓ | 89.05% ↓ | 86.54% |
| *Pneumococcal Conjugate* | 70.07% ↓ | 71.05% ↓ | 77.86% ↑ | 72.99% |
| *Hepatitis A* | 78.35% ↓ | 76.64% ↓ | 78.83% ↓ | 77.94% |
| *Rotavirus* | 71.29% ↓ | 69.10% ↓ | 77.86% ↑ | 72.75% |
| *Influenza* | 19.71% ↓ | 18.73% ↓ | 19.22% ↓ | 19.22% |
| *Combination #3* | 63.26% ↓ | 63.75% ↓ | 73.97% ↑ | 66.99% |
| *Combination #7* | 54.74% ↓ | 53.53% ↓ | 64.23% ↑ | 57.50% |
| *Combination #10* | 16.30% ↓ | 13.63% ↓ | 16.55% ↓ | 15.49% |
| Immunizations for Adolescents (IMA) | | | | |
| *Meningococcal* | 53.28% ↓ | 47.27% ↓ | 53.04% ↑ | 49.12% |
| *Tdap* | 82.97% ↓ | 73.27% ↓ | 76.40% ↑ | 75.29% |
| *HPV* | 20.68% ↓ | 13.03% ↓ | 21.17% ↓ | 15.51% |
| *Combination #1* | 53.04% ↓ | 47.05% ↓ | 52.80% ↑ | 48.89% |
| *Combination #2* | 19.95% ↓ | 12.19% ↓ | 20.68% ↓ | 14.74% |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| Lead Screening in Children (LSC) | 66.63% ↑ | 64.48% ↑ | 68.86% ↑ | 66.64% |
| Breast Cancer Screening (BCS) | 51.37% ↓ | 41.10% ↓ | 45.93% ↓ | 48.48% |
| Breast Cancer Screening (BCS-E) | 51.34% | 41.28% ↓ | 45.93% | 48.49% |
| Cervical Cancer Screening (CCS) | 47.69% ↓ | 46.83% ↓ | 46.96% ↓ | 47.16% |
| Chlamydia Screening in Women (CHL) | | | | |
| *16-20 Years* | 47.88% ↓ | 49.30% ↓ | 49.13% ↑ | 48.55% |
| *21-24 Years* | 58.14% ↓ | 64.33% ↑ | 61.32% ↑ | 60.69% |
| *Total* | 49.41% ↓ | 53.26% ↓ | 50.84% ↑ | 50.54% |
| Effectiveness of Care: Respiratory Conditions | | | | |
| Appropriate Testing for Children with Pharyngitis (CWP) | | | | |
| *Appropriate Testing for Pharyngitis (3-17)* | 82.34% ↑ | 84.00% ↑ | 83.24% ↑ | 82.97% |
| *Appropriate Testing for Pharyngitis (18-64)* | 73.55% ↑ | 75.05% ↑ | 73.14% ↑ | 73.70% |
| *Appropriate Testing for Pharyngitis (65+)* | NA | NA | NA | NA |
| *Appropriate Testing for Pharyngitis (Total)* | 81.37% ↑ | 82.85% ↑ | 82.16% ↑ | 81.94% |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) | 24.48% ↑ | 25.29% ↑ | 23.87% ↑ | 24.31% |
| Pharmacotherapy Management of COPD Exacerbation (PCE) | | | | |
| *Systemic Corticosteroid* | 47.99% ↑ | 58.62% ↑ | 46.15% ↓ | 48.22% |
| *Bronchodilator* | 76.42% ↓ | 76.72% ↑ | 80.77% ↑ | 78.28% |
| Asthma Medication Ratio (AMR) | | | | |
| *5-11 Years* | 86.69% ↑ | 75.41% ↓ | 80.89% ↓ | 83.08% |
| *12-18 Years* | 74.01% ↑ | 60.80% ↓ | 74.05% ↓ | 72.95% |
| *19-50 Years* | 66.89% ↑ | 55.96% ↓ | 61.70% ↑ | 63.13% |
| *51-64 Years* | 54.96% ↓ | 52.94% ↑ | 61.70% ↑ | 57.14% |
| *Total* | 76.52% ↑ | 64.97% ↓ | 74.01% ↓ | 74.20% |
| Plan All-Cause Readmissions (PCR-AD) | | | | |
| *Observed Readmission Rate* | 13.62% ↑ | 9.88% ↓ | 12.20 ↑ | 12.38% |
| *Expected Readmission Rate* | 11.14% ↑ | 10.14% ↑ | 10.77 ↓ | 10.81% |
| *Observed/Expected (O/E) Ratio* ∞ | 1.22% ↓ | 0.97% ↓ | 1.13% ↑ | 1.11% |
| *Outlier Rate* | 67.13% ↑ | 65.83% ↓ | 59.72 ↓ | 64.08% |
| Effectiveness of Care: Cardiovascular Conditions | | | | |
| Controlling High Blood Pressure (CBP) | 54.50% ↑ | 52.07% ↑ | 57.42% ↓ | 54.66% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) | NA | NA | NA | NA |
| Statin Therapy for Patients with Cardiovascular Disease (SPC) | | | | |
| *Received Statin Therapy - 21-75 years (Male)* | 75.37% ↑ | 79.13% ↑ | 79.21% ↓ | 77.29% |
| *Statin Adherence 80% - 21-75 years (Male)* | 54.26% ↓ | 65.93% ↑ | 57.45% ↓ | 56.97% |
| *Received Statin Therapy - 40-75 years (Female)* | 72.83% ↓ | 84.38% ↑ | 72.80% ↑ | 73.98% |
| *Statin Adherence 80% - 40-75 years (Female)* | 51.35% ↓ | 56.79% ↑ | 52.92% ↑ | 52.54% |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Received Statin Therapy - Total* | 74.05% ↑ | 81.52% ↑ | 76.02% ↑ | 75.62% |
| *Statin Adherence 80% - Total* | 52.77% ↓ | 61.63% ↑ | 55.29% ↑ | 54.78% |
| Cardiac Rehabilitation (CRE) | | | | |
| *Cardiac Rehabilitation - Initiation (18-64)* | 1.78% ↓ | 1.85% ↑ | NQ | 1.79%** |
| *Cardiac Rehabilitation - Engagement1 (18-64)* | 2.37% ↓ | 3.70% ↑ | NQ | 2.69%** |
| *Cardiac Rehabilitation - Engagement2 (18-64)* | 0.59% ↓ | 3.70% ↑ | NQ | 1.35%** |
| *Cardiac Rehabilitation - Achievement (18-64)* | 0.00% | 3.70% ↑ | NQ | 0.90%** |
| *Cardiac Rehabilitation - Initiation (65+)* | NA | NA | NQ | NA* |
| *Cardiac Rehabilitation - Engagement1 (65+)* | NA | NA | NQ | NA* |
| *Cardiac Rehabilitation - Engagement2 (65+)* | NA | NA | NQ | NA* |
| *Cardiac Rehabilitation - Achievement (65+)* | NA | NA | NQ | NA* |
| *Cardiac Rehabilitation - Initiation (Total)* | 1.76% ↓ | 1.85% ↑ | NQ | 1.79%** |
| *Cardiac Rehabilitation - Engagement1 (Total)* | 2.35% ↓ | 3.70% ↑ | NQ | 2.68%** |
| *Cardiac Rehabilitation - Engagement2 (Total)* | 0.59% ↓ | 3.70% ↑ | NQ | 1.34%** |
| *Cardiac Rehabilitation - Achievement (Total)* | 0.00% | 3.70% | NQ | 0.89%** |
| Effectiveness of Care: Diabetes | | | | |
| Hemoglobin A1c Control for Patients With Diabetes (HBD) | | | | |
| *Poor HbA1c Control* ∞ | 50.85% ↑ | 45.74% ↓ | 41.36% ↓ | 45.99% |
| *Adequate HbA1c Control* | 42.09% ↓ | 47.20% ↑ | 50.12% ↑ | 46.47% |
| Eye Exam for Patients With Diabetes (EED) ◊ | 59.37% ↓ | 55.23% ↑ | 60.34% ↑ | 58.31% |
| Blood Pressure Control for Patients With Diabetes (BPD) | 61.07% ↑ | 62.04% ↑ | 58.39% ↓ | 60.50% |
| Kidney Health Evaluation for Patients With Diabetes (KED) | | | | |
| *18-64 Years* | 19.24% ↑ | 20.18% ↑ | 25.49% ↑ | 21.69% |
| *65-74 Years* | 18.60% ↓ | NA | NA | NA* |
| *75-85 Years* | NA | NA | NA | NA* |
| *Total* | 19.24% ↑ | 20.16% ↑ | 25.48% ↑ | 21.67% |
| Statin Therapy for Patients with Diabetes (SPD) | | | | |
| *Received Statin Therapy* | 62.06% ↓ | 53.22% ↓ | 62.30% ↑ | 61.36% |
| *Statin Adherence 80%* | 52.36% ↑ | 60.81% ↑ | 52.88% ↑ | 53.22% |
| Effectiveness of Care: Behavioral Health | | | | |
| Antidepressant Medication Management (AMM) ◊ | | | | |
| *Effective Acute Phase Treatment* | 51.80% ↑ | 59.23% ↓ | 55.42% ↑ | 54.41% |
| *Effective Continuation Phase Treatment* | 31.52% ↑ | 39.91% ↑ | 34.24% ↑ | 33.96% |
| Follow-Up Care for Children Prescribed ADHD Medication (ADD) ◊ | | | | |
| *Initiation Phase* | 56.06% ↑ | 46.63% ↑ | 51.77% ↑ | 52.99% |
| *Continuation and Maintenance (C&M) Phase* | 66.92% ↓ | 54.55% ↓ | 63.72% ↓ | 63.34% |
| Follow-Up After Hospitalization for Mental Illness (FUH) | | | | |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *6–17 years – 30-Day Follow-Up* | 68.53% ↑ | 66.79% ↑ | 66.97% ↑ | 67.65% |
| *6–17 years – 7-Day Follow-Up* | 41.96% ↑ | 38.09% ↓ | 41.24% ↑ | 41.04% |
| *18–64 years – 30-Day Follow-Up* | 51.67% ↓ | 48.23% ↑ | 53.69% ↑ | 51.79% |
| *18–64 years – 7-Day Follow-Up* | 32.38% ↑ | 29.16% ↑ | 33.29% ↑ | 32.12% |
| *65+ years – 30-Day Follow-Up* | NA | NA | NA | NA* |
| *65+ years – 7-Day Follow-Up* | NA | NA | NA | NA* |
| *30-Day Follow-Up* | 62.46% ↑ | 59.39% ↑ | 61.87% ↑ | 61.69% |
| *7-Day Follow-Up* | 38.53% ↑ | 34.53% ↑ | 38.19% ↑ | 37.69% |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | | | | |
| *6–17 years – 30-Day Follow-Up* | 64.64% ↑ | 55.13% ↑ | 61.21% ↑ | 61.56% |
| *6–17 years – 7-Day Follow-Up* | 46.41% ↑ | 35.90% ↑ | 41.21% ↑ | 42.45% |
| *18–64 years – 30-Day Follow-Up* | 37.26% ↓ | 37.23%↑ | 38.08% ↓ | 37.57% |
| *18–64 years – 7-Day Follow-Up* | 23.89% ↓ | 25.55%↑ | 26.69% ↑ | 25.27% |
| *65+ years – 30-Day Follow-Up* | NA | NA | NA | NA* |
| *65+ years – 7-Day Follow-Up* | NA | NA | NA | NA* |
| *Total – 30-Day Follow-Up* | 47.27% ↓ | 43.72%↑ | 46.64% ↑ | 46.37% |
| *Total– 7-Day Follow-Up* | 32.12% ↑ | 29.30%↑ | 32.06% ↑ | 31.57% |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) | | | | |
| *30 days (13–17)* | NA | NA | NA | NA* |
| *7 Days (13–17)* | NA | NA | NA | NA* |
| *30 days (18–64)* | 38.34% ↓ | 39.08% ↓ | 37.97%↓ | 38.36% |
| *7 Days (18–64)* | 27.98% ↓ | 25.29% ↓ | 24.05% ↓ | 26.03% |
| *30 days (65+)* | NA | NA | NA | NA* |
| *7 Days (65+)* | NA | NA | NA | NA* |
| *30 days (Total)* | 36.27% ↓ | 36.96% ↓ | 36.14% ↓ | 36.36% |
| *7 Days (Total)* | 26.47% ↓ | 23.91% ↓ | 22.89% ↓ | 24.68% |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) ◊ | | | | |
| *30-Day Follow-Up: 13-17 Years* | 20.59% ↓ | NA | 16.13% ↓ | 21.09%* |
| *7-Day Follow-Up: 13-17 Years* | 13.24% ↓ | NA | 6.45% ↓ | 11.72%* |
| *30-Day Follow-Up: 18+ Years* | 23.90% ↓ | 21.88% ↓ | 22.34% ↓ | 22.89% |
| *7-Day Follow-Up: 18+ Years* | 14.47% ↓ | 14.38% ↑ | 12.71% ↓ | 13.78% |
| *30-Day Follow-Up: Total* | 23.32% ↓ | 22.75% ↑ | 21.74% ↓ | 22.63% |
| *7-Day Follow-Up: Total* | 14.25% ↓ | 14.29% ↑ | 12.11% ↓ | 13.49% |
| Pharmacotherapy for Opioid Use Disorder (POD) | | | | |
| *Pharmacotherapy for Opioid Use Disorder (16-64)* | 24.70% ↓ | 38.83% ↑ | 25.15% ↓ | 28.21% |
| *Pharmacotherapy for Opioid Use Disorder (65+)* | NA | NA | NA | NA* |
| *Pharmacotherapy for Opioid Use Disorder (Total)* | 24.70% ↓ | 38.83% ↑ | 25.15% ↓ | 28.21% |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD) | 74.63% ↑ | 74.48% ↑ | 71.75% ↑ | 73.44% |
| Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) | 73.22% ↓ | 63.64% ↑ | 72.07% ↓ | 71.88% |
| Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) | 76.79% ↑ | NA | 66.67% ↓ | 72.45%* |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | 55.43% ↓ | 62.19% ↑ | 59.55% ↑ | 57.90% |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | | | | |
| *Blood Glucose Testing (1–11)* | 34.45% ↓ | 33.82% ↓ | 39.66% ↑ | 36.17% |
| *Cholesterol Testing (1–11)* | 23.10% ↓ | 25.29% ↑ | 25.84% ↑ | 24.42% |
| *Blood Glucose and Cholesterol Testing (1–11)* | 20.47% ↓ | 24.12% ↑ | 23.88% ↑ | 22.27% |
| *Blood Glucose Testing (12–17)* | 51.53% ↑ | 52.88% ↑ | 52.54% ↑ | 52.10% |
| *Cholesterol Testing (12–17)* | 32.47% ↓ | 30.58% ↑ | 34.39% ↑ | 32.98% |
| *Blood Glucose and Cholesterol Testing (12–17)* | 29.90% ↓ | 28.57% ↑ | 32.14% ↑ | 30.60% |
| *Blood Glucose Testing (Total)* | 44.68% ↑ | 44.11% ↓ | 47.73% ↑ | 45.74% |
| *Cholesterol Testing (Total)* | 28.72% ↓ | 28.15% ↑ | 31.19% ↑ | 29.56% |
| *Blood Glucose and Cholesterol Testing (Total)* | 26.12% ↓ | 26.52% ↑ | 29.06% ↑ | 27.28% |
| Effectiveness of Care: Overuse/Appropriateness | | | | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) | NQ | 1.20% ↓ | 1.16% ↓ | 1.17% |
| Appropriate Treatment for Upper Respiratory Infection (URI) | | | | |
| *3 Months–17 Years* | 73.31% ↑ | 76.28% ↑ | 72.88% ↓ | 73.79% |
| *18–64 Years* | 58.67% ↑ | 58.91% ↑ | 60.34% ↑ | 59.34% |
| *65+ Years* | NA | NA | NA | NA* |
| *Total* | 71.67% ↑ | 74.87% ↑ | 71.59% ↓ | 72.31% |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) | | | | |
| *3 Months–17 Years* | 51.59% ↑ | 58.18% ↓ | 52.82% ↑ | 46.32% |
| *18–64 Years* | 41.22% ↓ | 32.02% ↓ | 38.76% ↓ | 60.94% |
| *65+ Years* | NA | NA | NA | NA* |
| *Total* | 49.99% ↑ | 56.27% ↓ | 51.10% ↑ | 48.13% |
| Use of Imaging Studies for Low Back Pain (LBP) | 70.82% ↓ | 64.99% ↓ | 68.91% ↓ | 30.95% |
| Use of Opioids at High Dosage (HDO) ∞ | 0.98% ↓ | 1.51% ↑ | 0.96% ↑ | 1.05% |
| Use of Opioids from Multiple Providers (UOP) ∞ | | | | |
| *Multiple Prescribers* | 12.44% ↓ | 20.10% ↓ | 14.73% ↓ | 14.55% |
| *Multiple Pharmacies* | 2.15% ↑ | 3.65% ↑ | 2.16% ↑ | 2.38% |
| *Multiple Prescribers and Multiple Pharmacies* | 1.06% ↑ | 2.60% ↑ | 0.99% ↑ | 1.26% |
| Risk of Continued Opioid Use (COU) ∞ | | | | |
| *18–64 years – >=15 Days Covered* | 6.16% ↑ | 8.66% ↑ | 5.44% ↓ | 6.38% |
| *18–64 years – >=31 Days Covered* | 2.32% ↓ | 4.37% ↑ | 3.44% ↓ | 3.11% |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *65+ years – >=15 Days Covered* | NA | NA | NA | NA* |
| *65+ years – >=31 Days Covered* | NA | NA | NA | NA* |
| *Total – >=15 Days Covered* | 6.16% ↑ | 8.66% ↑ | 5.48% ↓ | 6.39% |
| *Total – >=31 Days Covered* | 2.32% ↓ | 4.37% ↑ | 3.48% ↓ | 3.12% |
| Access/Availability of Care | | | | |
| Adults' Access to Preventive/Ambulatory Health Services (AAP) | | | | |
| *20-44 Years* | 81.07% ↓ | 80.08% ↓ | 82.16% ↓ | 81.26% |
| *45-64 Years* | 88.06% ↓ | 84.90% ↑ | 87.91% ↓ | 87.60% |
| *65+ Years* | 72.32% ↓ | NA | 70.00% ↓ | 71.05% |
| *Total* | 83.89% ↓ | 81.50% ↓ | 84.51% ↓ | 83.72% |
| Oral Evaluation, Dental Services (OED) | | | | |
| *Oral Evaluation, Dental Services (0-2)* | 18.92% | 18.93% | 19.64% | 19.18% |
| *Oral Evaluation, Dental Services (3-5)* | 60.52% | 56.18% | 59.88% | 59.21% |
| *Oral Evaluation, Dental Services (6-14)* | 62.75% | 57.21% | 64.75% | 62.52% |
| *Oral Evaluation, Dental Services (15-20)* | 45.77% | 41.42% | 48.47% | 46.16% |
| *Oral Evaluation, Dental Services (Total)* | 52.50% | 45.39% | 53.33% | 51.38% |
| Topical Fluoride for Children (TFC) | | | | |
| *Topical Fluoride for Children (1-2)* | 10.06% | 9.20% | 9.21% | 9.50% |
| *Topical Fluoride for Children (3-4)* | 19.62% | 18.59% | 15.99% | 18.10% |
| *Topical Fluoride for Children (Total)* | 14.56% | 13.38% | 12.16% | 13.38% |
| Initiation and Engagement of AOD Dependence Treatment (IET) ◊ | | | | |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years* | 65.96% ↓ | NA | 67.35% ↓ | 69.57%* |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | 0.00% ↓ | NA | 2.04% ↓ | 0.87%* |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years* | NA | NA | NA | NA* |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | NA | NA | NA | NA* |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years* | 65.96% ↑ | 65.32% ↑ | 60.67% ↑ | 63.88% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | 4.26% ↓ | 1.61% ↑ | 3.77% ↓ | 3.57% |
| *Total: Initiation of AOD Treatment: 13-17 Years* | 66.17% ↓ | 68.87% ↑ | 62.08% ↑ | 65.14% |
| *Total: Engagement of AOD Treatment: 13-17 Years* | 3.56% ↓ | 1.32% ↑ | 3.69% ↓ | 3.18% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years* | 42.93% ↓ | 44.49% ↑ | 44.59% ↑ | 43.89% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years* | 3.26% ↓ | 7.22% ↓ | 8.88% ↑ | 6.23% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years* | 36.54% ↓ | 65.93% ↑ | 49.36% ↑ | 45.60% |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years* | 14.29% ↓ | 26.37% ↓ | 27.90% ↑ | 21.12% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years* | 42.83% ↑ | 44.49% ↓ | 42.22% ↓ | 42.93% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 4.85% ↓ | 5.40% ↓ | 9.42% ↑ | 6.70% |
| *Total: Initiation of AOD Treatment: 18+ Years* | 41.82% ↓ | 46.88% ↑ | 44.00% ↓ | 43.62% |
| *Total: Engagement of AOD Treatment: 18+ Years* | 5.93% ↓ | 8.32% ↓ | 11.89% ↑ | 8.66% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: Total* | 44.67% ↓ | 47.16% ↑ | 46.65% ↑ | 45.93% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: Total* | 3.00% ↓ | 6.74% ↓ | 8.27% ↑ | 5.79% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: Total* | 37.54% ↓ | 67.68% ↑ | 50.41% ↑ | 46.93% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 13.92% ↓ | 24.24% ↓ | 27.05% ↑ | 20.40% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: Total* | 48.08% ↑ | 48.89% ↑ | 46.21% ↓ | 47.53% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: Total* | 4.71% ↓ | 4.60% ↓ | 8.21% ↑ | 6.01% |
| *Total: Initiation of AOD Treatment: Total* | 45.63% ↓ | 50.31% ↑ | 46.87% ↓ | 47.00% |
| *Total: Engagement of AOD Treatment: Total* | 5.55% ↓ | 7.23% ↓ | 10.61% ↑ | 7.80% |
| Prenatal and Postpartum Care (PPC)° | | | | |
| *Timeliness of Prenatal Care Under 21 (Admin only rate)* | 80.75% | 85.63% | 80.45% | 81.03% |
| *Postpartum Care Under 21 (Admin only rate)* | 52.62% | 52.79% | 54.45% | 52.83% |
| *Timeliness of Prenatal Care Over 21 (Admin only rate)* | 81.38% | 87.42% | 89.46% | 85.56% |
| *Postpartum Care Over 21 (Admin only rate)* | 52.62% | 51.30% | 57.59% | 53.83% |
| *Timeliness of Prenatal Care (Total per IDSS)* | 92.46%↓ | 90.27% ↓ | 92.94% ↓ | 91.89% |
| *Postpartum Care (Total per IDSS)* | 75.18%↑ | 67.15% ↓ | 80.05% ↑ | 74.13% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | | | | |
| *6–11 Years* | 58.94% ↑ | 61.24% ↑ | 59.81% ↑ | 59.65% |
| *12–17 Years* | 63.06% ↓ | 56.25% ↓ | 65.85% ↑ | 63.03% |
| *Total* | 61.46% ↓ | 58.37% ↓ | 63.68% ↑ | 61.73% |
| Utilization | | | | |
| Well-Child Visits in the First 30 Months of Life (W30) | | | | |
| *First 15 Months* | 58.08% ↑ | 57.17% ↓ | 57.65% ↓ | 57.66% |
| *15 Months–30 Months* | 70.23% ↑ | 67.98% ↑ | 68.08% ↑ | 68.81% |
| Child and Adolescent Well-Care Visits (WCV) | | | | |
| *3–11 Years* | 46.15% ↑ | 45.05% ↑ | 45.22% ↑ | 45.58% |
| *12–17 Years* | 40.67% ↑ | 35.00% ↓ | 39.00% ↑ | 39.14% |
| *18–21 Years* | 21.06% ↑ | 18.29% ↓ | 22.44% ↑ | 21.21% |

| HEDIS Measure/Data Element | Magnolia HEDIS MY 2023 CAN Rates | Molina HEDIS MY 2023 CAN Rates | United HEDIS MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Total* | 41.92% ↑ | 40.16% ↑ | 41.02% ↑ | 41.26% |

*NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NQ: Not Required*
**: This statewide average includes CCO rates with small denominators.*
***: This statewide average was calculated with data from only two CCOs.*
*◇: Measure has a "Trend with Caution" guidance notes from NCQA for MY 2023.*
*∞: Lower rate indicates better performance*

All three CAN CCOs showed more than a 10-percentage point improvement in the Adult BMI Assessment (ABA) measure for MY 2023. The rates for UHC and Magnolia remained consistent year-over-year for the most part. Molina CAN showed the most improvement year-over-year. However, it was unclear whether the Molina rate improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years. When comparing the previous rates (MY 2022) to the MY 2023 rates, some improvements were shown for 88 rates for United, 84 rates for Molina, and 57 rates for Magnolia.

**Magnolia CAN** improved by 10 percentage points or more for the 6-17 years of age - 30-Day Follow-Up indicator for the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure.

**Molina CAN** improved by 10 percentage points or more for the following MY 2023 HEDIS measures:

- The 18-64 years of age indicator for the Appropriate Testing for Children with Pharyngitis (CWP) measure.
- The Statin adherence 80% - 21-75 years of age (Male) indicator, the Statin adherence 80% - 40-75 years of age (Female) indicator, and the Statin adherence 80% - Total indicator for the Statin Therapy for Patients with Cardiovascular Disease (SPC) measure.
- The Poor HbA1c Control indicator, and the Adequate HbA1c Control indicator for the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure.
- The Blood Pressure Control for Patients with Diabetes (BPD) measure.
- The Statin Adherence 80% indicator for the Statin Therapy for Patients with Diabetes (SPD) measure.
- The Initiation Phase indicator for the Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure.

- The Total Initiation of AOD Treatment: 13-17 years of age indicator for the Initiation and Engagement of AOD Dependence Treatment (IET) measure.

**Magnolia CAN** rates fell by 10 percentage points or more for:

- The 65-74 years of age indicator for the Kidney Health Evaluation for Patients with Diabetes (KED) measure.
- The 18-64 years of age - 30-Day Follow-Up indicator for the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure.

**United CAN** rates fell by 10 percentage points or more for:

- The Counseling for Nutrition and Counseling for Physical Activity indicators for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure.
- The 30-Day Follow-up and the 7-Day Follow-Up indicators for 13-17 years of age for the .Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measure.
- The Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) measure.

## HEDIS Performance Measure Validation - CHIP Program

The statewide average is calculated as the average of the health plan rates and shown in the last column of the table. Rates highlighted in green showed a substantial improvement of more than 10% year over year. The rates highlighted in red indicate a substantial decrease in the rate of more than 10%. The arrows indicate a change in the rate from the previous measure year. For example, an arrow pointing up (↑) indicates an improvement in the rate and a down arrow (↓) indicates the rate was lower than the previous measure year. For rates where an arrow is not displayed, there was no change in the reported rate.

**Table 28: HEDIS® Performance Measure Data for CHIP Programs**

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| Effectiveness of Care: Prevention and Screening | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | | | |
| *BMI Percentile* | 56.69% ↑ | 66.67% ↓ | 61.68% |
| *Counseling for Nutrition* | 41.36% ↑ | 36.98% ↓ | 39.17% |
| *Counseling for Physical Activity* | 41.85% ↑ | 33.58% ↓ | 37.71% |

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| Childhood Immunization Status (CIS) | | | |
| *DTaP* | 84.44% ↑ | 85.16% ↑ | 84.83% |
| *IPV* | 93.37% ↑ | 92.21% ↑ | 92.74% |
| *MMR* | 93.95% ↑ | 92.21% ↑ | 93.01% |
| *HiB* | 92.22% ↑ | 90.02% ↑ | 91.03% |
| *Hepatitis B* | 88.47% ↓ | 91.73% ↑ | 90.24% |
| *VZV* | 93.37% | 91.73% ↓ | 92.48% |
| *Pneumococcal Conjugate* | 82.71% ↓ | 85.16% ↑ | 84.04% |
| *Hepatitis A* | 86.74% | 84.43% ↓ | 85.49% |
| *Rotavirus* | 82.13% ↓ | 82.48% ↓ | 82.32% |
| *Influenza* | 23.63% ↓ | 22.38% ↓ | 22.96% |
| *Combination #3* | 74.93% ↓ | 80.29% ↑ | 77.84% |
| *Combination #7* | 66.28% ↓ | 68.61% ↑ | 67.55% |
| *Combination #10* | 18.44% ↓ | 19.71% ↓ | 19.13% |
| Immunizations for Adolescents (IMA) | | | |
| *Meningococcal* | 55.96% ↑ | 53.04% ↑ | 54.50% |
| *Tdap/Td* | 89.54% ↑ | 82.97% ↓ | 86.25% |
| *HPV* | 20.19% ↑ | 18.98% ↓ | 19.59% |
| *Combination #1* | 55.96% ↑ | 53.04% ↑ | 54.50% |
| *Combination #2* | 19.71% ↑ | 18.49% ↓ | 19.10% |
| Lead Screening in Children (LSC) | 65.99% ↑ | 58.64% ↓ | 62.01% |
| Chlamydia Screening in Women (CHL) | | | |
| *16–20 Years* | 38.65% ↓ | 43.25% ↑ | 41.74% |
| *21–24 Years* | NA | NA | NA* |
| *Total* | 38.65% ↓ | 43.25% ↑ | 41.74% |
| Effectiveness of Care: Respiratory Conditions | | | |
| Appropriate Testing for Children with Pharyngitis (CWP) | | | |
| *3–17 Years* | 84.21% ↑ | 85.00% ↑ | 84.72% |
| *18–64 Years* | 76.23% ↑ | 80.00% ↑ | 78.65% |
| *65+ Years* | NA | NA | NA* |
| *Total* | 83.95% ↑ | 84.84% ↑ | 84.53% |
| Asthma Medication Ratio (AMR) | | | |
| *5–11 Years* | 75.53% ↓ | 89.09% ↓ | 84.17% |
| *12–18 Years* | 72.22% ↓ | 83.84% ↓ | 80.21% |
| *19–50 Years* | NA | NA | NA* |
| *51–64 Years* | NA | NA | NA* |
| *Total* | 73.91% ↓ | 86.26% ↓ | 82.12% |
| Plan All-Cause Readmissions (PCR-AD) | | | |

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *Observed Readmission Rate* | NA | NA | NA* |
| *Expected Readmission Rate* | NA | NA | NA* |
| *Observed/Expected (O/E) Ratio ∞* | NA | NA | NA* |
| *Outlier Rate* | NA | NA | NA* |
| Effectiveness of Care: Cardiovascular Conditions | | | |
| Controlling High Blood Pressure (CBP) | NA | NA | NA* |
| Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) | NA | NA | NA* |
| Effectiveness of Care: Diabetes | | | |
| Hemoglobin A1c Control for Patients With Diabetes (HBD) | | | |
| *Poor HbA1c Control ∞* | NA | NA | NA* |
| *Adequate HbA1c Control* | NA | NA | NA* |
| Eye Exam for Patients With Diabetes (EED) ◊ | NA | NA | NA* |
| Blood Pressure Control for Patients With Diabetes (BPD) | NA | NA | NA* |
| Kidney Health Evaluation for Patients With Diabetes (KED) | | | |
| *18-64* | NA | NA | NA* |
| *65-74* | NA | NA | NA* |
| *75-85* | NA | NA | NA* |
| *Total* | NA | NA | NA* |
| Statin Therapy for Patients With Diabetes (SPD) | | | |
| *Received Statin Therapy* | NA | NA | NA* |
| *Statin Adherence 80%* | NA | NA | NA* |
| Effectiveness of Care: Behavioral | | | |
| Antidepressant Medication Management (AMM) ◦ | | | |
| *Effective Acute Phase Treatment* | NA | NA | NA* |
| *Effective Continuation Phase Treatment* | NA | NA | NA* |
| Follow-up care for children prescribed ADHD Medication (ADD) ◦ | | | |
| *Initiation Phase* | 47.78% ↑ | 52.58% ↑ | 50.86% |
| *Continuation and Maintenance (C&M) Phase* | 52.44% ↓ | 60% ↓ | 56.93% |
| Follow-Up After Hospitalization for Mental Illness (FUH) | | | |
| *6-17 years - 30-Day Follow-Up* | 64.71% ↓ | 63.98% ↓ | 64.24% |
| *6-17 years - 7-Day Follow-Up* | 34.31% ↓ | 37.1% ↓ | 36.11% |
| *18-64 years - 30-Day Follow-Up* | NA | NA | NA* |
| *18-64 years - 7-Day Follow-Up* | NA | NA | NA* |
| *65+ years – 30-Day Follow-Up* | NA | NA | NA* |
| *65+ years – 7-Day Follow-Up* | NA | NA | NA* |
| *Total-30-day Follow-Up* | 64.22% ↓ | 63.21% ↓ | 63.58% |
| *Total-7-day Follow-Up* | 33.94% ↓ | 36.79% ↓ | 35.76% |

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | | | |
| *6-17 years - 30-Day Follow-Up* | NA | NA | NA* |
| *6-17 years - 7-Day Follow-Up* | NA | NA | NA* |
| *18-64 years - 30-Day Follow-Up* | NA | NA | NA* |
| *18-64 years - 7-Day Follow-Up* | NA | NA | NA* |
| *65+ years – 30-Day Follow-Up* | NA | NA | NA* |
| *65+ years – 7-Day Follow-Up* | NA | NA | NA* |
| *Total-30-day Follow-Up* | NA | 66.67% ↓ | NA* |
| *Total-7-day Follow-Up* | NA | 40% ↓ | NA* |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) | | | |
| *30 days (13-17)* | NA | NA | NA* |
| *7 Days (13-17)* | NA | NA | NA* |
| *30 days (18-64)* | NA | NA | NA* |
| *7 Days (18-64)* | NA | NA | NA* |
| *30 days (65+)* | NA | NA | NA* |
| *7 Days (65+)* | NA | NA | NA* |
| *30 days (Total)* | NA | NA | NA* |
| *7 Days (Total)* | NA | NA | NA* |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)◦ | | | |
| *30 days (13-17)* | NA | NA | NA* |
| *7 days (13-17)* | NA | NA | NA* |
| *30 days (18+)* | NA | NA | NA* |
| *7 days (18+)* | NA | NA | NA* |
| *30 days (Total)* | NA | NA | NA* |
| *7 days (Total)* | NA | NA | NA* |
| Pharmacotherapy for Opioid Use Disorder (POD) | | | |
| *16-64* | NA | NA | NA* |
| *65+* | NA | NA | NA* |
| *Total* | NA | NA | NA* |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD) | NA | NA | NA* |
| Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) | NA | NA | NA* |
| Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) | NA | NA | NA* |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | | | |
| *Blood Glucose Testing (1-11)* | 35.56% ↓ | 36.78% ↓ | 36.36% |
| *Cholesterol Testing (1-11)* | 24.44% ↓ | 35.63% ↑ | 31.82% |
| *Blood Glucose and Cholesterol Testing (1-11)* | 22.22% ↓ | 32.18% ↑ | 28.79% |

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *Blood Glucose Testing (12-17)* | 47.37% ↓ | 62.22% ↑ | 57.81% |
| *Cholesterol Testing (12-17)* | 28.95% ↓ | 36.67% ↑ | 34.38% |
| *Blood Glucose and Cholesterol Testing (12-17)* | 26.32% ↓ | 34.44% ↑ | 32.03% |
| *Blood Glucose Testing (Total)* | 42.98% ↓ | 53.93% ↑ | 50.52% |
| *Cholesterol Testing (Total)* | 27.27% ↓ | 36.33% ↑ | 33.51% |
| *Blood Glucose and Cholesterol Testing (Total)* | 24.79% ↓ | 33.71% ↑ | 30.93% |
| Effectiveness of Care: Overuse/Appropriateness | | | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) | 1.18% ↑ | 1.34% ↑ | 1.29% |
| Appropriate Treatment for Upper Respiratory Infection (URI) | | | |
| *3 months-17 Years* | 70.69% ↑ | 69.57% ↑ | 69.97% |
| *18-64 Years* | 65.26% ↑ | 59.24% ↑ | 61.11% |
| *65+ Years* | NA | NA | NA* |
| *Total* | 70.54% ↑ | 69.21% ↑ | 69.69% |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) | | | |
| *3 Months – 17 Years* | 40.00% ↑ | 38.26% ↑ | 38.85% |
| *18-64 Years* | NA | NA | NA* |
| *65+ Years* | NA | NA | NA* |
| *Total* | 39.89% ↑ | 37.97% ↑ | 38.62% |
| Use of Imaging Studies for Low Back Pain (LBP) | NA | NA | NA* |
| Use of Opioids at High Dosage (HDO) ∞ | NA | NA | NA* |
| Risk of Continued Opioid Use (COU) ∞ | | | |
| *18-64 years - >=15 Days Covered* | NA | 0.00% | 0.00%* |
| *18-64 years - >=31 Days Covered* | NA | 0.00% | 0.00%* |
| *65+ - >=15 Days Covered* | NA | NA | NA* |
| *65+ - >=31 Days Covered* | NA | NA | NA* |
| *Total - >=15 Days Covered* | NA | 0.00% | 0.00%* |
| *Total - >=31 Days Covered* | NA | 0.00% | 0.00%* |
| Access/Availability of Care | | | |
| *Oral Evaluation, Dental Services (OED)* | | | |
| *Oral Evaluation, Dental Services (0-2)* | 29.34% | 30.28% | 29.90% |
| *Oral Evaluation, Dental Services (3-5)* | 61.01% | 65.08% | 63.50% |
| *Oral Evaluation, Dental Services (6-14)* | 64.30% | 69.01% | 67.37% |
| *Oral Evaluation, Dental Services (15-20)* | 49.01% | 54.75% | 52.85% |
| *Oral Evaluation, Dental Services (Total)* | 57.60% | 62.49% | 60.78% |
| Topical Fluoride for Children (TFC) | | | |
| *Topical Fluoride for Children (1-2)* | 12.37% | 14.06% | 13.37% |
| *Topical Fluoride for Children (3-4)* | 21.50% | 22.60% | 22.14% |

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *Topical Fluoride for Children (Total)* | 17.91% | 19.18% | 18.66% |
| Initiation and Engagement of AOD Dependence Treatment (IET) ◦ | | | |
| *Initiation of AOD – Alcohol Abuse or Dependence (13–17)* | NA | NA | NA* |
| *Engagement of AOD – Alcohol Abuse or Dependence (13–17)* | NA | NA | NA* |
| *Initiation of AOD – Opioid Abuse or Dependence (13–17)* | NA | NA | NA* |
| *Engagement of AOD – Opioid Abuse or Dependence (13–17)* | NA | NA | NA* |
| *Initiation of AOD – Other Drug Abuse or Dependence (13–17)* | NA | 43.59% ↓ | 48.39%* |
| *Engagement of AOD – Other Drug Abuse or Dependence (13–17)* | NA | 10.26% ↓ | 6.45%* |
| *Initiation of AOD – Total (13–17)* | NA | 47.73% ↓ | 50.72%* |
| *Engagement of AOD – Total (13–17)* | NA | 9.09% ↓ | 5.80%* |
| *Initiation of AOD – Alcohol Abuse or Dependence (18+)* | NA | NA | NA* |
| *Engagement of AOD – Alcohol Abuse or Dependence (18+)* | NA | NA | NA* |
| *Initiation of AOD – Opioid Abuse or Dependence (18+)* | NA | NA | NA* |
| *Engagement of AOD – Opioid Abuse or Dependence (18+)* | NA | NA | NA* |
| *Initiation of AOD – Other Drug Abuse or Dependence (18+)* | NA | NA | NA* |
| *Engagement of AOD – Other Drug Abuse or Dependence (18+)* | NA | NA | NA* |
| *Initiation of AOD – Total (18+)* | NA | NA | NA* |
| *Engagement of AOD – Total (18+)* | NA | NA | NA* |
| *Initiation of AOD – Alcohol Abuse or Dependence (Total)* | NA | NA | NA* |
| *Engagement of AOD – Alcohol Abuse or Dependence (Total)* | NA | NA | NA* |
| *Initiation of AOD – Opioid Abuse or Dependence (Total)* | NA | NA | NA* |
| *Engagement of AOD – Opioid Abuse or Dependence (Total)* | NA | NA | NA* |
| *Initiation of AOD – Other Drug Abuse or Dependence (Total)* | NA | 38.30% ↓ | 44.74%* |
| *Engagement of AOD – Other Drug Abuse or Dependence (Total)* | NA | 8.51% ↓ | 5.26%* |
| *Initiation of AOD – Total (Total)* | 58.82% ↓ | 40.00% ↓ | 47.19% |
| *Engagement of AOD – Total (Total)* | 0.00% ↓ | 7.27% ↓ | 4.49% |
| Prenatal and Postpartum Care (PPC) ◊ | | | |
| *Timeliness of Prenatal Care Under 21 (Admin only rate)* | NA | NA | NA* |
| *Postpartum Care Under 21 (Admin only rate)* | NA | NA | NA* |
| *Timeliness of Prenatal Care (Total per IDSS)* | NA | NA | NA* |
| *Postpartum Care (Total per IDSS)* | NA | NA | NA* |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | | | |
| *1–11 Years* | NA | 57.14% ↑ | NA* |
| *12–17 Years* | 54.72% ↓ | 63.00% ↓ | 60.13% |
| *Total* | 55.84% ↓ | 61.48% ↓ | 59.43% |
| Utilization | | | |
| Well-Child Visits in the First 30 Months of Life (W30) | | | |

| HEDIS Measure/Data Element | Molina HEDIS MY 2023 CHIP Rates | United HEDIS MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *First 15 Months* | 69.03% ↓ | 63.90% ↓ | 66.11% |
| *15 Months–30 Months* | 80.53% ↓ | 80.90% ↑ | 80.76% |
| Child and Adolescent Well-Care Visits (WCV) | | | |
| *3–11 Years* | 44.93% ↓ | 44.94% ↑ | 44.94% |
| *12–17 Years* | 40.84% ↑ | 41.12% ↑ | 41.03% |
| *18–21 Years* | 22.74% ↓ | 25.03% ↑ | 24.29% |
| *Total* | 41.65% ↓ | 41.72% ↑ | 41.69% |

NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
*: This statewide average includes CCO rates with small denominators.
◊: *The measure has a "Trend with Caution" guidance notes from NCQA for MY 2023.*
∞: *Lower rate indicates better performance*

When comparing the previous CHIP rates (MY 2022) to the MY 2023 CHIP rates, improvement was shown in 36 rates for United and in 24 rates for Molina.

**UHC CHIP** improved by 10 percentage points or more for the the 1–11 years of age indicator of the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) measure.

**Molina CHIP** improved by 10 percentage points or more for the following HEDIS MY 2023 measures:

- The Tdap/Td indicator for the Immunizations for Adolescents (IMA) measure.
- The 18–64 years of age indicator for the Appropriate Treatment for Upper Respiratory Infection (URI) measure.

**UHC CHIP** rates fell by 10 percentage points or more for:

- The Counseling for Nutrition and Counseling for Physical Activity indicators for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure.
- The 12–17 years of age indicator for the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) measure.

**Molina CHIP** rates fell by 10 percentage points or more for the 5–11 years of age indicator and the Total indicator for the Asthma Medication Ratio (AMR) measure.

## Non-HEDIS Performance Measure Validation – CAN Program

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by the CCOs for MY 2023 are listed in *Table*

*29: CAN Adult and Child Core Set Measure Rates*. The statewide averages have been included where applicable.

**Table 29: CAN CMS Core Set Measure Rates**

| CMS Core Set Measure/ Data Element | Magnolia MY 2023 CAN Rates | Molina MY 2023 CAN Rates | United MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| **Adult Core Set Measures** | | | | |
| Primary Care Access and Preventative Care | | | | |
| COLORECTAL CANCER SCREENING (COL-AD) ◊ | | | | |
| *Ages 46 - 50◊* | 24.68% | 17.10% | 23.99% | 23.69% |
| *Ages 51- 65◊* | 47.91% | 28.19% | 44.36% | 44.44% |
| *Ages 66 - 75◊* | 35.71% | NA | 29.17% | 32.59%* |
| *Total ( Ages 46 – 75)* | 42.82% ↓ | 25.97% ↑ | 39.81% ↑ | 39.91% |
| SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD) | | | | |
| *Ages 18-65* | 0.64% ↑ | 2.89% ↑ | 0.71% ↑ | 1.05% |
| *Ages 65+* | 3.63% ↓ | NA | 0.00% | 1.97%* |
| *Total* | 0.67% ↑ | 2.89% ↑ | 0.71% ↑ | 1.06% |
| Maternal and Perinatal Health | | | | |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD) | | | | |
| *Most or Moderately Effective Contraception – 3 days* | 12.66% ↑ | 13.33% ↑ | 13.18% ↓ | 13.01% |
| *Most or Moderately Effective Contraception – 90 days* | 51.64% ↑ | 59.46% ↑ | 54.29% ↓ | 54.56% |
| *LARC - 3 Days* | 0.61% ↑ | 1.22% ↑ | 0.98% ↑ | 0.89% |
| *LARC - 90 Days Reported* | 11.35% ↑ | 12.38% ↑ | 11.26% ↓ | 11.59% |
| CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD) | | | | |
| *Most or Moderately Effective Contraception Rate* | 24.69% ↑ | 24.81% ↑ | 25.26% ↑ | 24.91% |
| *LARC Rate* | 2.92% ↑ | 2.85% ↑ | 2.55% ↑ | 2.78% |
| Care of Acute and Chronic Conditions | | | | |
| DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) ∞ | | | | |
| *Ages 18 - 64* | 27.16 ↑ | 24.06 ↓ | 25.01 ↑ | 25.78 |
| *Ages 65+* | NA | 0.00 | 0.00 | 0.00 |
| *Total* | 27.07 ↑ | 24.06 ↓ | 24.96 ↑ | 25.72 |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) ∞ | | | | |
| *Ages 40 - 64* | 57.01 ↓ | 41.63 ↓ | 63.35 ↑ | 57.22 |
| *Ages 65+* | 106.72 ↓ | 0.00 | 0.00 ↓ | 68.40 |
| *Total* | 57.43 ↓ | 41.55 ↓ | 63.03 ↑ | 57.29 |
| HEART FAILURE ADMISSION RATE (PQI-08) ∞ | | | | |

| CMS Core Set Measure/ Data Element | Magnolia MY 2023 CAN Rates | Molina MY 2023 CAN Rates | United MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Ages 18 - 64* | 45.82 ↓ | 48.12 ↓ | 53.09 ↓ | 48.96 |
| *Ages 65+* | 0.00 ↓ | 0.00 | 216.45 ↑ | 68.40 |
| *Total* | 45.66 ↓ | 48.10 ↓ | 53.42 ↓ | 49.00 |
| ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) ∞ | | | | |
| *Ages 18 - 39* | 1.87 ↑ | 0.63 ↓ | 1.11 ↓ | 1.33 |
| HIV VIRAL LOAD SUPPRESSION (HVL - AD) | | | | |
| *Ages 18 - 64* | 39.30% ↑ | 8.94% ↓ | 22.25% ↑ | 28.91% |
| *Ages 65+* | NA | NA | NA | NA* |
| *Total* | 38.94% ↑ | 8.80% ↓ | 22.03% ↑ | 28.66% |
| DIABETES CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: HEMOGLOBIN A1C (HbA1c) POOR CONTROL (>9.0%) (HPCMI-AD) ∞ | | | | |
| *Ages 18 - 64* | 73.20% | 79.59% | 66.67% | 71.32% |
| *Ages 65+* | 75.00% | NA | NA | NA* |
| *Total* | 73.21% | 79.59% | 66.85% ↓ | 71.39% |
| Behavioral Health Care | | | | |
| USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) ∞ | | | | |
| *Ages 18 - 64* | 1.01% ↓ | 2.62% ↑ | 1.03% ↑ | 1.24% |
| *Ages 65+* | NA | NA | NA | NA* |
| *Total* | 1.01% ↓ | 2.62% ↑ | 1.02% ↑ | 1.24% |
| CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) ∞ | | | | |
| *Ages 18 - 64* | 3.24% ↑ | 9.26% ↑ | 4.04% ↓ | 4.52% |
| *Ages 65+* | NA | NA | NA | NA* |
| *Total* | 3.22% ↑ | 9.26% ↑ | 4.07% ↓ | 4.52% |
| USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD) | | | | |
| *Overall* | 45.78% ↑ | 61.19% ↑ | 38.94% ↑ | 44.60% |
| *Prescription for Buprenorphine* | 40.25% ↑ | 56.16% ↑ | 37.55% ↑ | 41.03% |
| *Prescription for Oral Naltrexone* | 0.97% ↑ | 3.65% ↑ | 0.88% ↓ | 1.27% |
| *Prescription for Long-Acting, Injectable Naltrexone* | 0.14% ↑ | 0.00% | 0.25% ↑ | 0.17% |
| *Prescription for Methadone* | 4.98% ↑ | 1.37% ↑ | 1.01% ↓ | 2.71% |
| MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (MSC-AD) | | | | |
| *Percentage of Current Smokers and Tobacco Users: Ages 18 to 64* | NA | 7.51% | 36.02% | 10.92%* |
| *Advised Smokers and Tobacco Users to Quit: Ages 18 to 64* | NA | 5.94% | 26.82% | 8.44%* |
| *Discussed or Recommended Cessation Medications: Ages 18 to 64* | NA | 3.44% | 20.31% | 5.46%* |

| CMS Core Set Measure/ Data Element | Magnolia MY 2023 CAN Rates | Molina MY 2023 CAN Rates | United MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Discussed or Provided Other Cessation Strategies: Ages 18 to 64* | NA | 2.92% | 16.86% | 4.59%* |
| *Percentage of Current Smokers and Tobacco Users: Age 65 and Older* | NA | 3.74% | NA | 3.60%* |
| *Advising Users to Quit: Age 65 and Older* | NA | 0.00% | NA | 0.00%* |
| *Discussing Cessation Medications: Age 65 and Older* | NA | 0.00% | NA | 0.00%* |
| *Discussing Cessation Strategies: Age 65 and Older* | NA | 0.00% | NA | 0.00%* |
| *Percentage of Current Smokers and Tobacco Users: Total* | NA | 7.31% | 35.47% | 10.57%* |
| *Advising Users to Quit: Total* | NA | 5.63% | 26.42% | 8.03%* |
| *Discussing Cessation Medications: Total* | NA | 3.26% | 20.00% | 5.20%* |
| *Discussing Cessation Strategies: Total* | NA | 2.77% | 16.60% | 4.37%* |
| **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* | 1.58% ↑ | 2.00% ↓ | 1.42% ↑ | 1.57% |
| DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH) | | | | |
| *Age 1 Screening* | 6.33% ↑ | 37.47% ↑ | 36.71% ↓ | 26.20% |
| *Age 2 Screening* | 6.61% ↑ | 49.84% ↑ | 47.09% ↓ | 34.67% |
| *Age 3 Screening* | 4.95% ↓ | 46.38% ↑ | 46.70% ↓ | 31.36% |
| *Total Screening* | 6.06% ↑ | 43.39% ↑ | 42.24% ↓ | 29.97% |
| Maternal and Perinatal Health | | | | |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH) | | | | |
| *Most or Moderately Effective Contraception – 3 days* | 1.67% ↑ | 1.16% ↓ | 2.92% ↑ | 2.00% |
| *Most or Moderately Effective Contraception – 90 days* | 57.62% ↑ | 50.87% ↑ | 62.66% ↑ | 58.05% |
| *LARC - 3 Days* | 0.48% ↓ | 0.58% ↑ | 1.30% ↑ | 0.78% |
| *LARC - 90 Days Reported* | 15.95% ↑ | 16.18% ↑ | 14.61% ↓ | 15.54% |
| CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH) | | | | |
| *Most or Moderately Effective Contraception Rate* | 28.66% ↑ | 26.57% ↑ | 28.86% ↓ | 28.43% |
| *LARC Rate* | 2.28% ↓ | 2.27% ↑ | 2.41% ↓ | 2.33% |
| Dental and Oral Health Services | | | | |
| SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH) | | | | |
| *Numerator 1 At Least One Sealant* | 51.56% ↓ | 42.15% ↑ | 46.68% ↓ | 48.05% |
| *Numerator 2 All Four Molars Sealed* | 35.41% ↓ | 28.30% ↑ | 30.92% ↓ | 32.45% |
| ORAL EVALUATION, DENTAL SERVICES (OEV-CH) | | | | |

| CMS Core Set Measure/ Data Element | Magnolia MY 2023 CAN Rates | Molina MY 2023 CAN Rates | United MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Age <1* | 0.77% ↓ | 1.03% ↑ | 1.07% ↑ | 0.95% |
| *Ages 1–2* | 21.89% ↓ | 21.87% ↑ | 23.27% ↑ | 22.38% |
| *Ages 3–5* | 57.69% ↓ | 52.34% ↑ | 57.13% ↓ | 56.12% |
| *Ages 6–7* | 63.32% ↓ | 57.50% ↑ | 64.93% ↑ | 62.69% |
| *Ages 8–9* | 63.51% ↓ | 56.74% ↑ | 65.37% ↓ | 62.86% |
| *Ages 10–11* | 62.12% ↑ | 54.79% ↑ | 63.97% ↑ | 61.45% |
| *Ages 12–14* | 56.85% ↑ | 48.45% ↑ | 58.28% ↓ | 55.93% |
| *Ages 15–18* | 45.81% ↓ | 39.75% ↑ | 47.44% ↓ | 45.47% |
| *Ages 19–20* | 27.24% ↓ | 22.82% ↑ | 29.77% ↑ | 27.52% |
| *Total Ages <1–20* | 49.66% ↑ | 42.01% ↑ | 50.34% ↓ | 48.30% |
| PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1) | | | | |
| *Ages 1–2* | 11.42% ↓ | 10.79% ↑ | 11.16% ↑ | 11.14% |
| *Ages 3–5* | 27.25% ↓ | 23.97% ↑ | 27.00% ↓ | 26.35% |
| *Ages 6–7* | 31.40% ↓ | 27.58% ↑ | 32.54% ↑ | 31.09% |
| *Ages 8–9* | 30.69% ↓ | 26.18% ↑ | 32.42% ↑ | 30.50% |
| *Ages 10–11* | 29.29% ↑ | 24.31% ↑ | 29.37% ↓ | 28.46% |
| *Ages 12–14* | 25.91% ↑ | 20.56% ↑ | 27.48% ↑ | 25.66% |
| *Ages 15–18* | 18.22% ↑ | 14.69% ↑ | 19.38% ↑ | 18.15% |
| *Ages 19–20* | 7.39% ↓ | 5.79% ↓ | 9.65% ↑ | 7.93% |
| *Total Ages 1–20* | 23.87% ↓ | 19.85% ↑ | 24.53% ↑ | 23.33% |
| PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2) | | | | |
| *Ages 1–2* | 6.06% ↓ | 6.40% ↑ | 6.53% ↑ | 6.33% |
| *Ages 3–5* | 25.56% ↑ | 22.12% ↑ | 25.01% ↓ | 24.51% |
| *Ages 6–7* | 30.62% ↓ | 26.92% ↑ | 31.60% ↑ | 30.27% |
| *Ages 8–9* | 30.16% ↓ | 25.67% ↑ | 31.94% ↑ | 30.00% |
| *Ages 10–11* | 28.94% ↓ | 23.88% ↑ | 28.74% ↓ | 27.99% |
| *Ages 12–14* | 25.33% ↓ | 20.19% ↑ | 26.85% ↑ | 25.09% |
| *Ages 15–18* | 17.81% ↑ | 14.29% ↑ | 18.91% ↑ | 17.71% |
| *Ages 19–20* | 7.06% ↓ | 5.57% ↓ | 9.49% ↑ | 7.67% |
| *Total Ages 1–20* | 22.70% ↓ | 18.37% ↑ | 23.24% ↑ | 22.06% |
| PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3) | | | | |
| *Ages 1–2* | 4.02% ↑ | 2.85% ↓ | 3.27% ↑ | 3.41% |
| *Ages 3–5* | 0.42% | 0.31% ↓ | 0.38% | 0.38% |
| *Ages 6–7* | 0.01% ↑ | 0.02% | 0.03% ↑ | 0.02% |
| *Ages 8–9* | 0.00% | 0.07% ↓ | 0.02% ↑ | 0.02% |
| *Ages 10–11* | 0.00% | 0.05% | 0.01% ↑ | 0.01% |
| *Ages 12–14* | 0.00% | 0.05% | 0.03% ↑ | 0.02% |
| *Ages 15–18* | 0.00% | 0.06% | 0.01% ↑ | 0.02% |
| *Ages 19–20* | 0.00% | 0.00% | 0.00% | 0.00% |

| CMS Core Set Measure/ Data Element | Magnolia MY 2023 CAN Rates | Molina MY 2023 CAN Rates | United MY 2023 CAN Rates | Statewide Average |
|---|---|---|---|---|
| *Total Ages 1-20* | 0.47% ↑ | 0.63% ↓ | 0.46% ↑ | 0.50% |

*NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
**: This statewide average includes CCO rates with small denominators.*
*∞ Lower rate indicates better performance.*

When comparing the previous rates (MY 2022) to the MY 2023 rates, some improvement was shown in 42 rates for Magnolia, 57 for Molina, and 48 for United.

**Magnolia CAN** improved by 10 percentage points or more for the following CMS Core Set measure rates for the CAN population:

- The most or moderately effective contraception-90 days indicator for the Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD) measure.
- The 65+ years of age indicator for the Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05) measure.
- The 65+ years of age indicator for the Heart Failure Admission Rate (PQI-08) measure.
- The ages 18-64 years of age indicator for the HIV Viral Load Suppression measure (HVL - AD).
- The most or moderately effective contraception-90 days indicator for the Contraceptive Care – Postpartum Women 15-20 years of age (CCP-CH) measure.

**Molina CAN** improved by 10 percentage points or more for the following CMS Core Set measure rates for the CAN population:

- The 40-64 years of age indicator and the Total indicator for the Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05) measure.
- The Overall and the Prescription for Buprenorphine indicators for the Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) measure.

**United CAN** rates increased more than 10 percentage points for the 65+ years of age indicator for the Heart Failure Admission Rate (PQI-08) measure. A lower rate for this measure indicates better performance.

## Non-HEDIS Performance Measure Validation – CHIP Program

*Table 30: CHIP Non-HEDIS Performance Measure Rates* provides an overview of rates reported by United and Molina for the CHIP population.

Table 30: CHIP CMS Core Set Measure Rates

| CMS Core Set Measure/Data Element | Molina MY 2023 CHIP Rates | United MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| **Adult Core Set Measures** | | | |
| Primary Care Access and Preventative Care | | | |
| SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD) | | | |
| *Ages 18 - 64* | 1.32% ↑ | 0.60% ↑ | 0.79% |
| *Ages 65+* | NA | NA | NA* |
| *Total* | 1.32% ↑ | 0.60% ↑ | 0.79% |
| Care of Acute and Chronic Conditions | | | |
| DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) ∞ | | | |
| *Ages 18 - 64* | 67.53 ↑ | 0.00 | 22.68 |
| *Ages 65+* | NA | NA | NA* |
| *Total* | 67.53 ↑ | 0.00 | 22.68 |
| HEART FAILURE ADMISSION RATE (PQI-08) ∞ | | | |
| *Ages 18 - 64* | 0.00 | 0.00 | 0.00 |
| *Ages 65+* | NA | NA | NA* |
| *Total* | 0.00 | 0.00 | 0.00 |
| ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) ∞ | | | |
| *Ages 18 - 39* | 9.65 ↑ | 0.00 | 3.24 |
| Care of Acute and Chronic Conditions | | | |
| HIV VIRAL LOAD SUPPRESSION (HVL - AD) | | | |
| *Ages 18 - 64* | NA | NA | NA* |
| *Ages 65+* | NA | NA | NA* |
| *Total* | NA | NA | NA* |
| DIABETES CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: HEMOGLOBIN A1C (HbA1c) POOR CONTROL (>9.0%) (HPCMI-AD) ∞ | | | |
| *Ages 18 - 64* | NA | NA | NA* |
| *Ages 65+* | NA | NA | NA* |
| *Total* | NA | NA | NA* |
| Behavioral Health Care | | | |
| USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) ∞ | | | |
| *Ages 18 - 64* | NA | NA | NA* |
| *Ages 65+* | NA | NA | NA* |
| *Total* | NA | NA | NA* |
| CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) ∞ | | | |
| *Ages 18 - 64* | NA | NA | NA* |
| *Ages 65+* | NA | NA | NA* |
| *Total* | NA | NA | NA* |
| USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD) | | | |
| *Overall* | NA | NA | NA* |

| CMS Core Set Measure/Data Element | Molina MY 2023 CHIP Rates | United MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *Prescription for Buprenorphine* | NA | NA | NA* |
| *Prescription for Oral Naltrexone* | NA | NA | NA* |
| *Prescription for Long-acting, Injectable Naltrexone* | NA | NA | NA* |
| *Prescription for Methadone* | NA | NA | NA* |
| MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (MSC-AD) | | | |
| *Percentage of Current Smokers and Tobacco Users: Ages 18 to 64* | NA | NA | NA* |
| *Advised Smokers and Tobacco Users to Quit: Ages 18 to 64* | NA | NA | NA* |
| *Discussed or Recommended Cessation Medications: Ages 18 to 64* | NA | NA | NA* |
| *Discussed or Provided Other Cessation Strategies: Ages 18 to 64* | NA | NA | NA* |
| *Percentage of Current Smokers and Tobacco Users: Age 65 and Older* | NA | NA | NA* |
| *Advising Users to Quit: Age 65 and Older* | NA | NA | NA* |
| *Discussing Cessation Medications: Age 65 and Older* | NA | NA | NA* |
| *Discussing Cessation Strategies: Age 65 and Older* | NA | NA | NA* |
| *Percentage of Current Smokers and Tobacco Users: Total* | NA | NA | NA* |
| *Advising Users to Quit: Total* | NA | NA | NA* |
| *Discussing Cessation Medications: Total* | NA | NA | NA* |
| *Discussing Cessation Strategies: Total* | NA | NA | NA* |
| **Child Core Set Measures** | | | |
| Primary Care Access and Preventative Care | | | |
| SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH) | | | |
| *Ages 12 - 17* | 1.71% ↑ | 1.44% ↑ | 1.52% |
| DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH) | | | |
| *Age 1 Screening* | NA | NA | NA* |
| *Age 2 Screening* | 56.32% ↓ | 53.45% ↓ | 54.53% |
| *Age 3 Screening* | 53.00% ↓ | 52.52% ↑ | 52.72% |
| *Total Screening* | 55.13% ↑ | 52.87% ↑ | 53.76% |
| Maternal and Perinatal Health | | | |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH) | | | |
| *Most or Moderately Effective Contraception – 3 days* | NA | NA | NA* |
| *Most or Moderately Effective Contraception – 90 days* | NA | NA | NA* |
| *LARC - 3 Days* | NA | NA | NA* |
| *LARC - 90 Days Reported* | NA | NA | NA* |
| CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH) | | | |
| *Most or Moderately Effective Contraception Rate* | 27.92% ↑ | 27.46% ↓ | 27.60% |
| *LARC Rate* | 2.43% ↑ | 2.28% ↑ | 2.33% |
| Dental and Oral Health Services | | | |
| SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH) | | | |
| *Numerator 1 At Least One Sealant* | 38.21% ↑ | 45.04% ↓ | 42.94% |

| CMS Core Set Measure/Data Element | Molina MY 2023 CHIP Rates | United MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *Numerator 2 All Four Molars Sealed* | 25.71% ↑ | 31.29% ↓ | 29.58% |
| ORAL EVALUATION, DENTAL SERVICES (OEV-CH) | | | |
| *Age <1* | NA | NA | NA* |
| *Ages 1–2* | 29.49% ↓ | 30.09% ↓ | 29.85% |
| *Ages 3–5* | 58.81% ↑ | 62.86% ↑ | 61.26% |
| *Ages 6–7* | 63.29% ↓ | 69.27% ↓ | 67.13% |
| *Ages 8–9* | 66.53% ↑ | 69.92% ↓ | 68.70% |
| *Ages 10–11* | 59.61% ↓ | 69.51% ↓ | 66.19% |
| *Ages 12–14* | 58.50% ↑ | 65.28% ↑ | 62.97% |
| *Ages 15–18* | 46.66% ↑ | 53.26% ↓ | 51.07% |
| *Ages 19–20* | 32.65% ↓ | 38.71% ↓ | 36.70% |
| *Total Ages <1–20* | 54.52% ↓ | 60.51% ↓ | 58.40% |
| PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1) | | | |
| *Ages 1–2* | 15.35% ↓ | 16.94% ↑ | 16.30% |
| *Ages 3–5* | 29.52% ↑ | 32.00% ↓ | 31.03% |
| *Ages 6–7* | 32.36% ↓ | 36.08% ↓ | 34.77% |
| *Ages 8–9* | 34.35% ↓ | 37.28% ↓ | 36.26% |
| *Ages 10–11* | 28.74% ↓ | 36.57% ↓ | 34.01% |
| *Ages 12–14* | 28.20% ↑ | 30.68% ↓ | 29.85% |
| *Ages 15–18* | 19.57% ↑ | 21.23% ↓ | 20.70% |
| *Ages 19–20* | 9.52% ↓ | 15.35% ↑ | 13.35% |
| *Total Ages 1–20* | 26.41% ↓ | 29.38% ↓ | 28.36% |
| PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2) | | | |
| *Ages 1–2* | 10.18% ↓ | 11.66% ↑ | 11.06% |
| *Ages 3–5* | 28.11% ↑ | 30.71% ↑ | 29.70% |
| *Ages 6–7* | 31.31% ↓ | 35.28% ↓ | 33.88% |
| *Ages 8–9* | 33.90% ↓ | 36.88% ↓ | 35.84% |
| *Ages 10–11* | 28.37% ↓ | 36.28% ↓ | 33.69% |
| *Ages 12–14* | 27.51% ↑ | 30.34% ↓ | 29.40% |
| *Ages 15–18* | 18.75% ↑ | 20.84% ↓ | 20.17% |
| *Ages 19–20* | 9.52% ↓ | 14.94% ↑ | 13.08% |
| *Total Ages 1–20* | 25.38% ↓ | 28.67% ↓ | 27.54% |
| PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3) | | | |
| *Ages 1–2* | 3.23% ↓ | 3.30% ↓ | 3.27% |
| *Ages 3–5* | 0.20% ↓ | 0.34% ↓ | 0.29% |
| *Ages 6–7* | 0.16% ↓ | 0.00% | 0.06% |
| *Ages 8–9* | 0.00% ↓ | 0.00% | 0.00% |
| *Ages 10–11* | 0.22% ↑ | 0.00% | 0.07% |
| *Ages 12–14* | 0.27% ↑ | 0.00% | 0.09% |

| CMS Core Set Measure/Data Element | Molina MY 2023 CHIP Rates | United MY 2023 CHIP Rates | Statewide Average |
|---|---|---|---|
| *Ages 15-18* | 0.30% ↑ | 0.02% ↑ | 0.11% |
| *Ages 19-20* | 0.00% ↑ | 0.00% | 0.00% |
| *Total Ages 1-20* | 0.38% ↓ | 0.18% | 0.25% |

*NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
**: This statewide average includes CCO rates with small denominators.*
*∞ Lower rate indicates better performance.*

When comparing the previous rates (MY 2022) to the MY 2023 rates, 22 rates for Molina and 14 rates for United showed some improvement.

**Molina CHIP** improved by 10 percentage points or more for the Numerator 1 At Least One Sealant indicator of the Sealant Receipt on Permanent First Molars (SFM-CH) measure. The 18-64 years of age and the Total indicator rates fell by 10 percentage points or more for the Diabetes Short -Term Complications Admission Rate (PQI01-AD) measure.

## Performance Improvement Project Validation

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

Each CCO is required to submit the performance improvement projects (PIPs) they have conducted during the preceding 12 months to Constellation for validation. For the 2024 - 2025 EQRs, the CCOs submitted the following PIPs:

**Table 31: CAN Performance Improvement Projects Submitted for Validation**

| CCO | Performance Improvement Project | Performance Improvement Project Aim |
|---|---|---|
| **Magnolia** | Adult and Child Respiratory Disease | Increase the percentage of the ratio of controller medications to total asthma medications during the treatment period. Also, increased use of spirometry to confirm the COPD diagnosis. |
| | Reducing Preterm Births | Decrease the preterm birth rate for pregnant members with a diagnosis of Hypertension/Pre-Eclampsia. |
| | Sickle Cell Disease Outcomes | Increase compliance with Hydroxyurea for eligible members. |
| **Molina** | Asthma | Increase the compliance rate of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. |
| | Chronic Obstructive Pulmonary Disease | Increase the rate of Medicaid members with pulmonary issues be dispensed a systemic corticosteroid within 14 days or a bronchodilator within 30 days of inpatient discharge or emergency department visit for a COPD related event. |
| | Follow Up after Hospitalization for Mental Illness | Increase the number of MSCAN members who receive follow-up within 7 and 30 days of discharge for selected mental illness. |

| CCO | Performance Improvement Project | Performance Improvement Project Aim |
|---|---|---|
| | Prenatal and Postpartum Care | Increase the number of members who receive a prenatal care visit in the first trimester, on the enrollment date or within 42 days of enrollment.<br>Increase the number of members who receive a postpartum care visit on or between 21 and 56 days of delivery. |
| | Sickle Cell Disease | Increase the percentage of members with sickle cell disease, who are enrolled and /or receive case management or follow-up services after hospitalization during the measurement year. |
| | Obesity | To increase the percentage of members who had an outpatient visit with a PCP or OB/GYN that includes a weight assessment counseling for nutrition, physical activity, and body mass index. |
| **United** | Improving Pregnancy Outcomes | Reduce the total number of preterm deliveries. |
| | Respiratory Illness Management | Improve the percentage of members with asthma and chronic obstructive pulmonary disease who are dispensed the appropriate medications to manage their respiratory conditions. |
| | Sickle Cell Disease Management Decreasing ER Utilization | Decrease emergency room utilization for members diagnosed with sickle cell disease. |

**Table 32: CHIP Performance Improvement Projects Submitted for Validation**

| CCO | Performance Improvement Project | Performance Improvement Project Aim |
|---|---|---|
| **Molina – CHIP** | Asthma | Increase the compliance rate of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. |
| | Follow Up after Hospitalization | Increase the number of CHIP members who receive follow-up within 7 and 30 days of discharge for selected mental illness. |
| | Obesity | To increase the percentage of CHIP members who had an outpatient visit with a PCP or OB/GYN that includes weight assessment counseling for nutrition, physical activity, and body mass index. |
| | Well Care- Well Child | Increase the number of CHIP members who receive at least 6 or more well care/well child visits during the first 0 to 15 months of life and who turned 15 months old during the measurement year. |
| **United – CHIP** | Adolescent Well Care (AWC) | Improve and sustain adolescent well-care visits with a PCP or OB/GYN practitioner during the measurement year. |
| | Follow-up after Hospitalization for Mental Illness (FUH) | Improve the number of post hospitalization follow-up visits 7 days post discharge and 30 days post discharge. |
| | Child Member Satisfaction, Getting Needed Care | Increase the percentage of members who answer the CAHPS® Child survey question Getting Needed Care with a score of 8, 9 or 10. Question 46: Easy to see a specialist. |

| CCO | Performance Improvement Project | Performance Improvement Project Aim |
|---|---|---|
| | Reducing Adolescent and Childhood Obesity | Improve communication between the provider and the member regarding weight, physical activity, and nutritional counseling. |

## Technical Methods for Data Collection and Validation

The validation of the PIPs was conducted in accordance with the CMS protocol titled, *"EQR Protocol 1: Validation of 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

Constellation validates and scores the submitted PIPs using the CMS-designed protocol and proprietary worksheets to evaluate the validity and confidence in the results of each project. The proprietary worksheets were developed based on the requirements included in Protocol 1, which include the two activities displayed in *Table 33: Constellation's PIP Validation Activities per CMS Protocol*.

**Table 33: Constellation's PIP Validation Activities per CMS Protocol**

| Activity One: Assess the PIP Methodology | | |
|---|---|---|
| **Step** | **Description** | **Step Questions** |
| 1 | Review the Selected PIP Topic(s) | Are the selected PIP topic(s) appropriate? |
| 2 | Review the PIP Aim Statement | How appropriate and adequate is the aim statement? |
| 3 | Review the Identified PIP Population | Did the Plan clearly identify the population for the PIP in relation to the PIP aim statement? |
| 4 | Review Sampling Methods | Are the sampling methods appropriate and will they produce valid and reliable results? |
| 5 | Review the Selected PIP Variables and Performance Measures | Do the selected variables identify the Plan's performance on the PIP questions objectively and reliably and use clearly defined indicators of performance? |

| Activity One: Assess the PIP Methodology | | |
|---|---|---|
| **Step** | **Description** | **Step Questions** |
| 6 | Review Data Collection Procedures | Are the procedures the Plan used to collect the data that inform the PIP measurement valid and reliable? |
| 7 | Review Data Analysis and Interpretation of PIP Results | Were appropriate techniques used, and were the analysis and interpretation of PIP results accurate? |
| 8 | Assess Improvement Strategies | Did the Plan apply appropriate interventions for achieving improvement? |
| 9 | Assess the Likelihood that Significant and Sustained Improvement Occurred | What is the likelihood that significant and sustained improvement occurred as a result of the PIP? |
| **Activity Two: Perform Overall Validation and Reporting of PIP Results** | | |
| 1 | Perform Validation | Using the worksheet, score steps in Activity 1 to answer: Were the steps considered met, partially met, or not met? Which category does the overall PIP validation score fall into: High Confidence, Confidence, Low Confidence, or Not Credible? |
| 2 | Report Results | Are recommendations and/or corrective actions documented in the PIP validation worksheet and the CCO's annual report? |

The PIP validation process follows a structured, nine-step methodology designed to ensure accuracy, reliability, and meaningful healthcare improvements. Each PIP is systematically reviewed to assess topic selection, aim statement clarity, population identification, sampling methods, PMs, data collection, analysis, intervention strategies, and sustainability of improvement. This comprehensive approach evaluates the methodological soundness of each project, ensuring that findings are free from bias and capable of supporting data-driven decision-making.

A weighted scoring system is applied to each step, prioritizing critical areas that have the most significant impact on the validity of results. Higher weights are assigned to essential components, such as selecting appropriate PMs, using valid sampling techniques, and implementing meaningful improvement strategies. Other elements, including population documentation, data sources, and analysis procedures, are evaluated with proportionate weight to ensure a balanced and rigorous assessment. Each component is scored as "Met," "Not Met," or "Not Applicable" to provide a standardized and objective evaluation. Failure to meet key elements can significantly affect the overall credibility of the results.

The final validation score determines the level of confidence in the reported finding (see *Table 34*). Projects scoring 90 to 100% are classified as High Confidence, indicating strong methodological integrity with minimal documentation concerns. A Confidence rating between

70 and 89% suggests minor issues that introduce slight bias but do not compromise overall results. A Low Confidence rating between 60 to 69% signals major deviations from established methods that may impact data integrity, while projects scoring below 60% are deemed Not Credible, indicating significant flaws that prevent validation of the reported outcomes.

**Table 34: Constellation's PIP Audit Designation Categories**

| 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.<br>*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.<br>*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.<br>*Validation findings between 60%–69% are classified here.* |
| Reported Results NOT Credible | Major errors that put the results of the entire project in question.<br>*Validation findings below 60% are classified here.* |

## OVERVIEW OF PIP VALIDATION RESULTS

The following tables provide a summary of the validation results, project performance over time, and interventions for each of the PIPs. An arrow pointing up (↑) indicates that project's performance on the measure is improving. The down arrows (↓) indicate the project's performance on the measure is declining. Cells highlighted in green indicate a statistically significant improvement in performance. The yellow highlighted cells indicate a statistically significant decline in performance. Cells without highlighting indicate the change was not statistically significant.

## CAN PIP VALIDATION RESULTS

**Magnolia** submitted three PIPs regarding Reducing Preterm Births, Sickle Cell Disease Outcomes, and Asthma/COPD. The results of the validations for those PIPS follow.

**Table 35: Magnolia PIP Performance Findings**

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) | R4 (MY) | R5 (MY) |
| Reducing Preterm Births | 74/75=99% High Confidence in Reported Results | Percentage of members in the denominator who gave birth prior to 37 weeks gestation during the measurement period. | 14.47% (2020-2021) | 11.4% | 15.8% ↑ (2021-2022) | 15.1% ↓ (2022-2023) | 15.4% ↑ (2023-2024) | N/A | N/A |
| Sickle Cell Disease Outcomes | 80/80=100% High Confidence in Reported Results | Compliance rate of Hydroxyurea for members who are prescribed to take the medication. | 37.5% (2018-2019) | 47% | 34.7% ↓ (2019-2020) | 20.6% ↓ (2020-2021) | 25.8% ↑ (2021-2022) | 25.9% ↑ (2022-2023) | 30.5% ↑ (2023-2024) |
| Adult and Child Respiratory Disease | 80/80=100% High Confidence in Reported Results | Percentage of members 12-18 years of age who have a medication ratio of 50% or greater during the measurement year. | 71.2% (2019) | 76.9% | 70.2% ↓ (2020) | 70.3% ↑ (2021) | 71.1% ↑ (2022) | 74.0% ↑ (2023) | N/A |
| | | Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. | 28.4% (2019) | 36.8% | 26.5% ↓ (2020) | 21.8% ↓ (2021) | 22.3% ↑ (2022) | 24.5% ↑ (2023) | N/A |

Statistically significant improvement in performance  Statistically significant decline in performance

R1 – Remeasurement 1; R2 – Remeasurement 2; R3 – Remeasurement 3; R4 – Remeasurement 4; R5 – Remeasurement 5; N/A = not applicable as no measurement has been conducted

Table 36: PIP Interventions - Magnolia

| Interventions |
|---|
| **Reducing Preterm Births** |
| • Member outreach on pregnancy related topics.<br>• Completing Notification of Pregnancy as applicable.<br>• Enrolling members in the Start Smart for Baby program.<br>• Home blood pressure monitoring program.<br>• Nutritional status assessments.<br>• Referral to Care Management for continuous follow-up.<br>• Medical record review for monitoring and tracking.<br>• Member and provider education on the clinical practice guidelines. |
| **Sickle Cell Disease Outcomes** |
| • The Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and on the importance of medication adherence.<br>• Letters are mailed to the providers of those members identified, encouraging the provider to discuss medication adherence at the member's next scheduled appointment.<br>• Outreach is conducted to all members who received letters to provide education and to address any barriers/concerns.<br>• Texting campaigns to encourage medication refill reminders. |
| **Asthma/COPD** |
| • 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.<br>• Distribution of the updated HEDIS Quick Reference Guides for MY 2023 to providers.<br>• The Pharmacy Team mailed letters to both members and providers in the AMR population encouraging the addition of a long-term controller medication.<br>• Interactive texting campaigns for medication refill and missed refill reminders. |

**Molina CAN** submitted six CAN PIPs regarding Asthma, COPD, Follow up After Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. The results of the validations for those PIPS follow.

**Table 37: Molina CAN PIP Performance Findings**

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | |
|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) |
| Asthma Medication Ratio | 80/80=100% High Confidence in Reported Results | Percentage of members 5-64 years of age who were compliant for a ratio of controller medications to total asthma medications of 0.50 or greater. | 66.0% (2021) | 72.9% | 68.2% ↑ (2022) | 64.7% ↓ (2023) | 84.8% ↑ (2024)* |
| Pharmacotherapy Management of COPD Exacerbation | 80/80=100% High Confidence in Reported Results | Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications. | 40.0% (2021) | 53.4% | 47.1% ↑ (2022) | 57.9% ↑ (2023) | 62.1% ↑ (2024)* |
| | | Percentage of COPD exacerbations for MSCAN members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event. | 80.0% (2021) | 81.8% | 74.2% ↓ (2022) | 77.2% ↑ (2023) | 75.9% ↓ (2024)* |
| Follow-up After Hospitalization for Mental Illness | 74/75=99% High Confidence in Reported Results | Percentage of discharges for which the MSCAN members received follow-up within 30 days of discharge. | 16.9% (2021) | 50.0% | 49.2% ↑ (2022) | 52.1% ↑ (2023) | 27.5% ↓ (2024)* |
| | | Percentage of discharges for which the MSCAN members received follow-up within 7 days of discharge. | 8.1% (2021) | 28.3% | 30.3% ↑ (2022) | 31.1% ↑ (2023) | 19.66% ↓ (2024)* |
| Prenatal and Postpartum Care | 74/75=99% High Confidence in | Percentage of deliveries that receive a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment | 89.7% (2021) | 93.6% | 88.7% ↓ (2022) | 87.0% ↓ (2023) | 89.4% ↑ (2024)* |

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | |
|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) |
| | Reported Results | Percentage of deliveries that had a postpartum visit on or between 7 and 84 days of delivery. | 30.8% (2021) | 74.3% | 48.4% ↑ (2022) | 51.1% ↑ (2023) | 35.4% ↓ (2024)* |
| Sickle Cell Disease | 74/75=99% High Confidence in Reported Results | Percentage of members 6 years of age and older with sickle cell disease who receive case management services during the measurement year. | 4.9% (2021) | 15.9% | 8.7% ↑ (2022) | 9.5% ↑ (2023) | 8.3% ↓ (2024)* |
| Obesity | 74/75=99% High Confidence in Reported Results | Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile during the measurement year. | 12.6% (2021) | 61.3% | 27.9% ↑ (2022) | 27.7% ↓ (2023) | 14.0% ↓ (2024)* |
| | | Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year. | 11.5% (2021) | 52.3% | 14.9% ↑ (2022) | 15.7% ↑ (2023) | 7.5% ↓ (2024)* |
| | | Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year. | 8.4% (2021) | 57.4% | 15.5% ↑ (2022) | 15.6% ↑ (2023) | 7.3% ↓ (2024)* |

Statistically significant improvement in performance  Statistically significant decline in performance

R1 – Remeasurement 1; R2 – Remeasurement 2;R3 – Remeasurement 3; 4th quarter rates are reported for remeasurements; * Q1 2024 which is the most recent remeasurement as of validation

**Table 38: Molina CAN PIP Interventions**

| Interventions |
|---|
| **Asthma Medication Ratio** |
| • Asthma education video on proper use of inhalers<br>• Monitoring of non-compliant members and encouraging providers to contact members to close the gap in care<br>• Telephone call campaign to encourage members to get their annual wellness exams<br>• Provider toolkits and educational materials |

| Interventions |
| --- |
| • Member educational materials<br>• School Visits |
| **Pharmacotherapy Management of COPD Exacerbation** |
| • Smoking Cessation Program that provides access to over-the-counter tobacco cessation products<br>• Provider education tools<br>• Quality Performance Tool Dashboard<br>• Case management enrollment<br>• Staff training |
| **Follow-up After Hospitalization for Mental Illness** |
| • Transition of Care (TOC) Coaches: Once notified of assigned admitted members, TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan.<br>• Discharge planning checklist<br>• Processes to improve efficiency of scheduling follow-up appointments<br>• Provider education |
| **Prenatal and Postpartum Care** |
| • Provider education<br>• Member incentives - gift cards and car seats<br>• Member outreach events<br>• Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize an electric breast pump for the first six months of their child's life |
| **Sickle Cell Disease** |
| • Internal monitoring and tracking for inpatient care and emergency department visits<br>• Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population.<br>• Collaboration with the MS Sickle Cell Foundation<br>• Member educational materials |
| **Obesity** |
| • Provider education<br>• Member incentives, member outreach, and member events for awareness and education |

**United CAN** submitted four CAN PIPs regarding Reducing 30-Day Psychiatric Inpatient Readmission Rates, Improving Pregnancy Outcomes, Respiratory Illness Management, and Sickle Cell Disease Management Decreasing Emergency Room (ER) Utilization. The results of the validation for those PIPS follow.

**Table 39: United CAN PIP Performance Findings**

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) | R4 (MY) |
| Reducing 30-Day Psychiatric Inpatient Readmission Rates | 74/75=99% High Confidence in Reported Results | Percentage of mental health readmissions from the five identified inpatient psychiatric facilities within 30 days of discharge. | 18.0% (2018) | 14.2% | 19.2% ↓ (2019) | 17.7% ↑ (2020) | 21.4% ↓ (2021) | 18.7% ↑ (2022) |
| | | Percentage of members readmitted who were discharged from any of the five identified psychiatric facilities and were enrolled in high-risk case management services. | 26% (2018) | 100% | 46% ↑ (2019) | 38% ↓ (2020) | 28% ↓ (2021) | 19% ↓ (2022) |
| Improving Pregnancy Outcomes | 94/95=99% High Confidence in Reported Results | Percentage of women who had a live birth that received a prenatal care visit in the first trimester or within 42 days of enrollment. | 92.2% (2019) | 94.9% | 91.5% ↓ (2020) | 93.7% ↑ (2021) | 96.8% ↑ (2022) | 92.9% ↓ (2023) |
| Respiratory Illness Management | 74/75=99% High Confidence in Reported Results | The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 to November 30 of the measurement year and who were dispensed appropriate medications: Bronchodilators. | 74.9% (2019) | 85.2% | 75.1% ↑ (2020) | 76.4% ↑ (2021) | 78.4% ↑ (2022) | 80.8% ↑ (2023) |
| | | The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 to November 30 of the measurement | 42.2% (2019) | 53.8% | 54.0% ↑ (2020) | 49.9% ↓ (2021) | 50.8% ↑ (2022) | 46.2% ↓ (2023) |

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) | R4 (MY) |
| | | year and who were dispensed appropriate medications: Systemic Corticosteroid. | | | | | | |
| | | The percentage of asthma members 5–64 years of age who are identified as having persistent asthma and had a ratio of controller medications to total medications of 0.50 or greater during the measurement year. | 70.7% (2019) | 72.9% | 74.1% ↑ (2020) | 73.4% ↓ (2021) | 75.8% ↑ (2022) | 74.0% ↓ (2023) |
| Sickle Cell Disease Management Decreasing ER Utilization | 80/80=100% High Confidence in Reported Results | The number of members 5-64 years of age during the measurement year who were identified as a persistent super user of emergency room services for sickle cell disease complications. A lower rate is better. | 36.3% (2019) | 26.8% | 26.4% ↑ (2020) | 28.5% ↓ (2021) | 28.9% ↓ (2022) | 24.8% ↑ (2023) |

Statistically significant improvement in performance  Statistically significant decline in performance

R1 – Remeasurement 1; R2 – Remeasurement 2; R3 – Remeasurement 3; R4 – Remeasurement 4

### Table 40: United CAN PIP Interventions

| Interventions |
|---|
| **Reducing 30-Day Psychiatric Inpatient Readmission Rates** |
| • Collaboration with high volume Hinds County outpatient and inpatient providers to schedule and facilitate meetings to discuss ways to improve readmission rates by increasing the seven-day follow-up appointment rate.<br>• Meds to Beds Program to provide transition solutions to coordinate care and discharge medications for members discharged from inpatient facilities.<br>• Enhanced Case Management.<br>• Direct referrals to Genoa Pharmacy.<br>• Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from Inpatient level of care. |
| **Improving Pregnancy Outcomes** |
| • Home visit care management services in seven underserved communities in MS. |

| Interventions |
| --- |
| • Care management for high-risk pregnant members and their babies less than a year old.<br>• The Optum Whole Person Care Program provides telephonic and/or face-to-face outreach to high-risk members to educate the member and help with establishing an obstetric practice.<br>• Dedicated maternity Member Services Team for telephonic outreach to low-risk members or to members whose risk is unknown to identify any barriers such as transportation/childcare and to connect the member to support resources.<br>• Member and provider education with the First Steps packets and the OB toolkits.<br>• National Healthy Starts Program to address social needs.<br>• Provider education with OB Toolkits.<br>• Weekly data analysis with risk stratification.<br>• Healthy Starts Program to address social needs. |
| **Respiratory Illness Management** |
| • Clinical practice consultants visit high volume practices to discuss clinical practice guidelines and evidence-based quality performance guidelines and assist with interpreting patient care opportunity reports.<br>• Pharmacy outreach to ensure members have educational materials, prescriptions are filled and assist with overrides or claims issues related to prescribed inhalers.<br>• Communication with clinics regarding non-compliant members, patient care opportunity reports, and provider education. |
| **Sickle Cell Disease Management Decreasing ER Utilization** |
| • Outreach to providers encouraging the use of hydroxyurea for patients who do not have a pharmacy claim for hydroxyurea.<br>• Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients.<br>• Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments.<br>• Telehealth campaigns and after-hour care newsletters.<br>• Weekly interdisciplinary rounds for Case Management.<br>• Provider education with the After Hour Care newsletter. |

## CHIP PIP VALIDATION RESULTS

**Molina CHIP** submitted four CHIP PIPs regarding Well Care/Well Child, Asthma Medication Ratio, Obesity, and Follow-up After Hospitalization for Mental Illness. The results of the validations for those PIPS follow.

**Table 41: Molina CHIP PIP Performance Findings**

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | |
|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) |
| Asthma Medication Ratio | 85/85=100% High Confidence in Reported Results | Percentage of MS CHIP asthmatic members 5-19 years of age who were compliant for a ratio of controller medications to total asthma medications of 0.50 or greater (HEDIS AMR measure). | 84.5% (2021) | 72.9% | 82.6% ↓ (2022) | 75.8% ↓ (2023) | 80.7% ↑ (2024) |
| Follow-up After Hospitalization for Mental Illness | 74/75=99% High Confidence in Reported Results | Percentage of discharges for which the CHIP members received follow-up within 30 days of discharge. | 14.3% (2021) | 50.0% | 67.0% ↑ (2022) | 55.0% ↓ (2023) | 37.5% ↓ (2024)* |
| | | Percentage of discharges for which the CHIP members received follow-up within 7 days of discharge. | 7.1% (2021) | 28.3% | 36.1% ↑ (2022) | 32.0% ↓ (2023) | 25.0% ↓ (2024)* |
| Obesity | 74/75=99% High Confidence in Reported Results | Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile during the measurement year. | 0% (2021) | 61.3% | 23.1% ↑ (2022) | 24.5% ↑ (2023) | 11.1% ↓ (2024)* |
| | | Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year. | 0% | 52.3% | 13.2% ↑ (2022) | 16.2% (2023) | 6.4% ↓ (2024)* |
| | | Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year. | 0% | 57.4% | 13.6% ↑ (2022) | 15.6% (2023) | 6.0% ↓ (2024)* |
| Well Care/Well Child | 79/80= 99% | The percentage of members who turn 15 months old during the measurement period | 42.6% (2021) | 56.1% | 72.8% ↑ (2022) | 69.0% ↓ (2023) | 63.1% ↓ (2024)* |

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | |
|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) |
| | High Confidence in Reported Results | who had six or more well-child visits with a PCP during their first 15 months of life. | | | | | |

Statistically significant improvement in performance  Statistically significant decline in performance

R1 – Remeasurement 1; R2 – Remeasurement 2;R3 – Remeasurement 3; 4th quarter rates are reported for remeasurements; * Q1 2024 which is the most recent remeasurement as of validation

### Table 42: PIP Interventions – Molina CHIP

| Interventions |
|---|
| **Asthma Medication Ratio** |
| • Asthma education for members on the proper use of an inhaler<br>• Telephone campaigns to encourage members to get annual wellness exams<br>• Provider education with toolkits and assistance with member outreach |
| **Follow-up After Hospitalization for Mental Illness** |
| • Transition of Care collaborative on-site discharge planning<br>• Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation<br>• Implementation of a Discharge Planning Checklist<br>• Behavioral health provider engagement to establish processes to ensure members can be seen within 7 days or 30 days post discharge |
| **Obesity** |
| • Provider toolkits to help facilitate tracking reports and address areas needed<br>• Member education, community outreach, and incentives |
| **Well Care/Well Child** |
| • Provider education, periodic face-to-face visits offering HEDIS toolkits, non-compliant member list, provider portal training, and HEDIS Tip Sheets for well visits<br>• Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale<br>• Member incentives provided on the day of the screening |

**United CHIP** submitted four CHIP PIPs regarding Adolescent Well Care, Follow Up After Hospitalization, Obesity, and Member Satisfaction (Getting Needed Care). The results of the validation for those PIPS follow.

**Table 43: PIP Performance Findings – United CHIP**

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | |
|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) |
| Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV) | 75/75=100% High Confidence in Reported Results | The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (Age 12-17). | 36.4% (2020) | 50.6% | 40.2% ↑ (2021) | 39.9% ↓ (2022) | 41.1% ↑ (2023) |
| | | The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (Age 18-21). | 19.6% (2020) | 24.5% | 25.3% ↑ (2021) | 24.9% ↓ (2022) | 25.0% ↑ (2023) |
| Follow Up After Hospitalization for Mental Illness | 74/75 = 99% High Confidence in Reported Results | Percentage of discharges for which the CHIP members received follow-up within 30 days of discharge. | 55.8% (2012) | 69.5% | 65.8% ↑ (2021) | 67.5% ↑ (2022) | 63.2% ↓ (2023) |
| | | Percentage of discharges for which the CHIP members received follow-up within 7 days of discharge. | 25.4% (2012) | 42.3% | 35.1% ↑ (2021) | 41.1% ↑ (2022) | 36.8% ↓ (2023) |
| Reducing Adolescent and Childhood Obesity | 94/95=100% Hight Confidence in Reported Results | Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile during the measurement year. | 30.7% (2016) | 74.5% | 70.1% ↑ (2021) | 72.3% ↑ (2022) | 66.7% ↓ (2023) |
| | | Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year. | 40.6% (2016) | 49.4% | 53.0% ↑ (2021) | 47.9% ↓ (2022) | 36.9% ↓ (2023) |
| | | Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence | 36.7% (2016) | 50.1% | 49.9% ↑ (2021) | 48.7% ↓ (2022) | 33.6% ↓ (2023) |

| PIP Topic | Validation Score | Performance Measure | Performance Measure Results | | | | |
|---|---|---|---|---|---|---|---|
| | | | Baseline (MY) | Goal | R1 (MY) | R2 (MY) | R3 (MY) |
| | | of counseling for physical activity during the measurement year. | | | | | |
| Getting Needed Care CAHPS | 94/95=100% High Confidence in Reported Results | Percentage of parents of members 17 years of age or under as of December 31 of the measurement year who provided a valid response to the CAHPS® adult survey with a score of 8, 9 or 10 for easy to see a specialist. | 80.9% (2017) | 89.6% | 90.3% ↑ (2021) | 87.0% ↓ (2022) | 84.7% ↓ (2023) |

Statistically significant improvement in performance  Statistically significant decline in performance

R1 – Remeasurement 1; R2 – Remeasurement 2; R3 – Remeasurement 3; + For ease of data presentation, baseline and most recent three remeasurements are presented.

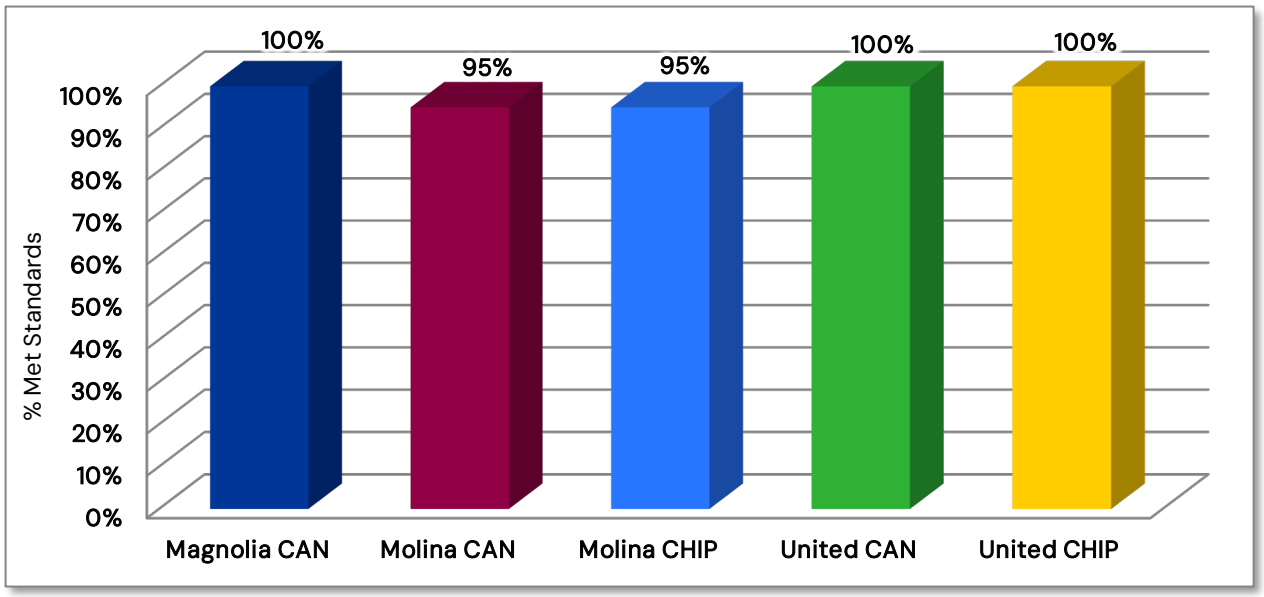
### Table 44: United CHIP PIP Interventions

| Interventions |
|---|
| **Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)** |
| • Phone calls to noncompliant members and after-hours and weekend clinic days. Staff collaborated with participating clinics to close care gaps.<br>• Clinical practice consultants and clinical transformation consultants conduct educational sessions with providers on HEDIS requirements.<br>• Resumption of the Farm to Fork activities for members to receive educational materials regarding wellness visits and immunizations. |
| **Follow Up After Hospitalization for Mental Illness** |
| • Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay.<br>• Continue demographic workflow to improve capture of current contact numbers for enrollees.<br>• Fax blasts sent to practitioners and clinical staff sharing the requirements for behavioral health practitioners and PCPs to communicate relevant treatment information involving member care.<br>• Case management initiate calls to schedule follow-up appointments. |
| **Reducing Adolescent and Childhood Obesity** |
| • Member and provider education.<br>• Phone calls to noncompliant members.<br>• After-hours and weekend clinic days.<br>• Clinical Practice Consultants conduct routine visits to PCPs to provide education on HEDIS measures and appropriate coding and billing.<br>• Community outreach activities such as the Farm to Fork Program and health fairs. |

| Interventions |
| --- |
| **Getting Needed Care CAHPS** |
| • Member education regarding the provider network and how to access care.<br>• Clinical Practice Consultants make face-to-face visits with high volume clinics to discuss the CAHPS survey.<br>• Provide member education during phone calls and town hall meetings regarding United's provider network.<br>• Offer case management to providers to support or expedite referrals. |

*Figure 5: Quality Improvement Findings* displays the percentage of "Met" scores for each health plan for the Quality Improvement section.

**Figure 5: Quality Improvement Findings**




*Scores were rounded to the nearest whole number*

*Tables 45* and *46* display the strengths, weaknesses, and recommendations for the Quality Improvement section.

**Table 45: Quality Improvement Strengths**

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| The QI Programs were structured and comprehensive with well-defined committees. | ✓ | | |
| Each QI Program covers a wide range of health care aspects, including physical, behavioral, and oral health, ensuring that members receive holistic and integrated care across the entire health care continuum. | ✓ | | |
| Utilization data from various sources is used for quality monitoring. | ✓ | | |
| The QI Programs place a strong emphasis on health equity, addressing health and care inequalities, and ensuring culturally and linguistically appropriate services. This is crucial for reducing disparities and improving health outcomes for diverse populations. | ✓ | | |
| THE CCOs were fully compliant with all information systems standards and HEDIS determination standards for the CAN and CHIP HEDIS performance measures. | ✓ | | |
| Based on the validation of performance measure rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. | ✓ | | |
| The CCOs improved or remained consistent overall with MY 2023 rates. | ✓ | | |

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| The performance improvement projects received scores within the high confidence in reported results range across health plans, with most validation scores ranging between 99% and 100%. | ✓ | | |
| Comprehensive intervention strategies were implemented across multiple PIPs. Plans deployed member outreach initiatives, provider education programs, case management services, and technology-driven interventions such as telehealth campaigns, text reminders, and pharmacy outreach programs. | ✓ | | |

### Table 46: Quality Improvement Weaknesses and Recommendations

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| United requires its members to submit requests for information regarding the QI Program in writing. | *Include information in the Member Handbook regarding the QI program and provide a phone number for members to call instead of requiring them to submit a written request for additional information.* | ✓ | | |
| Some of the QI Program Descriptions contained incorrect information regarding the health plan's credentialing and recredentialing responsibilities. | *Update Program Descriptions and include the health plans' responsibilities related to DOM's centralized credentialing process.* | ✓ | | |
| 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. | *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 for Magnolia. The HEDIS Compliance Audit Final Audit Report also identified areas of improvement in reporting enrollment information. | *Improve processes for maintaining and reporting accurate enrollment counts for measure rate reporting.* | ✓ | | |
| While Molina seems to have experienced improvements in measure rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years. | *Improve processes for rate validation and trending to identify measure reporting concerns.* | ✓ | | |

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| Several PIP performance measures did not show consistent improvement over time, with some indicators stagnating or declining despite continued interventions. | *Reassess interventions using data-driven evaluations to refine strategies and improve outcomes.* | ✓ | | |
| Low adherence rates were noted for certain chronic condition management PIP measures, particularly in asthma/COPD, obesity management, and sickle cell disease interventions. | *Enhance patient engagement with personalized outreach and targeted reminders Strengthen provider collaboration to improve health outcomes in PIPs.* | ✓ | | |

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

**Table 47: Quality Improvement Comparative Data**

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Quality Improvement (QI) Program<br>*42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)* | | | | | |
| The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members | Met | Partially Met ↓ | Partially Met ↓ | Met | Met |
| The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities | Met | Met | Met | Met | Met |
| The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems | Met | Met | Met | Met | Met |
| An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s) | Met | Met | Met | Met ↑ | Met ↑ |
| Quality Improvement Committee | | | | | |
| The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The composition of the QI Committee reflects the membership required by the contract | Met | Met | Met | Met | Met |
| The QI Committee meets at regular intervals | Met | Met | Met | Met | Met |
| Minutes are maintained that document proceedings of the QI Committee | Met | Met | Met | Met | Met |
| Performance Measures<br>*42 CFR §438.330 (c) and §457.1240 (b)* | | | | | |
| Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures" | Met | Met | Met | Met | Met |
| Quality Improvement Projects | | | | | |
| Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM | Met | Met | Met | Met | Met |
| The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects" | Met | Met | Met | Met | Met |
| Provider Participation in Quality Improvement Activities | | | | | |
| The CCO requires its providers to actively participate in QI activities | Met | Met | Met | Met | Met |
| Providers receive interpretation of their QI performance data and feedback regarding QI activities | Met | Met | Met | Met | Met |
| The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines | Met | Met | Met | Met ↑ | Met ↑ |
| CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Initial visits for newborns<br>CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Initial visits for newborns | Met | Met | Met | Met | Met |
| CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: EPSDT screenings and results<br>CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Well-Baby and Well-Child screenings and results | Met | Met | Met | Met ↑ | Met ↑ |

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

## E. Utilization Management

*42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)*

The Utilization Management (UM) review covers program structure, design, and evaluation; medical necessity assessments, appeals, care management, and transitional care management.

### Utilization Management (UM) Program

Constellation's review of the plans' UM Programs found that each plan has developed Program Descriptions and related policies and procedures that define the structure and components of the UM Program and the lines of responsibility and accountability. The programs are evaluated annually for effectiveness. Medical necessity determination guidelines related to medical necessity and coverage decisions are updated and approved at least annually.

United's UM Program is integrated within the UnitedHealthcare Clinical Services area, and the CMO provides clinical oversight of the program. Magnolia's UM Program is structured within the Population Health and Clinical Operations department. Authority, oversight, and lines of responsibility of the UM Program are clearly identified within policies and procedures. Molina's Health Care Services Program is integrated within the UM Program, wherein the CMO has authority and responsibility.

### 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*

Clinical reviews are conducted by licensed healthcare professionals who apply both internal and external clinical criteria. Annual inter-rater reliability (IRR) testing is conducted to assess consistency in decision-making among reviewers. Non-clinical staff can issue administrative benefit approvals, while a physician or other appropriately licensed healthcare professional issue all medical necessity denials. Reviewers, whether employed or under contract, are appropriately qualified, well-trained, and hold current professional licensure. Each plan maintains policies to ensure that no financial incentives are provided to providers or UM staff to deny coverage or services to members.

The plans have established guidelines for medical necessity determinations and ensure timely notifications to providers and members. Constellation's review of a sample of approval files revealed that authorization requests were reviewed in a timely manner by qualified healthcare professionals. Similarly, the review of denial files showed that determinations were made promptly, second-level reviews were conducted properly, and the reasons for adverse benefit determinations were clearly communicated. However, errors were identified in some denial notices, particularly regarding the appeal instructions in a sample of United denial files—the notices incorrectly informed members that an oral request for an appeal must be followed by a written request within 30 days.

Pharmacy Program Descriptions detail each plan's drug coverage, including information about how to obtain prior authorization of medications. Additional information regarding the Pharmacy Program and a link to the current Universal Preferred Drug List is available on all three of the plan's websites.

It was noted that United's Provider Manual incorrectly listed Optum Rx as the Pharmacy Benefit Manager. During the onsite discussion, United clarified that Gainwell is the current Pharmacy Benefit Manager, with the change effective as of July 1, 2024.

## Appeals

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

Processes for filing and managing verbal and written member appeals are documented in policies. The CCOs include information about appeals in CAN and CHIP member and provider materials, UM Program Descriptions, and on health plan websites. This information includes definitions of appeal terminology, information about how to file an appeal, and information about who can file an appeal. Timeframes for standard and expedited appeal acknowledgement, resolution, and extensions are clearly documented.

Appeals are logged, categorized, and analyzed for trends and quality improvement opportunities. For the sample appeal files reviewed for the 2024 EQR, it was found that Magnolia and Molina addressed the appeals in a timely manner and appropriately credentialed reviewers made the appeal determinations. One United CAN resolution letter was addressed to the provider rather than the member, and two United CAN files were not

resolved within the required timeframe. Overall, each appeal standard was met by the health plans for the 2024 EQR review period.

### Care Management, Coordination and Continuity of Care

*42 CFR § 208, 42 CFR § 457.1230 (c)*

Each health plan has developed and implemented Care Management, Disease Management, and Population Health Management Programs in accordance with the contractual requirements. The health plans use various resources to identify potential candidates for Care Management services.

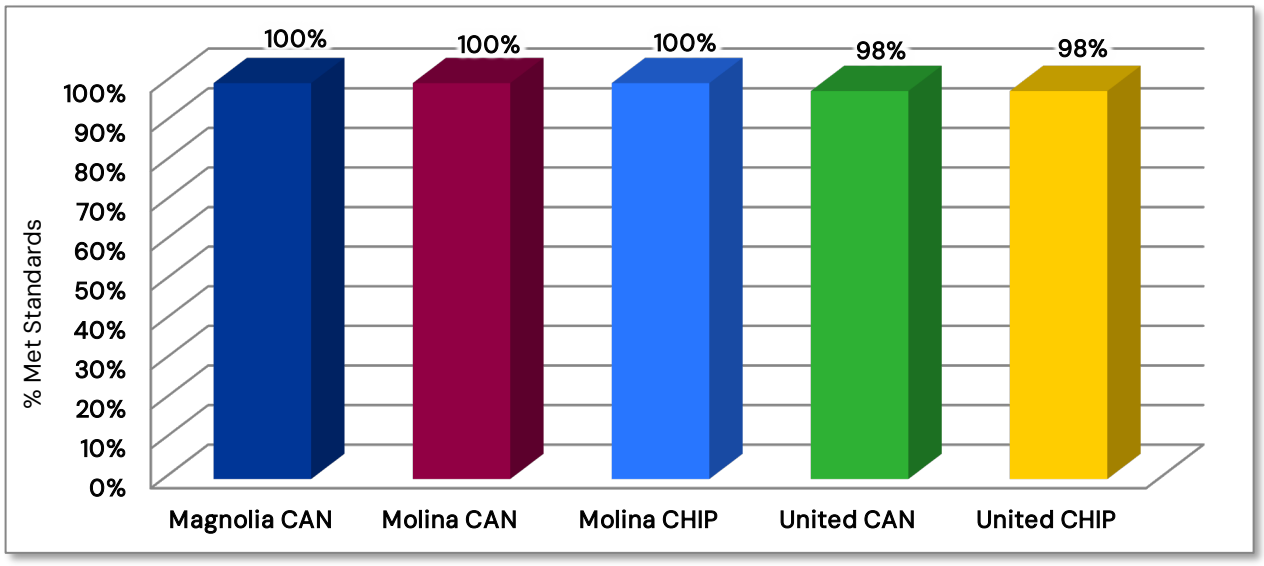
Once a member is referred to care management services, each health plan conducts a Health Risk Assessment to evaluate the member's needs and risk level. Based on these assessments, the health plans deliver care management interventions to ensure comprehensive, coordinated care tailored to each member's needs and risk level.

The health plans also provide care transition services for members moving across different care settings. Interdisciplinary transitional care teams work to ensure continuity of care and a successful transition for members as they move between home and community-based settings, using a range of methods and resources. Each health plan also provides specialized services to address the health needs of their members and to promote member engagement.

Sample care management files indicate that comprehensive assessments were appropriately conducted to identify members' treatment needs, and care management activities were carried out in accordance with the members' assigned risk levels.

As noted in *Figure 6: Utilization Management Findings*, the percentage of "Met" scores for the Utilization Management section ranged from 98% to 100%.

Figure 6: Utilization Management Findings




*Scores were rounded to the nearest whole number.*

Strengths, weaknesses, and recommendations for the UM section of the review are found in *Table 48* and *Table 49*.

Table 48: Utilization Management Strengths

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| The sample approval and denial files indicated reviews were completed in a timely manner according to contractual standards for all health plans. Criteria and procedures for the evaluation of medical necessity of services for members were applied consistently. | | ✓ | ✓ |
| Each Mississippi health plan describes processes for filing and managing verbal and written member appeals in policies, member and provider materials, UM Program Descriptions, and websites. | ✓ | | ✓ |
| Timeframes associated with standard and expedited appeals are clearly documented for appeal acknowledgment, resolution, and extension for each health plan. | ✓ | | ✓ |
| Regarding the sample of appeal files reviewed for the 2024 EQR, Magnolia and Molina files were addressed in a timely manner and reflected that appropriately credentialed reviewers made the appeal determinations. | | ✓ | |
| Each health plan has specialized programs to offer tailored programs to address members' specific needs and promote member engagement. | ✓ | | ✓ |

**Table 49: Utilization Management Weaknesses and Recommendations**

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| United's Provider Manual incorrectly listed Optum Rx as the Pharmacy Benefit Manager. | *Ensure all provider materials include correct information about the current Pharmacy Benefit Manager.* | ✓ | | ✓ |
| United and Molina's CAN and CHIP Adverse Benefit Determination letters and UHC's policy incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. Also, an additional UHC policy and UHC's website included incorrect information stating that a written request is required when a verbal request is submitted. This is no longer a contractual requirement. | *Ensure adverse benefit determination notices, policies, and websites include correct information about appeal filing processes and requirements.* | | | ✓ |
| Molina's CAN and CHIP Member Handbooks do not address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. | *Ensure Member Handbooks address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf.* | | | ✓ |

An overview of all scores for the UM section is illustrated in *Table 50: Utilization Management Services Comparative Data for the 2024 EQR*.

**Table 50: Utilization Management Services Comparative Data for the 2024 EQR**

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Utilization Management (UM) Program | | | | | |
| The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to | Met | Met | Met | Met | Met |
| Structure of the program | Met | Met | Met | Met | Met |
| Lines of responsibility and accountability | Met | Met | Met | Met | Met |
| Guidelines/standards to be used in making utilization management decisions | Met | Met | Met ↑ | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Timeliness of UM decisions, initial notification, and written (or electronic) verification | Met | Met | Met | Met | Met |
| Consideration of new technology | Met | Met | Met | Met | Met |
| The appeal process, including a mechanism for expedited appeal | Met | Met | Met | Met | Met |
| The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services | Met | Met | Met | Met | Met |
| Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee | Met | Met | Met | Met | Met |
| The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions | Met | Met | Met | Met | Met |
| Medical Necessity Determinations<br>*42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228* | | | | | |
| Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations | Met | Met | Met | Met | Met |
| Utilization management decisions are made using predetermined standards/criteria and all available medical information | Met | Met | Met | Met | Met |
| Utilization management standards/criteria are reasonable and allow for unique individual patient decisions | Met | Met | Met | Met | Met |
| Utilization management standards/criteria are consistently applied to all members across all reviewers | Met | Met | Met | Met | Met |
| The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List | Met | Met | Met | Met | Met |
| The CCO has established policies and procedures for prior authorization of medications | Met | Met | Met | Met | Met |
| Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Utilization management standards/criteria are available to providers | Met | Met | Met | Met | Met |
| Utilization management decisions are made by appropriately trained reviewers | Met | Met | Met | Met | Met |
| Initial utilization decisions are made promptly after all necessary information is received | Met | Met | Met | Met | Met |
| A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services | Met | Met | Met | Met | Met |
| All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist | Met | Met | Met | Met | Met |
| Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal | Met ↑ | Met ↑ | Met | Partially Met ↓ | Partially Met ↓ |
| Appeals<br>*42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | | |
| The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including | Met | Met | Met | Met | Met |
| The definitions of an adverse benefit determination and an appeal and who may file an appeal | Met | Met | Met | Met | Met |
| The procedure for filing an appeal | Met ↑ | Met ↑ | Met | Met | Met |
| Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case | Met | Met | Met | Met | Met |
| A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Timeliness guidelines for resolution of the appeal as specified in the contract | Met | Met | Met | Met | Met |
| Written notice of the appeal resolution as required by the contract | Met | Met | Met | Met | Met |
| Other requirements as specified in the contract | Met | Met | Met | Met | Met |
| The CCO applies the appeal policies and procedures as formulated | Met ↑ | Met ↑ | Met | Met ↑ | Met ↑ |
| Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee | Met | Met | Met | Met | Met |
| Appeals are managed in accordance with the CCO confidentiality policies and procedures | Met | Met | Met | Met | Met |
| Care Management<br>*42 CFR § 208, 42 CFR § 457.1230 (c)* | | | | | |
| The CCO has developed and implemented a Care Management and a Population Health Program | Met | Met | Met | Met | Met |
| The CCO uses varying sources to identify members who may benefit from Care Management | Met | Met | Met | Met | Met |
| A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level | Met | Met | Met | Met | Met |
| The detailed health risk assessment includes:<br>Identification of the severity of the member's conditions/disease state | Met | Met | Met | Met | Met |
| Evaluation of co-morbidities or multiple complex health care conditions | Met | Met | Met | Met | Met |
| Demographic information | Met | Met | Met | Met | Met |
| Member's current treatment provider and treatment plan, if available | Met | Met | Met | Met | Met |
| The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The risk level assignment is periodically updated as the member's health status or needs change | Met | Met | Met | Met | Met |
| The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members | Met | Met | Met | Met | Met |
| The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract | Met | Met | Met | Met | Met |
| The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services | Met | Met | Met | Met | Met |
| The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan | Met | Met | Met | Met | Met |
| CAN: The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants<br>CHIP: The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants | Met | Met | Met | Met | Met |
| Transitional Care Management | | | | | |
| The CCO monitors continuity and coordination of care between PCPs and other service providers | Met | Met | Met | Met | Met |
| The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting | Met | Met ↑ | Met | Met | Met |
| The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The CCO meets other Transition of Care contract requirements | Met | Met | Met | Met | Met |
| Annual Evaluation of the Utilization Management Program | | | | | |
| A written summary and assessment of the effectiveness of the UM program is prepared annually | Met | Met | Met | Met | Met |
| The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM | Met | Met | Met | Met | Met |

## F. Delegation

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

The delegation review includes the health plans' policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. Constellation requested a list of delegated entities, the services delegated, and a copy of the oversight monitoring conducted for each delegated entity.

Magnolia reported delegation agreements with the six entities identified in *Table 51: Magnolia Delegated Entities and Services*.

**Table 51: Magnolia Delegated Entities and Services**

| Magnolia Delegated Entities | Magnolia 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 (formerly National Imaging Associates) | Radiology Utilization Management |
| Turning Point | Musculoskeletal Surgical Quality and Safety and Utilization Management |

Magnolia conducts a pre-delegation review prior to the activation of a 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 that is 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 accountabilities 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.

Molina has delegation agreements with the entities listed in *Table 52: Molina Delegated Entities and Services*.

**Table 52: Molina Delegated Entities and Services**

| Molina Delegated Entities | Molina Delegated Services |
|---|---|
| March Vision | Vision Administration |
| Medical Transportation Management (MTM) | Non-Emergent Transportation |
| Progeny | Care management, utilization management |
| Skygen | Dental Administration |
| CVS/Caremark | Pharmacy Benefit Manager |
| HealthMap | Case Management |
| Infomedia Group, Inc. d/b/a Carenet Healthcare Services | Nurse Advice Line |
| Accordant Care Rare | Case Management |

Molina ensures that all delegated entities are qualified to perform services and comply with regulations. Molina maintains accountabilities for all activities conducted by third-party entities. Before delegating services, Molina conducts a pre-delegation assessment of the third-party entity's understanding, staff credentials, compliance with standards, policies, procedures, and other necessary areas to ensure they can perform the delegated services. Ongoing monitoring is conducted and reported to the appropriate committee 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 to be substandard, a corrective action plan is issued. The Delegation Oversight team monitors the

plan and reports to relevant committees. Termination of the agreement may be recommended if there is no improvement.

Copies of the annual delegation audits and monitoring reports were provided for all delegates. During the previous EQRs (2022 and 2023), Constellation found issues with the annual oversight monitoring for CVS/Caremark. For this review, the 2023 annual audit was provided. Since DOM has transitioned to a Statewide Pharmacy Benefit Manager, the contract with CVS/Caremark was terminated before the 2024 annual audit was scheduled to be conducted.

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

**Table 53: United Delegated Entities and Services**

| United Delegated Entities | United Delegated Services |
|---|---|
| Optum Behavioral Health | Behavioral Health case management, utilization management, quality management, network contract management |
| Dental Benefit Providers | Call center services, claims processing timeliness, network adequacy |
| Medical Transportation Management *(CAN Only)* | Non-Emergency Transportation (NET) benefit services broker, NET provider network, NET claims processing, NET quality management, NET call center operations |
| eviCore National | Radiology and Cardiology utilization management services, prior authorization handling, call center services |
| MARCH Vision Care | Vision and eye care benefit administration services, vision network contract management, call center operations, claims processing |
| OptumRX | Pharmacy benefit administration services, network adequacy, call center services, claims processing timeliness, prior authorization handling |

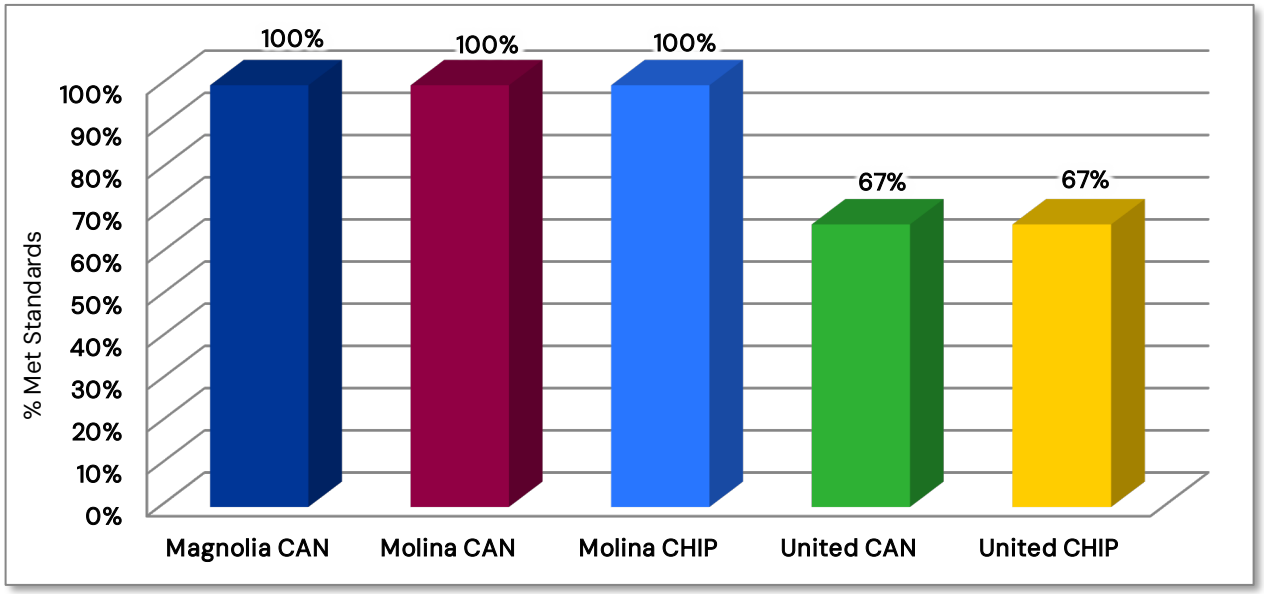
United has established policies and processes for ensuring that oversight of delegated vendors occurs as required by its contract with DOM. United's policy indicated that monitoring for each delegate's performance is conducted on an ongoing basis, and a formal review is conducted at least once per year. Copies of each subcontractor's scorecards were provided for review. Results of these scorecards were reported to the Delegated Vendor Joint Oversight Committee, Service Quality Improvement Subcommittee, and the Compliance Committee. If there are performance issues, these committees recommend the next steps to remedy the identified issues.

United's policy DVO-01, Operations / Delegated Vendor Oversight, mentions annual reviews or annual audits several times. The policy states, "Perform yearly targeted audits of delegated vendor assignments to include items such as member and provider correspondence/material, notification timeliness, handbooks, portals and websites." The policy also indicates the results

will be included in the Annual Quality Management Program Evaluation. However, the results of the formal annual audits were not provided. This was discussed onsite, and additional information was requested. United responded, "monitoring of the delegated entities and the activities assigned to them are accomplished through several ongoing activities. All subcontractors submit monthly/quarterly reports to demonstrate compliance with Service Level Agreements and program effectiveness. The evaluations of these performance measures are reviewed annually and documented within the MSCAN & CHIP Subcontractor Annual Evaluation report. Evaluations pertaining to utilization, clinical, and quality are measured separately within those perspective program evaluations." The Subcontractor Annual Evaluation report referenced in United's response and provided for review was a summary that included a description of the delegated entities, scorecard assessment results, and interventions or action plans where applicable. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring, and the annual audits were not included in the Annual Quality Management Program Evaluation as required by the *CAN Contract, Section 15,* and the *CHIP Contract, Section 14*.

*Figure 7: Delegation Findings* displays the percentage of "Met" scores for each health plan for the Delegation section. United was found to be non-compliant with the requirement for annual monitoring of subcontractors.

**Figure 7: Delegation Findings**




*Scores were rounded to the nearest whole number.*

*Tables 54* and *55* display the strengths, weaknesses, and recommendations for the Administration section.

**Table 54: Delegation Strengths**

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| The health plans' delegation oversight programs include a thorough pre-delegation review, ongoing monitoring, and annual evaluations to ensure that delegated entities meet standards and regulatory requirements. | ✓ | | ✓ |
| The Delegation Oversight Programs had a structured approach for identifying deficiencies and implementing corrective actions through a Corrective Action Plan. This proactive approach helps in addressing issues promptly and improving the performance of delegated entities. | ✓ | | |
| Each health plan mandates that all third-party entities enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights. | ✓ | | |

**Table 55: Delegation Weaknesses and Recommendations**

| Weaknesses | Recommendations | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation as required by the *DOM CAN Contract, Section 15,* and *CHIP Contract, Section 14.* | *Conduct a formal annual audit of all subcontractors and include the results of this oversight monitoring in the Annual Quality Management Program Evaluation as required by the DOM CAN Contract, Section 15, and the CHIP Contract, Section 14.* | ✓ | | |

*Table 56: Delegation Services Comparative Data for the 2024 EQR* illustrates the scoring for each standard reviewed during the 2024 EQR.

**Table 56: Delegation Services Comparative Data for the 2024 EQR**

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| Delegation<br>*42 CFR § 438.230 and 42 CFR § 457.1233(b)* | | | | | |
| The CCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements. | Met | Met | Met | Met | Met |

| Standard | Magnolia CAN | Molina CAN | Molina CHIP | United CAN | United CHIP |
|---|---|---|---|---|---|
| The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions | Met | Met | Met | Met | Met |
| The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions | Met | Met | Met | Partially Met ↑ | Partially Met ↑ |

## FINDINGS SUMMARY

*Table 57: Scoring Overview* provides an overview of the scoring for each section of the EQR. The percentages of "Met" scores highlighted in green indicate the health plan sustained or showed an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings. Molina CHIP sustained or showed improvement in five review areas. Magnolia, Molina CAN, and United CAN sustained or showed improvement in four review areas. United CHIP sustained or showed improvement in three review areas.

Table 57: Overall Scoring

| | Met | Partially Met | Not Met | Not Evaluated/ Not Applicable | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|
| **Administration** | | | | | | |
| Magnolia CAN | 31 | 0 | 0 | 0 | 31 | 100% ↑ |
| Molina CAN | 31 | 0 | 0 | 0 | 31 | 100% ↑ |
| Molina CHIP | 31 | 0 | 0 | 0 | 31 | 100% ↑ |
| United CAN | 30 | 1 | 0 | 0 | 31 | 96.8% ↓ |
| United CHIP | 30 | 1 | 0 | 0 | 31 | 96.8% ↓ |
| **Provider Services** | | | | | | |
| Magnolia CAN | 46 | 3 | 0 | 0 | 49 | 93.9 ↓ |
| Molina CAN | 45 | 3 | 1 | 0 | 49 | 91.8 ↓ |
| Molina CHIP | 43 | 4 | 0 | 0 | 47 | 91.4 ↓ |
| United CAN | 47 | 1 | 1 | 0 | 49 | 95.9% |
| United CHIP | 45 | 1 | 1 | 0 | 47 | 95.7 ↓ |
| **Member Services** | | | | | | |
| Magnolia CAN | 33 | 0 | 0 | 0 | 33 | 100% |
| Molina CAN | 32 | 1 | 0 | 0 | 33 | 96.9 ↓ |
| Molina CHIP | 31 | 1 | 0 | 0 | 32 | 96.8% ↑ |

| | Met | Partially Met | Not Met | Not Evaluated/ Not Applicable | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|
| United CAN | 33 | 0 | 0 | 0 | 33 | 100% |
| United CHIP | 32 | 0 | 0 | 0 | 32 | 100% |
| **Quality Improvement** | | | | | | |
| Magnolia CAN | 19 | 0 | 0 | 0 | 19 | 100% |
| Molina CAN | 18 | 1 | 0 | 0 | 19 | 94.7% ↑ |
| Molina CHIP | 18 | 1 | 0 | 0 | 19 | 94.7% ↑ |
| United CAN | 19 | 0 | 0 | 0 | 19 | 100% |
| United CHIP | 19 | 0 | 0 | 0 | 19 | 100% |
| **Utilization** | | | | | | |
| Magnolia CAN | 54 | 0 | 0 | 0 | 54 | 100% ↑ |
| Molina CAN | 54 | 0 | 0 | 0 | 54 | 100% ↑ |
| Molina CHIP | 54 | 0 | 0 | 0 | 54 | 100% ↑ |
| United CAN | 53 | 1 | 0 | 0 | 54 | 98.1% ↑ |
| United CHIP | 53 | 1 | 0 | 0 | 54 | 98.1% ↑ |
| **Delegation** | | | | | | |
| Magnolia CAN | 3 | 0 | 0 | 0 | 3 | 100% |
| Molina CAN | 3 | 0 | 0 | 0 | 3 | 100% ↑ |
| Molina CHIP | 3 | 0 | 0 | 0 | 3 | 100% ↑ |
| United CAN | 2 | 1 | 0 | 0 | 3 | 66.7% ↓ |
| United CHIP | 2 | 1 | 0 | 0 | 3 | 66.7% ↓ |
| **Totals** | | | | | | |
| **Magnolia CAN** | **186** | **3** | **0** | **0** | **189** | **98% ↑** |
| **Molina CAN** | **183** | **5** | **1** | **0** | **189** | **96.8% ↑** |
| **Molina CHIP** | **180** | **6** | **0** | **0** | **186** | **96.8% ↑** |
| **United CAN** | **184** | **4** | **1** | **0** | **189** | **97.4% ↓** |
| **United CHIP** | **181** | **4** | **1** | **0** | **186** | **97.3%** |

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

*Table 58: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons* displays and allows a comparison of the total percentage of standards scored as "Met" for the *Part 438 Subpart D* and QAPI Standards for the 2022 through 2024 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings for the CCO. Those highlighted in yellow represent a decline from the CCO's prior review. Up (↑) and down (↓) arrows are included to further illustrate the change from the previous reviews.

Table 58: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons

| Federal Standards | Magnolia CAN | | | Molina CAN | | | Molina CHIP | | | United CAN | | | United CHIP | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 |
| Availability of Services (§ 438.206, § 457.1230)<br><br>Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)* | **87%** | 87% | 89% | **93% ↑** | 87% | 78% | **93% ↑** | 87% | 78% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Coordination and Continuity of Care *(§ 438.208, § 457.1230)* | **100%** | 100% | 94% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100% ↑** | 94% | 100% |
| Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* | **100%** | 100% | 92% | **100% ↑** | 92% | 100% | **100% ↑** | 92% | 100% | **100%** | 100% | 92% | **92%↓** | 100% | 100% |
| Confidentiality *(§ 438.224)* | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Grievance and Appeal Systems *(§ 438.228, § 457.1260)* | **100%** | 100% | 80% | **100% ↑** | 90% | 95% | **100% ↑** | 90% | 95% | **100% ↑** | 90% | 75% | **100% ↑** | 90% | 70% |
| Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)* | **100%** | 100% | 50% | **100% ↑** | 50% | 50% | **100% ↑** | 50% | 50% | **67% ↓** | 100% | 50% | **67% ↓** | 100% | 50% |

| Federal Standards | Magnolia CAN | | | Molina CAN | | | Molina CHIP | | | United CAN | | | United CHIP | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 | 2024 | 2023 | 2022 |
| Practice Guidelines *(§ 438.236, § 457.1233)* | **89% ↓** | 100% | 82% | **89% ↓** | 100% | 100% | **71% ↓** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Health Information Systems *(§ 438.242, § 457.1233)* | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)* | **100%** | 100% | 100% | **95% ↑** | 79% | 89% | **95% ↑** | 79% | 89% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Disenrollment Requirements and Limitations *(§ 438.56)* | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Enrollee Rights Requirements *(§ 438.100)* | **100%** | 100% | 100% | **100% ↑** | 67% | 100% | **100% ↑** | 67% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% |
| Emergency and Post-Stabilization Services *(§ 438.114)* | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% | **100%** | 100% | 100% |

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

## Attachments

- Attachment 1:  Assessment of Corrective Actions from Previous EQR
- Attachment 2:  MississippiCAN CAHPS®ECHO 3.0 Report Summary

## Attachment 1: Assessment of Corrective Actions from Previous EQR

## CONSTELLATION QUALITY HEALTH EXTERNAL QUALITY REVIEW
### ASSESSMENT OF CORRECTIVE ACTIONS 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.<br><br>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.<br><br>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%<br>• Chief Financial Officer attended 25%<br>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.<br>*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:<br>• 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.<br>• Member notification of inclusion and of the availability of a hearing 30 days before restrictions are implemented.<br>• The member's ability to request a change in pharmacy due to moving, transportation barriers, etc.<br>• 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.<br>• Provision of care management and education reinforcement | 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 |
| • Review after the initial one-year lock-in period and then every six months to determine the need for continued lock-in.<br>*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:<br>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…"<br>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."<br>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. | 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. | ✓ | |

| 2023 EQR Findings | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| *Corrective Action Plan: Ensure geographic access standards for all provider types are included in a policy.* | | | |
| 2. Practitioner Accessibility<br>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. | | | |
| Policy MS.PRVR.10, Evaluation of the Accessibility of Services, defines appointment access standards, but does not include the appointment access standard for specialists.<br><br>All appointment access standards are appropriately documented in the Provider Manual and Member Handbook.<br><br>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.<br><br>*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:<br>1.3 Guidelines/standards to be used in making utilization management decisions; | | | |

| 2023 EQR Findings | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| 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.<br>*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. | ✓ | |

## Molina Healthcare of Mississippi – 2023 Corrective Action Plan – CAN

| 2023 EQR Findings – CAN | 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 Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states the Compliance Officer chairs the committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President of Compliance.<br>*Corrective Action Plan: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.* | Jeremy Ketchum will chair the Compliance Committee moving forward. See document: Compliance Committee Charter uploaded to the portal. | ✓ | |
| **PROVIDER SERVICES** | | | |
| **II A. Adequacy of the Provider Network** | | | |
| 2. Practitioner Accessibility<br>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. | | | |
| Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Issues noted with the policy include:<br>For specialists, the policy defines the appointment access standard as 20-30 calendar days. This is an uncorrected deficiency from the previous EQR. | Documents provided: CAP Item#2 MSCAN Provider Manual and EQR 2023 CAP No. 2-3<br>On pages 73-74, the following has been updated in the MSCAN Provider Manual:<br>For routine visits with Behavioral Health/Substance Use Disorder providers, Molina has revised the MSCAN provider manual to state that the standard is 7 calendar days. | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| For routine visits with Behavioral Health/Substance Use Disorder providers, the policy states the standard is 21 calendar days; however, it includes additional information that the initial visit must be scheduled within 10 business days.<br>Issues were noted in the appointment access standards documented in the CAN Provider Manual. These include:<br>For routine visits with Behavioral Health/Substance Use Disorder providers, the CAN Provider Manual states the standard is 14 calendar days. This is an uncorrected deficiency from the previous EQR.<br>The CAN Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use Disorder providers is seven calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge."<br>The CAN Provider Manual does not include the appointment access standard for Emergency Providers.<br>*Corrective Action: Revise Policy MHMS-QI-006, Access to Care, and the CAN Provider Manual to address the identified deficiencies. Refer to the CAN Contract, Section 7 (B) (2).* | Molina has included the full contractual requirement for Behavioral Health/Substance Use Disorder providers.<br>Molina has included the appointment access standard for Emergency Providers.<br>Policy MHMS-QI-006, Access to Care, has been revised to indicate specialist appointment access standard as not to exceed 45 days (pg.4 of policy). Also, the language regarding the initial visit scheduling within 10 days has been removed.<br>Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented to the Quality Improvement Committee for review and approval at the Quarter 1 2024 meeting.<br>A redlined copy of the revised policy is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP". | | |
| 2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards. | | | |
| Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. <u>This is an uncorrected deficiency from the previous EQR.</u> | Documents provided: EQR 2023 CAP No. 2-3, MHMS-MM-003-Member Rights and Responsibilities<br>Policy MHMS-QI-006, Access to Care, has been revised to indicate the frequency for conducting appointment and after-hour accessibility audits and the department that conducts the audits (pg. 7).<br>Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to identify the frequency for conducting the appointment and after-hour accessibility audits and the department or entity that conducts the audits.* | requirements (by February 2024). The policy will then be presented to the Quality Improvement Committee for review and approval at Quarter 1 2024 meeting.<br>A redlined copy of the revised policy is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP" | | |
| **II B. Provider Education** | | | |
| 2. Initial provider education includes:<br>2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM; | | | |
| The CAN Provider Manual refers the reader to the website to obtain benefits information.<br>Molina's website at Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards does not define the limit on the number of home health visits allowed, but states members under 21 can get additional visits if authorized. However, the Molina Healthcare Benefits at a Glance – MississippiCAN Covered Services document (found by using the "view and print" link on the same web page) shows a limit of 25 visits per year. This is an uncorrected deficiency from the previous EQR.<br>*Corrective Action Plan: Revise the CAN benefits grid on the website to state the limit on the number of home health visits. Also, revise the "Molina Healthcare Benefits at a Glance MississippiCAN Covered Services" document found by using the "view and print" link at Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards to include the correct limit for the number of home health services visits.* | Molina has added "Limited to 36 visits per year" on the MSCAN member website.<br>MSCAN Member Website: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx<br>In addition, we have removed the Molina Healthcare Benefits at a Glance MississippiCAN Covered Services" document from the website to only reflect the benefits and services that are included in the grid. | ✓ | |
| **Member Services** | | | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| **III A. Member Rights and Responsibilities** | | | |
| 3. Member responsibilities include the responsibility:<br>3.5 To inform the CCO of changes in family size, address changes, or other health care coverage. | | | |
| Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN web page listing member responsibilities do not include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.<br>*Corrective Action Plan: Revise Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN web page listing member responsibilities to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.* | Molina has updated the MSCAN member website to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.<br>MSCAN Member Website:<br>https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx | ✓ | |
| **III B. Member CCO Program Education** | | | |
| 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:<br>1.1 Full disclosure of benefits and services included and excluded in coverage; | | | |
| The CAN Member Handbook does not specify the limitation on the number of visits allowed for home health services.<br>*Corrective Action Plan: Revise the CAN Member Handbook to state the limitation on the number of home health visits per year.* | See document- CAP #6 MSCAN Member handbook. Molina has added "Limited to 36 visits per year" in the MSCAN member handbook. | ✓ | |
| 2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network. | | | |
| Molina staff confirmed there is no policy that addresses the process for informing members of changes to programs and benefits within 30 calendar days prior to implementation. | This language will be included in the revised Member Handbook in accordance with the Policy & Procedure language<br>**2.2.2024**<br>Updated Response: Policy MHMS-MM-007 Enhanced and Covered Services uploaded to the portal. | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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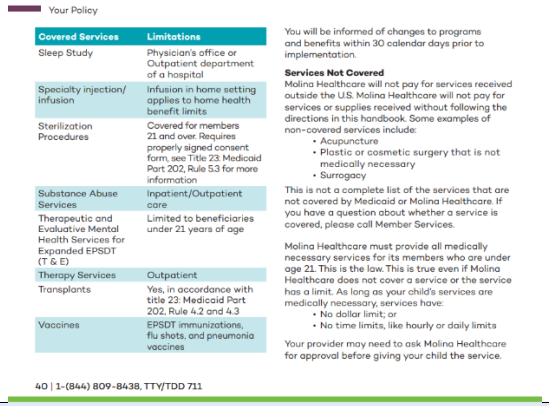
| *Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.* | 2/2/2024: Molina has added this language in the MSCAN Member Handbook on page 40.<br><br>Please see below screenshot for reference. MSCAN Handbook has been uploaded to portal.<br><br>  | | |
| **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. | | | |
| Information about operations of the Member Services Contact Center is found in Policy MHMS-M&PCC-04, Member Services General Operations. As noted in the policy, the Member Services Contact Center hours of operation are 7:30 a.m. to 8:00 p.m., Monday through Friday and one weekend a month excluding State holidays. As written in the policy, it appears that the call center is open until 8 p.m. one weekend per month. However, onsite discussion confirmed the weekend hours are 8 a.m. to 5 p.m. | Policy MHMS-MPCC-04 Member Service General Operations has been updated on page 2. | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| *Corrective Action Plan: Revise Policy MHMS-M&PCC-04, Member Services General Operations, to list the correct weekend hours of operation for the call center.* | | | |
| **III G. Grievances** | | | |
| 2. The CCO applies the grievance policy and procedure as formulated. | | | |
| Six CAN resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no steps were provided in the letters. Instead, the members were asked to contact the Member Services Department after the grievance was closed.<br>*Corrective Action: Ensure that processes are in place to comply with Policy MHMS-MRT-01, Member Complaints and Grievances regarding the use of extensions when needed to obtain additional information needed to resolve a grievance.* | We are working with the Division of Medicaid to establish a process to submit for extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team with be educated on the update by the end of Q2 2024.<br>We will be sure the steps taken will be in the letters.<br>**2.1.2024 Response:**<br>The Division is working on a process to address this CAP. For now, the process would be for all extensions:<br>Submit the request to:<br>Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov<br>Lucretia Causey Lucretia.Causey@medicaid.ms.gov<br>Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov<br>Patricia Collins<br>Subject "Expedited Approval – 14 Day extension.<br>All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day.<br>All inquiries received after 12 noon will be responded by 12 noon the following day.<br>We Have attached a workflow that speaks to this update as well as the letters. A verbiage template has been comprised for unable to contact cases that speaks to the steps we took to complete the case. This verbiage has been included in the workflow along with the template and an example. The workflow will be presented and implemented to the team on 2/5/2024. | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| **Quality Improvement** | | | |
| **IV A. Quality Improvement (QI) Program** | | | |
| 4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). | | | |
| There were several errors and/or missing information in the 2023 QI Work Plan. Those included:<br>In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1.<br>The Availability of Practitioners section (PDF pages 16 – 28) and the Accessibility of Services section (PDF pages 29 – 30) lacked benchmark goals for each activity.<br>The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications which measure those scores apply.<br>The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists.<br>The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care practitioners instead of behavioral health practitioners.<br>The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. However, Policy | See document EQR 2023_CAP No. 10 and 26_MSCAN_CHIP<br>The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected and benchmark/goals were updated.<br>For easy identification, all changes in the document are in red. Corrections below:<br>Program Operation - Page 11. "Met" changed to "Ongoing"<br>Availability of Practitioners:<br>Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500"<br>Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500"<br>Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500"<br>Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles".<br>Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles",<br>Oncologists: "1:30 minutes OR 1:30 miles" | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| MHMS-QI-006, Access to Care lists this timeframe as seven calendar days.<br><br>The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care.<br><br>In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days.<br><br>*Corrective Action Plan: Correct the errors identified in the 2023 QI Work Plan.* | Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles",<br>Psychiatrists: "1:30 minutes OR 1:30 miles"<br>Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days<br>Results/Timeframe/Date the Goal: (see above):<br>Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type<br>Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available."<br>Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine"<br>Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners"<br>Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly.<br>Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10" | | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30".<br>A revised copy of the work plan is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP"<br>**2.2.2024- Updated Response**<br>The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24"<br>The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24"<br>See document EQR 2023_CAP No. 10 and 26_MSCAN_CHIP<br>The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected, and benchmark/goals were updated.<br>For easy identification, all changes in the document are in red. Corrections below:<br>Program Operation - Page 11. "Met" changed to "Ongoing"<br>Availability of Practitioners:<br>Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500" | | |

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|---|---|---|---|
| | | Corrected | Not Corrected |
| | Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500"<br>Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500"<br>Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles".<br>Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles",<br>Oncologists: "1:30 minutes OR 1:30 miles"<br>Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles",<br>Psychiatrists: "1:30 minutes OR 1:30 miles"<br>Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days<br>Results/Timeframe/Date the Goal: (see above):<br>Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type<br>Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The | | |

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| | rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available."<br>Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine"<br>Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners"<br>Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly.<br>Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10"<br>Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30".<br>A revised copy of the work plan is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP"<br>**2.2.2024- Updated Response**<br>The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24"<br>The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24"<br>**2.19.2024 – Updated Response** | | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | • As indicated, Work Plan has been revised and updated with terminology utilized in Policy QI-006 in slide and sections as indicated below:<br>SLIDES 30 & 31 changes:<br>Access to appointments for PCPs are monitored by preventive primary care, routine sick, urgent care, and after hours. Goals are set to meet regulatory requirements.<br>Preventive primary care (PCP): 90% Not to exceed 30 days<br>Preventive primary care (OB/GYN): 90% Not to exceed 30 days<br>Routine Sick (PCP): 90% Not to exceed 7 days<br>Routine Sick (OB/GYN): 90% Not to exceed 7 days<br>After review of the policy and work plan, the language used in the policy needed clarifying. Therefore, the Policy MHMS-QI-006 has been revised with the appropriate language for Routine Sick for PCP and OB/GYN (page 3 of 7) and congruent language was used in the work plan (pages 30-31). The policy will be sent back to the QIC for approval of the changes during Q1 2024 QIC Meeting. A redline copy of the policy is provided with this response.<br>The 2023 QI Work Plan with the aforementioned revisions is provided (pages 30-31). However, the 2024 QI Work Plan is currently unavailable at this time. It is expected by March 2024. | | |
| **IV E. Provider Participation in Quality Improvement Activities** | | | |
| 3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines. | | | |
| The CAN Member Handbook does not specify the limitation on the number of visits allowed for home health services.<br>Molina adopts and disseminates clinical practice and preventive health guidelines that focus on key topics relevant to the health plan's members. Per Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, | See documents: CAP #11 MCAN Member Handbook and EQR Audit 2023_CAP No. 11 and 27 MSCAN_CHIP.<br>The monitoring of provider compliance against two aspects of the Clinical Practice Guidelines annual report will be provided by February 29, 2024. The report will focus on perinatal care and PPC HEDIS measures. Also, we have included the 2022 Performance | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| Molina annually measures performance against at least two important aspects of the clinical practice guidelines.<br>During the onsite, Constellation Quality Health questioned Molina regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided.<br>*Corrective Action Plan: On an annual basis, measure provider performance against at least two of the clinical guidelines as required by the MS CAN Contract, Section 10 (M) and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.* | measures Report (EQR Audit 2023_CAP No 11 and 27_MSCAN_CHIP_1-12-24.)<br>Molina has added "Limited to 36 visits per year" in the MSCAN member handbook on page 38. | | |
| 4. The CCO tracks provider compliance with EPSDT service provision requirements for:<br>4.2 EPSDT screenings and results; | | | |
| Molina provides coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and educates members and providers regarding the services and resources available. Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, provides an overview of Molina's process for monitoring and reporting compliance with the EPSDT program. This policy indicates that members who receive an abnormal finding during their EPSDT screening are identified, and the member is contacted regarding the need for follow-up.<br>An example of the EPSDT Tracker for 2023 was provided. The tracking process listed in the tracker indicates staff utilizes the Claims lookup tool to identify all claims members received after the original EPSDT/Well Child exam to determine potential diagnosis and referral/follow-up. If no claims could be associated as a referral, the list is passed to designated staff to call. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the | See document: EQR 2023 CAP No. 12 and 28 EPSDT_Well Child and Tracking Report.<br>The EPSDT/Well Child Tracker is a working, fluid document that is being updated continuously. The manual process for EPSDT/Well Child tracking follow-up treatment and referrals includes the following: First, members who receive an abnormal finding during their EPSDT screening are identified via claims data and ICD 10/z codes on a monthly basis. The contact info on the member and provider, with dates of service, is listed. Follow-up and referrals are identified using the QNXT claims look-up tool. Quality staff reviews and documents information into the EPSDT/Well Child Tracker. In columns T-AD of the tracker contains the follow-up referral information, diagnosis, date, and/or staff contact to member. The tracker is located on the Quality SharePoint. An automated system of the EPSDT/Well Child tracker is in process. A copy of the EPSDT/Well Child Tracker is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| members. Also, Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, page 7, indicates work is being done to create an automated tracking dashboard for documenting recent/previous calls made to members' parents and the results of those calls.<br>*Corrective Action Plan: Implement a system for documenting the outreach made to members and the results of that outreach as noted in Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment.* | document is "EQR Audit 2022_CAP No. 12 and 28_EPSDT/Well Child Tracking Report_<br>**2.2.2024 Updated Response**<br>The language from Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, page 7, regarding the creation of an automated tracking system has been removed. A redline version of the policy is included with this submission and is applicable to the MSCAN line of business. The title of the document is "CAP Item 12_Policy MHMS-QI-003_EPSDT_MSCAN_1-26-24." | | |
| **IV F. Annual Evaluation of the Quality Improvement Program** | | | |
| 1. A written summary and assessment of the effectiveness of the QI program is prepared annually. | | | |
| At least annually, Molina conducts a formal evaluation of the QI Program. Molina uses internal Quality Specialists, external survey vendors, and analysts to collect, analyze, and report on the data using manual analysis and electronic software. Evaluation of quality activities will include a description of limitations and barriers to improvements. The QI Program 2022 Annual Evaluation was provided but did not include the results of the Geo Access reports referenced in Section Five and the Provider Directory analysis referenced in Section 11 of the 2022 QI Work Plan.<br>This continues to be an issue and was identified in the 2020, 2021, and 2022 EQRs. *The CAN Contract, Section 10 (D)* and *Exhibit G,* requires the QI Program Annual Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. | See document: EQR Audit 2023_CAP No. 13 and 29_2022 QI Evaluation.<br>The 2022 QI Program Evaluation has been revised to include analysis of the Geo Access Reports/Network Adequacy (pg. 33-35 and Provider Online Directory (pg. 40-42).<br>A revised copy of the 2022 Annual Evaluation is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2023_CAP No. 13 and 29_2022 QI Evaluation_" | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| *Corrective Action Plan: The results of all activities completed in 2022 and/or an update for the ongoing activities must be added to the 2022 QI Program Annual Evaluation to meet the requirements in the CAN Contract, Section 10, and Exhibit G. Develop a process to review the QI Program Annual Evaluation to ensure all activities are included.* | | | |
| **Utilization Management** | | | |
| **V B. Medical Necessity Determinations** | | | |
| 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. | | | |
| CAN Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. This is no longer a contractual requirement. Molina acknowledged awareness and responded that they have updated the Adverse Benefit Determination letters and removed the requirement of a written request after a verbal appeal request is initiated.<br>*Corrective Action Plan: Remove the requirement that a member must follow a verbal appeal request with a written request from the Adverse Benefit Determination letters.* | The CAN Adverse Benefit Determination Letter has been updated to match the contractual requirements. Requirement for written request has been removed from the letter.<br>See document attached: The CAN Adverse Benefit Determination Letter has been updated to match the contractual requirements. Requirement for written request has been removed from the letter. CAP #14 and #30 MHMS ABD Letter_Re Appeal Notification | ✓ | |
| **V C. Appeals** | | | |
| 2. The CCO applies the appeal policies and procedures as formulated. | | | |
| In Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the "Procedure" section indicates notification is given to the Division of the need for additional information and when the extension of an appeal is in the Member's [best] interest. However, seven CAN files were extended based on | We are working with the Division of Medicaid to establish a process to submit for an extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team will be educated on the update by the end Q2 of 2024. | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| the lack of receipt of a signed Authorized Representative Form and subsequently closed with no indication of notification to the Division.<br>*Corrective Action: Ensure that processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals and that the appropriate notification is provided to the Division when appeal extensions are needed.* | **2.2.2024. Updated Response**<br>The Division is working on a process to address this CAP. For now the process would be for all extensions:<br>Submit the request to<br>Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov<br>Lucretia Causey Lucretia.Causey@medicaid.ms.gov<br>Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov<br>Patricia Collins<br>Subject "Expedited Approval – 14 Day extension<br>All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day.<br>All inquiries received after 12 noon will be responded by 12 noon the following day.<br>We have attached a work flow that speaks to this update. The workflow will be presented and implemented to the team on 2/5/2024. | | |
| **Delegation** | | | |
| 2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions. | | | |
| Molina's Procedure DO -1.001, Delegation Oversight, contained an overview of the pre-delegation assessment, post-implementation and ongoing monitoring conducted as part of the oversight of a delegate. This procedure indicates a comprehensive annual delegation oversight audit is conducted by the Director of Delegation Oversight and Audit. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation oversight audit report was not provided. This was an issue identified during the 2022 EQR. | See Documents for CVS uploaded to the Portal for both CAP #16 and 32.<br>**2.2.2024 Updated Response**<br>In response to the CAP (Corrective Action Plan) feedback regarding the oversight of CVS as a delegated subcontractor.<br>Oversight of CVS Pharmacy Benefit Manager (PBM) oversight is primarily the responsibility of our Pharmacy Operations Team and not under the purview of the Delegation Oversight Team. PBM functions involve various tasks that differ from those overseen by the Delegation Oversight Team.<br>The CHIP and CAN Contract, sections which states, "The Contractor must monitor each Subcontractor's performance on an ongoing | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| *Corrective Action Plan: The annual delegation oversight audit was not conducted as required by the CAN Contract, Section 15 (B).* | basis, subject it to formal review at least once a year." CVS's oversight, however, occurs more frequently due to the complex and dynamic nature of their responsibilities.<br>CVS's role as a PBM involves extensive monitoring, with monitoring reports, dashboards, and Surveillance Summaries being provided on a regular basis, including daily, monthly, and quarterly reports. This frequency of monitoring is necessitated by the robustness of the functions they perform, which go beyond the scope of an annual audit. To provide further clarification and insight into our oversight processes, I have included "MHI Pharm 14 Pharmacy Operations Surveillance Policy and Procedure." This document outlines the comprehensive procedures and guidelines we follow for monitoring and surveillance within Pharmacy Operations. It will offer you a more detailed understanding of our PBM oversight surveillance practice.<br>MHI Pharmacy Operations Surveillance Policy and Procedure uploaded to the portal.<br>**2/22/2024**<br>Molina has provided documentation of the annual audits conducted for our PBM CVS. The annual internal audits entitled Molina Executive Dashboard, which monitors timelines. An external audit conducted by external PBM auditor Health Strategies is also included. **PBM oversight is under the purview of Pharmacy Operations not the Molina Delegation Oversight team.**<br>**From a oversight perspective that relates the review of annual State Contract Review activities for CVS/CareMark as stated in this procedure.**<br>**3/6/2024** The annual review referenced conducted by Molina Pharmacy Operations Analysts partner with regional Molina pharmacy representatives has been provided in the document attached entitled *MS MedicaidCHIP_Contract Review Summary 2023__*.<br>**3.18.2024** | | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | This annual audit document the auditor share between Molina and CVS will be completed at the end of this year for 2023.<br><br>This auditing process involves a comprehensive examination and analysis, which often requires thorough investigation and extensive communication between our teams.<br><br>Due to the depth of the discovery process and the necessity for meticulous back-and-forth communication, we have historically completed the audit towards the end of the year.<br><br>**3.26.2024**<br>Please see attached 2023 annual audit for CVS. The Delegation audit for 2023 has been completed. After speaking with the Pharmacy auditing team, it was determined that the team members who work on this task did not fully understand the ask because they are new to the team. The new team member was under the impression we were asking for a document performed for another audit. The miscommunication was cleared up and it was determined that the delegation audit was completed. See document attached. | | |

## Molina Healthcare of Mississippi – 2023 Corrective Action Plan – CHIP

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | 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. | | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states the Compliance Officer chairs the committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President of Compliance.<br>*Corrective Action Plan: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.* | Jeremy Ketchum will chair the Compliance Committee moving forward. See document: Compliance Committee Charter uploaded to the portal. | ✓ | |
| **PROVIDER SERVICES** | | | |
| **II A. Adequacy of the Provider Network** | | | |
| 2. Practitioner Accessibility<br>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. | | | |
| Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Issues noted with the policy include:<br>For specialists, the policy defines the appointment access standard as 20-30 calendar days. <u>This is an uncorrected deficiency from the previous EQR.</u><br>For routine visits with Behavioral Health/Substance Use Disorder providers, the policy states the standard is 21 calendar days; however, it includes additional information that the initial visit must be scheduled within 10 business days.<br>Issues were noted in the appointment access standards documented in the CHIP Provider Manual. These include:<br>The CHIP Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use | See documents CAP #18 CHIP Provider Manual and EQR Audi 2023_CAP No 2-3 and 18-19.<br>The following changes has been made to the CHIP Provider Manual:<br>Molina has included the full contractual requirement for Behavioral Health/Substance Use Disorder providers.<br>Molina has included the appointment access standard for Emergency Providers.<br>Policy MHMS-QI-006, Access to Care, has been revised to indicate specialist appointment access standard as not to exceed 45 days (pg.4 of policy). Also, the language regarding the initial visit scheduling within 10 days has been removed.<br>Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| Disorder providers is seven calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge."<br><br>The CHIP Provider Manual does not include the appointment access standard for Emergency Providers.<br><br>*Corrective Action: Revise Policy MHMS-QI-006, Access to Care, and the CHIP Provider Manual to address the identified deficiencies. Refer to the CHIP Contract, Section 7 (B) (2).* | at to the Quality Improvement Committee for review and approval at Quarter 1 2024 meeting.<br><br>A redlined copy of the revised policy is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP" | | |
| 2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards. | | | |
| Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. <u>This is an uncorrected deficiency from the previous EQR.</u><br><br>*Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to identify the frequency for conducting the appointment and after-hour accessibility audits and the department or entity that conducts the audits.* | See document EQR Audi 2023_CAP No 2-3 and 18-19.<br><br>Policy MHMS-QI-006, Access to Care, has been revised to indicate the frequency for conducting appointment and after-hour accessibility audits and the department that conducts the audits (pg. 7).<br><br>Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2024 meeting.<br><br>A redlined copy of the revised policy is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP" | ✓ | |
| **II B. Provider Education** | | | |
| 2. Initial provider education includes:<br>2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums; | | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| Molina's website at Home > Members > CHIP > About CHIP > What's Covered > Benefits and Rewards does not define the limit on the number of home health visits allowed, but states home health services must be approved. The "Molina Healthcare Benefits at a Glance – CHIP Covered Services" document found by using the "view and print" link found on the same page correctly states the limit is 36 visits per year.<br>*Corrective Action Plan: Revise the benefits grid on Molina's website at Home > Members > CHIP > About CHIP > What's Covered > Benefits and Rewards to list the limitation on the number of home health visits.* | See document MSEQR_Molina Healthcare of MississippiCAN CHIP 2023 CAP #20<br>Molina has added "Limited to 36 visits per year" on the CHIP member website.<br>CHIP member website<br>https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx<br>In addition, we have removed the Molina Healthcare Benefits at a Glance CHIP Covered Services" document from the website to only reflect the benefits and services that are included in the grid. | ✓ | |
| **Member Services** | | | |
| **III A. Member Rights and Responsibilities** | | | |
| 3. Member responsibilities include the responsibility:<br>3.5 To inform the CCO of changes in family size, address changes, or other health care coverage. | | | |
| Policy MHMS ME 003, Member Rights and Responsibilities, and the CHIP web page listing member responsibilities do not include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.<br>*Corrective Action Plan: Revise Policy MHMS ME 003, Member Rights and Responsibilities, and the CHIP web page listing member responsibilities to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.* | See document MSEQR_Molina Healthcare of MississppiCAN CHIP 2023 CAP # 21<br>Molina has updated the CHIP member website to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.<br>CHIP member website:<br>https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/quality/rights.aspx | ✓ | |
| **III B. Member CCO Program Education** | | | |
| 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:<br>1.1 Full disclosure of benefits and services included and excluded in coverage; | | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| Issues identified in benefits documentation in the CHIP Member Handbook include:<br>• For Emergency Ambulance Services, the CHIP Member Handbook states, "Unlimited based on life threatening condition present" and this is not stated on the benefits information on the CHIP website. Molina staff were unable to explain the restriction about life threatening conditions.<br>• The CHIP Member Handbook, page 39, does not specify the number of visits allowed for home health services.<br>• For Eye Care – Vision Services, the CHIP Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the CHIP website states, "1 eye exam and 1 pair of glasses annually."<br>*Corrective Action Plan: Correct the identified issues with member benefit documentation.* | Molina has added "unlimited" under the emergency ambulance services requirement on the CHIP member website here https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx<br>Molina has added "Limited to 36 visits per year" in the CHIP member handbook. See document CAP #22 uploaded to the portal.<br>Molina has updated the CHIP member handbook and the CHIP member website with the vision benefits being administered on a calendar year basis.<br>**2.2.2024- Updated Response:**<br>1/24/2024: Molina has removed "based on life threatening condition present" from the CHIP member handbook. | ✓ | |
| 2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network. | | | |
| Molina staff confirmed there is no policy that addresses the process for informing members of changes to programs and benefits within 30 calendar days prior to implementation.<br>*Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.* | This language will be included in the revised Member Handbook in accordance with the Policy & Procedure language on Covered Services and Enhanced Services.<br>**2.2.2024- Updated Response**<br>See CAP Item #23 MHMS- MM-007- Enhanced and Covered Services uploaded to the portal. | ✓ | |
| **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. | | | |
| Information about operations of the Member Services Contact Center is found in Policy MHMS-M&PCC-04, Member Services General Operations. As noted in the policy, the Member Services Contact Center hours of operation are 7:30 a.m. to 8:00 p.m., Monday through Friday and one | Policy MHMS-MPCC-04 Member Service General Operations has been updated on page 2. | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| weekend a month excluding State holidays. As written in the policy, it appears that the call center is open until 8 p.m. one weekend per month. However, onsite discussion confirmed the weekend hours are 8 a.m. to 5 p.m.<br>*Corrective Action Plan: Revise Policy MHMS-M&PCC-04, Member Services General Operations, to list the correct weekend hours of operation for the call center.* | | | |
| **III G. Grievances** | | | |
| 2. The CCO applies the grievance policy and procedure as formulated. | | | |
| Five CHIP resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no steps were provided. Instead, the members were asked to contact the Member Services Department after the grievance was closed.<br>*Corrective Action: Ensure that processes are in place to comply with Policy MHMS-MRT-01, Member Complaints and Grievances, regarding the use of extensions when needed to obtain additional information needed to resolve a grievance.* | We are working with the Division of Medicaid to establish a process to submit for extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team with be educated on the update by the end of Q2 2024.<br>**2.2.2024- Updated Response**<br>The Division is working on a process to address this CAP. For now the process would be for all extensions:<br>Submit the request to:<br>Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov<br>Lucretia Causey Lucretia.Causey@medicaid.ms.gov<br>Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov<br>Patricia Collins<br>Subject "Expedited Approval – 14 Day extension<br>All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day.<br>All inquiries received after 12 noon will be responded by 12 noon the following day. | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | We Have attached a work flow that speaks to this update as well as the letters. A verbiage template has been comprised for unable to contact cases that speaks to the steps we took to complete the case. This verbiage as been included in the workflow along with the template and an example. The workflow will be presented and implemented to the team on 2/5/2024. | | |
| **Quality Improvement** | | | |
| **IV A. Quality Improvement (QI) Program** | | | |
| 4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). | | | |
| There were several errors and/or missing information in the 2023 QI Work Plan. Those included:<br>• In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1.<br>• The Availability of Practitioners section (PDF pages 16 – 28) and the Accessibility of Services section (PDF pages 29 – 30) lacked benchmark goals for each activity.<br>• The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications which measure those scores apply.<br>• The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists.<br>• The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care practitioners instead of behavioral health practitioners. | See document EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP.<br>The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected and benchmark/goals were updated.<br>For easy identification, all changes in the document are in red. Corrections below:<br>• Program Operation - Page 11. "Met" changed to "Ongoing"<br>• Availability of Practitioners:<br>• Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500"<br>• Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500"<br>• Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500" | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| • The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. However, Policy MHMS-QI-006, Access to Care lists this timeframe as seven calendar days.<br>• The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care.<br>• In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days.<br>*Corrective Action Plan: Correct the errors identified in the 2023 QI Work Plan.* | • Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles".<br>• Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles", Oncologists: "1:30 minutes OR 1:30 miles"<br>• Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles", Psychiatrists: "1:30 minutes OR 1:30 miles"<br>• Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days<br>• Results/Timeframe/Date the Goal: (see above):<br>• Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type<br>• Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available."<br>• Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine"<br>• Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners"<br>• Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly.<br>• Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10"<br>• Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30".<br>A revised copy of the work plan is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP"<br>**2.2.2024 Updated Response**<br>The updated, Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24"<br>The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24"<br>See document EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP.<br>The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected, and benchmark/goals were updated.<br>For easy identification, all changes in the document are in red. Corrections below:<br>Program Operation – Page 11. "Met" changed to "Ongoing"<br>Availability of Practitioners: | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| | Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500"<br>Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500"<br>Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500"<br>Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles".<br>Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles", Oncologists: "1:30 minutes OR 1:30 miles"<br>Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles", Psychiatrists: "1:30 minutes OR 1:30 miles"<br>Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days<br>Results/Timeframe/Date the Goal: (see above):<br>Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available."<br>Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine"<br>Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners"<br>Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly.<br>Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10"<br>Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30".<br>A revised copy of the work plan is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP"<br>**2.2.2024 Updated Response**<br>The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24"<br>The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24"<br>**2.19.2024 – Updated Response**<br>• As indicated, Work Plan has been revised and updated with terminology utilized in Policy QI-006 in slide and sections as indicated below:<br>SLIDES 30 & 31 changes:<br>Access to appointments for PCPs are monitored by preventive primary care, routine sick, urgent care, and after hours. Goals are set to meet regulatory requirements.<br>Preventive primary care (PCP): 90% Not to exceed 30 days<br>Preventive primary care (OB/GYN): 90% Not to exceed 30 days<br>Routine Sick (PCP): 90% Not to exceed 7 days<br>Routine Sick (OB/GYN): 90% Not to exceed 7 days<br>After review of the policy and work plan, the language used in the policy needed clarifying. Therefore, the Policy MHMS-QI-006 has been revised with the appropriate language for Routine Sick for PCP and OB/GYN (page 3 of 7) and congruent language was used in the work plan (pages 30-31). The policy will be sent back to the QIC for approval of the changes during Q1 2024 QIC Meeting. A redline copy of the policy is provided with this response.<br>The 2023 QI Work Plan with the aforementioned revisions is provided (pages 30-31). However, the 2024 QI Work Plan is currently unavailable at this time. It is expected by March 2024. | | |
| **IV E. Provider Participation in Quality Improvement Activities** | | | |
| 3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines. | | | |
| Molina adopts and disseminates clinical practice and preventive health guidelines that focus on key topics relevant to the health plan's members. Per Policy MHMS-QI- | See document uploaded: EQR Audit 2023_CAP No. 11 and 27_1-12-24_MSCAN_CHIP. | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina annually measures performance against at least two important aspects of the clinical practice guidelines.<br>Constellation Quality Health questioned Molina during the onsite regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided.<br>*Corrective Action Plan: On an annual basis, measure provider performance against at least two of the clinical guidelines as required by the MS CHIP Contract, Section 9 (M) and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.* | The monitoring of provider compliance against two aspects of the Clinical Practice Guidelines annual report will be provided by February 29, 2024. The report will focus on perinatal care and PPC HEDIS measures. Report (EQR Audit 2023_CAP No 11 and 27_MSCAN_CHIP_1-12-24.) | | |
| 4. The CCO tracks provider compliance with EPSDT service provision requirements for:<br>4.2 Well-Baby and Well-Child screenings and results; | | | |
| Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provides an overview of Molina's process for monitoring and reporting compliance with the Well-Baby/Well-Child program. This policy indicates that members who receive an abnormal finding during their Well-Baby-Well-Child screening are identified, and the member contacted regarding the need for follow-up.<br>An example of the Well-Baby/Well-Child Tracker for 2023 was provided. The tracking process listed in the tracker indicates staff utilizes the Claims lookup tool to identify all claims members received after the original Well Child exam to determine potential diagnosis and referral/follow-up. If no claims could be associated as a referral, the list is passed to designated staff to call. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. Also, Policy MHMS-QI-005, Well-Baby/Well-Child | See document uploaded: EQR Audit 2023_CAP No. 12 and 28_EPSDT_Well Child Tracking Report<br><br>**2.2.2024- Updated Response**<br>The language from Policy MHMS-QI-005, Well-Baby/Well-Child Services and Immunization Services, page 7, regarding the creation of an automated tracking system has been removed. A redline version of the policy is included with this submission and is applicable to the CHIP line of business. The title of the document is "CAP Item 28_Policy MHMS-QI-005_Well Child_CHIP_1-26-24." | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| Services and Immunization Services, page 7, indicates work is being done to create an automated tracking dashboard for documenting recent/previous calls made to members' parents and the results of those calls.<br>*Corrective Action Plan: Implement a system for documenting the outreach made to members with an abnormal finding on a Well-Baby/Well-Child exam to ensure a follow-up referral and treatment is received as required by the CHIP Contract, Section 5 (D) and Policy MHMS-QI-005, Well-Baby/Well-Child Services and Immunization Services.* | | | |
| **IV F. Annual Evaluation of the Quality Improvement Program** | | | |
| 1. A written summary and assessment of the effectiveness of the QI program is prepared annually. | | | |
| At least annually, Molina conducts a formal evaluation of the QI Program. Molina uses internal Quality Specialists, external survey vendors, and analysts to collect, analyze, and report on the data using manual analysis and electronic software. Evaluation of quality activities will include a description of limitations and barriers to improvements. The QI Program 2022 Annual Evaluation was provided but did not include the results of the Geo Access reports referenced in Section 5 and the Provider Directory analysis referenced in Section 11 of the 2022 QI Work Plan.<br>This continues to be an issue and was identified in the 2020, 2021, and 2022 EQRs. *The CHIP Contract, Section 9 (D)* and *Exhibit F,* requires the QI Program Annual Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of | See document uploaded: EQR Audit 2023_CAP No. 13 and 29_2022 QI Evaluation | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| demonstrated improvements and overall effectiveness of the QI program.<br>*Corrective Action Plan: The results of all activities completed in 2022 and/or an update for the ongoing activities must be added to the 2022 QI Program Annual Evaluation to meet the requirements in the CHIP Contract, Section 9, and Exhibit F.* | | | |
| **Utilization Management** | | | |
| **V B. Medical Necessity Determinations** | | | |
| 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. | | | |
| The review of a sample of denial decisions indicated that Molina promptly communicated and provided an overview of the rationale for the determination and process for filing an appeal. However, the CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except when an expedited appeal is requested. This is no longer a contractual requirement. Molina acknowledged awareness and responded that they have updated the Adverse Benefit Determination letters and removed the requirement for a written request after a verbal request is initiated.<br>*Corrective Action Plan: Remove the requirement that a member must follow a verbal appeal request with a written request from the Adverse Benefit Determination letters.* | The CHIP Adverse Benefit Determination Letter has been updated to match the contractual requirements. Requirement for written request has been removed from the letter.<br>See document: Cap #14 and #30 MHMS ABD Letter_ Re Appeal Notification_ | ✓ | |
| **V C. Appeals** | | | |
| 2. The CCO applies the appeal policies and procedures as formulated. | | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| In Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the "Procedure" section includes that notification is given to the Division of the need for additional information and when the extension of an appeal is in the Member's [best] interest. However, five CHIP files were extended based on the lack of receipt of a signed Authorized Representative Form and subsequently closed with no indication of notification to the Division.<br>*Corrective Action: Ensure processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals, and that the appropriate notification is provided to the Division when appeal extensions are needed.* | We are working with the Division of Medicaid to establish a process to submit for extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team with be educated on the update by the end of Q2.<br>**2.2.2024- Updated Response**<br>The Division is working on a process to address this CAP. For now the process would be for all extensions:<br>Submit the request to<br>Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov<br>Lucretia Causey Lucretia.Causey@medicaid.ms.gov<br>Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov<br>Patricia Collins<br>Subject "Expedited Approval – 14 Day extension<br>All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day.<br>All inquiries received after 12 noon will be responded by 12 noon the following day.<br>We Have attached a work flow that speaks to this update. The workflow will be presented and implemented to the team on 2/5/2024. | ✓ | |
| **Delegation** | | | |
| 2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions. | | | |
| Molina's Procedure DO -1.001, Delegation Oversight contained an overview of the pre-delegation assessment, post-implementation and ongoing monitoring conducted as part of the oversight of a delegate. This procedure indicates a comprehensive annual delegation oversight audit is conducted by the Director of Delegation Oversight and Audit. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. | See Documents for CVS uploaded to the Portal for both CAP #16 and 32.<br>**2.2.2024 Updated Response**<br>Oversight of CVS Pharmacy Benefit Manager (PBM) oversight is primarily the responsibility of our Pharmacy Operations Team and not under the purview of the Delegation Oversight Team. PBM | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| However, the annual delegation oversight audit report was not provided. This was an issue identified during the 2022 EQR.<br><br>*Corrective Action Plan: The annual delegation oversight audit was not conducted as required by the CHIP Contract, Section 14 (B).* | functions involve various tasks that differ from those overseen by the Delegation Oversight Team.<br><br>The CHIP and CAN Contract, sections which states, "The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year." CVS's oversight, however, occurs more frequently due to the complex and dynamic nature of their responsibilities.<br><br>CVS's role as a PBM involves extensive monitoring, with monitoring reports, dashboards, and Surveillance Summaries being provided on a regular basis, including daily, monthly, and quarterly reports. This frequency of monitoring is necessitated by the robustness of the functions they perform, which go beyond the scope of an annual audit. To provide further clarification and insight into our oversight processes, I have included "MHI Pharm 14 Pharmacy Operations Surveillance Policy and Procedure." This document outlines the comprehensive procedures and guidelines we follow for monitoring and surveillance within Pharmacy Operations. It will offer you a more detailed understanding of our PBM oversight surveillance practice.<br><br>MHI Pharmacy Operations Surveillance Policy and Procedure uploaded to the portal.<br><br>**2/22/2024**<br>Molina has provided documentation of the annual audits conducted for our PBM CVS. The annual internal audits entitled Molina Executive Dashboard, which monitors timelines. An external audit conducted by external PBM auditor Health Strategies is also included. **PBM oversight is under the purview of Pharmacy Operations not the Molina Delegation Oversight team.**<br><br>**3.18.2024**<br>This annual audit document the auditor share between Molina and CVS will be completed at the end of this year for 2023. | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| | This auditing process involves a comprehensive examination and analysis, which often requires thorough investigation and extensive communication between our teams.<br><br>Due to the depth of the discovery process and the necessity for meticulous back-and-forth communication, we have historically completed the audit towards the end of the year.<br><br>**3.26.2024**<br>Please see attached 2023 annual audit for CVS. The Delegation audit for 2023 has been completed. After speaking with the Pharmacy auditing team, it was determined that the team members who work on this task did not fully understand the ask because they are new to the team. The new team member was under the impression we were asking for a document performed for another audit. The miscommunication was cleared up and it was determined that the delegation audit was completed. See document attached. | | |

## UnitedHealthcare Community Plan of Mississippi –2023 Corrective Action Plan - MSCAN

| 2023 EQR Findings - CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| **PROVIDER SERVICES** | | | |
| **II C. Provider Education** | | | |
| 2. Initial provider education includes:<br>2.8 Medical record handling, availability, retention, and confidentiality; | | | |
| The CAN Care Provider Manual lists medical record documentation requirements and states the provider must have a policy for medical record retention. However, the Care Provider Manual does not indicate the requirement for medical record retention.<br>*Corrective Action Plan: Revise the CAN Care Provider Manual to include the required timeframe for medical record retention.* | UHCs' template agreements with providers, including the regulatory appendices that are part of those agreements, include the required document retention requirements.<br><br>Standard Contract Language:<br>Maintenance. Medical Group will maintain Medical Group Records for at least 10 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.<br><br>The language can be found in the following sections of the base agreements and the Regulatory Appendix.<br>Supporting Documentation:<br>-Finding1_MSCAN_MS MGA Agreement_pg11sec5.9<br>-Finding1_MSCAN_MS Ancillary Agreement_pg9sec4.10<br>-Finding1_MSCAN_MS Facility Agreement_pg8sec4.10<br>-Finding1_MSCAN_MS FQHC_RHC Agreement_pg8sec4.10<br>-Finding1_MSCAN_MS Medicaid CAN Regulatory Appendix_pg7sec3.9<br><br>UHC's response – 1/22/2024<br>The Provider Manual has been updated to include the required timeframe for medical record retention.<br>Supporting Documentation:<br>-Finding1_PMG 20231121-125415 CAN CLEAN_Final_pg 49<br>-Finding1_PMG 20231121-125415_Final_MSCAN REDLINE | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| 2.12 A description of the role of a PCP and the reassignment of a member to another PCP; | | | |
| The CAN Care Provider Manual addresses the roles and responsibilities of PCPs. Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the CAN Care Provider Manual. Refer to the CAN Contract, Section 7 (H) 2 (r).<br>*Corrective Action Plan: Revise the CAN Care Provider Manual to include information about requirements for a PCP to request reassignment of a member to another PCP.* | This information can be found on page 57 in the Responsibility of the PCP section 2023 Care Provider Manual MississippiCAN.<br><br>Language in the manual Pg 57:<br>For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify us by regular mail: UnitedHealthcare Community Plan c/o Medical Director 795 Woodlands Parkway-Suite 301 Ridgeland, MS 39157<br>Supporting Documentation:<br>-Finding2_MSCAN_Care Prov Manual_pg57 | ✓ | |
| **Utilization Management** | | | |
| **V. C. Appeals** | | | |
| 1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:<br>1.2 The procedure for filing an appeal; | | | |
| Policy USCMM 0712, Appeal Process and Record Documentation, states that "The consumer/representative or provider may initiate the appeal process or in writing via mail, facsimile, or electronic medium, or verbally if expedited."<br>*Corrective Action Plan: Revise policy USCMM 0712 Appeal Process and Record Documentation, to correct the wording on page 2, Section A, #4 that indicates that appeals may be filed verbally if expedited.*<br><br>Policy UCSMM.07.11, Appeal Review Timeframes, states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date." | Policy USCMM 0712, Appeals Process and Record Documentation has been updated to remove expedited requirement for filing an appeal verbally.<br>Supporting Documentation:<br>-Finding3_CAN_UCSMM 07 12 Appeal Process and Record Documentation_RevisedCAP_pg2<br><br>Policy USCMM.07.11, Appeal Review Timeframes, has been updated to remove the written attestation requirement following a verbal appeal.<br>Supporting Documentation:<br>-Finding3_CAN_UCSMM 07 11 Appeal Review Timeframes_RevisedCAP_pg3 | ✓ | |

| 2023 EQR Findings - CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
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| | | Corrected | Not Corrected |
| *Corrective Action Plan: Revise Policy UCSMM.07.11 Appeal Review Timeframes, to correct the wording on page 3 that states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date."*<br><br>The CHIP download on United's website indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing." This does not align with process guidelines for filing verbally or in writing. | The CHIP PDF download, MS-Appeals-Grievances, has been updated to remove the written attestation requirement following a verbal appeal.<br>Supporting Documentation:<br>-Finding3&6_MS-Appeals-Grievance_pg3 | | |
| 2. The CCO applies the appeal policies and procedures as formulated. | | | |
| The Acknowledgement Letters 3 CAN files were addressed to the provider or Appeals Department, but language appeared to be communicating to the member.<br>*Corrective Action Plan: Ensure that processes are in place to review the language within the acknowledgement letters so that they accurately address the filer.*<br><br>The Resolution Letters for 4 CAN files were addressed to the provider, but the language within the resolution letter appeared to be communicating with the member.<br>*Corrective Action Plan: Ensure that processes are in place to review the language within the resolution letters so that it accurately addresses the filer.*<br><br>2 CAN files lacked a Written Consent or Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf. | A separate section of the letter has been created to specifically address the provider in addition to the member response section.<br><br>Continuation of quarterly meetings with the appeals and grievance team to review and identify any errors within the resolution letters.<br><br>Supporting Documentation:<br>-Finding4&7_MS Provider Facing Letter Proposal<br><br>The current process follows the National Committee for Quality Assurance (NCQA) guidance on utilization management (UM) review on expedited appeal requests and ensures that written consent or appointment of representative forms are in place as needed.<br><br>Supporting Documentation:<br>-Finding4&7_MS AOR Job Aid | ✓ | |

| 2023 EQR Findings – CAN | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| *Corrective Action Plan: Ensure that processes are in place to ensure that Written Consent or Appointment of Representative Forms are in place as needed.* | | | |

## UnitedHealthcare Community Plan of Mississippi – 2023 Corrective Action Plan – CHIP

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| **PROVIDER SERVICES** | | | |
| **II C. Provider Education** | | | |
| 2. Initial provider education includes:<br>2.12 A description of the role of a PCP and the reassignment of a member to another PCP; | | | |
| The CHIP Care Provider Manual addresses the roles and responsibilities of PCPs. Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the *CHIP Care Provider Manual. Refer to the CHIP Contract, Section 7 (H) 2 (r).*<br>*Corrective Action Plan: Revise the CHIP Care Provider Manual to include information about requirements for a PCP to request reassignment of a member to another PCP.* | This information can be found on page 55 in the PCP Responsibilities section 2023 Care Provider Manual Mississippi Children's Health Insurance Program (CHIP).<br><br>Language in the manual Pg 55:<br>For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify us through the Provider Portal, calling, or by regular mail:<br>UnitedHealthcare Community Plan c/o Medical Director 795 Woodlands Parkway-Suite 301 Ridgeland, MS 39157<br>Supporting Documentation:<br>-Finding5_MSCHIP_Provider Manual_DRAFT_pg55 | ✓ | |
| **Utilization Management** | | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| **V. C. Appeals** | | | |
| 1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:<br>1.2 The procedure for filing an appeal; | | | |
| Policy USCMM 0712, Appeal Process and Record Documentation, states that "The consumer/representative or provider may initiate the appeal process or in writing via mail, facsimile, or electronic medium, or verbally if expedited."<br><br>*Corrective Action Plan: Revise policy USCMM 0712 Appeal Process and Record Documentation, to correct the wording on page 2, Section A, #4 that indicates that appeals may be filed verbally if expedited.*<br><br>Policy UCSMM.07.11, Appeal Review Timeframes, states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date."<br><br>*Corrective Action Plan: Revise Policy UCSMM.07.11 Appeal Review Timeframes, to correct the wording on page 3 that states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date."*<br><br>The CHIP download on United's website indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing." This does not align with process guidelines for filing verbally or in writing. | Policy USCMM 0712, Appeals Process and Record Documentation has been updated to remove expedited requirement for filing an appeal verbally.<br>Supporting Documentation:<br>-Finding3_CAN_UCSMM 07 12 Appeal Process and Record Documentation_RevisedCAP_pg2<br><br>Policy USCMM.07.11, Appeal Review Timeframes, has been updated to remove the written attestation requirement following a verbal appeal.<br>Supporting Documentation:<br>-Finding3_CAN_UCSMM 07 11 Appeal Review Timeframes_RevisedCAP_pg3<br><br>The CHIP PDF download, MS-Appeals-Grievances, has been updated to remove the written attestation requirement following a verbal appeal.<br>Supporting Documentation:<br>-Finding3&6_MS-Appeals-Grievance_pg3 | ✓ | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| *Corrective Action Plan: Correct the CHIP download on the United website that indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing."* | | | |
| 2. The CCO applies the appeal policies and procedures as formulated. | | | |
| The Acknowledgement Letters for 4 CHIP files were addressed to the provider or Appeals Department, but language appeared to be communicating to the member.<br>*Corrective Action Plan: Ensure that processes are in place to review the language within the acknowledgement letters so that they accurately address the filer.*<br><br>The Resolution Letters for 3 CHIP files were addressed to the provider, but the language within the resolution letter appeared to be communicating with the member.<br>*Corrective Action Plan: Ensure that processes are in place to review the language within the resolution letters so that it accurately addresses the filer.*<br><br>*2 CHIP files lacked a Written Consent or Appointment of Representative Form when a provider filed an appeal on the member's behalf.*<br>*Corrective Action Plan: Ensure that processes are in place to ensure that Written Consent or Appointment of Representative Forms are in place as needed.* | A separate section of the letter has been created to specifically address the provider in addition to the member response section. Continuation of quarterly meetings with the appeals and grievance team to review and identify any errors within the resolution letters.<br>Supporting Documentation:<br>-Finding4&7_MS Provider Facing Letter Proposal<br><br>The current process follows the National Committee for Quality Assurance (NCQA) guidance on utilization management (UM) review on expedited appeal requests and ensures that written consent or appointment of representative forms are in place as needed.<br>Supporting Documentation:<br>-Finding4&7_MS AOR Job Aid | ✓ | |
| **V E. Transitional Care Management** | | | |

| 2023 EQR Findings – CHIP | Actions Taken by CCO To Address Findings | 2024 EQR Findings | |
|---|---|---|---|
| | | Corrected | Not Corrected |
| 2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting. | | | |
| A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, there were three CHIP transitional care management files that did not have ongoing documentation of notes that entail a follow-up schedule of the members' progress and process of case closure.<br>*Corrective Action: Please ensure to obtain and accurately document a follow-up schedule of the members' process receiving care management services.* | The process for the C&S Behavioral Health Care Coordination & Advocacy (BH CCA) outlines the process for care management services. Refresher training and staff coaching sessions were held in December 2023 and January 2024.<br>Supporting Documentation:<br>-Finding8_KB0054407_Redacted_pgs4-8 | ✓ | |

## Attachment 2: 2024 CAHPS®ECHO 3.0 Summary

## 2024 CAHPS® ECHO 3.0 Report Summary

Constellation contracted with DataStat, Inc., an NCQA Certified CAHPS Survey Vendor, to conduct Experience of Care and Behavioral Health Outcomes (ECHO) Surveys, developed by the Agency for Healthcare Research and Quality (AHRQ), to learn about the experiences of adult and child members who have received counseling or treatment from network providers. The surveys address key topics such as access to counseling and treatment, provider communication, plan information, and overall rating of counseling and treatment received. For MississippiCAN, attempts were made to survey 2,250 adult enrollee households and 2,250 child enrollee households. For CHIP, attempts were made to survey 1,500 enrollee households. The surveys for both MississippiCAN and CHIP were conducted by mail from October 31, 2024, through February 20, 2025, using a standardized survey procedure and questionnaire.

The results of these surveys can be used by the State and by the health plans to assess CAN and CHIP enrollees' experiences regarding their behavioral healthcare; identify strengths and weaknesses in quality of care and services; make determinations about resource allocation to improve weaknesses; and identify the effects of health plan efforts to improve over time.

### Summary of Overall Rating Question

Survey recipients were asked to rate their experience with counseling or treatment from 0 (worst) to 10 (best). The figures below display the proportion of members who provided ratings of 8, 9, or 10, along with the overall MississippiCAN Adult and Child as well as CHIP ratings.

**Figure 1: Summary of Overall Rating Question – MississippiCAN Adult**

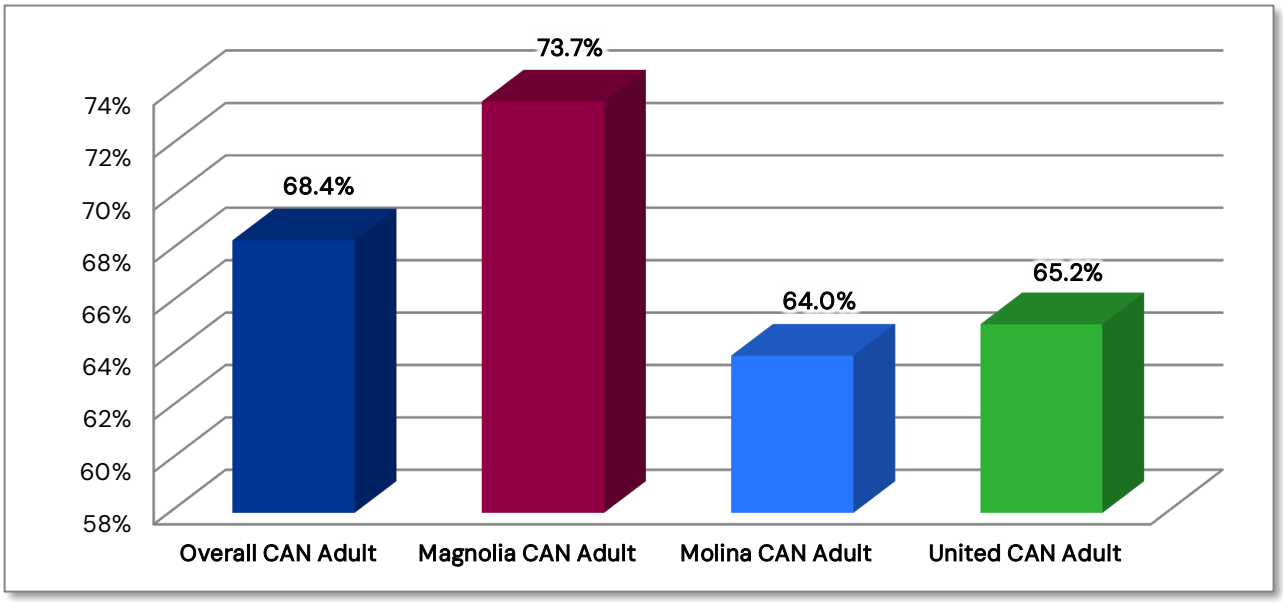


Figure 2: Summary of Overall Rating Question – MississippiCAN Child

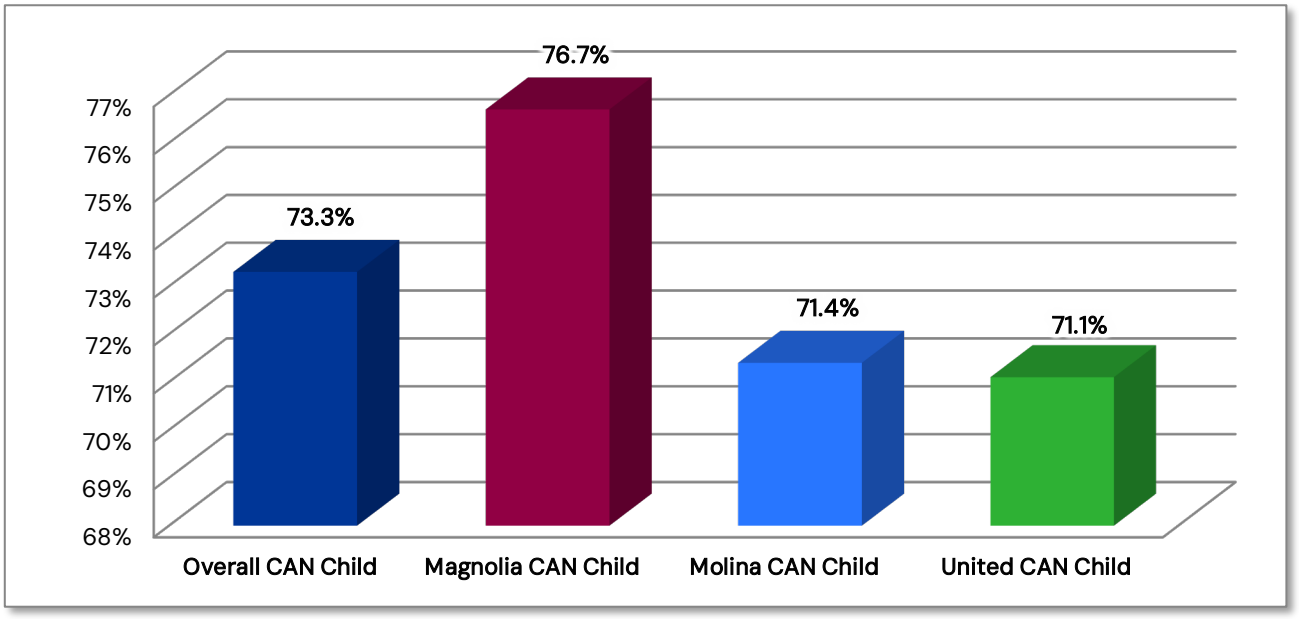
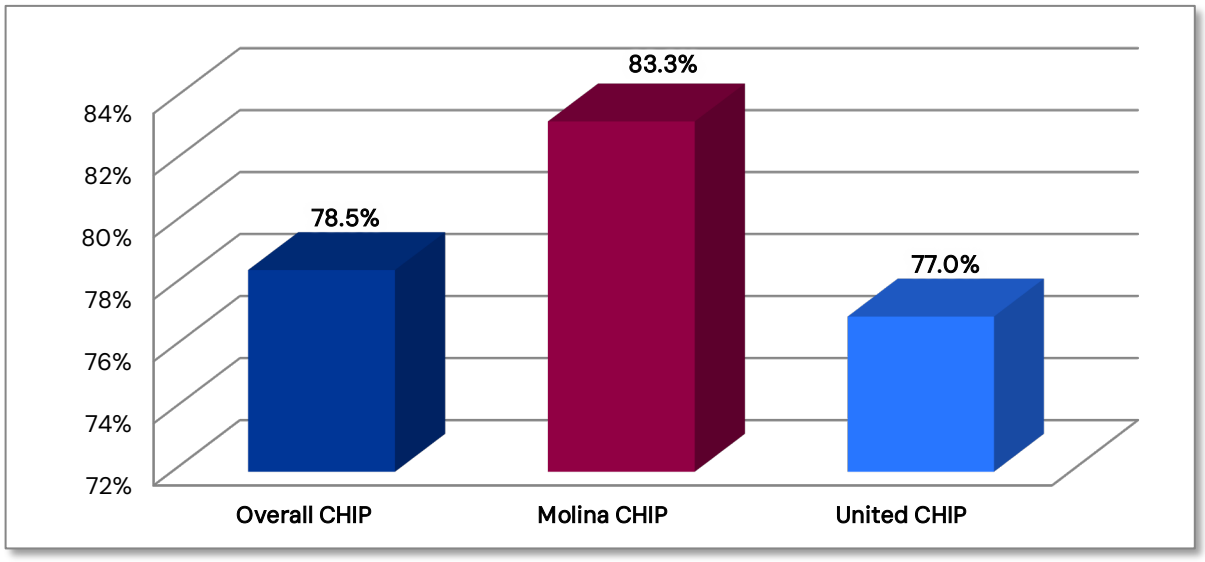



Figure 3: Summary of Overall Rating Question – CHIP




## Summary of Key Strengths and Opportunities for Improvement

Reponses to survey questions that indicate a positive experience are labeled as achievements and are summarized as achievement scores. Achievement scores for survey questions are computed as the proportion of enrollees who indicate a positive experience; therefore, the lower the achievement score, the greater the need for the health plan to improve.

The following tables display the ten survey questions most highly correlated with member satisfaction with counseling and treatment and their corresponding achievement scores. Among the ten items, the five questions with the highest achievement scores are presented first as Key Strengths. These are areas that appear to matter the most to members, and where the health plans are doing well. The five questions with the lowest achievement scores are presented second, as Opportunities for Improvement. These are areas that appear to matter the most to members, but where the health plans are not doing as well and could focus quality improvement efforts.

**Table 1: Key Strengths and Opportunities for Improvement – MSCAN Adult**

| Key Strengths – MSCAN Adult | Achievement Score |
|---|---|
| Q13. Clinicians usually or always showed respect | 91.2 |
| Q15. Usually or always felt safe with clinicians | 89.5 |
| Q11. Clinicians usually or always listened carefully | 88.7 |
| Q14. Clinicians usually or always spent enough time | 86.6 |
| Q18. Usually or always involved as much as you wanted in treatment | 82.3 |
| **Opportunities for Improvement – MSCAN Adult** | **Achievement Score** |
| Q27. Care responsive to cultural needs | 60.0 |
| Q17. Told about side effects of medication | 65.9 |
| Q22. Given as much information as wanted to manage condition | 75.9 |
| Q29. A lot or somewhat helped by treatment | 81.9 |
| Q12. Clinicians usually or always explained things | 82.0 |

**Table 2: Key Strengths and Opportunities for Improvement – MSCAN Child**

| Key Strengths – MSCAN Child | Achievement Score |
|---|---|
| Q14. Clinicians usually or always showed respect | 94.7 |
| Q13. Clinicians usually or always explained things | 93.3 |
| Q12. Clinicians usually or always listened carefully | 90.7 |
| Q20. Usually or always got professional help wanted for child | 88.1 |
| Q28. Care responsive to cultural needs | 87.5 |
| **Opportunities for Improvement – MSCAN Child** | **Achievement Score** |
| Q42. Getting help from customer service was not a problem | 59.1 |
| Q30. A lot or somewhat helped by treatment | 80.4 |
| Q21. Child usually or always had someone to talk to when troubled | 84.0 |
| Q23. Given as much information as wanted to manage condition | 84.1 |
| Q15. Clinicians usually or always spent enough time | 85.3 |

Table 3: Key Strengths and Opportunities for Improvement - CHIP

| Key Strengths – CHIP | Achievement Score |
|---|---|
| Q13. Clinicians usually or always explained things | 95.1 |
| Q12. Clinicians usually or always listened carefully | 93.8 |
| Q21. Child usually or always had someone to talk to when troubled | 92.7 |
| Q20. Usually or always got professional help wanted for child | 91.5 |
| Q18. Usually or always involved as much as you wanted in treatment | 91.5 |
| **Opportunities for Improvement – CHIP** | **Achievement Score** |
| Q35. Much better or a little better able to deal with symptoms or problems compared to 1 year ago | 74.0 |
| Q33. Much better or a little better able to deal with social situations compared to 1 year ago | 75.0 |
| Q23. Given as much information as wanted to manage condition | 78.0 |
| Q25. Felt that they could refuse a specific type of treatment | 81.7 |
| Q30. A lot or somewhat helped by treatment | 86.7 |