Constellation Quality Health

Mississippi External Quality Review

Annual Comprehensive Technical Report

Contract Year
2025 – 2026

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Prepared on behalf of the
Mississippi Division of Medicaid

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ACRONYMS, ABBREVIATIONS, AND INITIALISMS

Acronym	Definition
Aqurate	Aqurate Health Data Management, Inc.
BBA	Balanced Budget Act of 1997
CAHPS®	Consumer Assessment of Healthcare Providers and Systems, a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
CAN	Coordinated Access Network
CAP	Corrective Action Plan
CCO	Coordinated Care Organization
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
Constellation	Constellation Quality Health
DOM	Division of Medicaid
ECHO	Experience of Care and Behavioral Health Outcomes
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FAR	Final Audit Report
FWA	Fraud, Waste, and Abuse
HEDIS®	Healthcare Effectiveness Data Information Set, a registered trademark of the National Committee for Quality Assurance (NCQA)
IDSS	Interactive Data Submission System
Magnolia	Magnolia Health Plan
MCO	Managed Care Organization
Molina	Molina Healthcare of Mississippi
MY	Measure Year
NA	Not Applicable
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PIP	Performance Improvement Project
PM	Performance Measure
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
Roadmap	Record of Administration, Data Management, and Processes
UM	Utilization Management
UMC	Utilization Management Committee

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 the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the Mississippi Division of Medicaid (DOM) contracted with Constellation Quality Health (Constellation), an external quality review organization (EQRO), to conduct external quality reviews (EQR) for all coordinated care organizations (CCOs) participating in the MississippiCAN (CAN) and Mississippi CHIP (CHIP) Medicaid Managed Care Programs. The CCOs include:

- 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 healthcare through a system that promotes timeliness, accessibility, and quality of healthcare services. This was accomplished by conducting the following activities for the CAN and CHIP programs: validation of performance improvement projects, performance measures, surveys, and network adequacy; assessment of compliance with state and federal regulations; and access studies for each health plan. Constellation also conducted the Behavioral Health Member Satisfaction Survey for each CCO. This report is a compilation of the EQR activities conducted in the 2025-2026 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

Health plan staffing is sufficient to conduct required activities, and key positions are filled in compliance with contractual requirements. Lines of reporting within the organizations are clearly conveyed on the CCOs' Organizational Charts.

Policies and procedures are developed to guide staff and ensure compliance with laws, regulations, and contractual requirements. The health plans follow appropriate processes for policy development, ongoing management, and at least annual review. Staff are educated about new and revised policies and can access policies on intranet sites and policy management platforms.

Compliance Plans describe processes for ensuring compliance with laws, regulations, and contractual requirements. Magnolia and Molina's Compliance Plans addressed required elements; however, Molina's documentation regarding exclusion status monitoring did not address requirements for querying the Social Security Death Master File. Fraud, Waste, and Abuse (FWA) Plans detail processes to prevent, detect, and respond to FWA, and Codes of Conduct define expectations for business conduct. Both health plans require compliance training at employment and annually for all staff and provide multiple options for anonymous and confidential reporting of compliance and FWA concerns without fear of retaliation.

CCO Compliance Committees oversee the Compliance Programs. Magnolia 's Compliance Committee Charter defined the committee's purpose, objectives, meeting frequency, quorum, and attendance requirements. Although required by policy, Molina had not developed a Compliance Committee Charter.

The CCOs' Beneficiary Health Management Programs are in place to manage and assist members who have overutilized and/or misused pharmacy benefits. Processes and requirements for the Beneficiary Health Management Program are thoroughly documented in health plan policies.

Both health plans have policies to protect the privacy and confidentiality of protected health information and to define allowed and prohibited uses of this information. The plans require confidentiality statements from employees and include confidentiality in compliance training.

Review and assessment of each CCO's Information Systems Capabilities Assessment documentation and related policies and procedures indicated the CCOs' information systems infrastructures were capable of meeting contractual requirements. Both CCOs met or exceeded timelines required by the State specific to clean claims. 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 have established provider orientation and education processes, with initial provider orientation completed within 30 days of network entry and ongoing education delivered through multiple channels. Provider Manuals and websites offer extensive guidance for providers; however, discrepancies were identified in member benefit information between Magnolia's CAN Provider Manual and CAN Member Handbook. Provider education includes medical record documentation standards, and provider compliance is evaluated through routine medical record audits with interventions implemented for substandard performance.

Both Magnolia and Molina inappropriately referenced using results of medical record reviews to make credentialing determinations.

The health plans have established appropriate policies and procedures for adopting, reviewing, updating, and disseminating evidence-based clinical practice and preventive health guidelines. Information about the guidelines is disseminated in Provider Manuals and other provider communication forums, and links to specific guidelines are available on the plans' websites. Review found that providers may be hindered from accessing some of the guidelines on plan websites due to nonfunctional or incorrect hyperlinks.

Constellation conducted validation reviews of the CCOs' provider satisfaction surveys and found that low response rates may not reflect the population of the CCOs' network providers. Constellation recommends the CCOs continue their efforts to improve survey response rates for better representation of providers.

Review of the CCOs' Provider Network File Questionnaires confirmed the CCOs collect, update, and validate provider data using systems such as CenProv, Pega, and QNXT. Documentation confirmed data verification and update processes.

Documentation of provider geographic access standards was compliant with contractual requirements. The CCOs routinely run and evaluate geographic access reports to assess network adequacy, identify deficiencies, and guide interventions. Additionally, the CCOs consider member survey, complaint, grievance, and out-of-network utilization data. Appointment access standards are documented in policies, provider and member materials, and on health plan websites. However, some of the member handbooks and plan websites listed outdated or conflicting appointment access timeframes. The CCOs assess provider compliance with appointment access standards through appointment access studies while also considering complaints, grievances, and member satisfaction survey results. The health plans take action to address noncompliance.

Comprehensive web-based and printed Provider Directories are maintained. Review of the web-based Provider Directories confirmed inclusion of all required elements. Magnolia's printed directory included all required elements, while Molina's printed directories did not consistently include provider website URLs.

For the Provider Access Studies and Directory Validations conducted by Constellation, successful contact rates improved for Magnolia CAN, Molina CAN, and Molina CHIP; routine appointment availability improved for Magnolia CAN, but declined for Molina CAN and Molina CHIP; urgent appointment availability improved for Molina CHIP, but declined for Magnolia CAN and Molina CAN; and provider directory validation accuracy improved for Magnolia CAN, Molina CAN, and Molina CHIP.

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 programs ensure member access to essential healthcare services, promote preventive care, and maintain compliance with federal requirements. Members receive clear, consistent information about their rights, responsibilities, and covered benefits through multiple communication channels, including Member Handbooks, welcome materials, and CCO websites. Advance written notice of at least 30 days is provided for any changes to covered services.

Both Magnolia and Molina demonstrate a strong commitment to supporting members across the healthcare continuum—from enrollment and benefit navigation to care access and grievance resolution. Member Services contact information and program details are widely available through member and provider materials and online resources.

Call Centers assist members with provider selection, transportation coordination, grievances, and appeals. Staff use annually reviewed call scripts, receive quarterly training, and operate under performance standards, which are established by DOM and monitored by each CCO. Call data are routinely analyzed to drive quality improvement, with corrective actions implemented as needed. Extended service hours are available, with after-hours support provided through a 24-hour Nurse Advice Line staffed by registered nurses.

Member education is prioritized through timely distribution of New Member Packets, preventive care outreach, community engagement initiatives, and proactive call center support that encourages early primary care utilization and appropriate use of services.

Health plan grievance processes are described in policies, Member Handbooks, Provider Manuals, and online materials. However, a review of policies showed that some areas need clarification, including the explanation of who may file a grievance (Magnolia). The review of CAN and CHIP grievance files for both health plans found documentation and process issues. These included date errors, missing or undated resolution or extension notices, and limited documentation of investigation and resolution activities.

Quality Improvement

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

The documents submitted for the 2025 EQRs describe Magnolia's and Molina's Quality Improvement (QI) programs and governance structures for 2024–2025, emphasizing their commitment to high-quality, equitable, and culturally responsive care. Magnolia's program focuses on improving health outcomes, reducing disparities, enhancing member experience, supporting providers, and ensuring patient safety through data-driven methodologies, utilization analysis, and population-based initiatives. Oversight is provided by the Board of

Directors and the Quality Improvement Committee, with clearly defined roles, provider performance monitoring, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) compliance tracking, and an annually updated Quality Work Plan. Magnolia's 2024 Program Evaluation highlights accomplishments, challenges, and priorities for 2025.

Molina's QI Program Description similarly outlines a comprehensive framework centered on continuous improvement, health equity, and integrated physical and behavioral health services, with oversight by the Board and the Quality Improvement and Health Equity Transformation Committee. While Molina demonstrates ongoing monitoring, provider engagement, and annual program evaluation, the review identified documentation inconsistencies, including inaccurate statements about provider credentialing, misalignment of behavioral health access standards with policy, and missing audit results referenced in the QI Work Plan. Overall, both organizations demonstrate structured QI programs with strong governance, though noted gaps require corrective action.

Performance Measure Validation: Constellation conducted a validation review of the Healthcare Effectiveness Data Information Set (HEDIS®, a registered trademark of the National Committee for Quality Assurance) and CMS Adult and CMS Child Core Set measures following the CMS protocol. This process assessed the production of these measures by the health plans 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), a National Committee for Quality Assurance (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 2024) to the previous year (MY 2023). 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 of the rates reported by the CCOs and the statewide averages 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 2024 CAN Rates	Molina HEDIS MY 2024 CAN Rates
Substantial Increase in Rate (>10% improvement)		
Adult BMI Assessment (ABA)	81.70%	62.57%

Measure/Data Element	Magnolia HEDIS MY 2024 CAN Rates	Molina HEDIS MY 2024 CAN Rates
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		
BMI Percentile	69.10%	65.21%
Childhood Immunization Status (CIS)		
DTaP	82.24%	74.21%
Pneumococcal Conjugate	82.00%	73.48%
Combination #3	77.13%	69.10%
Asthma Medication Ratio (AMR)		
12-18 Years	76.64%	79.34%
19-50 Years	69.30%	72.46%
51-64 Years	61.46%	64.00%
Total	78.40%	80.37%
Glycemic Status Assessment for Patients With Diabetes (GSD) ⋄		
Glycemic Status <8.0%	56.93%	52.31%
*Glycemic Status >9.0% **	35.04%	39.17%
Kidney Health Evaluation for Patients With Diabetes (KED)		
65-74 Years	39.39%	N/A
Plan All-Cause Readmissions (PCR-AD) ⋄⋄		
Outlier Rate	78.37%	77.51%
Adult Immunization Status (AIS-E)		
Pneumococcal 66+	25.76%	N/A
Substantial Decrease in Rate (>10% decrease)		
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	41.79%	47.33%

N/A: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
**: Lower rate indicates better performance*
⋄: Measure has "Trend with Caution" guidance from NCQA for MY 2024
⋄⋄: Measure has "Break in Trending" guidance from NCQA for MY 2024

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
Substantial Increase in Rate (>10% improvement)	
Asthma Medication Ratio (AMR)	
5-11 Years	91.14%
Total	83.97%
Substantial Decrease in Rate (>10% decrease)	
Initiation and Engagement of AOD Dependence Treatment (IET)	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD – Total (Total)	39.39%

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

Measure/Data Element	Magnolia MY 2024 CAN Rates	Molina MY 2024 CAN Rates
Substantial Increase in Rate (>10% improvement)		
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05) *		
Ages 65+	75.02	0.00
HIV Viral Load Suppression (HVL - AD)		
Ages 18 - 64	40.77%	29.10%
Total	40.23%	29.41%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *		
Ages 18 - 64	56.58%	47.59%
Total	56.63%	47.59%
Substantial Decrease in Rate (>10% decrease)		
Heart Failure Admission Rate (PQI-08) *		
Ages 65+	225.06	625.00

**: Lower rate indicates better performance*

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

Measure/Data Element	Molina MY 2024 CHIP Rates
Substantial Increase in Rate (>10% improvement)	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *	
Ages 18 - 64	15.71

**: 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 2025/2026 EQRs, the CCOs submitted 14 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
Magnolia	
Reducing Preterm Births	79/79=100% High Confidence in Reported Results
Sickle Cell Disease Outcomes	85/85=100% High Confidence in Reported Results
Adult and Child Respiratory Disease	80/80=100% High Confidence in Reported Results
FUH Follow-up After Hospitalization for Mental Illness (new measure)	75/75=100% High Confidence in Reported Results
Molina	
Asthma Medication Ratio	85/85=100% High Confidence in Reported Results
Pharmacotherapy Management of COPD Exacerbation	80/80=100% High Confidence in Reported Results
Follow-up After Hospitalization for Mental Illness	85/85=100% High Confidence in Reported Results
Prenatal and Postpartum Care	85/85=100% High Confidence in Reported Results
Sickle Cell Disease	80/80=100% High Confidence in Reported Results
Obesity	85/85=100% High Confidence in Reported Results

Table 6: CHIP Performance Improvement Projects Submitted for Validation

Project	Validation Score
Molina	
Asthma Medication Ratio	85/85=100% High Confidence in Reported Results
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results
Obesity	80/80=100% High Confidence in Reported Results
Well-Care/Well-Child	80/80=100% High Confidence in Reported Results

Utilization Management

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

The Utilization Management (UM) programs demonstrate a strong commitment to ensuring access to medically necessary services, maintaining regulatory compliance, and supporting effective care coordination for members.

Both organizations have established UM programs designed to promote consistent and impartial utilization decisions. UM Program Descriptions, along with supporting policies and procedures, clearly define program structure, operational components, and lines of responsibility and accountability. Magnolia's UM program is overseen by senior leadership, including the Chief Medical Officer, Vice President of Population Health and Clinical Operations, and Behavioral Health Medical Director, with formal approval by the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC). Similarly, Molina's UM program operates under its Healthcare Services Program and is overseen by the Vice President, Assistant Vice President, and Chief Medical Officer, who jointly manage clinical policies and UM operations.

Each UM program applies nationally recognized, evidence-based medical necessity criteria and encompasses a broad range of services, including 24-hour nurse triage, referrals, prior authorization, concurrent review, discharge planning, and care coordination. Both programs emphasize appropriate resource utilization and permit emergency and post-stabilization care to be provided without prior authorization. Audit results and file reviews demonstrated that utilization determinations are made timely and consistently by qualified clinical professionals.

The health plans describe their processes for filing and managing member appeals in policies, member and provider materials, UM Program Descriptions, and on plan websites. Appeal terminology is clearly defined. Molina's policy inaccurately states that verbal appeals must be followed by a signed written appeal, which is inconsistent with regulatory requirements. Timeframes for standard and expedited appeals, including acknowledgment, resolution, and

allowable extensions, are clearly documented for each health plan. Appeals are tracked and reviewed to identify trends and opportunities for improvement. A review of appeal files for each health plan showed that appeals were handled on time, reviewed by appropriately credentialed physicians, and resulted in clear decisions supported by clinical criteria.

The health plans offer Care Management, Disease Management, and Population Health Management programs. They use several data sources to identify members who may benefit from care management. Once referred, members receive services based on their needs and risk levels. Each health plan also provides care transition services, coordinated by an interdisciplinary team, to help members move smoothly between home and community settings. However, a review of policies showed that neither health plan clearly described the transition of care process for new members. A review of care management files showed that care management activities were conducted according to the member's assigned risk level and contractual regulations.

Delegation

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

For the Delegation portion of the 2025 EQR, both Molina and Magnolia achieved full compliance, meeting all three of three standards for a score of 100%. Molina's and Magnolia's delegation oversight programs demonstrate strong adherence to federal, state, and contractual requirements through formal written agreements, pre-delegation reviews, annual audits, and ongoing monitoring. Both organizations retain ultimate accountability for delegated services, utilize committee oversight to review performance and audit results, and implement corrective actions as needed to ensure quality, compliance, and effective oversight of delegated entities.

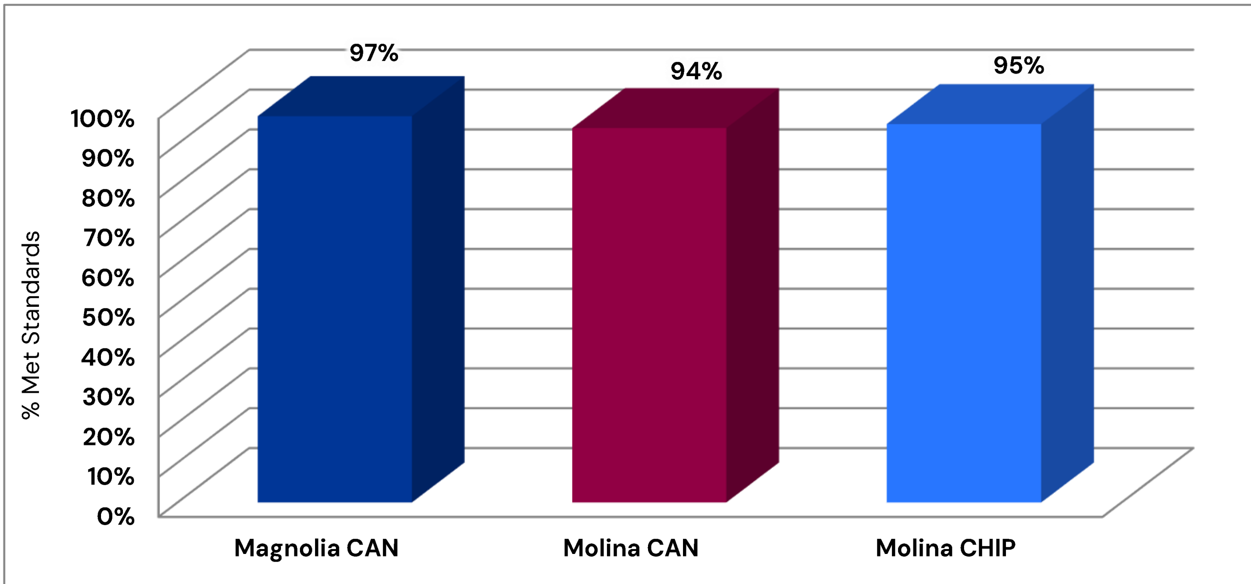
Corrective Action Plans and Recommendations from Previous EQR

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 2025 EQRs, Constellation assessed the degree to which each health plan implemented the actions to address deficiencies identified during the 2024 EQRs. The 2025 EQRs revealed uncorrected deficiencies for both Magnolia and Molina. The complete CAP report for each health plan is included in *Attachment 1* of this report.

Conclusions

For the 2025 EQRs, the CCOs met most of the requirements set forth in *42 CFR Part 438 Subpart D*, the QAPI program requirements described in *42 CFR § 438.330*, and the requirements of the *DOM Contracts. Figure 1* illustrates the percentage of "Met" standards achieved by each health plan during the 2025 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 *Subpart D* and QAPI standards.

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

Category	Report Section	Number of CAN Standards	Magnolia CAN		Molina CAN	
			Number of Standards Scored as "Met"	2025 Score	Number of Standards Scored as "Met"	2025 Score
Availability of Services *(§ 438.206, § 457.1230)* Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	15	15	100%	12	80%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	18	18	100%	18	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* *Emergency and Post Stabilization Service* *(§ 438.114)*	Utilization Management, Section V. B	13	13	100%	13	100%
Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%	1	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	18	90%	18	90%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	3	3	100%	3	100%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	9	8	89%	8	89%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%	4	100%

Category	Report Section	Number of CAN Standards	Magnolia CAN		Molina CAN	
			Number of Standards Scored as "Met"	2025 Score	Number of Standards Scored as "Met"	2025 Score
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	19	100%	16	84%
Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. D	2	2	100%	2	100%
Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	3	3	100%	3	100%

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

Table 8: Compliance Review Results for Part 438 Subpart D and QAPI Standards—CHIP

Category	Report Section	Number of CHIP Standards	Molina CHIP	
			Number of Standards Scored as "Met"	2024 Overall Score
Availability of Services *(§ 438.206, § 457.1230)* Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	15	12	80%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	18	18	100%

Category	Report Section	Number of CHIP Standards	Molina CHIP	
			Number of Standards Scored as "Met"	2024 Overall Score
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* *Emergency and Post Stabilization Service* *(§ 438.114)*	Utilization Management, Section V. B	13	13	100%
Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G Utilization Management, Section V. C	20	18	90%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	3	3	100%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	7	6	86%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	16	84%
Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. D	2	2	100%
Enrollee Rights *(§ 438.100)*	Member Services, Section III. A	3	3	100%

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

Overall Recommendations and Opportunities for Improvement

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

Strengths	Quality	Timeliness	Access to Care
Administration			
The health plans have appropriate processes established for new policy development, ongoing policy management and review, and staff education about new and revised policies.	✓		
All key positions were filled according to contractual requirements, and no staffing issues were noted.	✓		
Compliance Plans, FWA Plans, Codes of Conduct, and policies define processes for ensuring compliance with laws, regulations, and accreditation standards, processes for preventing, detecting, responding to FWA, and appropriate business conduct.	✓		
Compliance training is mandatory for all employees, Board members, and/or contractors to ensure understanding of federal and state statutes, regulations, guidelines, and responsibilities.	✓		
Open communication channels are maintained for employees to report compliance and/or FWA concerns, and retaliation against those who report concerns is prohibited.	✓		
The health plans conduct regular audits and monitoring activities that help identify risks and compliance gaps, take action to address any areas of concern, and evaluate the effectiveness of interventions.	✓		
The Beneficiary Health Management Programs, formerly the Pharmacy Lock-in Programs, maintained by the CCOs meet all requirements and are in place to manage and assist members who have overutilized and/or misused pharmacy benefits.	✓		
The CCOs ensure the confidentiality of PHI through established policies, employee training, confidentiality agreements, and system security safeguards.	✓		
Magnolia and Molina provided documentation to demonstrate their infrastructure can meet contractual and information systems requirements. Both adequately demonstrated data collection and storage capabilities, processing procedures, and claim data tabulation and processing. Both CCOs showed adequate support of QA and UM program activities and other contractual requirements via flowcharts and technical layouts.	✓		
Both 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.	✓		
Both CCOs have the capabilities to perform Medicaid claims and encounter data processing as required by DOM.	✓		
Provider Services			
The CCOs have established processes for notifying primary care providers (PCPs) of members assigned to their panels and for ensuring all providers can verify member enrollment and eligibility.	✓	✓	✓

Strengths	Quality	Timeliness	Access to Care
Processes are in place to monitor provider limitations on panel size to ensure appropriate access for members.			✓
The geographic access standards for the CCOs' provider networks are compliant with contractual requirements, as confirmed in policy and as demonstrated in the geographic access reports submitted for review.			✓
The health plans routinely monitor and assess their networks. Appropriate processes are in place to address any identified network deficiencies or gaps.	✓		✓
Both Magnolia and Molina monitor providers' quality of care and service and take appropriate action to address identified issues.	✓		
The health plans make Provider Directories available online and in print form and routinely assess the accuracy of the directory information.			✓
Provider directory data is updated regularly to allow monitoring of provider network adequacy.	✓		✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
The CCOs adopt PHGs and CPGs from evidence-based sources with input from physicians and other health care professionals and review them annually and when there are changes in scientific evidence and/or national standards.	✓		
The CCOs' provider satisfaction surveys were administered by certified vendors and met CMS Survey Validation protocol.	✓		
For both health plans, analysis of provider satisfaction survey results identified areas of improvement.	✓		
Member Services			
Member materials are clearly written in easy-to-understand format.	✓		✓
Preventive care is emphasized through community outreach, health fairs, mobile health initiatives, and proactive call center engagement.	✓	✓	✓
Both health plans summarize grievance data, trends, and root causes and report them quarterly to the Quality Improvement Committee for review and discussion.	✓		
Grievance terminology is clearly defined in policy, Member Handbooks, Provider Manuals, and on each of the health plan's website.	✓		
Certified vendors conducted member satisfaction surveys. Results were analyzed, used to identify improvement areas, and shared with stakeholders.	✓		
Quality Improvement			
The QI Programs were designed to improve health outcomes, reduce disparities, enhance member experience, support providers, and promote patient safety.	✓		
The programs included mechanisms to assess the quality and appropriateness of care for all members, including those with special health care needs, addressing physical, behavioral, and social health services.	✓		
The QI Programs promoted health equity by integrating behavioral health and substance use services and using data on demographics and social factors to ensure culturally and linguistically appropriate care for all members.	✓		
Providers actively participate in QI activities through the Provider Profiling Program and Provider Analytics, which offer insights into performance and support improvement strategies.	✓		

Strengths	Quality	Timeliness	Access to Care
The QI Programs undergo an annual evaluation to assess its effectiveness, identify opportunities for improvement, and refine interventions to enhance healthcare quality and member satisfaction.	✓		
Molina CAN and CHIP, and Magnolia CAN were both fully compliant with all IS Standards and HEDIS determination standards for the 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 prior year rates.	✓		
Utilization Management			
Review of the sampled approval and denial files demonstrated that determinations were completed within the timeframes required by applicable contractual standards for all health plans.		✓	✓
Each health plan maintains a tracking system to monitor appeal timeliness and ensure adherence to turnaround requirements.	✓	✓	
All CAN and CHIP appeal files selected for the 2025 EQR were completed by the appropriate credentialed physicians and according to contractual regulations.	✓		
The health plans have multiple strategies to promote member engagement through incentive programs, and specialized coordinators to conduct outreach to members.	✓		✓
Each health plan has specialized models of care to ensure members receive tailored services based upon their identified needs.	✓		✓
Delegation			
The CCOs demonstrated strong oversight and adherence to quality standards in delegated services.	✓		
Processes and policies ensure compliance with state and federal requirements.	✓		
Regular monitoring, annual evaluations, and routine reporting ensure ongoing oversight and performance tracking.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Administration				
Issues noted with documentation of Molina's Compliance Program included: • The Compliance Plan, FWA Plan, and related policies failed to address required queries of the Social Security Death Master File. • A policy inappropriately referenced provider credentialing activities in relation to exclusion status monitoring. Since 2022, credentialing is not a health plan function.	*Recommendation: Ensure documentation regarding the Compliance Program is complete and accurate and that committee charters are developed per policy.*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
• A Compliance Committee Charter was not developed as required by health plan policy.				
Provider Services				
Although provider credentialing has not been a CCO responsibility since 2022, some policies inappropriately referenced using results of other health plan activities, including medical record reviews and cultural competency activities, to make credentialing determinations.	*Recommendation: Because provider credentialing is not a health plan responsibility, ensure references to credentialing are removed from policies.*	✓		
Incorrect provider appointment access standards were documented in Molina's Access to Care policy (MHMS-QI-006), CAN and CHIP Provider Manuals, and CAN and CHIP websites.	*Recommendation: Ensure all applicable documents and the CAN and CHIP websites include the correct appointment access standards.*		✓	✓
Molina's call study results indicated the timeframe used to measure appointment access for routine BH/SUD visits did not correspond to the timeframe in the Access to Care policy (MHMS-QI-006). During onsite discussion, the reviewer requested clarification from the health plan; however, Molina did not provide the requested clarification.	*Recommendation: Ensure appropriate timeframes are used to assess provider compliance with appointment access standards.*		✓	✓
Discrepancies were noted in documentation of member benefits for behavioral health services and orthotics/prosthetics when comparing Magnolia's CAN Provider Manual and CAN Member Handbook.	*Recommendation: Ensure Provider Manuals and Member Handbooks provide consistent information about member benefits.*	✓		✓
Links to some clinical practice guidelines on both CCOs' websites were non-functional, incorrect and/or did not allow access without a username and password.	*Recommendation: Ensure hyperlinks to clinical practice guidelines are correct and functional. Consider creating a library of guidelines on websites rather than using hyperlinks.*	✓		✓
Low response rates for provider satisfaction surveys may introduce bias into generalization.	*Recommendation: Implement targeted strategies to improve participation through provider reminders and education about importance of provider satisfaction surveys.*	✓		
Member Services				
Each health plan contained incomplete documentation throughout the grievance process, and many files were not completed in accordance with established policies and contractual guidelines.	*Recommendation: Ensure that steps are taken to demonstrate compliance with the management of grievance files per policy and contractual regulations.*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Low response rates were noted for member satisfaction surveys for both plans.	*Recommendation: Increase response rate through education and continued outreach.*	✓		
Quality Management				
Molina's QI Program Description incorrectly states that Molina credentials and recredentials providers. Molina does not perform these functions. This issue was previously identified in the 2023 and 2024 EQRs and has not been corrected.	*Recommendation: The health plans should review all documents and eliminate any references to plans' role in credentialing or recredentialing individual practitioners, provider organizations, facilities, and institutions.*	✓		
The behavioral health appointment standards in Molina's 2024 and 2025 QI Work Plans were not consistent with Policy MHMS-QI-006.	*Recommendation: Update the behavioral health appointment standards in the 2024 and 2025 QI Work Plans to ensure accuracy and alignment.*	✓		
Molina's QI Work Plan referenced an annual review of HEDIS medical records and delegation oversight activities. However, the results of these audits were not incorporated into the 2024 QI Program Evaluation, limiting the ability to fully assess the effectiveness of the QI Program.	*Recommendation: Ensure that the results and outcomes of all studies and activities are fully documented and incorporated into the QI Program Evaluation, in accordance with the CAN Contract, Section 10 (D), Exhibit G, and the CHIP Contract, Section 9(D)(8) and Exhibit F.*	✓		
CCOs should follow State requirements for rate submission. Monitor and investigate reasons for measure rates that increased or decreased by 10 percentage points or more. CCOs should improve processes for rate validation and trending to identify measure reporting concerns. CCOS should provide notification when submitted rates are changed and provide explanations for the change.	*Recommendation: CCOs should improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures. CCOs must review requirements and report measures as required for submission by DOM.*	✓		
Utilization Management				
Magnolia's Member Handbook requires prior authorization for new members to continue medically necessary services, which conflicts with CAN Contract requirements.	*Recommendation: The health plan should review Member Handbook and ensure contract requirements related to continuation of medically necessary services.*	✓		✓
Molina's policy regarding prior authorization for continuing services beyond 30 days for new members lacks sufficient clarity.	*Recommendation: The health plan should review policy to clarify prior authorization for continuing services beyond 30 days for new members.*	✓		✓
Molina's Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), inaccurately states that a verbal appeal must be followed by a signed written appeal, which conflicts with regulatory requirements.	*Recommendation: Remove the requirement that a verbal appeal must be followed by a written appeal.*			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Review identified prior authorization guidance deficiencies in both health plans, including contract conflicts in Magnolia's Member Handbook and insufficient policy clarity in Molina's post-transition authorization requirements.	*Recommendation: Update policies and Member Handbooks to describe the transition of care process clearly and accurately.*			✓
Delegation				
Magnolia's Oversight of Delegated Vendor Services policy indicates a summary of the annual evaluation is presented at the next Quality Improvement Committee meeting for review and comment. The recently completed annual summaries were not found in the committee minutes.	*Recommendation: Present the summary of the annual evaluation for each delegated vendor as mentioned in policy.*	✓		

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 Quality Health 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 2025-2026 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 Quality Health has developed targeted recommendations to support CCOs in fulfilling the Quality Strategy's goals. These recommendations are detailed in *Table 10*.

Table 10: DOM Quality Strategy Goals

DOM Quality Strategy Goal	Recommendation
Make Care Affordable	• Address avoidable emergency department (ED) utilization by improving timely follow-ups after hospital visits and ensuring better medication adherence for chronic conditions like asthma and sickle cell disease. • Align affordability strategies with Mississippi Value Based Payment (MS VBP) program which ties financial incentives to maternal health and mental health outcomes and minimizes wasteful spending.
Work with Communities to Promote Best Practices of Healthy Living	• Strengthen community-based education on obesity, and sickle cell disease, as PIPs show low adherence rates to recommended treatments despite outreach efforts. • 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. • 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. • 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 Their Care	• Increase follow-up rates for mental health and maternity patients by expanding case management efforts and direct patient outreach, as several post-hospitalization follow-up rates have room for improvement. • Implement more proactive outreach strategies, such as text and call reminders, incentives for preventive care, and educational materials tailored to high-risk populations. • Utilize CAHPS survey findings as performance drivers and increase response rate through reminders and education.
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. • 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

The Mississippi Division of Medicaid has requested that Constellation conduct an optional EQR activity, the 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, 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 1,500 adult Medicaid enrollee households and 1,500 child Medicaid enrollee households. For Mississippi CHIP, attempts were made to survey 750 enrollee households. The surveys for both MississippiCAN and Mississippi CHIP were conducted by mail during the period from October 16, 2025, through January 29, 2026, using a standardized survey procedure and questionnaire. See *Attachment 2* for a summary of the 2025 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 CAN and 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 to the health plan. This report describes the data aggregation and analysis, as well as how conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addressed the corrective actions from the previous year's review, if applicable. Annually, Constellation prepares an annual comprehensive technical report, which is a compilation of the individual annual review findings, for the State. The comprehensive technical report for contract year 2025 through 2026 contains data regarding results of the EQRs conducted for the CAN and CHIP programs for 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 a virtual onsite visit with each plan. After completing each annual review, Constellation submits a detailed technical report to DOM and to the health plan (covered in the preceding *Background* section). For a health plan not meeting requirements, Constellation requires the plan to submit a Corrective Action Plan (CAP) 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 actions.

Table 11 displays the dates of the EQRs conducted for each health plan.

Table 11: External Quality Review Dates

Health Plan	Annual EQR Initiated	Onsite Conducted	Report Submitted to DOM
Magnolia Health Plan CAN	7/3/25	9/10/25 – 9/11/25	10/21/25
Molina Healthcare CAN Molina Healthcare CHIP	7/3/25	12/3/25 – 12/4/25	1/20/26

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." Each section below includes a Comparative Data table that reflects 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.

Administration

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

Organizational Charts provided by the CCOs, along with onsite discussion, confirmed key positions are filled as contractually required and the health plans' staffing is sufficient to conduct required activities. The Organizational Charts display lines of reporting within the organization. At the time of the onsite visit, Magnolia reported they were in the process of filling two Care Manager positions.

Magnolia and Molina develop and implement policies and procedures to guide staff and ensure compliance with laws, regulations, and contractual requirements. Adequate processes are in place for policy development and ongoing management, including annual and as needed reviews. The health plans ensure staff have access to policies via intranet sites, policy management platforms, and/or SharePoint sites, and educate staff about new and revised policies.

The CCOs have developed Compliance Plans which provide detailed information about processes for ensuring compliance with laws, regulations, and contractual requirements and FWA Plans that describe processes to prevent, detect, and respond to FWA. Staff are further

guided by written Codes of Conduct, supplied at the time of employment and annually, that include expectations for ethical and professional business behavior. Magnolia's and Molina's Compliance Plans included all required elements. For Molina, the Compliance Plan and FWA Plan addressed exclusion status monitoring for employees, providers, vendors, etc. However, the Compliance Plan and FWA Plan, along with related policies and procedures, failed to address required queries of the Social Security Death Master File. Additionally, a procedure incorrectly referenced provider credentialing, which has not been a health plan function since 2022.

Each CCO has a Compliance Committee to oversee the Compliance Programs, advise the Compliance Officer, support efforts to identify risks, promote compliance, and address compliance complaints and concerns. Magnolia had an established Compliance Committee Charter that defines the committee's purpose and objectives, meeting frequency, attendance requirement, quorum requirement, etc. For Molina, although a procedure (C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight) required the CCO to maintain a Compliance Committee Charter, Molina was unable to provide a formal charter for the committee.

Both health plans require compliance training to ensure employees understand compliance expectations, responsibilities, and applicable federal and state requirements. New employees are required to complete the training within 30 days of hire, and all employees must complete annual training. Training covers topics such as the Code of Conduct, Compliance Program elements, ethics, fraud and abuse prevention, and role-specific requirements. The CCOs ensure open lines of communication with Compliance Officers and provide multiple options for employees and others to report compliance and FWA concerns anonymously and/or confidentially. The CCOs prohibit retaliation against those who report compliance or FWA issues.

Each of the health plans has a Beneficiary Health Management Program, formerly known as the Pharmacy Lock-in Program, to manage and assist members who have overutilized and/or misused pharmacy benefits. Processes and requirements for the Beneficiary Health Management Program are thoroughly documented in health plan policies; however, Molina's 2025 Molina Healthcare Health Care Services Program Description was not updated to reflect the name change for the program.

Both health plans have policies to protect the privacy and confidentiality of PHI in accordance with federal and state laws. The policies apply to employees and leadership, define allowed and prohibited uses of PHI, require confidentiality agreements and training, and outline member rights, security safeguards, and procedures for handling breaches and violations.

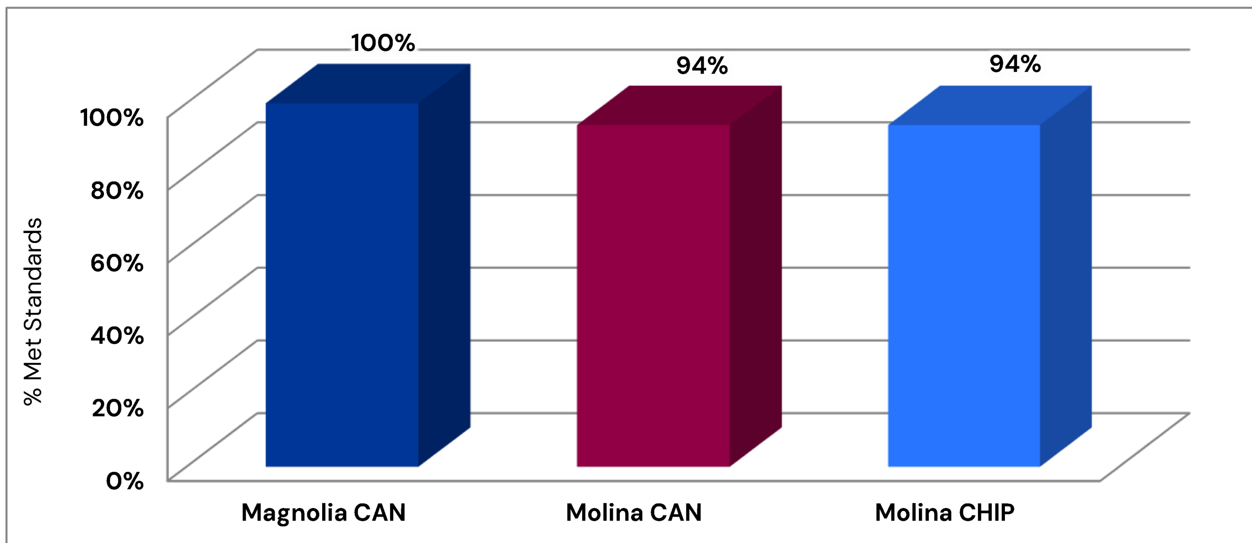
Information Systems Capabilities Assessment

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 the CCOs' information systems infrastructures were capable of meeting contractual requirements. Both CCOs met or exceeded timelines required by the State specific to clean claims payment. The 2025 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.

Figure 2 displays the percentage of "Met" scores for each health plan for the 2025-2026 Administration review.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number.

Tables 12 and *13* display the strengths, weaknesses, and recommendations for the Administration section.

Table 12: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
The health plans have established appropriate processes for new policy development, ongoing policy management and review, and staff education about new and revised policies.	✓		

Strengths	Quality	Timeliness	Access to Care
All key positions were filled according to contractual requirements, and no staffing issues were noted.	✓		
Compliance Plans, FWA Plans, Codes of Conduct, and policies define processes for ensuring compliance with laws, regulations, and accreditation standards, processes for preventing, detecting, responding to FWA, and appropriate business conduct.	✓		
Compliance training is mandatory for all employees, Board members, and/or contractors to ensure understanding of federal and state statutes, regulations, guidelines, and responsibilities.	✓		
Open communication channels are maintained for employees to report compliance and/or FWA concerns, and retaliation against those who report concerns is prohibited.	✓		
The health plans conduct regular audits and monitoring activities that help identify risks and compliance gaps, take action to address any areas of concern, and evaluate the effectiveness of interventions.	✓		
The Beneficiary Health Management Programs maintained by the CCOs meet all requirements and are in place to manage and assist members who have overutilized and/or misused pharmacy benefits.	✓		
The CCOs ensure the confidentiality of PHI through established policies, employee training, confidentiality agreements, and system security safeguards.	✓		

Table 13: Administration Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Issues noted with documentation of Molina's Compliance Program included: • The Compliance Plan, FWA Plan, and related policies failed to address required queries of the Social Security Death Master File. • A policy inappropriately referenced provider credentialing activities in relation to exclusion status monitoring. Since 2022, credentialing is not a health plan function. • A Compliance Committee Charter was not developed as required by health plan policy.	*Recommendation: Ensure documentation regarding the Compliance Program is complete and accurate and that committee charters are developed per policy.*	✓		

The 2025 EQR scores for the Administration section are detailed in *Table 14*. In this table, down arrows (↓) indicate a change in the score from the 2024 EQR.

Table 14: Administration Comparative Data

Standard	Magnolia CAN	Molina CAN	Molina 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
Organizational Chart / Staffing			
The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: Chief Executive Officer	Met	Met	Met
Chief Operating Officer	Met	Met	Met
Chief Financial Officer	Met	Met	Met
Chief Information Officer	Met	Met	Met
Information Systems personnel	Met	Met	Met
Claims Administrator	Met	Met	Met
Provider Services Manager	Met	Met	Met
Provider contracting and education	Met	Met	Met
Member Services Manager	Met	Met	Met
Member services and education	Met	Met	Met
CAN: Complaint/Grievance Coordinator CHIP: Grievance and Appeals Coordinator	Met	Met	Met
Utilization Management Coordinator	Met	Met	Met
Medical/Care Management Staff	Met	Met	Met
Quality Management Director	Met	Met	Met
CAN: Marketing, member communication, and/or public relations staff CHIP: Marketing and/or Public Relations	Met	Met	Met
Medical Director	Met	Met	Met
Compliance Officer	Met	Met	Met
Operational relationships of CCO staff are clearly delineated	Met	Met	Met
Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*			
The CCO processes provider claims in an accurate and timely fashion	Met	Met	Met
The CCO tracks enrollment and demographic data and links it to the provider base	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
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
Compliance/Program Integrity			
The CCO has a Compliance Plan to guard against fraud, waste and abuse	Met	Met	Met
The Compliance Plan and/or policies and procedures address requirements	Met	Partially Met ↓	Partially Met ↓
The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Partially Met ↓	Partially Met ↓
The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met

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

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

Topics included in the Provider Services review include network adequacy, provider education, 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

Magnolia and Molina conduct initial provider orientation within 30 days of a provider's entry into the network. Policies describe the processes for initial orientation and the topics covered. The CCOs use a training presentation to guide the orientation sessions and provide additional resources to providers, including provider tool kits, Provider Manuals, website links, and additional training materials. Both health plans provide ongoing provider education through face-to-face/onsite visits, regional workshops, provider bulletins, newsletters, e-communications, webinars, mailings, website postings, and/or Provider Manual updates. The Provider Manuals and CCO websites provide comprehensive guidance to support providers' participation and day-to-day operations within the health plans' networks; however, discrepancies in member benefits were noted between Magnolia's CAN Provider Manual and CAN Member Handbook.

Provider education includes requirements for medical record documentation. The CCOs evaluate provider compliance with the medical record documentation requirements through routine medical record audits. Interventions for substandard performance include additional education, subsequent audits, and potential escalation for additional action. Although provider credentialing has not been a CCO responsibility since 2022, both Magnolia and Molina inappropriately referenced using results of medical record reviews to make credentialing determinations.

Practice Guidelines

§ 438.236, § 457.1233

The health plans have established policies and procedures for adopting, reviewing, updating, and disseminating evidence-based clinical practice and preventive health guidelines. The guidelines are selected from recognized, nationally accepted sources, reviewed by qualified clinical professionals, and updated at least annually and as needed for new scientific evidence or changes in national standards.

Information about the guidelines is provided in CCO Provider Manuals, newsletters, orientation materials, and targeted communications, and links to specific guidelines are available on the plans' websites. Additionally, hard copies are available upon request. Review of the links to the guidelines on Magnolia and Molina's websites confirmed the adopted guidelines cover a variety of topics pertinent to health plan membership; however, it also identified ongoing issues with providers' abilities to access some guidelines due to non-functional, incorrect, and restricted hyperlinks or links that directed users to unrelated guidelines.

Provider Satisfaction Survey Validation

Constellation conducted validation reviews of the CCOs' provider satisfaction surveys using the protocol developed by the Centers for Medicare and Medicaid Services (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.

Table 15 offers the sections of the worksheet that need improvement, the reasons, and the recommendations.

Table 15: Provider Satisfaction Survey Validation Results

Plan	Section	Reason	Recommendation
Magnolia CAN	Response Rate	The response rate was 4.7%, which is lower than	Continue efforts to improve the response rate to ensure the

Plan	Section	Reason	Recommendation
		the previous year's response rate of 5.2%.	results better represent the provider population.
Molina CAN and CHIP	Response Rate	As compared to previous year, there was a slight decrease from 7.7% to 7.5%.	Implement targeted strategies to improve participation through provider reminders and education about importance of provider satisfaction surveys.

The low response rates may not reflect the population of each of the CCOs' network providers. Constellation recommends the CCOs continue their efforts, including provider education and other targeted strategies, to improve survey response rates for better representation 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 CMS' *EQR Protocol 4: Validation of Network Adequacy*. The purpose of this validation was to determine whether each CCO maintained a provider network sufficient to ensure adequate access to covered services for enrolled members and to assess compliance with State-established network adequacy standards.

Network Adequacy Validation Documentation Requested

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.
- Health plan policies and procedures related to network development, provider contracting, and network monitoring, including geographic and appointment access standards.
- Provider Manual and Member Handbook.

- A sample of a provider contract.

Network Adequacy Validation Process

Table 16 displays the activities conducted for the Network Adequacy Validation for the CCOs.

Table 16: Network Adequacy Validation Activities

Activity One: Assess Data Collection Procedures	
Step	**Step Questions**
1.1	Were all data sources (and years of data) needed to calculate the indicators submitted by the CCO to the EQRO?
1.2	For each data source, were all variables needed to calculate the indicators included?
1.3	Are there any patterns in missing data that may affect the calculation of these indicators?
1.4	Do the CCO's data enable valid, reliable, and timely calculations of the indicators?
1.5	Did the CCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied?
1.6	During the time period included in the reporting cycle, have there been any changes in the CCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators?
1.7	If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters?
1.8	If LTSS data were used to calculate indicators, were all relevant LTSS provider services included?
1.9	If access and availability studies were conducted, does the CCO include appropriate calculations and sound methodology?
Activity Two: Assess CCO Network Adequacy Methods	
2.1	Are the methods selected by the CCO appropriate for the state?
2.2	Are the methods selected by the CCO appropriate to the state Medicaid and CHIP population(s)?
2.3	Are the methods selected by the CCO adequate to generate the data needed to calculate the indicators according to the State's expectations?
2.4	Does the CCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?
2.5	If the CCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population?
2.6	If the CCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions?
2.7	Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.
2.8	Does the CCO's approach for measuring time/distance indicators match the state's expectation?

Activity Two: Assess CCO Network Adequacy Methods	
2.9	Does the CCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation?
2.10	Does the CCO's approach for determining the maximum wait time for an appointment match the state's expectation?
2.11	Are the methods used to calculate the indicators rigorous and objective?
2.12	Are the methods used to calculate unlikely to be subject to manipulation?
Activity Three: Assess CCO Network Adequacy Results	
3.1	Did the CCO produce valid results?
3.2	Did the CCO produce accurate results?
3.3	Did the CCO produce reliable and consistent results?
3.4	Did the CCO accurately interpret its results?
Activity Four: Perform Overall Validation and Reporting of PIP Results	
1	Perform Validation
2	Report Results

The Network Adequacy Validation process follows a structured methodology designed to ensure accuracy, reliability, and meaningful healthcare improvements. 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 using methods appropriate for the State and populations served, adequacy of the methods for collecting the necessary data, use of methods that are rigorous and objective, while also being unlikely to manipulation, and the validity and accuracy of the results. Other elements are evaluated with proportionate weight to ensure a balanced assessment. Each component is scored as Met, Not Met, or Not Applicable (N/A) 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 17*). Projects scoring 90-100% are classified as High Confidence, indicating strong methodological integrity with minimal documentation concerns. A Confidence rating (70-89%) suggests minor issues that introduce slight bias but do not compromise overall results. A Low Confidence rating (60-69%) signals major deviations from established methods that may impact data integrity, while scoring below 60% results in a designation of Not Credible, indicating significant flaws that prevent validation of the reported outcomes.

Table 17: Network Adequacy Validation Rating

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

Network Adequacy Validation Results

Constellation reviewed the CCOs' policies and procedures related to network development, provider contracting, and network monitoring to assess the processes used to maintain network adequacy. Supporting documentation was reviewed to confirm that network requirements and access standards were communicated to providers. The reviews included assessments of geographic access reports and documentation of appointment access standards to determine whether the networks met State requirements for member access to primary care and specialty services.

An overview of the results for each activity conducted to assess network adequacy is found below.

Provider Network File Questionnaire – The purpose of the Provider Network File Questionnaire 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 18*.

Table 18: Overview of Provider Network File Questionnaire Findings

Domain	Magnolia CAN	Molina CAN	Molina CHIP
Data Management System	The plan collects data, updates and validates data using systems like CenProv and Pega.	The plan collects data, updates and validates data using systems like QNXT.	The plan collects data, updates and validates data using systems like QNXT.
Data Verification	The plan has submitted a workflow document detailing data verification process.	The plan has described the workflow for data verification.	The plan has described the workflow for data verification.
Updates to Provider Directories	The plan has submitted a workflow document detailing data update process and indicated updates take place daily.	The plan indicated that nightly and weekly updates are made to the provider directory.	The plan indicated that nightly and weekly updates are made to the provider directory.
Geographic Access Reporting	The plan has submitted geographic access data which tracks network adequacy.	The plan has submitted geographic access data which tracks network adequacy.	The plan has submitted geographic access data which tracks network adequacy.

Availability of Services – Magnolia and Molina have established processes for notifying primary care providers of the members assigned to their panels through the secure provider portals. Providers can also request this information from Provider Services Representatives and/or the Provider Services Call Center. Both CCOs monitor and track provider panel limitations to ensure adequate access for members.

Health plan policies define the geographic access standards for PCPs, specialists, and other provider types and are compliant with contractual requirements. The health plans generate routine geographic access reports to evaluate member access to primary care, specialty care, behavioral health services, and ancillary services. The results aid in identifying deficiencies and underlying barriers and are used to prioritize opportunities for improvement. Interventions are implemented to address identified gaps and may include network expansion, targeted recruitment by specialty or geographic area, scheduling process improvements, etc. The CCOs also assessed network adequacy by monitoring member experience data, including surveys, complaints, grievances, appeals, and out-of-network utilization.

Review of the CCO's geographic access reports confirmed the plans used appropriate parameters for each provider type and for urban and rural classifications.

Table 19 presents the Mississippi-defined geographic access standards for providers, the determination of whether the CCOs were compliant with (Met) the standards, and the percentages of members with appropriate geographic access for each provider type. DOM uses a single Pharmacy Benefits Administrator, responsible for claims management and payment, prior authorization, and the pharmacy network. Therefore, geographic access for pharmacies was not included in the validation.

Table 19: CCO Compliance with Geographic Access Standards

State Defined Geographic Access Standards			CCO Compliance with Access Standards						Percentages of Members with Access					
Provider Type	Urban	Rural	*Magnolia CAN		⋄Molina CAN		⋄Molina CHIP		*Magnolia CAN		⋄Molina CAN		⋄Molina CHIP	
			Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs (Adult and Pediatric)	2 within 15 miles	2 within 30 miles	Met	Met	Met	Met	Met	Met	99.9%	100%	99.6%	100%	99.6%	100%
Hospitals	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	99.9%	100%	100%	100%	100%	100%
General Dental Providers (Adult and Pediatric)	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	100%	100%	100%	100%	100%	100%
Dental Subspecialty Providers	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	100%	100%	98%	100%	97.9%	100%
Emergency Care Providers	1 within 30 minutes or 30 miles	1 within 30 minutes or 30 miles	Met	Met	Met	Met	Met	Met	100%	99.9%	100	99.5%	100%	99.5%
Urgent Care Providers	1 within 30 minutes or 30 miles	N/A	Met	N/A	Met	N/A	Met	N/A	100%	N/A	91%	N/A	91.8%	N/A
OB/GYN	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	100%	100%	100%	100%	99.9%	100%
DME Providers	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	99.9%	100%	100%	100%	100%	100%
Behavioral Health Providers (MH and SUD) (Adult and Pediatric)	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	99.9%	100%	100%	100%	100%	100%

State Defined Geographic Access Standards			CCO Compliance with Access Standards						Percentages of Members with Access					
Provider Type	Urban	Rural	*Magnolia CAN		⋄Molina CAN		⋄Molina CHIP		*Magnolia CAN		⋄Molina CAN		⋄Molina CHIP	
			Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Dialysis Providers	1 within 60 minutes or 60 miles	1 within 90 minutes or 90 miles	Met	Met	Met	Met	Met	Met	100%	100%	100%	100%	100%	100%
Specialists (adult & pediatric)														
Allergy/Immunology	1 within 30 minutes or 30 miles	1 within 60 minutes or 60 miles	Met	Met	Met	Met	Met	Met	99.4%	94.1%	90.6%	92.7%	91.1%	92.7%
Cardiology			Met	Met	Met	Met	Met	Met	100%	100%	100%	100%	100%	100%
Cardiothoracic Surgery			Met	Met	Met	Met	Met	Met	85.9%	84.4%	98.8%	91.4%	99.1%	96.1%
Dermatology			Met	Met	Met	Met	Met	Met	99.1%	91.4%	89.4%	81.8%	89.2%	81.4%
Endocrinology			Met	Met	Met	Met	Met	Met	99.8%	91.1%	87.6%	78.6%	87.1%	78.7%
ENT/Otolaryngology			Met	Met	Met	Met	Met	Met	99.6%	100%	99%	98.8%	99.1%	98.8%
Gastroenterology			Met	Met	Met	Met	Met	Met	99.5%	98.3%	99%	95.7%	99.1%	95.6%
General Surgery			Met	Met	Met	Met	Met	Met	99.9%	100%	99.6%	100%	99.7%	100%
Hematology/Oncology			Met	Met	Met	Met	Met	Met	99.6%	100%	99.6%	98.9%	99.6%	98.9%
Infectious Disease			Met	Met	Met	Met	Met	Met	99.5%	94.0%	80.9%	80.2%	81.2%	80.2%
Nephrology			Met	Met	Met	Met	Met	Met	99.1%	99.7%	99.2%	100%	96.6%	99.9%
Neurological Surgery			Met	Met	Met	Met	Met	Met	99.7%	96.1%	82.7%	92.1%	81.2%	81.5%
Neurology			Met	Met	Met	Met	Met	Met	99.8%	98.7%	99.4%	100%	96.6%	100%
Orthopedic Surgery			Met	Met	Met	Met	Met	Met	99.9%	100%	99.9%	100%	100%	100%
Plastic Surgery			Met	Met	Met	Met	Met	Met	99.6%	97.6%	83.2%	88.3%	81.3%	87.9%
Podiatry			Met	Met	Met	Met	Met	Met	100%	100%	90.2%	99.7%	90%	99.8%
Pulmonology			Met	Met	Met	Met	Met	Met	99.9%	100%	99.1%	100%	99.1%	100%
Radiation Oncology			Met	Met	Met	Met	Met	Met	99.1%	99.1%	97.3%	95.7%	97.5%	91.5%
Rheumatology			Met	Met	Met	Met	Met	Met	99.4%	94.3%	95.9%	86.4%	95.4%	86.3%
Urology			Met	Met	Met	Met	Met	Met	99.9%	100%	99.7%	98.1%	99.7%	97.9%

**Results are based on Magnolia's July 26, 2025, Physical and Behavioral Health GeoAccess Report and October 1, 2025, CAN Dental GeoAccess Report*

⋄Results are based on Molina's Q2 2025 GeoAccess Reports

Appointment access standards with which providers must comply are documented in health plan policies, Provider Manuals, member materials, and on the CCO websites. Review of these materials revealed that, while some policies and/or provider manuals have been updated to reflect revised contract standards, other materials—including member handbooks and plan websites—list outdated or conflicting timeframes. The CCOs conduct appointment access studies to assess provider compliance with appointment access standards and monitor member complaints, grievances, and member satisfaction survey results, etc. Providers that do not meet established performance thresholds are subject to corrective action processes, including corrective action plans, follow-up audits, and quality committee review when performance does not improve.

Magnolia's Q1 2025 call study results showed compliance rates that ranged from a high of 92.8% for pediatric sick visits to a low of 16% for behavioral health emergent visits. Magnolia reported current and ongoing interventions to improve provider compliance with the appointment access standards, including continuous in-person and/or virtual provider education, provision of written information regarding appointment access requirements, and development of a quick reference document for provider office scheduling staff.

Molina's Q2 2025 call study compliance rates ranged from a high of 76.74% for OB/GYNs to a low of 53.23% for PCPs. Molina reported interventions that included routine fax blasts to re-educate providers about appointment access standards and including appointment access standards as a discussion point for all provider visits.

Review demonstrated that the CCOs maintain both web-based and printed Provider Directories that include a comprehensive range of provider types, including PCPs, specialists, hospitals, behavioral health providers, and ancillary providers. Applicable policies define required Provider Directory elements and processes for routine maintenance, updates following provider network changes, and ongoing accuracy monitoring and validation through periodic audits and usability testing. Provider Directories are made available through health plan websites, DOM offices, and in hard copy upon request. Review of the web-based Provider Directories confirmed inclusion of all required elements. Review of printed Provider Directories confirmed inclusion of required provider types and for Magnolia, all required elements. Molina's printed directories did not consistently include provider website URLs, as specified in policy and in *42 CFR § 438.10(h))*.

The CCOs have established processes to ensure their provider networks can meet members' cultural, linguistic, accessibility, and complex care needs. Activities include routinely assessing member and provider demographic data and using feedback from surveys and grievances to identify gaps and guide improvements. Interventions employed to improve cultural competency within the networks include expanding training resources, launching tools to update provider demographic information, and initiating outreach to providers to improve participation in compliance training. Molina's Practitioner Network Cultural Responsiveness procedure (MHMS-

QI-011) inappropriately states provider race, ethnicity, and language information is obtained through initial credentialing processes. However, Molina has not conducted provider credentialing activities since 2022.

Overall, the Network Adequacy Validation results indicated High Confidence in Reported Results for both Magnolia and Molina, as shown in *Table 20*.

Table 20: Network Adequacy Validation Rating

CCO	Network Adequacy Validation Rating
Magnolia CAN	High Confidence in Reported Results
Molina CAN and CHIP	High Confidence in Reported Results

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 access-study confirmed PCP contact information. An overall accuracy rate was determined.

Validation Results

- **Magnolia CAN and CHIP** - The overall successful contact rate for Q1 2026 was 38% for CAN and 26% for CHIP. For CAN, this represents an increase from the successful contact rate of 27% in Q3 2025. The Q1 2026 study was the initial study for Magnolia CHIP; therefore, no comparison data is available. For both CAN and CHIP, the successful contact rate is below the goal rate of 95%. The Q1 2026 routine appointment compliance rate was 81% for CAN and 55% for CHIP. The urgent appointment compliance rate was 15% for CAN and 15% for CHIP. For CAN, this represents an increase in the compliance rate for routine appointments from 37% in Q3 2025, and a slight decrease from the previous rate of 16% for urgent appointment availability. The Q1 2026 Provider Directory Validation showed an accuracy rate of 63% for CAN (a 31%

improvement from the previous study's rate of 32%). For CHIP, the Provider Directory Validation showed an accuracy rate of 61%.

- **Molina CAN and CHIP Summary –** For Molina, the successful contact rates for Q4 2025 were 37% for CAN and 29% for CHIP. The successful contact rates for Q2 2025 were 27% for CAN and 15% for CHIP. The CAN program showed a 10% increase in the successful contact rate and the CHIP program showed a 14% increase in the successful contact rate. Both programs remain below the goal rate of 95% for successful contacts. For CAN in Q4 2025, the routine appointment compliance rate was 48% and the urgent appointment compliance rate was 19%. For CHIP, the routine appointment compliance rate was 42% and the urgent appointment compliance rate was 28%. For CAN, the routine and urgent appointment compliance rates decreased from the previous study. For CHIP, the routine appointment compliance rate declined from the previous study and urgent appointment compliance rate increased. The Provider Directory Validation for CAN showed an accuracy rate of 58% (a 29% increase from the previous study rate of 29%). For CHIP, the Provider Directory Validation showed an accuracy rate of 54% (a 34% improvement from the previous study's rate of 20%).

Table 21 provides an overview of the findings of the most recent studies.

Table 21: Overview of Call Study/Provider Directory Findings

	Magnolia CAN (Q1 2026)	Magnolia CHIP (Q1 2026)	Molina CAN (Q4 2025)	Molina CHIP (Q4 2025)
Successful Contact Rates	38%	26%	29%	37%
Provider Directory Accuracy Rates	63%	61%	58%	54%
Routine Appointment Availability	81%	55%	48%	42%
Urgent Appointment Availability	15%	15%	19%	28%

Overall, the results of the most recent Provider Access and Provider Directory Validation studies demonstrated the following trends (see *Table 22* below):

- Successful Contact Rates: Improved for Magnolia CAN, Molina CAN, and Molina CHIP.
- Routine Appointment Availability: Improved for Magnolia CAN but declined for Molina CAN and Molina CHIP.
- Urgent Appointment Availability: Improved for Molina CHIP but declined for Magnolia CAN and Molina CAN.

- Provider Directory Validation Accuracy: Improved for Magnolia CAN, Molina CAN, and Molina CHIP.

Table 22 displays trends in outcomes for these studies; up and down arrows (↑ and ↓) indicate improvement or decline from previous study results.

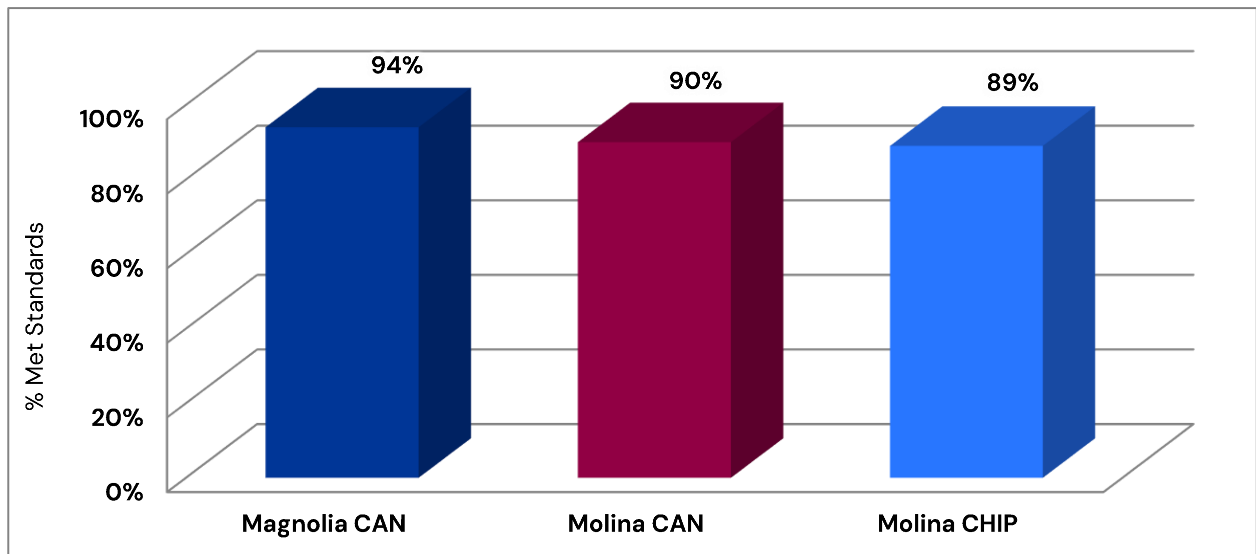
Table 22: Overview of Trends in Outcomes for Current to Previous Study

	Magnolia CAN	Magnolia CHIP	Molina CAN	Molina CHIP
Successful Contact Rates	↑	◊N/A	↑	↑
Provider Directory Accuracy Rates	↑	◊N/A	↑	↑
Routine Appointment Availability	↑	◊N/A	↓	↓
Urgent Appointment Availability	↓	◊N/A	↓	↑

◊N/A – No previous results for comparison. Q1 2026 was the initial study for Magnolia CHIP.

Figure 3 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 23 and *24* display the strengths, weaknesses, and recommendations for the Provider Services section.

Table 23: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
The CCOs have established processes for notifying PCPs of members assigned to their panels and for ensuring all providers can verify member enrollment and eligibility.	✓	✓	✓
Processes for monitoring provider limitations on panel size to ensure appropriate access for members are in place.			✓
The geographic access standards for the CCOs' provider networks are compliant with contractual requirements, as confirmed in policy and as demonstrated in the geographic access reports submitted for review.			✓
The health plans routinely monitor and assess their networks. Appropriate processes are in place to address any identified network deficiencies or gaps.	✓		✓
Both Magnolia and Molina monitor providers' quality of care and service and take appropriate action to address identified issues.	✓		
The health plans make Provider Directories available online and in print form and routinely assess the accuracy of the directory information.			✓
Provider directory data is updated regularly to allow monitoring of provider network adequacy.	✓		✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
The CCOs adopt PHGs and CPGs from evidence-based sources with input from physicians and other health care professionals and review them annually and when there are changes in scientific evidence and/or national standards.	✓		
The CCOs' provider satisfaction surveys were administered by certified vendors and met CMS Survey Validation protocol.	✓		
For both health plans, analysis of provider satisfaction survey results identified areas of improvement.	✓		

Table 24: Provider Services Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Although provider credentialing has not been a CCO responsibility since 2022, some policies inappropriately referenced using results of other health plan activities, including medical record reviews and cultural competency activities, to make credentialing determinations.	*Recommendation: Because provider credentialing is not a health plan responsibility, ensure references to credentialing are removed from policies.*	✓		
Incorrect provider appointment access standards were documented in Molina's	*Recommendation: Ensure all applicable documents and the CAN and CHIP websites*		✓	✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Access to Care policy (MHMS-QI-006), CAN and CHIP Provider Manuals, and CAN and CHIP websites.	*include the correct appointment access standards.*			
Molina's call study results indicated the timeframe used to measure appointment access for routine BH/SUD visits did not correspond to the timeframe in the Access to Care policy (MHMS-QI-006). During onsite discussion, the reviewer requested clarification from the health plan; however, Molina did not provide the requested clarification.	*Recommendation: Ensure appropriate timeframes are used to assess provider compliance with appointment access standards.*		✓	✓
Discrepancies were noted in documentation of member benefits for behavioral health services and orthotics/prosthetics when comparing Magnolia's CAN Provider Manual and CAN Member Handbook.	*Recommendation: Ensure Provider Manuals and Member Handbooks provide consistent information about member benefits.*	✓		✓
Links to some clinical practice guidelines on both CCOs' websites were non-functional, incorrect and/or did not allow access without a username and password.	*Recommendation: Ensure hyperlinks to clinical practice guidelines are correct and functional. Consider creating a library of guidelines on websites rather than using hyperlinks.*	✓		✓
Low response rates for provider satisfaction surveys may introduce bias into generalization.	*Recommendation: Implement targeted strategies to improve participation through provider reminders and education about importance of provider satisfaction surveys.*	✓		

Table 25: Provider Services Comparative Data displays the CCOs' scores for the standards reviewed during the 2025 EQRs. In this table, up and down arrows (↑ and ↓) indicate a change in the score from the 2024 EQR.

Table 25: Comparative Data Provider Services

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)*			
The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met	Met
The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met	Met
The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	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
Members have access to specialty consultation from network providers located within the contract specified geographic access standards	Met ↑	Met	Met
The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met	Met
Providers are available who can serve members with special needs, foreign language/cultural requirements, complex medical needs, and accessibility considerations	Met	Partially Met ↓	Partially Met ↓
The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met
The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy	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
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
The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards	Met	Partially Met ↓	Partially Met ↓
The CCO regularly maintains and makes available a Provider Directory that that includes all required elements	Met ↑	Met	Met
The CCO conducts appropriate activities to validate Provider Directory information	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
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*			

Standard	Magnolia CAN	Molina CAN	Molina CHIP
The CCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met
Initial provider education includes: A description of the Care Management system and protocols	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met
CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	Partially Met ↓	Met	Met
Procedure for referral to a specialist including standing referrals and specialists as PCPs	Met	Met ↑	Met ↑
Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Met	Met
CAN: Recommended standards of care including EPSDT screening requirements and services CHIP: Recommended standards of care including Well-Baby and Well-Child screenings and services	Met	Met	Met
CAN: Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services CHIP: Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services	Met	Met	Met
Medical record handling, availability, retention, and confidentiality	Met	Met	Met
Provider and member complaint, grievance, and appeal procedures including provider disputes	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
Prior authorization requirements including the definition of medically necessary	Met	Met	Met
A description of the role of a PCP and the reassignment of a member to another PCP	Met	Met ↑	Met
The process for communicating the provider's limitations on panel size to the CCO	Met	Met	Met
Medical record documentation requirements	Met	Met	Met
Information regarding available translation services and how to access those services	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Provider performance expectations including quality and utilization management criteria and processes	Met	Met	Met
A description of the provider web portal	Met	Met	Met
A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Met	Met ↑	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
Preventive Health and Clinical Practice Guidelines *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	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	Partially Met ↓	Partially Met
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: CAN: Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services CHIP: Pediatric and Adolescent preventive care with a focus on Well-Baby and Well-Child services	Met	Met	Met
Recommended childhood immunizations	Met	Met	Met
Pregnancy care	Met	Met	Met
Adult screening recommendations at specified intervals	Met	Met	N/A
Elderly screening recommendations at specified intervals	Met	Met	N/A
Recommendations specific to member high-risk groups	Met	Met	Met
Behavioral health	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	Partially Met ↓	Met	Met
The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers	Met	Partially Met ↓	Partially Met ↓
Provider Satisfaction Survey			

Standard	Magnolia CAN	Molina CAN	Molina CHIP
A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol	Met	Met	Met
The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	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

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

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

Both organizations have demonstrated a strong commitment to delivering high-quality services that prioritize member rights, education, accessibility, and support. Each plan has developed a comprehensive approach to member services, ensuring that members are informed, supported, and empowered to access healthcare.

Each plan has a member call center which serves as a central resource for members, helping with locating and selecting a PCP, scheduling appointments, replacing ID cards, requesting new member materials, and obtaining information about services. The call centers operate extended business hours, including evenings and weekends, and complies with contractual requirements. Calls received after hours are seamlessly routed to the 24-hour Nurse Advice Line, staffed by registered nurses, ensuring members always have access to support.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

Members are provided with clear, consistent, and accessible information regarding their rights, responsibilities, and available benefits through a variety of communication channels, including Member Handbooks, welcome packets, Provider Manuals, and CCO websites. These resources provide essential information about health plans, coverage, programs, and services.

Each plan acknowledges the importance of preventive care and continuity of care by guiding members to establish a relationship with a PCP and schedule an initial preventive care visit. The Member Handbook provides clear instructions on accessing the Provider Directory, choosing or changing a PCP, understanding covered benefits, and obtaining out-of-network services. It also includes information on urgent and emergent care, pharmacy benefits, and the Preferred Drug List.

Member CCO Program Education

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

Member education and engagement remain key priorities. New Member Packets are distributed within 14 days of enrollment and include identification cards and comprehensive benefit information including covered benefits, related copays, and services.

Member education is presented in an easy-to-understand format and reinforced through ongoing outreach efforts such as newsletters, targeted mailings, and community-based initiatives. Members receive written notification at least 30 days in advance of any changes to covered benefits or services.

Preventive Health and Chronic Disease Management Education

Preventive care is emphasized through community outreach, health fairs, mobile health initiatives, and proactive call center engagement. Staff encourage early and ongoing relationships with Primary Care Providers to improve health outcomes and reduce avoidable emergency department utilization.

Member Enrollment and Disenrollment

42 CFR § 438.56

Each CCO provides members with clear information regarding enrollment and disenrollment processes, including the circumstances under which a member may request voluntary disenrollment or may be subject to involuntary disenrollment. Members are informed of their rights and options and are provided with instructions for initiating a disenrollment request or requesting a change in health plan. Requests for disenrollment or plan changes must be submitted directly to DOM, either in writing or by telephone, in accordance with established procedures.

Grievances

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

The health plans have procedures in place to receive, document, acknowledge, investigate, and resolve member grievances within set timeframes. Grievance terms are clearly explained in policies, Member Handbooks, Provider Manuals, and on the health plans' websites. Policies explain who may file a grievance; however, Magnolia's policy included language that was not contractually specified regarding legal guardians of minors or incapacitated adults filing grievances.

The health plans require impartial decisions and appropriate clinical expertise for grievances involving medical issues. The Quality Improvement Committees review grievance data and trends quarterly to identify opportunities for improvement.

A review of CAN and CHIP grievance sample files showed that most grievances were handled appropriately. However, some issues were identified, including typographical errors in letters, incomplete intake and investigation documentation, grievances closed before resolution, missing or undated resolution or extension notices, incomplete review of all issues, and limited documentation of internal follow-up for concerns such as HIPAA breaches, fraud, waste, abuse, and credentialing.

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 the surveys to ensure that the results were reliable and valid. The results of the validation found that all the 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% to 15%, with most showing declines compared to the previous year. The lowest response rates were seen in Molina CHIP Child survey with rates below 10%.

Table 26 provides information about the areas that need improvement.

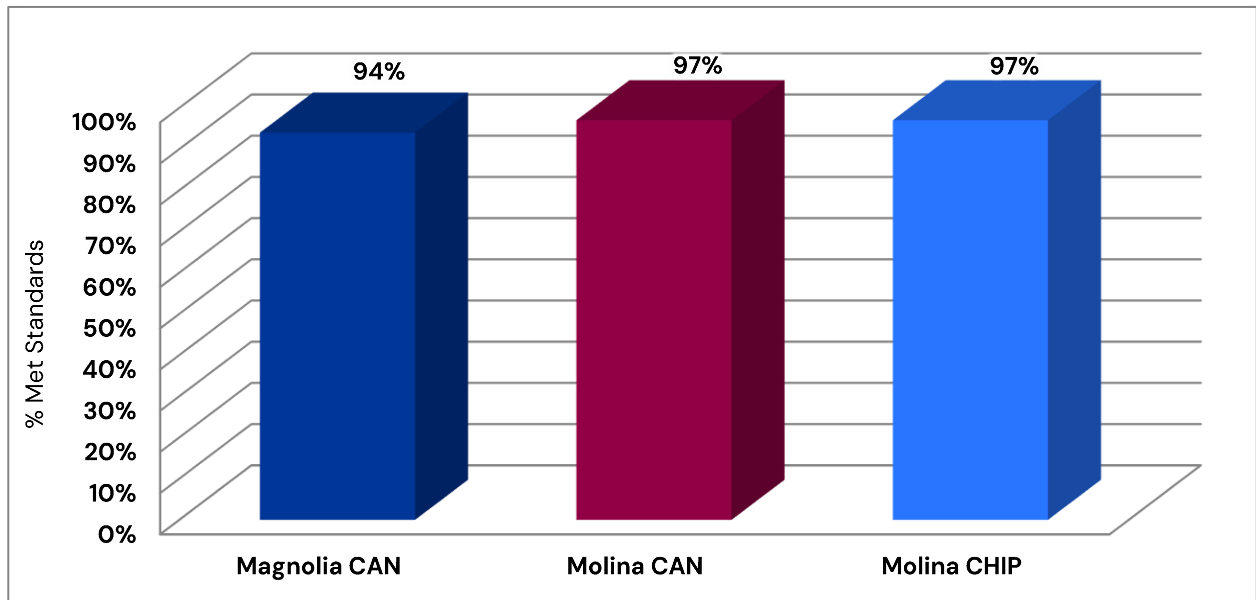
Table 25: Member Satisfaction Survey Validation Results

Plan	CAHPS Survey Version	Section	Reason	Recommendation
Magnolia CAN	5.1 H MY 2024 Adult	Response rate Procedures to handle missing data	Low response rate as compared to previous year. Rates decreased from 16.1% to 15.5%. Include more details about procedures to handle missing data.	Continue efforts to increase response rate through education and reminders. Identify and include procedures to handle missing data.
Magnolia CAN	5.1 H MY 2024 Child	Response rate Procedures to handle missing data	Even though response rate increased from 10.1% to 12.4%, it remains lower than the NCQA target and may introduce bias into generalizability of the findings. Include more details about procedures to handle missing data.	Continue efforts to increase response rate through education and reminders. Identify and include procedures to handle missing data.
Magnolia CAN	5.1 H MY 2024 Child CCC	Response rate Procedures to handle missing data	Response rate improved from 9.4% to 10.1%. However, it remains below NCQA target and may introduce bias into	Continue efforts to increase response rate through education and reminders. Identify and include

Plan	CAHPS Survey Version	Section	Reason	Recommendation
			generalizability. Include more details about procedures to handle missing data.	procedures to handle missing data.
Molina CAN	5.1 H MY 2024 Child	Response rate	There was a decline from 13% to 10.1%. This is below the NCQA target rate of 40%.	Continue efforts to increase response rate through education and reminders.
Molina CHIP	5.1 H MY 2024 Child Medicaid	Response rate	The response rate has slightly declined and is below the NCQA target.	Continue efforts to increase response rate through education and reminders.
Molina CHIP	5.1 H MY 2024 Child	Response rate	The response rate has slightly declined and is below the NCQA target.	Continue efforts to increase response rate through education and reminders.

Figure 4 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 27* and *Table 28*.

Table 26: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Member materials are clearly written in easy-to-understand format.	✓		✓
Preventive care is emphasized through community outreach, health fairs, mobile health initiatives, and proactive call center engagement.	✓	✓	✓
Both health plans summarize grievance data, trends, and root causes and report them quarterly to the Quality Improvement Committee for review and discussion.	✓		
Grievance terminology is clearly defined in policy, Member Handbooks, Provider Manuals, and on each of the health plan's website.	✓		
Certified vendors conducted member satisfaction surveys. Results were analyzed, used to identify improvement areas, and shared with stakeholders.	✓		

Table 27: Member Services Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Each health plan contained incomplete documentation throughout the grievance process, and many files were not completed in accordance with established policies and contractual guidelines.	*Recommendation: Ensure that steps are taken to demonstrate compliance with the management of grievance files per policy and contractual regulations.*	✓		
Low response rates were noted for member satisfaction surveys for both plans.	*Recommendation: Increase response rate through education and continued outreach.*	✓		

An overview of the scores for the Member Services section is illustrated in *Table 29*. In this table, down arrows (↓) indicate a change in the score from the 2024 EQR.

Table 28: Member Services Comparative Data

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Member Rights and Responsibilities *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
All member rights included	Met	Met	Met
All member responsibilities included	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*			
Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled	Met	Partially Met ↓	Partially Met ↓
Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	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
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
Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed	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
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
Call Center scripts are in-place and staff receive training as required by the contract	Met	Met	Met
Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee	Met	Met	Met
Member Enrollment and Disenrollment *42 CFR § 438.56*			
The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met
Member disenrollment is conducted in a manner consistent with contract requirements	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
The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
CAN: The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits CHIP: The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits	Met	Met	Met
The CCO provides educational opportunities to members regarding health risk factors and wellness promotion	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
The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met
The CCO reports results of the member satisfaction survey to providers	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
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*			
The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	Met	Met	Met
Definition of a grievance and who may file a grievance	Partially Met ↓	Met	Met
The procedure for filing and handling a grievance	Met	Met	Met
Timeliness guidelines for resolution of grievances as specified in the contract	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
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
The CCO applies the grievance policy and procedure as formulated	Partially 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
Grievances are managed in accordance with CCO confidentiality policies and procedures	Met	Met	Met
Practitioner Changes			

Standard	Magnolia CAN	Molina CAN	Molina CHIP
The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction	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

Quality Improvement

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

The 2025 Quality Management and Quality Improvement Program Descriptions outline Magnolia's and Molina's commitment to delivering high-quality, equitable, and safe care through systematic quality improvement processes, data-driven strategies, and leadership oversight. The programs focus on improving health outcomes, reducing disparities, enhancing member experience, supporting providers, and addressing the needs of members with complex conditions through integrated and culturally responsive services. However, a discrepancy remains in Molina's QI Program Description stating that Molina performs provider credentialing and recredentialing, despite not doing so; this issue was noted in the 2023 and 2024 EQRs and remains uncorrected in 2025.

Magnolia and Molina use data-driven quality and utilization management processes to assess the appropriateness of care for all members, including those with special health care needs, across physical, behavioral, and social health services. Annual and quarterly quality work plans guide measurable improvement goals, health equity initiatives, and regulatory compliance through ongoing monitoring and committee oversight. While these efforts demonstrate a strong commitment to quality and equitable care, a discrepancy was identified in the Molina Quality Improvement/Healthcare Services Work Plan where behavioral health appointment access standards do not align with the Access to Care policy.

Magnolia and Molina maintain strong governance structures for their Quality Programs, with Boards of Directors providing oversight and delegating implementation to quality committees led by senior clinical leadership and including network providers. Provider performance is monitored and enhanced through data-driven profiling, analytics, and regular feedback, while compliance with EPSDT and preventive care requirements is tracked through defined policies, reporting, and targeted interventions. Together, these activities support continuous quality improvement, provider engagement, and accountability across clinical and behavioral health services.

The Magnolia and Molina Quality Improvement Program Evaluations review 2024 activities to assess the effectiveness, outcomes, and challenges of their quality initiatives and to identify opportunities for improvement. Both evaluations emphasize enhancing healthcare quality,

member and provider satisfaction, and advancing health equity through refined strategies in 2025. However, Molina's 2024 QI Program Evaluation did not include results of the annual HEDIS medical record review and delegation oversight audits referenced in the QI Work Plan.

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®) and CMS Adult and CMS Child Core Set measures following the CMS protocol. This process assessed the production of these measures by the health plans to confirm reported information was valid. Constellation contracts with 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 as well as the 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 CCOs to undergo an NCQA HEDIS Compliance Audit. Magnolia and Molina contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audits. Each CCO was required to submit the completed NCQA Record of Administration, Data Management, and Processes (Roadmap) from the MY 2024 HEDIS Compliance Audit, associated supplemental documentation, NCQA Interactive Data Submission System (IDSS) files, the MY 2024 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, including:
  - 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 that is 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 performance measures per certified auditor report.

- Algorithmic compliance evaluation, including:
    - 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; its quality assurance practices, and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster.
- **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 reviews 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 whether the plan was Fully Compliant or not. *Table 30* provides an overview of the validation score definitions.

Table 30: 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

All health plans were fully compliant with all HEDIS and CMS Adult and CMS Child Core Set measures as shown in *Table 31* and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

Table 31: Performance Measure Validation Rating

CCO	Performance Measure Validation Rating
Magnolia CAN	Fully Compliant
Molina CAN	Fully Compliant
Molina CHIP	Fully Compliant

HEDIS Performance Measure Validation – CAN Program

All relevant HEDIS PMs for the current measure year (MY 2024) and the change from the current to previous year are reported in *Table 32*. Rates shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%).

Table 29: HEDIS Performance Measure Data for CAN Programs

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA)	81.70%	62.57%	77.19%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	69.10%	65.21%	67.15%
Counseling for Nutrition	48.91%	54.01%	51.46%
Counseling for Physical Activity	49.88%	50.61%	50.24%
Childhood Immunization Status (CIS)			
DTaP	82.24%	74.21%	78.22%
IPV	92.94%	89.29%	91.12%
MMR	92.70%	87.59%	90.15%
HiB	91.00%	87.59%	89.29%
Hepatitis B	91.00%	92.21%	91.61%
VZV	92.46%	86.86%	89.66%
Pneumococcal Conjugate	82.00%	73.48%	77.74%
Hepatitis A	82.00%	79.08%	80.54%
Rotavirus	75.43%	73.48%	74.45%
Influenza	19.22%	22.63%	20.92%
Combination #3	77.13%	69.10%	73.11%
Combination #7	62.04%	57.18%	59.61%
Combination #10	15.33%	19.46%	17.40%
Immunizations for Adolescents (IMA)			
Meningococcal	59.12%	52.31%	55.72%
Tdap	81.51%	78.35%	79.93%
HPV	22.14%	16.55%	19.34%
Combination #1	58.88%	51.58%	55.23%
Combination #2	20.68%	15.57%	18.13%
Lead Screening in Children (LSC)	72.29%	70.80%	72.15%
Cervical Cancer Screening (CCS)	53.77%	51.09%	52.43%
Chlamydia Screening in Women (CHL)			
16-20 Years	49.02%	50.19%	49.33%
21-24 Years	57.32%	55.59%	56.58%
Total	50.89%	52.23%	51.30%
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	21.60%	20.44%	21.09%
Oral Evaluation, Dental Services (3-5)	61.30%	58.55%	60.07%
Oral Evaluation, Dental Services (6-14)	63.06%	57.78%	61.36%
Oral Evaluation, Dental Services (15-20)	46.71%	41.49%	45.22%
Oral Evaluation, Dental Services (Total)	53.61%	48.20%	51.71%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	10.95%	9.70%	10.41%
Topical Fluoride for Children (3-4)	20.85%	20.06%	20.49%
Topical Fluoride for Children (Total)	15.59%	14.74%	15.21%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
3-17 Years	86.96%	87.54%	87.14%
18-64 Years	79.89%	83.04%	81.05%
65+ Years	N/A	N/A	N/A
Total	86.13%	86.90%	86.38%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	41.79%	47.33%	42.97%
Bronchodilator	73.80%	74.05%	73.86%
Asthma Medication Ratio (AMR)			
5-11 Years	86.28%	85.32%	86.02%
12-18 Years	76.64%	79.34%	77.13%
19-50 Years	69.30%	72.46%	70.07%
51-64 Years	61.46%	64.00%	61.98%
Total	78.40%	80.37%	78.85%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	63.75%	61.31%	62.53%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	N/A	N/A	N/A
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy - 21-75 years (Male)	73.87%	75.45%	74.20%
Statin Adherence 80% - 21-75 years (Male)	49.84%	59.04%	51.78%
Received Statin Therapy - 40-75 years (Female)	71.71%	75.00%	72.21%
Statin Adherence 80% - 40-75 years (Female)	48.45%	61.67%	50.52%
Received Statin Therapy - Total	72.76%	75.26%	73.21%
Statin Adherence 80% - Total	49.13%	60.14%	51.16%
Cardiac Rehabilitation (CRE)			
Initiation - 18-64 Years	3.55%	2.00%	3.14%
Engagement1 - 18-64 Years	5.67%	2.00%	4.71%
Engagement2 - 18-64 Years	3.55%	2.00%	3.14%
Achievement - 18-64 Years	0.00%	0.00%	0.00%
Initiation - 65+ years	N/A	N/A	N/A
Engagement1 - 65+ Years	N/A	N/A	N/A
Engagement2 - 65+ Years	N/A	N/A	N/A
Achievement - 65+ Years	N/A	N/A	N/A
Initiation – Total	3.55%	2.00%	3.14%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
Engagement1 – Total	5.67%	2.00%	4.71%
Engagement2 - Total	3.55%	2.00%	3.14%
Achievement - Total	0.00%	0.00%	0.00%
Effectiveness of Care: Diabetes			
Glycemic Status Assessment for Patients With Diabetes (GSD) ◊			
Glycemic Status <8.0%	56.93%	52.31%	54.62%
*Glycemic Status >9.0% **	35.04%	39.17%	37.10%
Eye Exam for Patients With Diabetes (EED)◊	66.67%	60.10%	63.38%
Blood Pressure Control for Patients With Diabetes (BPD)	63.02%	65.94%	64.48%
Kidney Health Evaluation for Patients With Diabetes (KED)			
18-64 Years	28.11%	29.01%	28.31%
65-74 Years	39.39%	N/A	36.11%
75-85 Years	N/A	N/A	0.00%
Total	28.19%	28.92%	28.35%
Statin Therapy for Patients with Diabetes (SPD)			
Received Statin Therapy	61.89%	57.53%	61.17%
Statin Adherence 80%	48.47%	53.40%	49.23%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (DMH)			
1-17	32.78%	26.78%	30.72%
18-64	40.79%	36.36%	39.44%
65+	26.38%	N/A	27.08%
Total	35.08%	29.22%	33.13%
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	54.59%	62.26%	56.75%
Effective Continuation Phase Treatment	34.34%	41.59%	36.39%
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	66.92%	62.77%	65.88%
6-17 years - 7-Day Follow-Up	41.33%	37.59%	40.39%
18-64 years - 30-Day Follow-Up	55.46%	49.15%	53.39%
18-64 years - 7-Day Follow-Up	33.89%	27.40%	31.75%
65+ years - 30-Day Follow-Up	N/A	N/A	N/A
65+ years - 7-Day Follow-Up	N/A	N/A	N/A
30-Day Follow-Up	63.46%	57.52%	61.82%
7-Day Follow-Up	39.08%	33.66%	37.58%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
30 days (6-17)	57.89%	49.37%	55.39%
7 days (6-17)	42.11%	35.44%	40.15%
30 days (18-64)	45.79%	46.56%	46.03%
7 days (18-64)	32.66%	27.48%	31.07%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
30 days (65+)	N/A	N/A	N/A
7 days (65+)	N/A	N/A	N/A
30 days (Total)	50.51%	47.62%	49.64%
7 days (Total)	36.34%	30.48%	34.58%
Diagnosed Substance Use Disorders (DSU)			
Alcohol (Total)	1.29%	1.30%	1.30%
Opioid (Total)	1.13%	1.02%	1.10%
Other (Total)	2.93%	2.87%	2.91%
Any (Total)	4.51%	4.31%	4.45%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
30 days (13-17)	N/A	N/A	N/A
7 Days (13-17)	N/A	N/A	N/A
30 days (18-64)	43.75%	35.96%	40.96%
7 Days (18-64)	33.13%	26.97%	30.92%
30 days (65+)	N/A	N/A	N/A
7 Days (65+)	N/A	N/A	N/A
30 days (Total)	41.14%	34.41%	38.81%
7 Days (Total)	30.29%	25.81%	28.73%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)◊			
30-Day Follow-Up: 13-17 Years	20.63%	N/A	18.82%
7-Day Follow-Up: 13-17 Years	11.11%	N/A	9.41%
30-Day Follow-Up: 18+ Years	26.45%	25.53%	26.14%
7-Day Follow-Up: 18+ Years	19.57%	18.44%	19.18%
30-Day Follow-Up: Total	25.37%	23.93%	24.90%
7-Day Follow-Up: Total	17.99%	16.56%	17.53%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	20.44%	32.69%	24.91%
Pharmacotherapy for Opioid Use Disorder (65+)	N/A	N/A	N/A
Pharmacotherapy for Opioid Use Disorder (Total)	20.44%	32.69%	24.91%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	75.97%	77.16%	76.27%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	79.95%	72.62%	78.65%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	85.11%	N/A	85.45%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	56.65%	58.31%	57.01%
Effectiveness of Care: Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 Months-17 Years	72.97%	74.54%	73.54%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
18-64 Years	58.87%	58.48%	58.75%
65+ Years	N/A	N/A	N/A
Total	71.28%	72.97%	71.89%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
3 Months–17 Years	52.64%	60.16%	44.38%
18-64 Years	40.69%	30.94%	62.07%
65+ Years	N/A	N/A	N/A
Total	50.85%	57.39%	46.66%
Use of Imaging Studies for Low Back Pain (LBP)	68.22%	67.85%	68.10%
Use of Opioids at High Dosage (HDO)	0.79%	1.27%	0.91%
Use of Opioids from Multiple Providers (UOP)			
Multiple Prescribers	13.05%	16.69%	13.99%
Multiple Pharmacies	1.08%	1.54%	1.20%
Multiple Prescribers and Multiple Pharmacies	0.50%	0.95%	0.61%
Risk of Continued Opioid Use (COU)			
18-64 years – >=15 Days Covered	8.34%	6.41%	7.70%
18-64 years – >=31 Days Covered	2.95%	2.83%	2.91%
65+ years – >=15 Days Covered	N/A	N/A	N/A
65+ years – >=31 Days Covered	N/A	N/A	N/A
Total – >=15 Days Covered	8.35%	6.41%	7.71%
Total – >=31 Days Covered	2.97%	2.83%	2.92%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20-44 Years	84.68%	84.90%	84.76%
45-64 Years	89.22%	84.49%	88.17%
65+ Years	67.24%	N/A	66.17%
Total	86.38%	84.76%	85.88%
Initiation and Engagement of AOD Dependence Treatment (IET)◊			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	72.50%	N/A	76.36%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%	N/A	1.82%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	N/A	N/A	N/A
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	N/A	N/A	N/A
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	64.92%	68.37%	65.76%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	5.90%	5.10%	5.71%
Total: Initiation of AOD Treatment: 13-17 Years	65.63%	71.30%	67.02%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
Total: Engagement of AOD Treatment: 13-17 Years	5.11%	5.22%	5.14%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	38.76%	43.81%	40.30%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	6.59%	10.62%	7.82%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	34.71%	63.54%	42.90%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	16.94%	29.17%	20.41%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	38.88%	41.63%	39.78%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	7.52%	8.59%	7.87%
Total: Initiation of AOD Treatment: 18+ Years	38.25%	44.97%	40.37%
Total: Engagement of AOD Treatment: 18+ Years	8.58%	11.73%	9.57%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.19%	46.47%	42.79%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.12%	10.37%	7.40%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	35.34%	64.29%	43.52%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	16.47%	28.57%	19.88%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	45.31%	46.38%	45.64%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	7.12%	7.97%	7.38%
Total: Initiation of AOD Treatment: Total	42.97%	48.37%	44.61%
Total: Engagement of AOD Treatment: Total	7.99%	10.89%	8.87%
Prenatal and Postpartum Care (PPC)◊			
Timeliness of Prenatal Care Under 21 (Admin only rate)	83.41%	87.71%	85.09%
Postpartum Care Under 21 (Admin only rate)	57.21%	58.55%	57.74%
Timeliness of Prenatal Care Over 21 (Admin only rate)	85.76%	89.22%	87.32%
Postpartum Care Over 21 (Admin only rate)	59.08%	57.21%	58.23%
Timeliness of Prenatal Care (Total per IDSS)	95.62%	91.97%	93.80%
Postpartum Care (Total per IDSS)	73.48%	66.91%	70.19%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1-11 Years	63.60%	59.81%	62.45%
12-17 Years	64.76%	65.96%	65.05%
Total	64.31%	63.06%	63.98%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	61.44%	59.47%	60.58%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
15 Months-30 Months	72.21%	69.77%	71.07%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	49.84%	47.18%	48.89%
12-17 Years	43.98%	38.45%	42.43%
18-21 Years	23.28%	20.56%	22.55%
Total	45.38%	42.72%	44.52%
Antibiotic Utilization for Respiratory Conditions (AXR)			
3m-17	43.27%	44.78%	43.80%
18-64	37.21%	41.63%	38.60%
65+	17.50%	N/A	18.60%
Total	42.30%	44.35%	43.01%
Plan All-Cause Readmissions (PCR-AD) ◇◇			
Observed Readmission Rate	12.95%	11.85%	12.57%
Expected Readmission Rate	9.20%	8.54%	8.97%
*Observed/Expected (O/E) Ratio **	1.41%	1.39%	1.40%
Outlier Rate	78.37%	77.51%	78.08%
ECDS Measures			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)			
The percentage of children and adolescents on antipsychotics who received blood glucose testing	46.00%	45.13%	45.78%
The percentage of children and adolescents on antipsychotics who received cholesterol testing	30.38%	29.69%	30.21%
The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	28.04%	27.91%	28.00%
Colorectal Cancer Screening (COL-E)			
46-50	29.75%	23.94%	28.58%
51-75	49.34%	31.03%	45.83%
Total	45.16%	29.45%	42.11%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)			
Initiation	57.37%	39.30%	52.24%
Continuation	66.37%	48.94%	59.67%
Breast Cancer Screening (BCS-E)	54.20%	42.29%	52.41%
Adult Immunization Status (AIS-E)			
Influenza 19-65	11.83%	7.72%	10.56%
Influenza 66+	12.12%	N/A	10.81%
Influenza Total	11.83%	7.72%	10.56%
Td/Tdap 19-65	30.27%	26.25%	29.02%
Td/Tdap 66+	16.67%	N/A	14.86%
Td/Tdap Total	30.24%	26.23%	29.00%

HEDIS Measure/Data Element	Magnolia HEDIS MY 2024 CAN	Molina HEDIS MY 2024 CAN	Statewide Average
Zoster 50-65	3.02%	4.07%	3.25%
Zoster 66+	4.55%	N/A	5.41%
Zoster Total	3.03%	4.10%	3.26%
Pneumococcal 66+	25.76%	N/A	22.97%
Postpartum Depression Screening and Follow-Up (PDS-E)			
Screening: Under 21	3.09%	N/A	3.09%
Follow-up: Under 21	N/A	N/A	N/A
Screening: Over 21	3.01%	N/A	3.01%
Follow-up: Over 21	N/A	N/A	N/A
Screening: As reported in IDSS	3.02%	1.12%	2.18%
Follow-up: As reported in IDSS	51.43%	N/A	51.22%
Prenatal Immunization Status (PRS-E)			
Influenza: Under 21	6.48%	N/A	6.48%
Tdap: Under 21	26.08%	N/A	26.08%
Combination: Under 21	3.55%	N/A	3.55%
Influenza: Over 21	8.32%	N/A	8.32%
Tdap: Over 21	26.35%	N/A	26.35%
Combination: Over 21	5.31%	N/A	5.31%
Influenza: As reported in IDSS	7.97%	6.38%	7.28%
Tdap: As reported in IDSS	26.30%	26.96%	26.59%
Combination: As reported in IDSS	4.97%	4.02%	4.56%

N/A: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not required; BR: Biased rate
**: Lower rate indicates better performance*
◇: Measure has "Trend with Caution" guidance from NCQA for MY 2024
◇◇: Measure has "Break in Trending" guidance from NCQA for MY 2024
∞: Change in rate not able to be calculated as prior rate for health plan was not reported

HEDIS Performance Measure Validation - CHIP Program

All relevant HEDIS PMs for MY 2024 and the change from the current to previous year are reported in *Table 33*. Rates shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%). A statewide average was not calculated for CHIP HEDIS measures because only one CCO, Molina, participated in the CHIP program during the measurement period. Consequently, plan-level results are reported without aggregation.

Table 30: CHIP HEDIS Performance Measure Results – Molina

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
Effectiveness of Care: Prevention and Screening	

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile	59.61%
Counseling for Nutrition	50.61%
Counseling for Physical Activity	49.15%
Childhood Immunization Status (CIS)	
DTaP	81.27%
IPV	92.70%
MMR	90.51%
HiB	91.00%
Hepatitis B	92.94%
VZV	89.54%
Pneumococcal Conjugate	81.75%
Hepatitis A	82.24%
Rotavirus	81.51%
Influenza	19.95%
Combination #3	76.64%
Combination #7	64.96%
Combination #10	15.57%
Immunizations for Adolescents (IMA)	
Meningococcal	54.99%
Tdap/Td	86.86%
HPV	21.41%
Combination #1	54.74%
Combination #2	20.44%
Lead Screening in Children (LSC)	57.42%
Chlamydia Screening in Women (CHL)	
16-20 Years	38.82%
Oral Evaluation, Dental Services (OED)	
Oral Evaluation, Dental Services (0-2)	32.34%
Oral Evaluation, Dental Services (3-5)	61.96%
Oral Evaluation, Dental Services (6-14)	63.85%
Oral Evaluation, Dental Services (15-20)	48.70%
Oral Evaluation, Dental Services (Total)	57.33%
Topical Fluoride for Children (TFC)	
Topical Fluoride for Children (1-2)	14.11%
Topical Fluoride for Children (3-4)	25.92%
Topical Fluoride for Children (Total)	20.77%

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
Effectiveness of Care: Respiratory Conditions	
Appropriate Testing for Children with Pharyngitis (CWP)	
3-17 Years	88.00%
18-64 Years	83.87%
Total	87.88%
Asthma Medication Ratio ()	
5-11 Years	91.14%
12-18 Years	76.62%
19-50 Years	N/A
51-64 Years	N/A
Total	83.97%
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	N/A
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	N/A
Cardiac Rehabilitation (CRE)	
Initiation - 18-64 Years	N/A
Engagement1 - 18-64 Years	N/A
Engagement2 - 18-64 Years	N/A
Achievement - 18-64 Years	N/A
Effectiveness of Care: Diabetes	
Glycemic Status Assessment for Patients With Diabetes (GSD) ◇	
Glycemic Status <8.0%	N/A
*Glycemic Status >9.0% **	N/A
Eye Exam for Patients With Diabetes (EED) ◇	N/A
Blood Pressure Control for Patients With Diabetes (BPD) ◇	N/A
Kidney Health Evaluation for Patients With Diabetes (ked) ◇	
Kidney Health Evaluation for Patients With Diabetes (18-64)	N/A
Effectiveness of Care: Behavioral	
Diagnosed Mental Health Disorders (DMH)	
1-17	26.20%
18-64	22.12%
Total	25.92%
Antidepressant Medication Management (AMM)	
Effective Acute Phase Treatment	N/A
Effective Continuation Phase Treatment	N/A
Follow-Up After Hospitalization for Mental Illness (FUH)	
6-17 years - 30-Day Follow-Up	64.00%
6-17 years - 7-Day Follow-Up	35.20%

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
18-64 years – 30-Day Follow-Up	N/A
18-64 years – 7-Day Follow-Up	N/A
Total-30-day Follow-Up	63.36%
Total-7-day Follow-Up	34.35%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
6-17 years – 30-Day Follow-Up	N/A
6-17 years – 7-Day Follow-Up	N/A
18-64 years – 30-Day Follow-Up	N/A
18-64 years – 7-Day Follow-Up	N/A
Total-30-day Follow-Up	N/A
Total-7-day Follow-Up	N/A
Diagnosed Substance Use Disorders (DSU)	
Alcohol (Total)	0.05%
Opioid (Total)	0.00%
Other (Total)	0.69%
Any (Total)	0.72%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	
30 days (13-17)	N/A
7 Days (13-17)	N/A
30 days (18-64)	N/A
7 Days (18-64)	N/A
30 days (65+)	N/A
7 Days (65+)	N/A
30 days (Total)	N/A
7 Days (Total)	N/A
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	
30 days (13-17)	N/A
7 days (13-17)	N/A
30 days (18+)	N/A
7 days (18+)	N/A
30 days (Total)	N/A
7 days (Total)	N/A
Pharmacotherapy for Opioid Use Disorder (POD)	
Pharmacotherapy for Opioid Use Disorder (16-64)	N/A
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD) ⋄	N/A
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) ⋄	N/A

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	N/A
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	N/A
Effectiveness of Care: Overuse/Appropriateness	
Appropriate Treatment for Upper Respiratory Infection (URI)	
3 months-17 Years	68.92%
18-64 Years	69.05%
65+ Years	N/A
Total	68.92%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	
3 Months – 17 Years	42.12%
18-64 Years	N/A
65+ Years	N/A
Total	41.74%
Use of Imaging Studies for Low Back Pain (LBP) ◇	N/A
Use of Opioids at High Dosage (HDO) *	N/A
Use of Opioids From Multiple Providers (UOP) *	
Multiple Prescribers	N/A
Multiple Pharmacies	N/A
Multiple Prescribers and Multiple Pharmacies	N/A
Risk of Continued Opioid Use (COU)	
18-64 years - >=15 Days Covered	N/A
18-64 years - >=31 Days Covered	N/A
Access/Availability of Care	
Initiation and Engagement of AOD Dependence Treatment (IET)	
Initiation of AOD - Alcohol Abuse or Dependence (13-17)	N/A
Engagement of AOD - Alcohol Abuse or Dependence (13-17)	N/A
Initiation of AOD - Opioid Abuse or Dependence (13-17)	N/A
Engagement of AOD - Opioid Abuse or Dependence (13-17)	N/A
Initiation of AOD - Other Drug Abuse or Dependence (13-17)	N/A
Engagement of AOD - Other Drug Abuse or Dependence (13-17)	N/A
Initiation of AOD - Total (13-17)	N/A
Engagement of AOD - Total (13-17)	N/A
Initiation of AOD - Alcohol Abuse or Dependence (18+)	N/A
Engagement of AOD - Alcohol Abuse or Dependence (18+)	N/A
Initiation of AOD - Opioid Abuse or Dependence (18+)	N/A
Engagement of AOD - Opioid Abuse or Dependence (18+)	N/A
Initiation of AOD - Other Drug Abuse or Dependence (18+)	N/A

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
Engagement of AOD – Other Drug Abuse or Dependence (18+)	N/A
Initiation of AOD – Total (18+)	N/A
Engagement of AOD – Total (18+)	N/A
Initiation of AOD – Alcohol Abuse or Dependence (Total)	N/A
Engagement of AOD – Alcohol Abuse or Dependence (Total)	N/A
Initiation of AOD – Opioid Abuse or Dependence (Total)	N/A
Engagement of AOD – Opioid Abuse or Dependence (Total)	N/A
Initiation of AOD – Other Drug Abuse or Dependence (Total)	N/A
Engagement of AOD – Other Drug Abuse or Dependence (Total)	N/A
Initiation of AOD – Total (Total)	39.39%
Engagement of AOD – Total (Total)	0.00%
Prenatal and Postpartum Care (PPC) ◇	
Timeliness of Prenatal Care Under 21 (Admin only rate)	N/A
Postpartum Care Under 21 (Admin only rate)	N/A
Timeliness of Prenatal Care (Total per IDSS)	N/A
Postpartum Care (Total per IDSS)	N/A
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) ◇	
1-11 Years	N/A
12-17 Years	60.00%
Total	54.05%
Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	70.26%
15 Months-30 Months	79.04%
Child and Adolescent Well-Care Visits (WCV)	
3-11 Years	47.66%
12-17 Years	40.78%
18-21 Years	24.85%
Total	43.28%
Antibiotic Utilization for Respiratory Conditions (AXR)	
3m-17	46.47%
18-64	42.86%
65+	N/A
Total	46.36%
Plan All-Cause Readmissions (PCR-AD) ◇◇	
Observed Readmission Rate	N/A
Expected Readmission Rate	N/A

HEDIS Measure/Data Element	Molina HEDIS MY 2024 CHIP Rates
*Observed/Expected (O/E) Ratio**	N/A
Outlier Rate	N/A
ECDS Measures	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	
The percentage of children and adolescents on antipsychotics who received blood glucose testing	47.62%
The percentage of children and adolescents on antipsychotics who received cholesterol testing	28.57%
The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	26.19%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	
Initiation	44.36%
Continuation	47.95%
Adult Immunization Status (AIS-E)	
Influenza 19-65	N/A
Td/Tdap 19-65	N/A
Zoster 19-65	N/A
Pneumococcal 19-65	N/A
Postpartum Depression Screening and Follow-Up (PDS-E)	
Screening: Under 21	N/A
Follow-up: Under 21	N/A
Screening: As reported in IDSS	N/A
Follow-up: As reported in IDSS	N/A
Prenatal Immunization Status (PRS-E)	
Influenza: Under 21	N/A
Tdap: Under 21	N/A
Combination: Under 21	N/A
Influenza: As reported in IDSS	N/A
Tdap: As reported in IDSS	N/A
Combination: As reported in IDSS	N/A

N/A: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not required
BR: Biased rate
**: Lower rate indicates better performance*
◇: Measure has "Trend with Caution" guidance from NCQA for MY 2024
◇◇: Measure has "Break in Trending" guidance from NCQA for MY 2024
∞: Change in rate not able to be calculated as prior rate for health plan was not reported

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 2024 are listed in *Table 34*. The statewide averages have been included where applicable.

Table 31: CAN CMS Core Set Measure Rates

CMS Core Set Measure/Data Element	Magnolia MY 2024 Rates	Molina MY 2024 Rates	Statewide Average
Adult Core Set Measures			
Dental and Oral Health Services			
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD) *			
Ages 18 – 64	239.09	251.50	243.41
Ages 65 +	150.04	0.00	133.96
Total	238.85	251.35	243.20
Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD)	0.86%	1.53%	1.14%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or Moderately Effective Contraception – 3 days	12.72%	12.61%	12.67%
Most or Moderately Effective Contraception – 90 days	53.83%	53.76%	53.80%
LARC - 3 Days	0.67%	1.05%	0.84%
LARC - 90 Days Reported	12.01%	12.06%	12.03%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or Moderately Effective Contraception Rate	30.90%	32.27%	31.46%
LARC Rate	4.67%	4.66%	4.67%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *			
Ages 18 – 64	26.67	18.70	23.89
Ages 65+	0.00	0.00	0.00
Total	26.60	18.69	23.85
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) *			
Ages 40 – 64	48.84	41.96	47.01
Ages 65+	75.02	0.00	66.98
Total	49.02	41.86	47.12
HEART FAILURE ADMISSION RATE (PQI-08) *			
Ages 18 – 64	46.68	44.73	46.00
Ages 65+	225.06	625.00	267.92
Total	47.14	45.07	46.42
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) *			

CMS Core Set Measure/Data Element	Magnolia MY 2024 Rates	Molina MY 2024 Rates	Statewide Average
Ages 18 – 39	0.94	2.95	1.72
HIV VIRAL LOAD SUPPRESSION (HVL – AD)			
Ages 18 – 64	40.77%	29.10%	37.93%
Ages 65+	N/A	N/A	N/A
Total	40.23%	29.41%	37.65%
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) *			
Ages 18 – 64	0.78%	0.00%	0.59%
Ages 65+	N/A	N/A	N/A
Total	0.78%	0.00%	0.59%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) *			
Ages 18 – 64	2.92%	7.11%	4.07%
Ages 65+	N/A	N/A	N/A
Total	2.91%	7.11%	4.06%
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-64	0.74%	5.58%	2.37%
Ages 65+	3.09%	N/A	3.38%
Total	0.75%	5.58%	2.38%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *			
Ages 18 – 64	56.58%	47.59%	54.84%
Ages 65+	N/A	N/A	N/A
Total	56.63%	47.59%	54.88%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	44.59%	61.27%	48.72%
Prescription for Buprenorphine	38.77%	59.31%	43.86%
Prescription for Oral Naltrexone	0.97%	0.98%	0.97%
Prescription for Long-Acting, Injectable Naltrexone	0.00%	0.00%	0.00%
Prescription for Methadone	5.65%	1.96%	4.74%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	N/A	N/A	N/A
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	N/A	N/A	N/A
Discussed or Recommended Cessation Medications: Ages 18 to 64	N/A	N/A	N/A
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	N/A	N/A	N/A
Percentage of Current Smokers and Tobacco Users: Age 65 and Older	N/A	N/A	N/A
Advising Users to Quit: Age 65 and Older	N/A	N/A	N/A

CMS Core Set Measure/Data Element	Magnolia MY 2024 Rates	Molina MY 2024 Rates	Statewide Average
Discussing Cessation Medications: Age 65 and Older	N/A	N/A	N/A
Discussing Cessation Strategies: Age 65 and Older	N/A	N/A	N/A
Percentage of Current Smokers and Tobacco Users: Total	N/A	N/A	N/A
Advising Users to Quit: Total	N/A	N/A	N/A
Discussing Cessation Medications: Total	N/A	N/A	N/A
Discussing Cessation Strategies: Total	N/A	N/A	N/A
Child Core Set Measures			
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 – 17	1.32%	2.59%	1.69%
Primary Care Access and Preventative Care			
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	5.23%	39.21%	20.43%
Age 2 Screening	5.64%	50.19%	25.65%
Age 3 Screening	5.33%	48.53%	26.12%
Total Screening	5.36%	44.49%	23.20%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or Moderately Effective Contraception – 3 days	3.78%	2.07%	3.16%
Most or Moderately Effective Contraception – 90 days	60.28%	59.09%	59.85%
LARC - 3 Days	1.89%	0.41%	1.35%
LARC - 90 Days Reported	13.95%	14.05%	13.98%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or Moderately Effective Contraception Rate	28.95%	28.32%	28.78%
LARC Rate	2.45%	2.87%	2.56%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	52.01%	44.58%	49.61%
Numerator 2 All Four Molars Sealed	36.97%	29.47%	34.55%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	1.53%	1.68%	1.60%
Ages 1–2	25.42%	24.15%	24.86%
Ages 3–5	59.31%	54.93%	56.55%
Ages 6–7	64.23%	59.90%	62.76%
Ages 8–9	64.67%	59.53%	62.88%
Ages 10–11	62.91%	56.10%	60.64%
Ages 12–14	57.08%	50.61%	55.00%

CMS Core Set Measure/Data Element	Magnolia MY 2024 Rates	Molina MY 2024 Rates	Statewide Average
Ages 15-18	46.81%	41.31%	45.17%
Ages 19-20	27.86%	23.32%	26.57%
Total Ages <1-20	51.47%	47.37%	49.80%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	12.72%	9.99%	11.04%
Ages 3-5	28.48%	23.85%	25.58%
Ages 6-7	32.59%	27.71%	31.05%
Ages 8-9	32.69%	27.70%	31.09%
Ages 10-11	30.88%	24.92%	29.04%
Ages 12-14	26.07%	21.50%	24.72%
Ages 15-18	18.60%	14.84%	17.59%
Ages 19-20	6.82%	6.83%	6.82%
Total Ages 1-20	24.96%	19.87%	22.85%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	7.47%	5.79%	6.43%
Ages 3-5	27.29%	22.42%	24.24%
Ages 6-7	32.33%	27.01%	30.65%
Ages 8-9	32.58%	27.59%	30.98%
Ages 10-11	30.77%	24.92%	28.96%
Ages 12-14	25.90%	21.50%	24.60%
Ages 15-18	18.47%	14.84%	17.50%
Ages 19-20	6.82%	6.83%	6.82%
Total Ages 1-20	24.16%	18.40%	21.77%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	3.90%	2.84%	3.25%
Ages 3-5	0.32%	0.37%	0.35%
Ages 6-7	0.01%	0.07%	0.03%
Ages 8-9	0.02%	0.00%	0.01%
Ages 10-11	0.01%	0.07%	0.03%
Ages 12-14	0.05%	0.05%	0.05%
Ages 15-18	0.01%	0.01%	0.01%
Ages 19-20	0.00%	0.20%	0.05%
Total Ages 1-20	0.45%	0.78%	0.59%
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	27.60%	29.66%	28.17%

N/A: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not required ; BR: Biased rate
**: Lower rate indicates better performance*
∞: Change in rate not able to be calculated as prior rate for health plan was not reported

<u>Non-HEDIS Performance Measure Validation – CHIP Program</u>

Table 35 provides an overview of rates reported by Molina for the CHIP population. A statewide average was not calculated for the CHIP Core Set measures because only Molina participated in the CHIP program during the measurement period. Consequently, plan-level results are reported without aggregation.

Table 35: CHIP CMS Core Set Measure Rates

CMS Core Set Measure/Data Element	Molina MY 2024 CHIP Rates
Adult Core Set Measures	
Dental and Oral Health Services	
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD) *	
Ages 18 - 64	62.84
Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD)	N/A
Care of Acute and Chronic Conditions	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *	
Ages 18 - 64	15.71
HEART FAILURE ADMISSION RATE (PQI-08) *	
Ages 18 - 64	0.00
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) *	
Ages 18 - 39	0.00
HIV VIRAL LOAD SUPPRESSION (HVL - AD)	
Ages 18 - 64	N/A
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)	
Ages 18 - 64	N/A
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)	
Ages 18 - 64	N/A
Behavioral Health Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)	
Ages 18-64	1.64%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *	
Ages 18 - 64	N/A
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)	
Overall	N/A
Prescription for Buprenorphine	N/A
Prescription for Oral Naltrexone	N/A
Prescription for Long-acting, Injectable Naltrexone	N/A
Prescription for Methadone	N/A

CMS Core Set Measure/Data Element	Molina MY 2024 CHIP Rates
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	N/A
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	N/A
Discussed or Recommended Cessation Medications: Ages 18 to 64	N/A
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	N/A
Child Core Set Measures	
Behavioral Health Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)	
Ages 12 - 17	1.97%
Primary Care Access and Preventative Care	
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	N/A
Age 2 Screening	50.83%
Age 3 Screening	54.64%
Total Screening	52.74%
Maternal and Perinatal Health	
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or Moderately Effective Contraception – 3 days	N/A
Most or Moderately Effective Contraception – 90 days	N/A
LARC - 3 Days	N/A
LARC - 90 Days Reported	N/A
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or Moderately Effective Contraception Rate	24.67%
LARC Rate	1.95%
Dental and Oral Health Services	
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)	
Numerator 1 At Least One Sealant	43.60%
Numerator 2 All Four Molars Sealed	29.29%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)	
Age <1	N/A
Ages 1–2	32.75%
Ages 3–5	59.75%
Ages 6–7	65.03%
Ages 8–9	67.36%
Ages 10–11	62.98%
Ages 12–14	56.61%
Ages 15–18	46.89%

CMS Core Set Measure/Data Element	Molina MY 2024 CHIP Rates
Ages 19–20	33.47%
Total Ages <1–20	55.24%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)	
Ages 1–2	15.99%
Ages 3–5	32.69%
Ages 6–7	36.26%
Ages 8–9	36.68%
Ages 10–11	33.38%
Ages 12–14	27.28%
Ages 15–18	20.60%
Ages 19–20	13.13%
Total Ages 1–20	28.21%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)	
Ages 1–2	10.14%
Ages 3–5	31.03%
Ages 6–7	35.90%
Ages 8–9	36.53%
Ages 10–11	33.38%
Ages 12–14	27.28%
Ages 15–18	20.60%
Ages 19–20	13.13%
Total Ages 1–20	27.50%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)	
Ages 1–2	4.55%
Ages 3–5	0.38%
Ages 6–7	0.09%
Ages 8–9	0.00%
Ages 10–11	0.08%
Ages 12–14	0.00%
Ages 15–18	0.04%
Ages 19–20	0.00%
Total Ages 1–20	0.40%
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	N/A

N/A: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not Required; BR: Biased Rate
**: Lower rate indicates better performance*
∞: Change in rate not able to be calculated as prior rate for health plan was not reported
–: New measure, no prior year or change data available for reporting.

Performance Measure Conclusions

Magnolia CAN showed improvement of 10 percentage points or more for the following MY 2024 HEDIS and CMS Core Set measure rates for the CAN population:

- Adult BMI Assessment (ABA).
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), the BMI Percentile indicator.
- Childhood Immunization Status (CIS), the DTaP, Pneumococcal Conjugate and the Combination #3 indicators.
- Glycemic Status Assessment for Patients With Diabetes (GSD), both the Poor HbA1c Control and the adequate HbA1c Control indicators
- Kidney Health Evaluation for Patients With Diabetes (KED), Kidney Health Evaluation for Patients With Diabetes (65-74) indicator. This can be attributed to the relatively small denominator for this indicator. Additionally, this measure has a Break in Trending guidance from NCQA for MY 2024.
- Plan All-Cause Readmissions (PCR-AD) Outlier rate indicator, however this measure has a Break in Trending guidance from NCQA for MY 2024.
- Adult Immunization Status (AIS-E), Pneumococcal 66+ indicator. This can be attributed to the relatively small denominator for this indicator.
- Chronic Obstructive Pulmonary Disease (COPD) OR Asthma in Older Adults Admission Rate (PQI-05) Ages 65+ indicator. This is an inverse measure where lower rate shows better performance. However, the numerator was 2 for MY 2023 and 1 for MY 2024 and the rate change should be reviewed with caution.
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD). This is an inverse measure where lower rate shows better performance.

Magnolia CAN did not experience any substantial decrease in rates for the HEDIS measures. The performance declined for one CMS Core set Measure: Heart Failure Admission Rate (PQI-08), Ages 65+ indicator.

Magnolia CAN Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) was not reported administratively as required by DOM.

Molina CAN showed improvement of 10 percentage points or more for the following MY 2024 HEDIS and CMS Core Set measure rates for the CAN population:

- Asthma Medication Ratio (AMR) Age 12-18, Age 19-50, Age 51-64 and Total indicators.

- Plan All-Cause Readmissions (PCR-AD) Outlier rate indicator. However, this measure has a Break in Trending guidance from NCQA for MY 2024.
- HIV VIRAL LOAD SUPPRESSION (HVL - AD) Ages 18 – 64 and Total.
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD). This is an inverse measure where lower rate shows better performance.

Molina CAN showed a decrease in rate of 10 percentage points or more for the following MY 2024 HEDIS and CMS Core Set measure rates for the CAN population:

- Pharmacotherapy Management of COPD Exacerbation (PCE): Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid indicator.
- Heart Failure Admission Rate (PQI-08) Ages 65+. This is an inverse measure where lower rate shows better performance.

Molina CHIP demonstrated an improvement in the reported rate for following MY 2024 HEDIS and CMS Core Set measure rates for the CHIP population:

- The Asthma Medication Ratio (AMR) Age 5-11 and Total indicators.
- Diabetes Short -Term Complications Admission Rate (PQI01-AD). This is an inverse measure where lower rate shows better performance.

Molina CHIP demonstrated a decrease in the reported rate for one MY 2024 HEDIS measure: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total); however, this is mostly driven by a small eligible population which was 33 members for MY 2024.

Molina CAN had omitted uploading the rates for a couple rates for the PMV activity. When Molina CAN resubmitted the rate sheets, the plan updated the rates for multiple measures and backed out rates for the Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) measure without providing explanation.

Molina CAN expressed challenges with pharmacy data completeness based on the pharmacy carve out for Mississippi Medicaid.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

Table 32: CAN Performance Improvement Projects Submitted for Validation

CCO	Performance Improvement Project	Performance Improvement Project Aim
Magnolia	AMR – Asthma Medication Ratio	Improve controller medication adherence for members with persistent asthma.
	Preterm Birth-HTN/Preeclampsia	Reduce preterm births among pregnant members with hypertension or preeclampsia.
	Sickle Cell – Hydroxyurea Adherence	Increase adherence to Hydroxyurea among members with Sickle Cell Disease.
	FUH-Follow-up After Mental Health Hospitalization	Improve timely follow-up care after behavioral health hospitalization.
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.
	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. 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.

Table 33: CHIP Performance Improvement Projects Submitted for Validation

CCO	Performance Improvement Project	Performance Improvement Project Aim
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.
	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.

CCO	Performance Improvement Project	Performance Improvement Project Aim
	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.

Technical Methods for Data Collection and Validation

PIP validation was conducted in accordance with CMS' *EQR Protocol 1: Validation of Performance Improvement Projects, February 2023*. The protocol validates project components and documentation to assess the overall study design and methodology. 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 to evaluate the validity and confidence in the results of each project using proprietary worksheets. These worksheets were developed based on the requirements included in *Protocol 1*, which include the two activities displayed in *Table 38*.

Table 34: 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?

Activity One: Assess the PIP Methodology		
Step	**Description**	**Step Questions**
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?
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 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, performance measures, 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 performance measures, 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 (N/A) 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 39*). Projects scoring 90-100% are classified as High Confidence, indicating strong methodological integrity with minimal documentation concerns. A Confidence rating (70-89%) suggests minor issues that introduce slight bias but do not compromise overall results. A Low Confidence rating (60-69%) 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 35: 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. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

<u>PIP Validation Results</u>

The following tables provide a summary of the validation results, project performance overtime, 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

Magnolia submitted four PIPs regarding Reducing Preterm Births, Sickle Cell Disease Outcomes, and Adult and Child Respiratory Disease, and Follow-up After Hospitalization for Mental illness. The results of the validations for those PIPS follow.

Table 40: PIP Performance Findings — Magnolia CAN

PIP Topic	Validation Score	Performance Measure	Performance Measure Results							
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)	R5 (MY)	R6 (MY)
Reducing Preterm Births	79/79=100% 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	15.79% ↑ (2024-2025)
Sickle Cell Disease Outcomes	85/85=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)	25.58% ↓ (2024-2025)
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	76.64% ↑ (2024)
		Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received	28.4% (2019)	36.8%	26.5% ↓ (2020)	21.8% ↓ (2021)	22.3% ↑ (2022)	24.5% ↑ (2023)	N/A	N/A (Retired)

PIP Topic	Validation Score	Performance Measure	Performance Measure Results							
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)	R5 (MY)	R6 (MY)
		appropriate spirometry testing to confirm the diagnosis.								
FUH Follow-up After Hospitalization for Mental Illness (new measure)	75/75=100% High Confidence in Reported Results	Percentage of discharges for age 6-17 years of age who were hospitalized for mental illness and had a follow-up visit with a mental health provider within 30 days.	65.32% (2022)	N/A	N/A	N/A	N/A	N/A	N/A	66.94% (2024)

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 41: PIP Interventions – Magnolia CAN

Interventions	
Reducing Preterm Births	
• Prenatal outreach • Blood pressure monitoring education • Aspirin use education for high-risk pregnancies	• CM referrals and follow-up support • Provider collaboration and chart reviews • Postpartum education and support call
Sickle Cell Disease Outcomes	
• Member outreach call and education kits • Provider education letters and alerts • Promotion of 90-day Hydroxyurea supply	• Pharmacy coordination for refills • Care management referrals for non-adherent members
Asthma/COPD	
• Refill reminder calls to members • Pharmacy review and member education letters • Provider fax alerts and eBlasts	• Automated calls to non-adherent members • Care management outreach for high-risk members
FUH – Mental Health Hospitalization Follow-up	
• Transition of care outreach after discharge • Scheduling assistance for follow-up appointments • Reminder calls and messages to members and caregivers	• Provider notification and follow-up coordination • Enrollment into behavioral health care management

Molina submitted six 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 are in *Table 42*.

Table 42: PIP Performance Findings — Molina CAN

<table>
<tr><th rowspan="2">PIP Topic</th><th rowspan="2">2025 Validation Score</th><th rowspan="2">Performance Measure</th><th colspan="6">Performance Measure Results</th></tr>
<tr><th>Baseline (MY)</th><th>Goal</th><th>R1 (MY)</th><th>R2 (MY)</th><th>R3 (MY)</th><th>R4 (MY)</th></tr>
<tr><td>Asthma Medication Ratio</td><td>85/85=100%
High Confidence in Reported Results</td><td>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.</td><td>66.0% (2021)</td><td>72.9%</td><td>68.2% ↑ (2022)</td><td>64.7% ↓ (2023)</td><td>84.8% ↑ (2024)*</td><td>87.17% ↑ (Q2 2025)</td></tr>
<tr><td rowspan="2">Pharmacotherapy Management of COPD Exacerbation</td><td rowspan="2">80/80=100%
High Confidence in Reported Results</td><td>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.</td><td>40.0% (2021)</td><td>53.4%</td><td>47.1% ↑ (2022)</td><td>57.9% ↑ (2023)</td><td>62.1% ↑ (2024)*</td><td>48.9% ↓ (Q2 2025)</td></tr>
<tr><td>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.</td><td>80.0% (2021)</td><td>81.8%</td><td>74.2% ↓ (2022)</td><td>77.2% ↑ (2023)</td><td>75.9% ↓ (2024)*</td><td>79.1% ↑ (Q2 2025)</td></tr>
<tr><td rowspan="2">Follow-up After Hospitalization for Mental Illness</td><td rowspan="2">85/85=100%
High Confidence in Reported Results</td><td>Percentage of discharges for which the MSCAN members received follow-up within 30 days of discharge.</td><td>16.9% (2021)</td><td>50.0%</td><td>49.2% ↑ (2022)</td><td>52.1% ↑ (2023)</td><td>27.5% ↓ (2024)*</td><td>54.73% ↑ (Q2 2025)</td></tr>
<tr><td>Percentage of discharges for which the MSCAN members received follow-up within 7 days of discharge.</td><td>8.1% (2021)</td><td>28.3%</td><td>30.3% ↑ (2022)</td><td>31.1% ↑ (2023)</td><td>19.66% ↓ (2024)*</td><td>34.41% ↑ (Q2 2025)</td></tr>
</table>

PIP Topic	2025 Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
Prenatal and Postpartum Care	85/85=100% High Confidence in Reported Results	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)*	85.4% ↓ (Q2 2025)
		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)*	50.0% ↑ (Q2 2025)
Sickle Cell Disease	80/80=100% 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)*	11.0% ↑ (Q2 2025)
Obesity	85/85=100% 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)*	20.9% ↓ (Q2 2025)
		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)*	14.1% ↑ (Q2 2025)
		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)*	12.4% ↑ (Q2 2025)

Statistically significant improvement in performance (green) — Statistically significant decline in performance (yellow)

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 36: PIP Interventions—Molina CAN

Interventions
Asthma Medication Ratio
• Actively promote the LANDYNN Project across the state aimed at educating members and empowering asthmatic members and communities • Asthma education video on proper use of inhalers • Asthma action plans for members • Provider education on controller prescribing • Case management for persistent asthma patients
Pharmacotherapy Management of COPD Exacerbation
• Smoking Cessation Program that provides access to over-the-counter tobacco cessation products • Provider education tools on COPD clinical guideline • Quality Performance Tool Dashboard • Case management enrollment • Staff training
Follow-up After Hospitalization for Mental Illness
• Discharge planning protocols and post-discharge follow-up calls • Case manager engagement with members • Coordination between behavioral health and PCPs • Crisis line promotion and member outreach
Prenatal and Postpartum Care
• OB provider outreach and engagement • Automated prenatal and postpartum reminders • Case management for high-risk pregnancies • Nurse home visiting program for postpartum support
Sickle Cell Disease
• Case management for high-risk members • Provider education SCD guidelines • Coordination with specialty hematology clinics • Patient education on hydroxyurea and preventive care
Obesity
• Provider training on BMI documentation • Parental reminders for well-child visits • Family nutrition and physical activity counseling • School-based wellness support • Expanded tracking through Molina's dashboard

CHIP

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

Table 37: PIP Performance Findings—Molina CHIP

PIP Topic	Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (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)	92% ↑ (Q2 2025)
Follow-up After Hospitalization for Mental Illness	80/80=100% 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)*	56.8% ↑ (Q2 2025)
		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)*	39.2% ↑ (Q2 2025)
Obesity	80/80=100% 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)*	18.8% ↑ (Q2 2025)
		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)*	14.0% ↑ (Q2 2025)
		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)*	12.2% ↑ (Q2 2025)

PIP Topic	Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
Well Care/Well Child	80/80=100% High Confidence in Reported Results	The percentage of members who turn 15 months old during the measurement period who had six or more well-child visits with a PCP during their first 15 months of life.	42.6% (2021)	56.1%	72.8% ↑ (2022)	69.0% ↓ (2023)	63.1% ↓ (2024)*	63.3% ↑ (Q2 2025)

Statistically significant improvement in performance — Statistically significant decline in performance

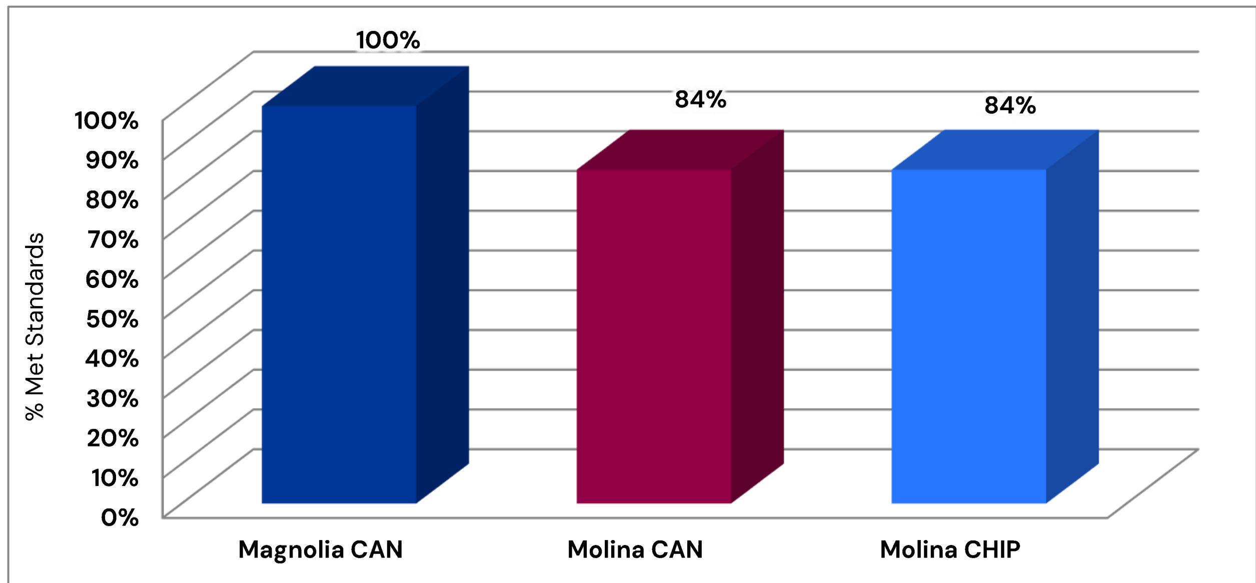
R1 – Remeasurement 1; R2 – Remeasurement 2;R3 – Remeasurement 3; 4th quarter rates are reported for remeasurements; * Q1 2024 which is the most recent remeasurement as of validation

Table 38: PIP Interventions – Molina CHIP

Interventions	
Asthma Medication Ratio	
• Pharmacy adherence monitoring • Asthma action plans for pediatric members • Case management outreach for families	• Provider education on controller prescribing • Use of MHMS dashboard for real-time tracking
Follow-up After Hospitalization for Mental Illness	
• Hospital discharge planning protocols • Case manager follow-up calls at 7 and 30 days • Provider outreach	• Integration of behavioral health with PCP follow-up care • Crisis line prometon and member education
Obesity	
• Provider training on BMI documentation • Automated reminder for parents about well-child visits • School-based wellness and health promotion campaigns	• Pediatric nutrition counseling and physical activity counseling • Expanding monitoring through MHMS Quality Dashboard
Well Care/Well Child	
• Extended pediatric clinical hours (evening/weekends) • Automated text reminders for families. • Telehealth availability for preventive care appointments	• Targeted outreach for infants, adolescents, and high-risk members • Case management follow-up form members missing multiple visits

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 46 and *47* display the strengths, weaknesses, and recommendations for the Quality Improvement section.

Table 39: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The QI Programs were designed to improve health outcomes, reduce disparities, enhance member experience, support providers, and promote patient safety.	✓		
The programs included mechanisms to assess the quality and appropriateness of care for all members, including those with special health care needs, addressing physical, behavioral, and social health services.	✓		
The QI Programs promoted health equity by integrating behavioral health and substance use services and using data on demographics and social factors to ensure culturally and linguistically appropriate care for all members.	✓		
Providers actively participate in QI activities through the Provider Profiling Program and Provider Analytics, which offer insights into performance and support improvement strategies.	✓		

Strengths	Quality	Timeliness	Access to Care
The QI Programs undergo an annual evaluation to assess effectiveness, identify opportunities for improvement, and refine interventions to enhance healthcare quality and member satisfaction.	✓		
Molina CAN and CHIP, and Magnolia CAN were both fully compliant with all IS Standards and HEDIS determination standards for the 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 prior year rates.	✓		
PIP topics are relevant to members and consistent with guidance.	✓		
Strong and significant improvement in quality measures and implements diverse and targeted outreach programs.	✓		

Table 40: Quality Improvement Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina's QI Program Description incorrectly states that Molina credentials and recredentials providers. Molina does not perform these functions. This issue was previously identified in the 2023 and 2024 EQRs and has not been corrected.	*Recommendation: The health plans should review all documents and eliminate any references to plans' role in credentialing or recredentialing individual practitioners, provider organizations, facilities, and institutions.*	✓		
The behavioral health appointment standards in Molina's 2024 and 2025 QI Work Plans were not consistent with Policy MHMS-QI-006.	*Recommendation: Update the behavioral health appointment standards in the 2024 and 2025 QI Work Plans to ensure accuracy and alignment.*	✓		
Molina's QI Work Plan referenced an annual review of HEDIS medical records and delegation oversight activities. However, the results of these audits were not incorporated into the 2024 QI Program Evaluation, limiting the ability to fully assess the effectiveness of the QI Program.	*Recommendation: Ensure that the results and outcomes of all studies and activities are fully documented and incorporated into the QI Program Evaluation, in accordance with the CAN Contract, Section 10 (D), Exhibit G, and the CHIP Contract, Section 9(D)(8) and Exhibit F.*	✓		
CCOs should follow State requirements for rate submission. Monitor and investigate reasons for measure rates that	*Recommendation: CCOs should improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures.*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
increased or decreased by 10 percentage points or more. CCOs should improve processes for rate validation and trending to identify measure reporting concerns. CCOS should provide notification when submitted rates are changed and provide explanations for the change.	*CCOs must review requirements and report measures as required for submission by DOM.*			

Table 48 provides an overview of each health plan's scores for the Quality Improvement standards. In this table, down arrows (↓) indicate a change in the score from the 2024 EQR.

Table 41: Quality Improvement Comparative Data

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*			
The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members	Met	Partially Met	Partially 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
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
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	Partially Met ↓	Partially Met ↓
Quality Improvement Committee			
The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met
The QI Committee meets at regular intervals	Met	Met	Met
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*			

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures"	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
The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met	Met	Met
Provider Participation in Quality Improvement Activities			
The CCO requires its providers to actively participate in QI activities	Met	Met	Met
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met
The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines	Met	Met	Met
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Initial visits for newborns CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Initial visits for newborns	Met	Met	Met
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: EPSDT screenings and results CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Well-Baby and Well-Child screenings and results	Met	Met	Met
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Diagnosis and/or treatment for children CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Diagnosis and/or treatment for children	Met	Met	Met
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*			
A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Partially Met ↓	Partially Met ↓
The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met

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)

UM programs are designed to support access to medically necessary services, regulatory compliance, and care coordination for members.

Constellation's review of the CCOs' UM Programs determined that each plan has established comprehensive Program Descriptions, along with supporting policies and procedures. These

documents clearly define the structure, scope, and operational components of the UM Program, including delineated lines of responsibility and accountability. Each UM Program undergoes an annual evaluation to assess overall effectiveness and to identify opportunities for improvement.

Both organizations have established UM programs intended to support fair, consistent, and impartial utilization decisions. UM Program Descriptions and supporting policies and procedures define program structure, operational components, and lines of responsibility and accountability. Magnolia's UM program is overseen by senior leadership, including the Chief Medical Officer, Vice President of Population Health and Clinical Operations, and Behavioral Health Medical Director, with formal approval by the UMC and QIC. Molina's UM program operates under its Healthcare Services Program and is overseen by the Vice President, Assistant Vice President, and Chief Medical Officer, who manage clinical policies and UM operations.

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 performed by licensed healthcare professionals who apply established internal and external clinical criteria when making determinations. The criteria are reviewed, updated as needed, and formally approved at least annually to ensure alignment with current clinical standards and regulatory requirements. To ensure consistency and accuracy in decision-making, annual inter-rater reliability (IRR) testing is conducted to evaluate alignment among reviewers.

Administrative benefit approvals may be issued by qualified non-clinical staff when no clinical judgment is required. However, a physician or other appropriately licensed healthcare professionals render all medical necessity denials. Each health plan maintains formal policies to ensure that no financial incentives are offered to providers or UM staff that would encourage the denial of coverage or services to members.

Constellation's review of a sample of approval files demonstrated that requests were evaluated within required timeframes and reviewed by appropriately qualified healthcare professionals. Similarly, the review of denial files indicated that adverse benefit determinations were rendered in a timely manner, second-level reviews were conducted in accordance with established procedures, and the rationale for each adverse determination was clearly documented and communicated to providers and members.

Opportunities for improvement were identified related to documentation of authorization processes and requirements. Magnolia's Member Handbook stated prior authorization is required for new members to continue medically necessary services, which conflicts with *CAN Contract* requirements allowing continuation of services without prior authorization. Molina's policy language regarding prior authorization for continuing services beyond 30 days for new members also lacked sufficient clarity.

Appeals

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

Each health plan's appeal process is outlined across Utilization Management Program Descriptions, relevant policies, Member Handbooks, Provider Manuals, and health plan websites. One of Molina's policies incorrectly stated that a verbal appeal must be followed by a signed written appeal, which is inconsistent with contractual requirements and *42 CFR § 438.402 (c) (3) (ii)*.

Timeliness requirements for appeals are addressed in each health plan's policies, Member Handbooks, and Provider Manuals, and specify that standard appeals must be resolved within 30 days and expedited appeals within 72 hours. Each health plan maintains a tracking system to monitor appeal timeliness and ensure adherence to turnaround requirements.

Health plans conduct ongoing monitoring of appeal trends across medical, behavioral health, and pharmacy services, with findings reviewed by the Quality Improvement Committee. Review of CAN and CHIP sample appeal files demonstrated that appeals were processed within required timeframes, included appropriate physician review, and provided clear rationales supported by clinical criteria.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

Each health plan offers a whole-person, member-focused approach to care for members. Policies, program descriptions, and Member Handbooks explain the purpose and goals of care management programs. Members are identified for care management through several sources, including self referrals, provider referrals, community agencies, and predictive modeling.

Once identified, members complete a Health Risk Assessment to review their health conditions, other needs, and social factors that may affect care. A qualified health professional develops a care plan and coordinates services, such as member education, discharge planning, appointment scheduling, and referrals to community resources. Each health plan uses specialized care models to tailor services to individual needs and uses outreach and incentive programs to encourage member engagement.

Transition of care and continuity of services ensure safe, coordinated transitions when members move between care settings, change providers, or experience benefit changes. Both health plans have transition of care processes in place; however, clarity issues were identified in Magnolia's Member Handbook and Molina's policies regarding the transition of care for new members. Magnolia's Member Handbook incorrectly stated that prior authorization is required within fifteen business days, which conflicts with contractual requirements for continuation of medically necessary services without prior authorization. Also, Molina's policies do not clearly define prior

authorization requirements beyond the initial 30 days for new members transitioning into the plan.

A review of CAN and CHIP care management sample files confirmed that assessments and care management activities were provided appropriately, based on the member's assigned risk levels.

Strengths, weaknesses, and recommendations for the Utilization Management section of the review are found in *Table 49* and *Table 50*.

Table 42: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Review of the sampled approval and denial files demonstrated that determinations were completed within the timeframes required by applicable contractual standards for all CCOs.		✓	✓
Each health plan maintains a tracking system to monitor appeal timeliness and ensure adherence to turnaround requirements.	✓	✓	
All CAN and CHIP appeal files selected for the 2025 EQR were completed by the appropriate credentialed physicians and according to contractual regulations.	✓		
The health plans have multiple strategies to promote member engagement through incentive programs, and specialized coordinators to conduct outreach to members.	✓		✓
Each health plan has specialized models of care to ensure members receive tailored services based upon their identified needs.	✓		✓

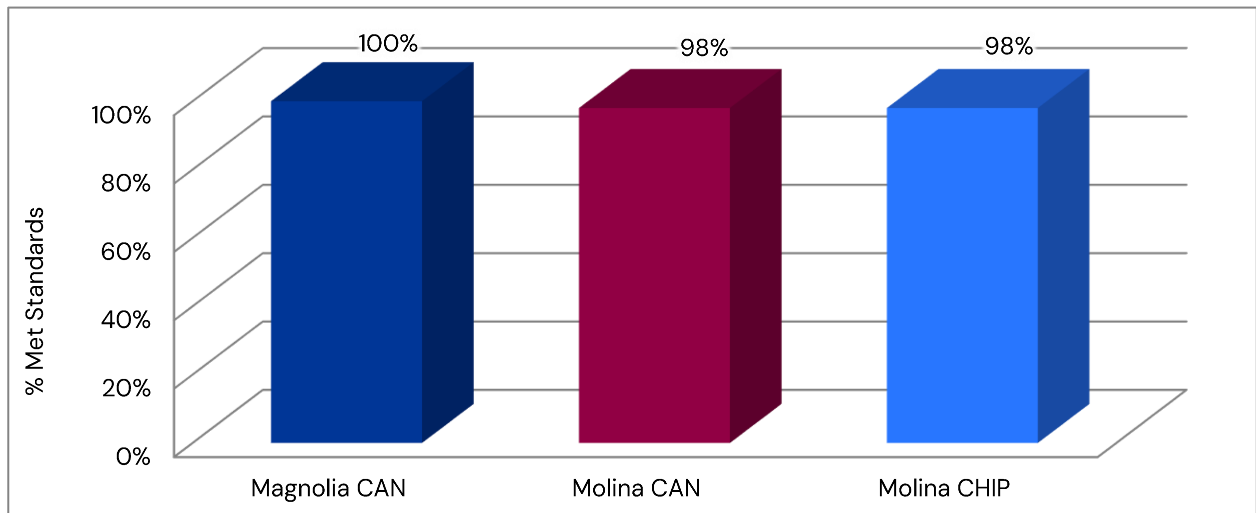
Table 50: Utilization Management Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Magnolia's Member Handbook requires prior authorization for new members to continue medically necessary services, which conflicts with CAN Contract requirements.	*Recommendation: Magnolia should review its Member Handbook and ensure it complies with contractual requirements related to continuation of medically necessary services .*	✓		✓
Molina's policy regarding prior authorization for continuing services beyond 30 days for new members lacks sufficient clarity.	*Recommendation: Molina should review its policy to clarify prior authorization for continuing services beyond 30 days for new members.*	✓		✓
Molina's Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), inaccurately states that a verbal appeal must be followed by a signed written appeal.	*Recommendation: Remove the requirement that a verbal appeal must be followed by a written appeal.*			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Review identified prior authorization guidance deficiencies in both health plans, including contract conflicts in Magnolia's Member Handbook and insufficient policy clarity in Molina's post-transition authorization requirements.	*Recommendation: Update policies and Member Handbooks to describe the transition of care process clearly and accurately.*			✓

An overview of the scores for the Utilization Management section is shown in *Figure 6*.

Figure 6: Utilization Management Findings



Scores were rounded to the nearest whole number

All scores for the Utilization Management section for the 2025 EQRs are listed in *Table 51*. In this table, down arrows (↓) indicate a change in the score from the 2024 EQR.

Table 43: Utilization Management Services Comparative Data for the 2025 EQR

Standard	Magnolia CAN	Molina CAN	Molina 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
Structure of the program	Met	Met	Met
Lines of responsibility and accountability	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Guidelines/standards to be used in making utilization management decisions	Met	Met	Met
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Met	Met
Consideration of new technology	Met	Met	Met
The appeal process, including a mechanism for expedited appeal	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
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	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
Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*			
Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations	Met	Met	Met
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met
The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Met	Met	Met
The CCO has established policies and procedures for prior authorization of medications	Met	Met	Met
Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met
Utilization management standards/criteria are available to providers	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Initial utilization decisions are made promptly after all necessary information is received	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
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	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
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*			
The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including	Met	Met	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met
The procedure for filing an appeal	Met	Partially Met ↓	Partially 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
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Met	Met
Written notice of the appeal resolution as required by the contract	Met	Met	Met
Other requirements as specified in the contract	Met	Met	Met
The CCO applies the appeal policies and procedures as formulated	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
Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*			
The CCO has developed and implemented a Care Management and a Population Health Program	Met	Met	Met
The CCO uses varying sources to identify members who may benefit from Care Management	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
The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met	Met
Evaluation of co-morbidities or multiple complex health care conditions	Met	Met	Met
Demographic information	Met	Met	Met
Member's current treatment provider and treatment plan, if available	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
The risk level assignment is periodically updated as the member's health status or needs change	Met	Met	Met
The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	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
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
The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	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 CHIP: The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to	Met	Met	Met

Standard	Magnolia CAN	Molina CAN	Molina CHIP
diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants			
Transitional Care Management			
The CCO monitors continuity and coordination of care between PCPs and other service providers	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
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
The CCO meets other Transition of Care contract requirements	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
The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met

Delegation

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

For the 2025 EQR, Magnolia reported delegation agreements with five entities identified in *Table 52*.

Table 44: Magnolia Delegated Entities and Services

Magnolia Delegated Entities	Magnolia Delegated Services
Envolve Dental (October 2024)	Dental Administrator, Claims, Network, Utilization Management, and Quality Management
Medical Transportation Management, Inc. (MTM) (November 2024)	Non-Emergency Transportation Claims, Network, Utilization Management, and Quality Management
Envolve Vision (November 2024)	Vision Services, Claims, Network, Utilization Management, and Quality Management
Evolent (fka National Imaging Associates) (December 2024)	Radiology Utilization Management

Magnolia Delegated Entities	Magnolia Delegated Services
Turning Point (November 2024)	Musculoskeletal Surgical Quality and Safety and Utilization Management

Molina reported delegation agreements with the eight entities listed in *Table 53*.

Table 45: 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
HealthMap	Case Management
Infomedia Group, Inc. d/b/a Carenet Healthcare Services	Nurse Advice Line
Accordant Care – CVS Caremark	Case Management
Evolent Health (New Century Health)	Utilization Management

All delegation arrangements are formalized through written agreements that outline responsibilities, monitoring, and corrective actions. Both health plans have a delegation oversight program to ensure the delegated entities meet federal, state, and contractual requirements through pre-delegation audits, annual reviews, and ongoing monitoring. Both health plans retain the ultimate accountability for all delegated services and have the authority to revoke agreements if standards are not met.

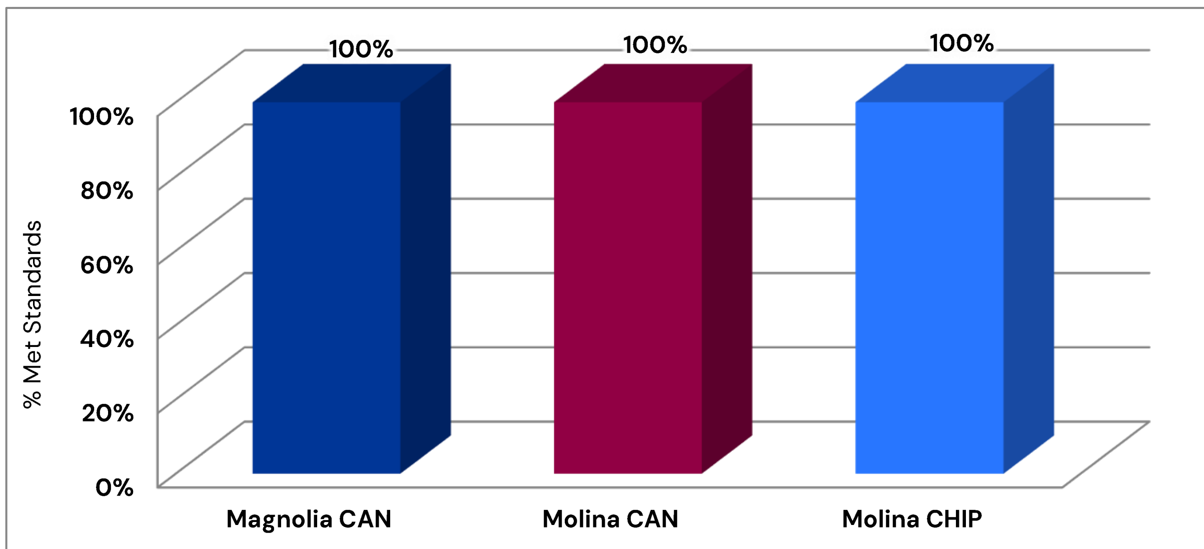
Both health plans have policies that describe the activities conducted prior to initiating a delegation agreement and annually thereafter. Magnolia's policy, MS.QI.14, Oversight of Delegated Vendor Services, indicates an onsite evaluation is preferred but may be conducted via telephone consultation. According to the policy, a summary of the annual evaluation is presented at the next Quality Improvement Committee meeting for review and comment. However, a summary of the annual evaluations was not found in the committee minutes. Magnolia agreed that the policy was confusing regarding when the committee receives the summaries.

If Magnolia's delegate chooses to sub-delegate a portion of the delegated activity, prior written approval must be received from Magnolia and DOM. The delegate oversees the work performed

by the sub-delegate, as outlined in the original delegation agreement. Failure on the part of the delegate to oversee any sub-delegated activity may result in termination of the delegation agreement with Magnolia.

For the Delegation portion of the 2025 EQRs, Magnolia and Molina each fully met three of three standards for a score of 100%, as noted in *Figure 7*.

Figure 7: Delegation Findings



Scores were rounded to the nearest whole number.

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

Table 46: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
The CCOs demonstrated strong oversight and adherence to quality standards in delegated services.	✓		
Processes and policies ensure compliance with state and federal requirements.	✓		
Regular monitoring, annual evaluations, and routine reporting ensure ongoing oversight and performance tracking.	✓		

Table 47: Delegation Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Magnolia's Oversight of Delegated Vendor Services policy indicates a summary of the annual evaluation is presented at the next Quality Improvement Committee meeting for review and comment. The recently completed annual summaries were not found in the committee minutes.	*Recommendation: Present the summary of the annual evaluation for each delegated vendor as mentioned in policy.*	✓		

Table 56 illustrates the scoring for each standard reviewed during the 2025 EQRs.

Table 48: Delegation Services Comparative Data for the 2025 EQR

Standard	Magnolia CAN	Molina CAN	Molina CHIP
Delegation *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
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
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

Findings Summary

Table 57 provides an overview of the scoring for each section of the 2025 EQRs. The percentages highlighted in green with no arrow indicate the score was unchanged from the previous EQR. Those highlighted in yellow with a down arrow represent a reduction in the prior review findings. Overall, Magnolia sustained or showed the most improvement from the previous EQR.

Table 49: 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	29	2	0	0	31	94% ↓
Molina CHIP	29	2	0	0	31	94% ↓
Provider Services						
Magnolia CAN	46	3	0	0	49	93.9%
Molina CAN	44	5	0	0	49	90% ↓
Molina CHIP	42	5	0	0	47	89% ↓
Member Services						
Magnolia CAN	31	2	0	0	33	93.9% ↓
Molina CAN	32	1	0	0	33	97%
Molina CHIP	31	1	0	0	32	97%
Quality Improvement						
Magnolia CAN	19	0	0	0	19	100%
Molina CAN	16	3	0	0	19	84% ↓
Molina CHIP	16	3	0	0	19	84% ↓
Utilization						
Magnolia CAN	54	0	0	0	54	100%
Molina CAN	53	1	0	0	54	98% ↓
Molina CHIP	53	1	0	0	54	98% ↓
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%
Totals						
Magnolia CAN	**184**	**5**	**0**	**0**	**189**	**97.4% ↓**
Molina CAN	**177**	**12**	**0**	**0**	**189**	**93.7% ↓**
Molina CHIP	**174**	**12**	**0**	**0**	**186**	**93.5% ↓**

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

Table 58 allows a comparison of the total percentage of standards scored as "Met" for Part 438 Subpart D and QAPI Standards for the 2025 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings for the CCO. Those highlighted in yellow represent a reduction from the CCO's prior review. Up (↑) and down (↓) arrows are included to further illustrate the change from the previous reviews.

Table 50: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons

Federal Standards	Magnolia CAN			Molina CAN			Molina CHIP		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	**100% ↑**	87%	87%	**80% ↓**	93% ↑	87%	**80% ↓**	93% ↑	87%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	**100% ↑**	87%	100%	**100% ↑**	93% ↓	100%	**100%**	100%	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* Emergency and Post-Stabilization Services *(§ 438.114)*	**100%**	100%	100%	**100%**	100% ↑	92%	**100%**	100% ↑	92%
Confidentiality *(§ 438.224)*	**100%**	100%	100%	**100%**	100%	100%	**100%**	100%	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	**90% ↓**	100%	100%	**90% ↓**	100% ↑	90%	**90% ↓**	100% ↑	90%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	**100%**	100%	100%	**100%**	100% ↑	50%	**100%**	100% ↑	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	**89%**	89%	100%	**89%**	89% ↓	100%	**86% ↑**	71% ↓	100%
Health Information Systems *(§ 438.242, § 457.1233)*	**100%**	100%	100%	**100%**	100%	100%	**100%**	100%	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	**100%**	100%	100%	**84% ↓**	95% ↑	79%	**84% ↓**	95% ↑	79%
Disenrollment Requirements and Limitations *(§ 438.56)*	**100%**	100%	100%	**100%**	100%	100%	**100%**	100%	100%
Enrollee Rights Requirements *(§ 438.100)*	**100%**	100%	100%	**100%**	100% ↑	67%	**100%**	100% ↑	67%

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 – 2024 Corrective Action Plan

<table>
<tr><th rowspan="2">2024 EQR Findings</th><th rowspan="2">Actions Taken by CCO
To Address Findings</th><th colspan="2">2025 EQR Findings</th></tr>
<tr><th>Corrected</th><th>Not Corrected</th></tr>
<tr><td colspan="4">PROVIDER SERVICES</td></tr>
<tr><td colspan="4">II B. Provider Education</td></tr>
<tr><td colspan="4">1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.</td></tr>
<tr><td>Magnolia submitted the Geo Access Mapping for dental, vision, and pharmacy providers after the onsite. The parameters used to measure access for dental providers were incorrect. The Envolve Dental Network Analysis dated October 1, 2024, indicates the parameters used were:
• 1 general/pediatric dentist within 30 miles or <u>60 minutes</u> (urban) and 1 general/pediatric dentist within 60 miles or <u>120 minutes</u> (rural)
• 1 dental specialist within 30 miles or <u>60 minutes</u> (urban) and 1 dental specialist within 60 miles or <u>120 minutes</u> (rural)
The CAN Contract, Section 7 (B) states the parameters for both general/pediatric dentists and dental subspecialty providers are 1 within <u>30 minutes</u> or 30 miles (urban) and 1 within <u>60 minutes</u> or 60 miles (rural).
Corrective Action Plan: Conduct Geo Access mapping for dental providers using the correct parameters and submit to Constellation for review. Ensure Envolve uses correct parameters for all future Geo Access mapping.</td><td>GEO Access mapping for Dental reflecting correct parameters. Uploaded.</td><td>✓</td><td></td></tr>
</table>

2024 EQR Findings	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
2. Practitioner Accessibility 2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.			
Elements that must be included in the Provider Directory are documented in Policy MS.PRVR.19, Provider Directory. Review of the online Provider Directory confirmed all the required elements are included. The printed (PDF) Provider Directory did not include the group affiliation (practice name) for individual providers. During the onsite discussion, Magnolia acknowledged this finding and stated practice names can be included in future printings of the Provider Directory. *Corrective Action: Ensure the printed Provider Directory includes all required information. Refer to the CAN Contract, Section 6 (E) and 42 C.F.R. § 438.10 (h).*	Ticket has been submitted with our Corporate OCOE Team. The OCOE team is responsible for the Medicaid provider directory pdf. Once the group affiliation is added and displayed for the individual providers, I will submit the website link where the provider directory is located.	✓	
II C. Preventive Health and Clinical Practice Guidelines			
2. The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members.			
The CPGs and PHGs are disseminated to providers via the health plan's website, provider orientation materials, provider newsletters, and/or special mailings. The review of the list of guidelines on Magnolia's website revealed a comprehensive list of adopted guidelines along with hyperlinks to access the individual guidelines. However, multiple hyperlinks were either non-functional, resulted in "page not found" or "page has been moved" error messages, required the reader to create an account and log in to access the information, or required membership with the entity to access the information.	The hyperlinks within the downloadable Adopted Clinical Practice and Preventive Health Guidelines document were removed. The updated CPG-Grid-Without-URL is attached along with a screenshot.		✓

2024 EQR Findings	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
Corrective Action Plan: Revise the hyperlinks to the CPGs and PHGs on Magnolia's website to ensure providers can access the information.			

Molina Healthcare of Mississippi - 2024 Corrective Action Plan – CAN

<table>
<tr><th rowspan="2">2024 EQR Findings - CAN</th><th rowspan="2">Actions Taken by CCO
To Address Findings</th><th colspan="2">2025 EQR Findings</th></tr>
<tr><th>Corrected</th><th>Not Corrected</th></tr>
<tr><td colspan="4">PROVIDER SERVICES</td></tr>
<tr><td colspan="4">II A. Adequacy of the Provider Network</td></tr>
<tr><td colspan="4">2. Practitioner Accessibility
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.</td></tr>
<tr><td>Appointment access standards for CAN are documented in Policy MHMS-QI-006, Access to Care, in the CAN Provider Manual, and on the CAN website. The following issues were noted:
Policy MHMS-QI-006, Access to Care, states that post-discharge appointments with BH/SUD providers when the CCO is aware of the discharge are required within 7 calendar of the discharge <u>and 30 calendar days from previous appointment</u>. The CAN Contract, Section 7 (B) (2) does not include "and 30 calendar days from previous appointment."
For routine visits with BH/SUD providers, the CAN Provider Manual and the CAN website indicate the timeframe is within 7 calendar days. The CAN Contract, Section 7 (B) (2) and Policy MHMS-QI-006 state the correct timeframe of within 21 calendar days.
For most appointment standards, Policy MHMS-QI-006 indicates Molina's goal is for 90% of appointments to be provided within the established timeframes. However, the policy states the goal for BH post-discharge appointments is for 75% of appointments to be provided within the established timeframe. Onsite discussion revealed this is</td><td>MSCAN Item #1
(Same as CHIP item # 7)

Revised the CAN Provider Manual on pg. 63 and the CAN website to reflect the correct timeframe of 21 days for routine visits with BH/SUD providers. Website changes can be reviewed here.

2/12/25 CORRECTIONS:
Policy MHMS-QI-006 (page 4) has been edited: Deleted statement, "and thirty (30) calendar days from previous appointment".
Policy MHMS-QI-006 (page 4) has been edited: Corrected statement: "Molina's goal is to have ninety (90) percent" (rather than "Molina's goal is to have seventy-five (75) percent").</td><td>✓</td><td></td></tr>
</table>

2024 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
incorrect; the goal for post-discharge BH appointments is 90%. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to reflect the correct timeframe for post-discharge BH/SUD provider appointments and to correct the goal for post-discharge BH/SUD provider appointments. Revise the CAN Provider Manual and CAN website to reflect the correct timeframe for routine visits with BH/SUD providers.*			
II B. Provider Education			
2. Initial provider education includes: 2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;			
The CAN Provider Manual addresses PCP referrals to specialists, and indicates prior authorization is not required for referrals to participating specialists, specialists acting as PCPs, etc. The CAN Provider Manual states, "Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Member Contact Center…" However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Molina staff stated that this is so that members may obtain a list of participating providers if needed. *Corrective Action Plan: Revise the CAN Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center.*	**MSCAN Item #2** Revised the CAN Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center on pg. 31 using the following statement: *"Additionally, members can call Molina's Member Contact Center at (844) 809-8438 to obtain a list of participating providers for self-referral if needed."*	✓	
2. Initial provider education includes: 2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.			

2024 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
The CAN Provider Manual does not include the required non-exclusivity statement. Refer to the *CAN Contract, Section 7 (H) 2 (s).* *Corrective Action Plan: Revise the CAN Provider Manual to include the required non-exclusivity requirements.*	**MSCAN Item # 3** Revised the CAN Provider Manual to include the required the following non-exclusivity statement on pg. 17. *"Molina may not enter into a Provider agreement that prohibits the Provider from contracting with another Payer or that prohibits or penalizes Molina for contracting with other Providers. Molina may not require Providers who agree to participate in the CHIP Program to contract with Molina's other lines of business."* **2.4.2025-** Corrected the non-exclusivity statement by removing the CHIP reference and adding "MississippiCAN" to reference the correct program.	✓	
II B. Preventive Health and Clinical Practice Guidelines			
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, and that are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.			
Discrepancies were noted in the frequency of reviewing CPGs and PHGs when comparing the following: • Per report of Molina staff during onsite discussion, the CPGs and PHGs are reviewed at least annually. • Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, states, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer." It then states, "All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly…" • The CAN Provider Manual indicates all CPGs and PHGs are reviewed at least monthly. • The QI Program Description indicates the CPGs and PHGs are reviewed at least quarterly.	**MSCAN Item # 4** (Same as CHIP Item # 9) Revised the CAN Provider Manual on pg. 71 to list the annual review frequency of the CPGs and PHGs. **2-12-2025 CORRECTIONS:** • Policy MHMS-QI-018 (page 6) has been edited to read, consistently with Provider Manual: "**All clinical practice guidelines and preventive health guidelines are updated at least annually, and more frequently, as needed**" (rather than, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer. All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly.) QI Program Description (page 45) has been edited to read, consistently with Provider Manual: "**All clinical practice and preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee**" (rather than, "Topics and effectiveness of clinical practice and preventive health guidelines are reviewed and approved by the	✓	

<table>
<tr><th rowspan="2">2024 EQR Findings – CAN</th><th rowspan="2">Actions Taken by CCO To Address Findings</th><th colspan="2">2025 EQR Findings</th></tr>
<tr><th>Corrected</th><th>Not Corrected</th></tr>
<tr><td>This was discussed during the onsite and Molina staff reported the CPGs and PHGs are reviewed at least annually.

Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.</td><td>Quality Improvement and Health Equity Transformation Committee at least annually, with review of changes occurring at least quarterly to identify new guidelines or changes to existing guidelines.”</td><td></td><td></td></tr>
<tr><td colspan="4">MEMBER SERVICES</td></tr>
<tr><td colspan="4">III B. Member CCO Program Education</td></tr>
<tr><td colspan="4">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:
1.1 Full disclosure of benefits and services included and excluded in coverage;</td></tr>
<tr><td>Discrepancies were identified in documentation of CAN member benefits. Findings for the CAN Member Handbook and website include:
• For Eye Care – Vision Services, the CAN Member Handbook states, “1 eye exam and 1 pair of glasses every fiscal year.” However, the website states, “1 eye exam and 1 pair of glasses, annually.”
• The website states that “Genetic Testing - Inheritable disease diagnosis” is available, but this is not indicated in the CAN Member Handbook.
• There is inconsistent wording regarding non-emergency transportation services. The CAN Member Handbook states that transportation is available “To medical appointments, vision exams and pharmacy visits immediately following a medical appointment.” The website states that transportation is available “To medical appointments, vision exams and pharmacy.”</td><td>Eye Car Benefit
Molina has revised the MSCAN member website to ensure that the eye care benefit language states that the benefit is being administered every fiscal year. This change can be found on the website here at:
https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx

Genetic Testing
The Molina website has been updated to accurately reflect the language regarding genetic testing. This language can also be found in the MSCAN member handbook. The updated language states: Inheritable disease diagnosis, such as Sickle Cell. This change can be found on the website here at:
https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx

Non-emergency transportation services
The Molina website has been updated to accurately reflect the language regarding non-emergency transportation services. The updated language states: To medical appointments, vision exams and</td><td>✓</td><td></td></tr>
</table>

2024 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
Corrective Action: Review and revise the CAN Member Handbook and website to ensure clear and consistent wording regarding covered benefits.	***pharmacy visits immediately following a medical appointment.*** This change can be found on the website here at: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx		
QUALITY IMPROVEMENT			
IV A. Quality Improvement (QI) Program			
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.			
The QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022. Constellation recommended this section of the QI Program Description be updated or removed. This recommendation was not completed. *Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing program.*	*Per EQR recommendations, the section that described the credentialing and recredentialing program (listed below) has been removed from QI Program Description (page 39). **<u>Implementing a Credentialing and Recredentialing Program</u>**: Molina maintains a comprehensive and detailed credentialing and recredentialing program designed to assure the network consists of quality practitioners who meet clearly defined criteria and standards. The credentialing and recredentialing program activities meet National Committee for Quality Assurance standards and regulatory requirements. This program includes, but is not limited to: • reviewing credentialing and recredentialing policies and procedures, including processes to check Opt-Out providers that elect not to provide services to Medicaid and CHIP members; • conducting peer reviews of credentialing and recredentialing decisions; • presenting Potential Quality of Care case summaries as directed by the designed Medical Director and quality staff to the Professional Review Committee for confidential peer review and oversight with the network team for proposed corrective action plans; • overseeing delegated credentialing activities; and • reviewing member Appeals and Grievances.		✓

2024 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
	Policies and procedures within the credentialing program describe the types of practitioners who are under the scope of the credentialing program as well as the process to assure the quality of the practitioners. The policies and procedures are reviewed annually and revised and updated as needed. The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners, and additional information as required. The information gathered is confidential, and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law. Molina designates the Professional Review (e.g., Credentialing) Committee, to make recommendations about credentialing decisions using a peer review process. Molina works with the Professional Review Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina enrollees. A practitioner may not provide care to Molina enrollees until the final decision from the Professional Review Committee is made. In situations of "clean files," network practitioners may not provide care for Molina enrollees until the final decision is made by the Molina Plan Chief Medical Officer.		

Molina Healthcare of Mississippi - 2024 Corrective Action Plan – CHIP

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II A. Adequacy of the Provider Network			
2. Practitioner Accessibility 2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.			
Appointment access standards for CHIP are documented in Policy MHMS-QI-006, Access to Care, in the CHIP Provider Manual, and on the CHIP website. The following issues were noted: Policy MHMS-QI-006, Access to Care, states that post-discharge appointments with BH/SUD providers when the CCO is aware of the discharge are required within 7 calendar days of the discharge <u>and 30 calendar days from previous appointment</u>. The *CHIP Contract, Section 7 (B) (2)* does not include "and 30 calendar days from previous appointment." For routine visits with BH/SUD providers, the CHIP Provider Manual and the CHIP website indicate the timeframe is within 7 calendar days. The *CHIP Contract, Section 7 (B) (2)* and Policy MHMS-QI-006 state the correct timeframe of within 21 calendar days. For most appointment standards, Policy MHMS-QI-006 indicates Molina's goal is for 90% of appointments to be provided within the established timeframes. However, the policy states that the goal for BH post-discharge appointments is for 75% of appointments to be provided within the established timeframe. Onsite discussion	**CHIP Item #7** CHIP Provider Manual on pg. 64 and the CAN website reflect the correct timeframe of 21 days for routine visits with BH/SUD providers. Website changes can be reviewed here. **2/12/25 CORRECTIONS:** • Policy MHMS-QI-006 (page 4) has been edited: Deleted statement, "and thirty (30) calendar days from previous appointment". • Policy MHMS-QI-006 (page 4) has been edited: Corrected statement: "Molina's goal is to have ninety (90) percent" (rather than "Molina's goal is to have seventy-five (75) percent"). **Item #1 revised document represents Item#7 as well.**	✓	

2024 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
revealed this is incorrect; the goal for post-discharge BH appointments is 90%. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to reflect the correct timeframe for post-discharge BH/SUD provider appointments and to correct the goal for post-discharge BH/SUD provider appointments. Revise the CHIP Provider Manual and CHIP website to reflect the correct timeframe for routine visits with BH/SUD providers.*			
II B. Provider Education			
2. Initial provider education includes: 2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;			
The CHIP Provider Manual addresses PCP referrals to specialists, and indicates prior authorization is not required for referrals to participating specialists, specialists acting as PCPs, etc. The CHIP Provider Manual states, "Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Member Contact Center…" However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Molina staff stated that this is so that members may obtain a list of participating providers if needed. *Corrective Action Plan: Revise the CHIP Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center.*	**CHIP Item #8** Revised the CHIP Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center on pg. 31 using the following statement: *"Additionally, members can call Molina's Member Contact Center at (844) 809-8438 to obtain a list of participating providers for self-referral if needed."*	✓	

<table>
<tr><th rowspan="2">2024 EQR Findings - CHIP</th><th rowspan="2">Actions Taken by CCO
To Address Findings</th><th colspan="2">2025 EQR Findings</th></tr>
<tr><th>Corrected</th><th>Not Corrected</th></tr>
<tr><td colspan="4">II C. Preventive Health and Clinical Practice Guidelines</td></tr>
<tr><td colspan="4">1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.</td></tr>
<tr><td>Discrepancies were noted in the frequency of reviewing CPGs and PHGs when comparing the following:
1. Per report of Molina staff during onsite discussion, the CPGs and PHGs are reviewed at least annually.
2. Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, states, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer." It then states, "All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly…"
3. The CHIP Provider Manual indicates CPGs are reviewed annually. It then states a review is conducted at least monthly. For PHGs, the CHIP Provider Manual states, "All guidelines are updated with each release by USPSTF…" but does not define the frequency of review.
4. The QI Program Description indicates the CPGs and PHGs are reviewed at least quarterly.
This was discussed during the onsite and Molina staff reported the CPGs and PHGs are reviewed at least annually.

Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.</td><td>CHIP Item # 9
Revised the CHIP Provider Manual on pg. 70 to list the annual review frequency of the CPGs and PHGs.

2-12-2025 CORRECTIONS:
• Policy MHMS-QI-018 (page 6) has been edited to read, consistently with Provider Manual: "All clinical practice guidelines and preventive health guidelines are updated at least annually, and more frequently, as needed" (rather than, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer. All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly.)
• QI Program Description (page 45) has been edited to read, consistently with Provider Manual: "All clinical practice and preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee" (rather than, "Topics and effectiveness of clinical practice and preventive health guidelines are reviewed and approved by the Quality Improvement and Health Equity Transformation Committee at least annually, with review of changes occurring at least quarterly to identify new guidelines or changes to existing guidelines."
Item #4 revised document represents Item# 9 as well.</td><td>✓</td><td></td></tr>
<tr><td colspan="4">2. The CCO communicates the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members to providers.</td></tr>
</table>

<table>
<tr><th rowspan="2">2024 EQR Findings – CHIP</th><th rowspan="2">Actions Taken by CCO
To Address Findings</th><th colspan="2">2025 EQR Findings</th></tr>
<tr><th>Corrected</th><th>Not Corrected</th></tr>
<tr><td>Molina submitted an explanation that the adopted guidelines are the same for CAN and CHIP; however, there were discrepancies noted in the guidelines listed on the CHIP website when comparing to the CAN website.
Additionally, the hyperlinks for the following guidelines were non-functional on the CHIP website:
5. Coronary and Other Vascular Disease
6. Heart Failure
7. Gestational Diabetes
8. Synagis
9. Clinical Management Guideline Compendium
The CHIP website includes the guideline for "Standards in Medical Care in Diabetes – 2019" while the CAN website includes "Standards of Care in Diabetes—2023."

Corrective Action: Revise the CHIP website to include the same guidelines as those listed on the CAN website. Update all the non-functional hyperlinks to the guidelines. Revise the CHIP website to include the current "Standards of Care in Diabetes—2023" guideline.</td><td>CHIP Item #10
The webpage with the non-functional hyperlinks was deleted as it is no longer needed.

Revised the CHIP website to include the current "Standards of Care in Diabetes—2023" guideline. Molina plans to utilize the following page for Clinical Practice Guidelines</td><td>✓</td><td></td></tr>
<tr><td colspan="4">MEMBER SERVICES</td></tr>
<tr><td colspan="4">III B. Member CCO Program Education</td></tr>
<tr><td colspan="4">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:
1.1 Full disclosure of benefits and services included and excluded in coverage;</td></tr>
<tr><td>Discrepancies were identified in documentation of CHIP member benefits. Findings for the CHIP Member Handbook and website include:
• The CHIP Member Handbook indicates that prior authorization is required for Ambulatory Surgical Center</td><td>The Molina website has been revised to indicate that prior authorization is required for ambulatory surgical center services. This is also included in the CHIP member handbook on page 19.

Substance Abuse Services Inpatient/Outpatient Care - Molina has revised the language on the Molina website to align with the language pertaining to Substance Abuse Services Inpatient/</td><td>✓</td><td></td></tr>
</table>

2024 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
Services. However, the website does not indicate the requirement of prior authorization for this service. • The website does not match the CHIP Member Handbook regarding covered services for Substance Abuse Services Inpatient/Outpatient Care. • The CHIP Member Handbook indicates coverage of Disease Management services "as indicated by PCP." This is not referenced on the website. • The CHIP Member Handbook qualifies Emergency Ambulance services as being unlimited "based on life threatening condition present." However, the website does not match this requirement. • The CHIP Member Handbook documents that prior authorization is required for Radiology/X-rays, which is not indicated on the website. *Corrective Action: Review and revise the CHIP Member Handbook and website to ensure clear and consistent wording regarding covered benefits.*	Outpatient Care in the MSCAN member handbook. This change can be found on the website here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Disease Management – Molina has revised the website to align with the language that is included in the CHIP member handbook. The language " as indicated by PCP" was added on the website located here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Emergency Ambulance Services – The language " Unlimited based on life threatening condition present" was added on the website located here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Radiology/X-ray – Molina has added "Prior authorization is required" for Radiology/X-rays on the website located here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx This language is also located in the CHIP member handbook, page 21.		
QUALITY IMPROVEMENT			
IV A. Quality Improvement (QI) Program			
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.			
The QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022. Constellation recommended this section of the QI Program Description be updated or removed. This recommendation was not completed.	*Per EQR recommendations, the section that described the credentialing and recredentialing program (listed below) has been removed from QI Program Description (page 39). **Implementing a Credentialing and Recredentialing Program**: Molina maintains a comprehensive and detailed credentialing and recredentialing program designed to assure the network consists of		✓

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing program.	quality practitioners who meet clearly defined criteria and standards. The credentialing and recredentialing program activities meet National Committee for Quality Assurance standards and regulatory requirements. This program includes, but is not limited to: •reviewing credentialing and recredentialing policies and procedures, including processes to check Opt-Out providers that elect not to provide services to Medicaid and CHIP members; •conducting peer reviews of credentialing and recredentialing decisions; •presenting Potential Quality of Care case summaries as directed by the designed Medical Director and quality staff to the Professional Review Committee for confidential peer review and oversight with the network team for proposed corrective action plans; •overseeing delegated credentialing activities; and •reviewing member Appeals and Grievances. Policies and procedures within the credentialing program describe the types of practitioners who are under the scope of the credentialing program as well as the process to assure the quality of the practitioners. The policies and procedures are reviewed annually and revised and updated as needed. The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners, and additional information as required. The information gathered is confidential, and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law. Molina designates the Professional Review (e.g., Credentialing) Committee, to make recommendations about credentialing decisions using a peer review process. Molina works with the Professional Review Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina enrollees. A practitioner may not provide care to Molina enrollees until the final decision from the Professional Review Committee is made. In		

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
	situations of “clean files,” network practitioners may not provide care for Molina enrollees until the final decision is made by the Molina Plan Chief Medical Officer.		

Attachment 2: 2025 CAHPS®ECHO 3.0 Summary

2025 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, 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 1,500 adult enrollee households and 1,500 child enrollee households. For CHIP, attempts were made to survey 750 enrollee households. The surveys for both MississippiCAN and CHIP were conducted by mail from October 16, 2025, through January 29, 2026, 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 the Molina CHIP ratings. An overall CHIP rating is not provided as Molina was the only plan participating in CHIP for the period under review.

Figure 1: Summary of Overall Rating Question – MississippiCAN Adult

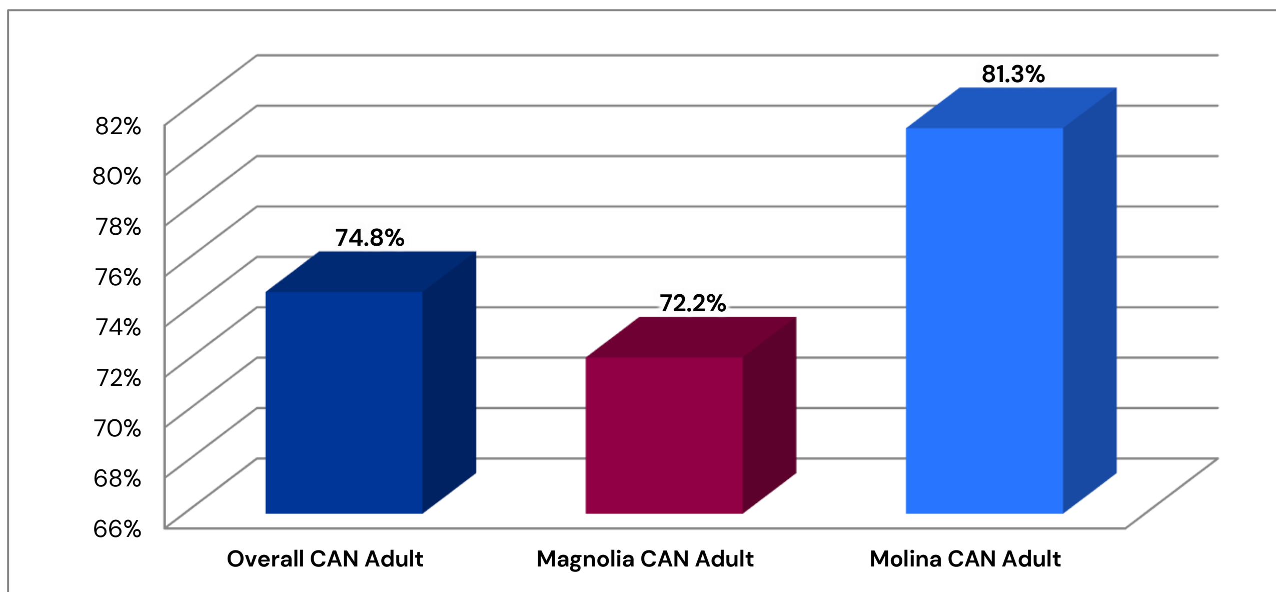


Figure 2: Summary of Overall Rating Question – MississippiCAN Child

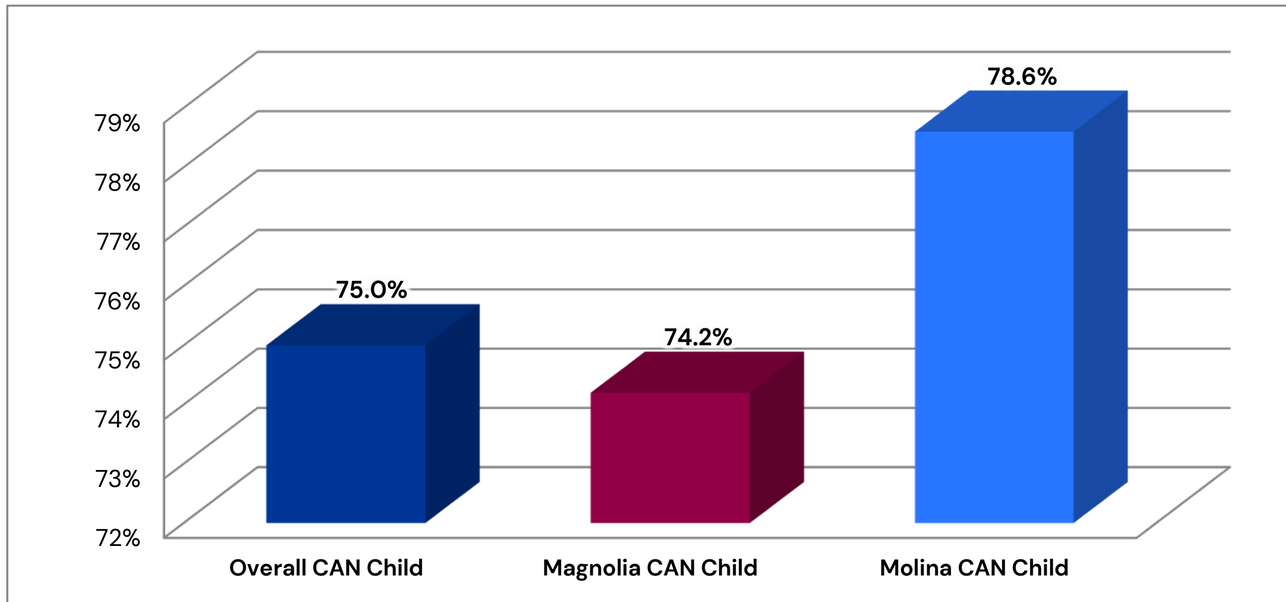
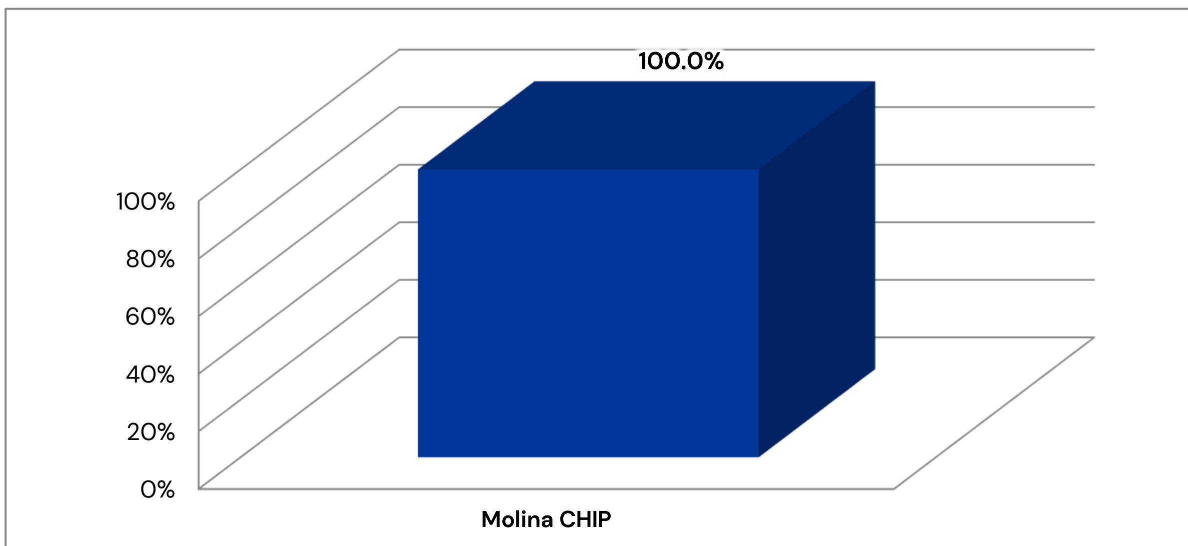


Figure 3: Summary of Overall Rating Question – CHIP



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
Q15. Usually or always felt safe with clinicians	95.5
Q13. Clinicians usually or always showed respect	92.0
Q14. Clinicians usually or always spent enough time	91.1
Q11. Clinicians usually or always listened carefully	89.4
Q12. Clinicians usually or always explained things	89.3
Opportunities for Improvement – MSCAN Adult	**Achievement Score**
Q41. Getting help from customer service was not a problem	46.2
Q39. Delays in treatment while waiting for plan approval were not a problem	52.6
Q5. Usually or always got urgent treatment as soon as needed	72.7
Q18. Usually or always involved as much as you wanted in treatment	83.0
Q29. A lot or somewhat helped by treatment	84.7

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

Key Strengths – MSCAN Child	Achievement Score
Q14. Clinicians usually or always showed respect	92.6
Q19. Goals of counseling or treatment discussed completely	91.3
Q12. Clinicians usually or always listened carefully	87.7
Q23. Given as much information as wanted to manage condition	86.3
Q24. Given information about rights as a patient	85.2
Opportunities for Improvement – MSCAN Child	**Achievement Score**
Q30. A lot or somewhat helped by treatment	78.9
Q5. Usually or always got urgent treatment as soon as needed	80.6
Q21. Child usually or always had someone to talk to when troubled	81.5
Q20. Usually or always got professional help wanted for child	82.7
Q7. Usually or always got appointment as soon as wanted	82.9

Table 3: Key Strengths and Opportunities for Improvement – CHIP

Key Strengths – CHIP	Achievement Score
Q14. Clinicians usually or always showed respect	88.9
Q13. Clinicians usually or always explained things	88.9
Q24. Given information about rights as a patient	87.5
Q32. Much better or a little better able to deal with daily problems compared to 1 year ago	80.0
Q35. Much better or a little better able to deal with symptoms or problems compared to 1 year ago	78.6
Opportunities for Improvement – CHIP	**Achievement Score**
Q30. A lot or somewhat helped by treatment	60.0
Q17. Told about side effects of medication	71.4
Q34. Much better or a little better able to accomplish things compared to 1 year ago	73.3
Q33. Much better or a little better able to deal with social situations compared to 1 year ago	73.3
Q23. Given as much information as wanted to manage condition	75.0