Constellation Quality Health

Magnolia Health Plan

2025 External Quality Review

Submitted: January 20, 2026

Prepared on behalf of the
Mississippi Division of Medicaid

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ACRONYMS, ABBREVIATIONS, AND INITIALISMS

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
CMS	Centers for Medicare & Medicaid Services
Code of Conduct	Business Ethics and Code of Conduct
Compliance Plan	Compliance and Ethics Program Description
Constellation	Constellation Quality Health
DOM	Division of Medicaid
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FWA	Fraud, Waste, and Abuse
FWA Plan	Fraud, Waste, and Abuse Plan
HEDIS®	Healthcare Effectiveness Data Informational Set, a registered trademark of NCQA
ISCA	Information System Capabilities Assessment
Magnolia	Magnolia Health Plan
MCO	Managed Care Organization
MY	Measure Year
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PHI	Protected Health Information
PIP	Performance Improvement Project
PM	Performance Measure
Provider Orientation	2024 – June 2025 Provider Orientation PowerPoint
Q1, Q3	Quarter One, Quarter Three
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement

QIC ..... Quality Improvement Committee
UM ..... Utilization Management
UMC ..... Utilization Management Committee

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Magnolia Health Plan (Magnolia). This report contains a description of the process and the results of the 2025 External Quality Review (EQR) conducted by Constellation Quality Health (Constellation) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) Program.

The goals of the review were to:

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

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

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

Summary and Overall Findings

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

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

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

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

To assess Magnolia's compliance with standards set forth in *42 CFR Part 438* and *457*, Constellation's review was divided into six areas: Administration, Provider Services, Member Services, Quality Improvement, Utilization Management, and Delegation. The following is a high-level summary of the review results for those areas.

Administration

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

For the Administration portion of the 2025 EQR, Magnolia fully met 31 of 31 standards for a score of 100%. Findings for Administration include the following:

- Magnolia maintains written policies for compliance, risk management, and operations. Policy CC.COMP.22, Policy Management, governs development, review, and annual review and approval of policies.
- Magnolia's Organizational Chart shows clear reporting lines and all key positions are filled in accordance with contractual requirements.
- Compliance and fraud, waste, and abuse (FWA) processes are defined in the Compliance Plan and FWA Plans. Staff receive the Code of Conduct at onboarding and annually along with ongoing refreshers. The Compliance Committee, composed of health plan and Board representatives, meets quarterly to advise the Compliance Officer and reports to the Board under a formal charter. All employees complete compliance training within 30 days of hire and annually through multiple formats, with confidentiality training required before staff can access systems containing protected information.

- The Pharmacy Lock-In Program is guided by a formal policy to restrict certain members to one pharmacy and one prescriber to prevent prescription drug misuse.
- On average, Magnolia pays 99% of clean claims within 30 days and 99.99% within 90 days. This meets the metric set internally by Magnolia while also meeting the benchmark set by Miss. Code Ann. § 83-9-5.
- Magnolia employs robust processes to collect and ensure the accuracy of enrollment data and member demographic information. Magnolia demonstrated adequate data collection and storage capabilities, processing procedures, and claim data tabulation and processing capabilities to support quality assurance and utilization management program activities and other contractual requirements.
- Magnolia has documented disaster recovery and business continuity plans that are tested and updated annually, focusing on recovering information technology capabilities to enable document recovery and continued operations.

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

For the Provider Services section of the 2025 EQR, Magnolia fully met 46 and partially met 3 of 49 standards for a score of 93.9%. Findings for Provider Services include the following:

- Magnolia's initial provider orientation is conducted appropriately, and the orientation process is documented in policy. Processes for ongoing provider education are appropriate but are not addressed in policy.
- The Provider Manual is comprehensive, although discrepancies were noted between the Provider Manual and Member Handbook regarding member benefits.
- Magnolia educates providers about medical record documentation standards, assesses provider compliance, and addresses medical record documentation deficiencies with applicable providers. Medical record audit results improved from 2023 to 2024, with the 2025 audit currently in progress.
- Magnolia adopts relevant evidence-based clinical practice and preventive health guidelines and disseminates them to providers in several ways. Magnolia's website includes a downloadable document listing adopted guidelines and sources. As noted in the 2024 EQR, a few guidelines were inaccessible due to hyperlink issues.
- An NCQA certified survey vendor conducted Magnolia's 2024 Provider Satisfaction Survey. The response rate was 4.7%, a decrease from the previous year's response rate of 5.2%. The overall provider satisfaction score was 79.8%, an improvement over the previous year

(75.5%). Results were presented to the Quality Improvement Committee during the December 2024 meeting.

- Magnolia notifies primary care providers (PCPs) of panel assignments and provides panel listings via the provider web portal. Processes to monitor provider panel limitations are in place but are not formalized in policy.
- Documented geographic access standards for providers meet contractual requirements. Magnolia monitors the geographic adequacy of its network through quarterly geographic access reports, network analyses, and member experience data (from surveys, grievances, appeals, out-of-network utilization) and implements interventions to address deficiencies.
- Appointment access standards are appropriately documented in policy and in the Provider Manual, but an error in one appointment access category was noted in the Member Handbook. Magnolia measures appointment accessibility at least annually and addresses issues with corrective actions and escalation for persistent non-compliance.
- Magnolia's printed and online Provider Directories include the required elements. Provider Directory accuracy audits are performed at least monthly, and a vendor performs routine Provider Directory cleanses to aid in identifying inaccurate provider data.
- Magnolia conducts annual assessments to ensure its network can meet the cultural, ethnic, racial, and linguistic needs of members. The health plan identified an issue related to low cultural competency training completion by network practitioners and implemented interventions to improve provider participation.
- The most recent Telephonic Provider Access Study, conducted by Constellation in Quarter 3 (Q3) 2025, showed a decrease in the overall successful contact rate (27%) from the previous study conducted in Q1 2025 (55%). The overall Provider Directory accuracy rate for the most recent study was 32%.

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

For the Member Services section of the review, Magnolia fully met 31 and partially met 2 of 33 standards for a score of 93.9%. Findings for Member Services include the following:

- Magnolia's Member Services program supports members by providing clear, timely, and accessible information to help them understand their benefits and obtain appropriate care.
- The New Member Packet, provided within 14 days of enrollment, includes required materials such as the Member Handbook, member ID card, benefit information, and educational resources. The New Member Packet and Member Handbook also educate members on covered services, enhanced benefits, health incentive programs, and how to access care.

- Members are provided with clear instructions on establishing a relationship with a PCP and a Medical Home and are encouraged to select a PCP and schedule an initial preventive care visit before seeking care for illness.
- The Member Services Department serves as a central point of contact for members, assisting with PCP selection, appointment scheduling, benefit inquiries, ID card replacement, transportation assistance, care management information, emergency support, and fraud reporting. The Member Services Call Center operates extended hours, including evenings and weekends, and after-hours calls are routed to a 24-hour Nurse Advice Line staffed by registered nurses.
- Member Services call data is routinely monitored to identify opportunities for improvement, and all performance metrics were met in 2024. Additionally, Magnolia maintains an active Member Advisory Committee to gather member feedback and support continuous improvement of Member Services and communications.
- Health plan policy comprehensively documents grievance requirements and resolution processes, including who may file a grievance. However, per DOM, a policy revision is needed to align appeal filing language with federal requirements in *42 CFR §438.402 (c)*.
- Grievance data and trends are reported quarterly to the Quality Improvement Committee for review and improvement. While most grievance files were compliant, issues were noted in a few files, including typographical errors in letters, incomplete intake notes, and insufficient investigation.
- Magnolia staff confirmed that PCP changes are handled like complaints and are closed within 24 hours after Call Center Representatives assist the member with selecting a new PCP. If dissatisfaction with the provider is an element, the grievance process is initiated. Practitioner changes due to dissatisfaction are logged and included in grievance analysis and reporting.

Quality Improvement

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

For the Quality Improvement portion of the 2025 EQR, Magnolia fully met 19 of 19 standards for a score of 100%. Findings for Quality Improvement include the following:

- Magnolia's Quality Improvement (QI) Program demonstrates the plan's commitment to improving health outcomes, reducing disparities, enhancing member experiences, and promoting patient safety through systematic methodologies and data-driven strategies.
- The Quality Improvement Committee (QIC), chaired by the Chief Medical Director, oversees the program's implementation and progress. The program also tracks compliance with Early

and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements and monitors provider adherence to clinical guidelines.

Performance Measure Validation

- Aqurate Health Data Management, Inc. (Aqurate) validated the performance measures (PMs) identified by DOM to determine the extent to which the CCO followed the specifications established for the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Informational Set (HEDIS) measures as well as the Adult and Child Core Set measures when calculating the PM rates. The final PM validation results reflected the measurement period of January 1, 2024, through December 31, 2024.
- Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Magnolia's NCQA-licensed organization. Aqurate found that Magnolia's information system and processes were compliant with applicable standards and HEDIS reporting requirements for HEDIS MY 2024.
- All relevant HEDIS performance measures for the current review year (2024) were compared to the previous year (2023) and the changes from 2023 to 2024 are reported in the Quality Improvement section of this report. *Table 1* highlights the CAN HEDIS measures found to have substantial increases or decreases in rates (i.e., a rate change of greater than 10%) from 2023 to 2024. No measures showed a substantial rate decrease in 2024.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2023	HEDIS MY 2024	Change from 2023 to 2024
Substantial Increase in Rate (>10% improvement)			
Adult BMI Assessment (ABA)	62.05%	81.70%	19.65%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	56.20%	69.10%	12.90%
Childhood Immunization Status (CIS)			
DTaP	71.29%	82.24%	10.95%
Pneumococcal Conjugate	70.07%	82.00%	11.92%
Combination #3	63.26%	77.13%	13.87%
Glycemic Status Assessment for Patients With Diabetes (GSD) ◇			
*PoorHbA1cControl**	50.85%	35.04%	-15.81%
AdequateHbA1cControl	42.09%	56.93%	14.84%
Kidney Health Evaluation for Patients With Diabetes (KED) ◇			
Kidney Health Evaluation for Patients With Diabetes (65-74)	18.60%	39.39%	20.79%
Plan All-Cause Readmissions (PCR-AD) ◇◇			

Measure/Data Element	HEDIS MY 2023	HEDIS MY 2024	Change from 2023 to 2024
Outlier Rate	67.13	78.37	11.24
Adult Immunization Status (AIS-E)			
Pneumococcal 66+	13.10%	25.76%	12.66%

**: 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.

- As shown in *Table 2*, two CMS Core Set measures demonstrated a significant improvement in rates while another saw a significant decline in performance. For all of these measures, a lower rate indicates better performance.

Table 2: CAN CMS Core Set Measures with Substantial Changes in Rates

CMS Core Set Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Substantial Increase in Rate (>10% improvement)			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) *			
Ages 65+	106.72	75.02	-31.70
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *			
Ages 18 - 64	73.20%	56.58%	-16.62%
Total	73.21%	56.63%	-16.59%
Substantial Decrease in Rate (>10% decrease)			
HEART FAILURE ADMISSION RATE (PQI-08) *			
Ages 65+	0	225.06	225.06

**: Lower rate indicates better performance*

Performance Improvement Project Validation

- PIP validation was conducted in accordance with CMS's *EQR Protocol 1: Validating Performance Improvement Projects*, which validates components of the project and its documentation to assess the overall study design and methodology.
- For this review, Magnolia submitted four PIPs: Reducing Preterm Births, Sickle Cell Disease Outcomes, Adult and Child Respiratory Disease, and Follow-up After Hospitalization for Mental illness. All the PIPs validated scored in the "High Confidence in Reported Results" range, as noted in *Table 3*. Details of each PIP's status and related interventions are included in the Quality Improvement section of this report.

Table 3: Performance Improvement Projects

Performance Improvement Project	Previous Validation Score	Current Validation Score
Reducing Preterm Births	74/75=99% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
Sickle Cell Disease Outcomes	80/80=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Adult and Child Respiratory Disease	80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
FUH Follow-up After Hospitalization for Mental illness (New measure)	N/A	75/75=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)

For the Utilization Management of the 2025 EQR, Magnolia fully met 54 of 54 standards for a score of 100%. Findings for Utilization Management include:

- Magnolia's UM Program is designed to ensure fair, consistent, and impartial utilization decisions while effectively coordinating medical and behavioral healthcare for members. The program is overseen by senior executives, including the Chief Medical Officer, the Vice President of Population Health and Clinical Operations, and the Behavioral Health Medical Director, with approval from the Utilization Management Committee (UMC) and the QIC.
- The UM process includes 24-hour nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning, and care coordination. All services must meet medical necessity criteria based on nationally recognized, evidence-based standards.
- The program ensures that decisions are made in compliance with policy. Standard requests are processed within three calendar days or two business days, and urgent requests are processed within 24 hours. Constellation's review of sample approval and denial files confirmed consistent application of medical necessity criteria and procedures and that Magnolia's UM Program met or exceeded its timeliness goals.
- Magnolia's appeal process is clearly defined across policies, the UM Program Description, Member Handbook, Provider Manual, and the health plan's website. These documents collectively outline the definition of adverse benefit determination and the procedures for filing an appeal. Various policies state that the health plan ensures appeals are reviewed by appropriately trained practitioners who were not involved in the initial decision.
- The timeliness requirements for standard and expedited appeals are reinforced through Magnolia's operational systems, including the Prime system, which uses color-coded alerts

to support timely completion. Review of sample appeal files demonstrated that they were resolved timely and according to contractual requirements.

- Magnolia's Care Management Program, Disease Management Program, and transitional care services identify members through multiple referral and data sources and involve a Health Risk Assessment to evaluate clinical and social needs. Treatment plans and care management activities are based on the member's risk level. Magnolia's multidisciplinary Transitional Care Management team supports members through transitions. However, the *CAN Contract* requires continuation of medically necessary services without prior authorization for new members, but the health plan's Member Handbook states that a prior authorization is required.

Delegation

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

For the Delegation portion of the 2025 EQR, Magnolia fully met 3 of 3 standards for a score of 100%. Findings for Delegation include:

- Magnolia's 2025 EQR highlights its robust framework for overseeing delegated vendor services, as outlined by policies that ensure compliance with state and federal regulations, emphasizing accountability, quality, and fraud prevention.
- Magnolia has established processes for delegation agreements, pre-delegation reviews, annual evaluations, and corrective actions. Delegated entities are monitored through routine reporting, annual audits, and Joint Oversight Committee meetings. Magnolia retains the ultimate accountability for all delegated services and has the authority to revoke agreements if standards are not met. The review identified strengths in quality and compliance, as well as ongoing efforts to address weaknesses through recommendations and corrective actions.

Corrective Action Plans and Recommendations from Previous EQR

Constellation requires the health plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met and provides technical assistance until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which Magnolia implemented the actions to address deficiencies identified during the previous EQR and found that issues persisted with incorrect hyperlinks to clinical practice guidelines on Magnolia's website.

Details regarding the 2024 CAP can be found in *Attachment 4: Assessment of Corrective Action Plans from Previous EQR*.

Conclusions

Overall, Magnolia met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the QAPI program requirements described in *42 CFR § 438.330*. *Table 4* provides an overall snapshot of Magnolia's compliance scores relative to each of the 13 Subpart D and QAPI standards above that were reviewed for Magnolia.

Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	15	15	100%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Sections V. D and V. E	18	18	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* • Emergency and Post Stabilization Service *(§ 438.114)*	Utilization Management, Section V. B	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 and 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	9	8	89%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	19	100%
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. D	2	2	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	3	3	100%

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

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

- For grievances, Policy MS.MBRS.07, Member Grievance and Complaints Process, does not align with *42 CFR §438.402 (c)* regarding who can file a grievance. A few grievance files reflected issues including typographical errors in letters, incomplete intake notes, and insufficient investigation.
- For practice guidelines, issues were noted with hyperlinks to several guidelines, resulting in inability to access the guidelines through Magnolia's website.

Table 5 provides an overview of the scoring of the current annual review as compared to the findings of the 2024 review. For 2025, 184 of 189 standards received a score of "Met." Five standards were scored as "Partially Met."

Table 5: Scoring Overview

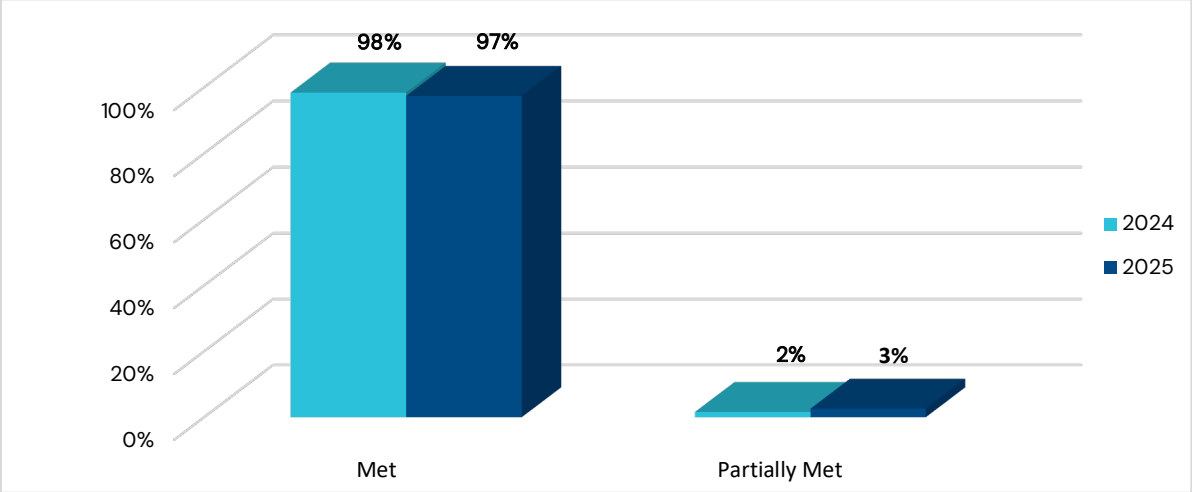
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2024	31	0	0	0	0	31	100%
2025	31	0	0	0	0	31	100%
Provider Services							
2024	46	3	0	0	0	49	93.9%
2025	46	3	0	0	0	49	93.9%
Member Services							
2024	33	0	0	0	0	33	100%
2025	31	2	0	0	0	33	93.9%
Quality Improvement							
2024	19	0	0	0	0	19	100%
2025	19	0	0	0	0	19	100%
Utilization							
2024	54	0	0	0	0	54	100%
2025	54	0	0	0	0	54	100%
Delegation							
2024	3	0	0	0	0	3	100%
2025	3	0	0	0	0	3	100%
Totals							
2024	**186**	**3**	**0**	**0**	**0**	**189**	**98.4%**

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2025	184	5	0	0	0	189	97.4%

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

The 2025 EQR shows that Magnolia achieved "Met" scores for 97.4% of the standards reviewed, and 2.6% of the standards were scored as "Partially Met." *Figure 1* provides a comparison of the current review results to the 2024 review results for Magnolia.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number.

Recommendations and Opportunities for Improvement

The following is a summary of key findings, recommendations, and corrective actions for the 2025 EQR. Specific details about strengths, weaknesses, recommendations, and corrective actions can be found in the sections that follow. Each item in the table below includes an indicator specifying whether it pertains to quality, timeliness, and/or access to care.

Table 6: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for policy development and ongoing management.	✓		
Health plan staffing is sufficient to ensure the CCO can conduct all required activities and provide all required services. Magnolia is working to fill two staffing vacancies.	✓		
Magnolia continues to meet expectations for clean claims payment over 30-day and 90-day timeframes.	✓	✓	

Strengths	Quality	Timeliness	Access to Care
Magnolia has well-documented and peer reviewed disaster recovery and business continuity plans.	✓		
Magnolia has well established infrastructure to enable accurate and complete member data collection.	✓		
The Compliance Plan, FWA Plan, and related policies and procedures outline processes to monitor for and respond to compliance issues and FWA.	✓		
The Code of Conduct sets expectations for ethical behavior and is reinforced during initial and annual compliance training activities, with refreshers provided throughout the year.	✓		
Magnolia's Pharmacy Lock-in Program meets all contractual requirements.	✓		
Multiple policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality and HIPAA requirements.	✓		
Provider Services			
Appropriate processes are in place for notifying primary care providers of assigned members and for providers to verify member enrollment.			✓
Magnolia monitors the status of providers' panels to ensure there are enough providers with open panels to provide appropriate member access.			✓
Geographic access standards for all provider types are appropriately documented in policy, and Magnolia conducts routine monitoring to ensure network adequacy.			✓
Magnolia conducts an annual assessment of members' cultural, ethnic, racial, and linguistic needs and has implemented interventions to increase provider participation in cultural competency training.	✓		✓
Magnolia conducts routine audits of provider compliance with appointment and after-hours access standards and implements interventions to improve compliance with the standards.			✓
Magnolia has recently contracted with a vendor to assist in improving Provider Directory accuracy. Additionally, corporate Provider Directory accuracy audits are conducted and two data coordinators dedicated to Provider Directory accuracy activities were hired.			✓
Magnolia adopts CPGs and PHGs from nationally recognized sources to guide healthcare decision-making.	✓		✓
Member Services			
Members receive a comprehensive New Member Packet within 14 days of enrollment that includes the Member Handbook, ID card, covered services/benefit information, and educational materials about health incentive programs, enhanced benefits, and how to access health care services.	✓	✓	✓
Member materials are written at or below a sixth grade reading level, verified using the Flesch-Kincaid Readability Scale, and formatted with appropriate font and plain language to promote understanding.	✓		✓
Magnolia has an active Member Advisory Committee that allows members an opportunity to share their feedback and thoughts with Member Services staff.	✓	✓	✓
A health plan policy clearly outlines processes for receiving, documenting, acknowledging, investigating, and resolving grievances, including related timeframes.	✓	✓	

Strengths	Quality	Timeliness	Access to Care
Grievance terminology is appropriately defined in policy, the Member Handbook, Provider Manual, and on Magnolia's website.	✓		
Magnolia uses a grievance tracking system that monitors cases from receipt through resolution and provides alerts for approaching deadlines.	✓	✓	
Grievance data, trends, and root causes are summarized and reported quarterly to the Quality Improvement Committee for review and discussion.	✓		
Quality Improvement			
Magnolia's QI Program is designed to improve health outcomes, reduce disparities, enhance member experience, support providers, and promote patient safety.	✓		
The program includes 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.	✓		
Magnolia's Quality Work Plan is a dynamic, annually updated document that outlines measurable goals, accountable individuals, target dates, data collection methods, and evaluation timelines.	✓		
Providers actively participate in QI activities through the Provider Profiling Program and Provider Analytics, which offer insights into performance and support improvement strategies.	✓		
The QI Program undergoes an annual evaluation to assess its effectiveness, identify opportunities for improvement, and refine interventions to enhance healthcare quality and member satisfaction.	✓		
Magnolia was fully compliant with all information system standards, and it was determined that Magnolia submitted valid and reportable rates for all measures in scope of the audit.	✓		
Utilization Management			
Review of a sample of denial files determined that all were processed timely, reviewed by appropriate health care professionals, and contained clearly documented rationales for the denial determinations. Documentation confirmed that denial decisions with rationales were communicated to members and providers within required timeframes.	✓	✓	
All physical and behavioral health turnaround time metric goals were met/exceeded (urgent concurrent, non-urgent pre-service, urgent pre-service, and post-service review).		✓	
Staff applying UM criteria are tested annually on applicable IRR domains. In 2024, staff were allowed two attempts to pass, with additional training required before retesting and remediation completed if the second attempt was unsuccessful. The initial pass rate was 95%, and the final pass rate was 99%.	✓		✓
Magnolia's Member Handbook presents the appeals process in clear, easy-to-understand language, supporting accessibility and encouraging member engagement in the appeals process.	✓		
Due to a barrier identified for pharmacy appeals, Magnolia's Pharmacy Director and Pharmacy Appeals Team formed a dedicated group to review pharmacy appeals, analyze key drivers, and provided guidance on required documentation and additional support.	✓		
Magnolia's use of the Prime system provides color-coded alerts to help staff maintain timely closure of appeals.	✓	✓	

Strengths	Quality	Timeliness	Access to Care
Magnolia's My Health Pays Incentive Program promotes member engagement in preventive health through financial incentives and multi-channel education, including provider outreach, in-person events, flyers, and motion graphic videos.	✓		✓
Magnolia noted that they employ multiple strategies to engage high-risk or hard-to-contact members, including up to three telephone attempts, home visits by resource coordinators, written correspondence, and other outreach methods.	✓		✓
Delegation			
Magnolia 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.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Administration				
Page 17 of the Compliance Plan includes the heading "Element 2: Corporate Compliance Officer/Compliance Committee" but the information included under the heading is specific to the local Magnolia Health Plan Compliance Officer and Committee.	*Recommendation: Revise the heading for Element 2 on page 17 of the Compliance Plan to correctly reflect the content included in this section.*	✓		
Provider Services				
Magnolia's processes for monitoring provider panel limitations are not addressed in a policy.	*Recommendation: Include the process for monitoring and tracking provider limitations on panel size in either a newly created policy or in an existing policy.*	✓		✓
Policy MS.PRVR.10, Evaluation of the Accessibility of Services, and the Provider Manual list the provider appointment access standard for routine behavioral health/substance use disorder visits as within 14 calendar days; however, the Member Handbook, page 38, states the timeframe is within 21 calendar days.	*Recommendation: Revise the Member Handbook to reflect the correct timeframe for routine behavioral health/substance use disorder visits, as documented in Policy MS.PRVR.10 and the Provider Manual.*	✓		✓
When comparing documentation of benefits in the Provider Manual and Member Handbook, discrepancies were noted in the benefits information listed for behavioral health services and orthotics and prosthetics.	*Corrective Action Plan: Correct the discrepancies noted above to ensure the Provider Manual and Member Handbook provide correct information about member benefits and related limitations.*			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The 2024 EQR found that several hyperlinks to CPGs/PHGs on Magnolia's website did not allow providers to access the specific guidelines. The current review continues to reflect that providers are unable to access several guidelines, specifically: • Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents • Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (second hyperlink) • Practitioner Training (for Substance Abuse Treatment)	*Corrective Action Plan: Revise the hyperlinks to the specified guidelines to ensure providers can access the information.*	✓		✓
Policy MS.QI.13, Medical Record Review, states, "Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re- credentialing."	*Corrective Action Plan: Revise Policy MS. QI.13, Medical Record Review, to remove the incorrect statement that medical record review results are shared with the Credentialing Department to be considered at recredentialing.*	✓		
Member Services				
Policy MS.MBRS.07, Member Grievance and Complaints Process, defines who can file a grievance. However, DOM staff reported that the policy language should align with the language in *42 CFR §438.402 (c)* and language that legal guardians for minors or incapacitated adults can file a grievance must be removed from the policy.	*Corrective Action Plan: Revise information in Policy MS.MBRS.07, Member Grievance and Complaints Process, to align with in 42 CFR §438.402 (c) by removing language that legal guardians for minors or incapacitated adults can file a grievance.*	✓		
Issues identified during review of sample grievance files were related to typographic errors related to dates in acknowledgement and/or resolution letters, insufficient documentation of the member's grievance at intake, premature closure of a grievance without resolution, and failure to investigate and resolve all issues included in the member's grievance.	*Corrective Action Plan: Conduct training for grievance staff related to reviewing letters for errors prior to mailing, clearly documenting specific information regarding the member's dissatisfaction at intake, use of extensions when appropriate to resolve grievances, and ensuring all issues are included in the investigation and resolution of grievances.*	✓	✓	✓
Quality Management				

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) was not reported administratively as required by DOM. The plan reported it using only the survey method.	*Recommendation: Plan must review requirements and report measures as required for submission by DOM.*	✓		
Utilization Management				
The Member Handbook describes Magnolia's transition of care process. While the *CAN Contract, Section 8(B)(5)* requires continuation of medically necessary services without prior authorization, the Member Handbook (page 41) incorrectly states that prior authorization is required within fifteen business days.	*Recommendation: Update the Member Handbook to clearly describe the transition of care process, ensuring it reflects current policy and aligns with contractual requirements.*	✓		
Delegation				
Policy MS.QI.14, Oversight of Delegated Vendor Services, indicates a summary of the annual evaluation is presented at the next QIC 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 MS.QI.14, Oversight of Delegated Vendor Services.*	✓		

METHODOLOGY

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

On July 3, 2025, Constellation sent notification of the initiation of the annual EQR to Magnolia (refer to *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN Program.

Further, Magnolia was invited to participate in a pre-onsite conference call with Constellation and DOM where the health plan could seek clarification on the review process and ask questions regarding any of the desk materials Constellation requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on August 4, 2025, at Constellation's offices (refer to *Attachment 1*).

The second was a virtual onsite review conducted on December 3 and 4, 2025. The onsite visit focused on areas not covered in the desk review or needing clarification. Refer to *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Magnolia's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

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

A. Administration

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

The Administration review includes policy management processes, health plan staffing, information management systems capabilities, compliance, program integrity, and processes to ensure confidentiality of information.

Magnolia maintains written policies to guide staff in conducting daily operations and maintaining compliance with laws and regulations, meeting contractual obligations; and managing risks. Policy CC.COMP.22, Policy Management, outlines processes for developing, reviewing, approving, and maintaining policies. Policies are reviewed and approved at least annually, with additional review and approval in the event of changes in laws, regulations, and/or contractual requirements. Magnolia uses the RSA Archer platform for policy management. This system maintains policy audit trails and approval dates. Employees are educated about new and revised policies and can access policies on Magnolia's intranet site, CNET, and the RSA Archer platform.

Magnolia's Organizational Chart clearly displays lines of reporting by department and/or functional area. Review confirmed all key positions are filled according to contractual requirements and no staffing issues were noted. Onsite discussion confirmed two Care Manager positions are vacant; however, interviews are in progress for one position and Magnolia is currently recruiting for the second.

Magnolia details processes to ensure compliance with laws and regulations and to prevent, detect, and respond to suspected or alleged FWA in the Magnolia Health Plan Compliance and Ethics Program Description (Compliance Plan) the corporate Fraud, Waste, and Abuse Plan (FWA Plan), and the Magnolia Health Plan FWA Plan. Detailed information about various compliance and FWA topics are included in related policies and procedures. During onboarding and annually, Magnolia provides staff with the Business Ethics and Code of Conduct (Code of Conduct), which outlines expectations for ethical and professional business behavior. Additionally, staff receive refreshers throughout the year and during the annual Compliance Week activities.

Magnolia's Compliance Committee is a cross-functional body that includes representatives from across the health plan and Board members. The Committee advises the Compliance Officer, supports oversight of the compliance program, evaluates legal and regulatory requirements, assesses risk, and establishes strategies to promote compliance and identify potential violations. The Compliance Committee meets at least quarterly and reports directly to the Board of Directors. A committee charter defines the committee's purpose and objectives, meeting frequency, the chairperson (Compliance Officer), and attendance and quorum requirements. Meeting minutes reflected a quarterly cadence for meetings, the presence of a quorum for each meeting, and appropriate attendance by voting members.

Employees are required to complete compliance training within 30 days of hire and annually. Training is delivered through interactive in-services, online training, newsletters, and live presentations, and results are reported to the Compliance Officer, executives, and management. Failure to complete the training may result in disciplinary action. New

employees are required to complete training related to confidentiality prior to being granted access to systems that contain protected/confidential information.

Magnolia's Pharmacy Lock-In Program, also known as the Beneficiary Health Management Program, is designed to prevent misuse or abuse of prescription benefits by limiting certain members to one designated pharmacy and, if applicable, one controlled substance prescriber for a defined timeframe. Processes and requirements for the program are documented in a policy that addresses member identification for potential inclusion in the program, criteria for exclusion, and related member notifications, appeal rights, case management referrals for member education, and ongoing monitoring of members in the program.

Health Information Systems

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

Magnolia meets its internal benchmarks for clean claims processing and employs robust procedures to verify member demographic and enrollment data. Magnolia demonstrates strong capabilities in data collection and storage, supported by comprehensive processes that ensure compliance with quality assurance, utilization management, and contractual obligations. Additionally, Magnolia maintains documented disaster recovery and business continuity plans, which undergo annual updates, reviews, and testing to prioritize the restoration of information technology functions for document recovery and uninterrupted operations. Overall, Magnolia's robust infrastructure and well-defined processes enable efficient and reliable workflows.

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

Figure 2: Administration Findings

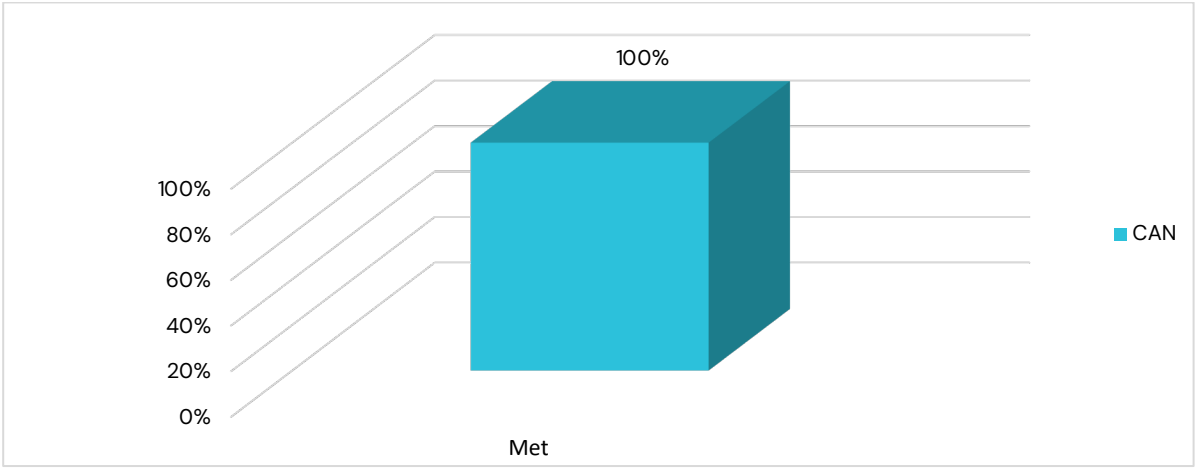


Table 7: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for policy development and ongoing management.	✓		
Health plan staffing is sufficient to ensure the CCO can conduct all required activities and provide all required services. Magnolia is working to fill two staffing vacancies.	✓		
Magnolia continues to meet expectations for clean claims payment over 30-day and 90-day timeframes.	✓	✓	
Magnolia has well-documented and peer reviewed disaster recovery and business continuity plans.	✓		
Magnolia has well established infrastructure to enable accurate and complete member data collection.	✓		
The Compliance Plan, FWA Plan, and related policies and procedures outline processes to monitor for and respond to compliance issues and FWA.	✓		
The Code of Conduct sets expectations for ethical behavior and is reinforced during initial and annual compliance training activities, with refreshers provided throughout the year.	✓		
Magnolia's Pharmacy Lock-in Program meets all contractual requirements.	✓		
Multiple policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality and HIPAA requirements.	✓		

Table 8: Administration Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Page 17 of the Compliance Plan includes the heading "Element 2: Corporate Compliance Officer/Compliance Committee" but the information included under the heading is specific to the local Magnolia Health Plan Compliance Officer and Committee.	*Recommendation: Revise the heading for Element 2 on page 17 of the Compliance Plan to correctly reflect the content included in this section.*	✓		

ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					All departments must maintain written policies to facilitate operations and training, and to describe processes and requirements for maintaining compliance with laws and regulations, meeting contractual obligations; and managing risks. Policy CC.COMP.22, Policy Management, outlines processes for developing, reviewing, approving, and maintaining policies. Policy review and onsite discussion confirmed policies are reviewed and approved at least annually, and additional review and approval are conducted when there are changes in laws, regulations, and/or contractual requirements. Magnolia maintains policy documentation in the RSA Archer platform, which maintains an audit trail and approval dates. Employees can access policies both on Magnolia's intranet site, CNET, and the RSA Archer platform. Employees are educated about both new and revised policies in a variety of ways.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a						All key positions are filled according to contractual requirements, and no staffing issues were noted. See standards below.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					The Chief Executive Officer position is filled in compliance with contractual requirements.
1.2 *Chief Operating Officer;	X					The Chief Operating Officer position is appropriately filled.
1.3 Chief Financial Officer;	X					The Chief Financial Officer is located in Mississippi, and the position is appropriately filled.
1.4 Chief Information Officer;	X					The Chief Information Officer position is filled in compliance with contractual requirements.
1.4.1 *Information Systems personnel;	X					Per onsite discussion, most Information Systems personnel are corporate-based with specific staff designated for Mississippi, and a Mississippi-based staff member is in place to handle hardware and/or other local issues.
1.5 Claims Administrator;	X					The Claims Administrator position is appropriately filled.
1.6 *Provider Services Manager;	X					The Provider Services Manager position is appropriately filled by a Mississippi resident.
1.6.1 *Provider contracting and education;	X					Staffing for provider contracting and provider education is appropriate, and there are no current vacancies.
1.7 *Member Services Manager;	X					The Member Services Manager position is appropriately filled by a Mississippi resident.
1.7.1 Member services and education;	X					Customer Services staffing is appropriate, and there are no current vacancies.
1.8 Complaint/Grievance Coordinator;	X					This position is appropriately filled.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Utilization Management Coordinator;	X					This position is appropriately filled.
1.9.1 *Medical/Care Management Staff;	X					As reflected in the Organizational Chart, Medical Management and Care Management staffing appear to be adequate. Onsite discussion confirmed two Care Manager positions are vacant; however, interviews are in progress for one position and Magnolia is currently recruiting for the second.
1.10 Quality Management Director;	X					The Quality Management Director position is filled in compliance with contractual requirements.
1.11 *Marketing, member communication, and/or public relations staff;	X					As reflected in the Organizational Chart, marketing, member communication, and/or public relations staffing are adequate with no vacancies noted. Onsite discussion confirmed the staff are located in Mississippi.
1.12 *Medical Director;	X					Staffing includes the Chief Medical Officer and four additional Medical Directors.
1.13 *Compliance Officer.	X					The Compliance Officer position is filled in compliance with contractual requirements.
2. Operational relationships of CCO staff are clearly delineated.	X					The Organizational Chart clearly displays lines of reporting and is grouped by department and/or functional area.
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					On average, Magnolia pays 99% of clean claims within 30 days and 99.99% of clean claims within 90 days. This exceeds the metric set internally by Magnolia and is in compliance with *Miss. Code Ann. § 83-9-5*, both

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						which define timeliness as 90% of claims paid in 30 days and 99% of claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia has checks to ensure that both enrollment data and member demographic information are captured correctly. Magnolia also captures data on member and provider characteristics, (such as member enrollment, provider type, distribution of claim types, etc.) to ensure data completeness. Magnolia is able to provide the data to the Mississippi Department of Insurance and any other oversight agencies.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Magnolia did not provide all requested ISCA supporting documentation due to the proprietary nature of Centene software and technology processes. However, Magnolia adequately demonstrated their data collection and storage capability, processing procedures, and claim data tabulation and processing, as well as showed adequate support of Quality Assurance and Utilization Management Program activities and other contractual requirements via attached flowcharts and technical layouts. The processes were reviewed and discussed during the onsite.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia has both a documented disaster recovery and a business continuity plan in place along with yearly updates (last updated on in February 2025) and conducts disaster recovery plan review and testing. Magnolia's disaster recovery and business continuity plans both focus on the recovery of Information Technology capabilities to allow for document recovery and continued operations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					The Magnolia Health Plan Compliance Plan is attached to Policy MS.COMP.100, Compliance Program Description. This document addresses Magnolia's processes and controls to prevent, detect, and correct compliance violations. The corporate FWA Plan is documented within Policy CC.COMP.16, Fraud, Waste and Abuse Plan. Addendum M of the policy includes the Magnolia Health Plan FWA Plan. This document outlines processes to "ensure the proper administration of Medicaid funds, prevent fraud, waste, and abuse, and maintain the fiscal integrity of the program." Detailed information about various compliance and FWA topics are included in related policies and procedures.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					See standards below.
2.1 Standards of conduct;						The Compliance Plan references the Code of Conduct, which outlines expectations for ethical and professional business behavior. General topics covered in the Code of Conduct include: • The organization's mission, values, and behavior expectations • Honesty and integrity • Protecting assets and information • Appropriate communication and public engagement

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Work environment inclusivity and safety • Key laws Magnolia staff reported that the Code of Conduct is provided to staff during onboarding and annually. Additionally, staff receive refreshers throughout the year and during the annual Compliance Week activities.
2.2 Identification of the Compliance Officer;						Roles and responsibilities of the health plan's Compliance Officer are described in the Compliance Plan. The roles and responsibilities include: • Overseeing Compliance Program planning, implementation, monitoring, and effectiveness. • Developing and monitoring compliance policies and procedures. • Reporting to the governing body, CEO, and Compliance Committee. • Coordinating and participating in compliance training and education programs. • Ensuring network providers and contractors adhere to compliance requirements. • Investigating, documenting, and acting on compliance issues. • Maintain reporting channels to encourage compliance and/or FWA reporting without fear of retaliation.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Referring potential fraud investigations to regulatory agencies and facilitate documentation requests. The review found that page 17 of the Compliance Plan, includes the heading "Element 2: Corporate Compliance Officer/Compliance Committee" but the information included under the heading is specific to the Magnolia Health Plan Compliance Officer and Committee. *Recommendation: Revise the heading for Element 2 on page 17 of the Compliance Plan to correctly reflect the content included in this section.*
2.3 Information about the Compliance Committee;						The Compliance Plan provides an overview of the Compliance Committee's purpose, functions, and composition.
2.4 Compliance training and education;						The Compliance Plan addresses compliance training and education as follows: • New employees must attend specific compliance training during orientation within 30 days of hire. • All employees and subcontractors are required to complete annual compliance training, which includes federal and state statutes, regulations, and guidelines. • Attendance and participation in training programs are a condition of continued employment, and failure to comply may result in disciplinary action. • Compliance training topics include compliance program elements, corporate ethics, fraud and abuse prevention, and department-specific compliance requirements. Specialized training is provided to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						corporate officers, managers, and employees whose actions affect compliance. • Training is delivered through interactive in-services, online training, newsletters, and live presentations. • Training activities are documented, and the training program is evaluated annually to correlate with changes in laws, regulations, and federal healthcare program requirements. Policy CC.COMP.10, Risk, Ethics & Compliance Training, indicates employees receive automated email reminders regarding training requirements, deadlines, instructions, and support resources. Training results and non-compliance are reported to the Compliance Officer, executives, and management staff. Onsite discussion confirmed new employees are required to complete training related to confidentiality prior to being granted access to systems that contain protected/confidential information.
2.5 Lines of communication;						Lines of communication are discussed in detail in the Compliance Plan. As noted, Magnolia has processes for submitting, recording, and responding to compliance questions and reports. The processes are designed to ensure confidential and anonymous reporting with prohibitions for retaliation against anyone who, in good faith, reports misconduct or other compliance issues. Staff and others are informed of communication methods via meetings, email, compliance articles, workplace posters, and other methods. Employees,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members, and others may make reports through the health plan and corporate Compliance Officers, CEO, Board of Directors, Ethics & Compliance Helpline, and on Centene's intranet, CNET.
2.6 Enforcement and accessibility;						As noted in the Compliance Plan, Magnolia communicates disciplinary guidelines through policies and procedures, compliance training, CNET articles and videos, workplace posters, and live presentations. Possible disciplinary actions depend on the severity and nature of the violation and include oral warnings, suspension, termination, or financial penalties. The Code of Conduct also addresses disciplinary actions that may result from non-compliance, warning that "Individuals who violate this Code may be subject to disciplinary action, up to and including termination of employment." Additionally, it informs that employees who fail to comply with laws or regulations may face civil and/or criminal liability.
2.7 Internal monitoring and auditing;						Per the Compliance Plan, Magnolia conducts monitoring and compliance audits by internal or external auditors to identify and address potential risks, deviations, or noncompliance. Internal or external auditors with healthcare regulation expertise conduct periodic audits to assess compliance with federal and state requirements, focusing on areas with high exposure to enforcement actions. Deviations are investigated, and corrective actions are implemented to address systemic issues and prevent recurrence. Results are shared with the Compliance Officer, Compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee, senior management, and the Board of Directors. Magnolia also conducts ongoing oversight of third parties to ensure adherence to performance standards and to ensure third-party contractors comply with regulatory requirements, hold proper licensure, and are not excluded from federal healthcare programs.
2.8 Response to offenses and corrective action;						The Compliance Plan outlines processes for addressing violations and ensuring corrective measures are implemented. The Compliance Officer or designee promptly investigates reported or indicated noncompliance. Corrective action plans are developed to address confirmed misconduct and prevent recurrence and are monitored to ensure effectiveness. Referrals may be made to law enforcement authorities, and reports may be made to state or federal authorities.
2.9 Exclusion status monitoring.						The Compliance Plan addresses exclusion and sanction monitoring for employees, including all officers, directors, associates, and subcontractors. Additionally, Magnolia prohibits the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs. As noted in the Magnolia Health Plan FWA Plan, Magnolia confirms the identity and exclusion status of providers during enrollment and reenrollment processes and monitors providers for sanctions and exclusions by

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performing routine checks of federal and state databases. For providers, monthly checks of the following are conducted: • Social Security Administration's Death Master File • National Plan and Provider Enumeration System • List of Excluded Individuals/Entities • Excluded Parties Lists System • Any other databases prescribed by the Secretary • Division of Medicaid's excluded provider list Additional information about exclusion status monitoring is found in Policy CC.COMP.36, Centene Exclusion Screening Requirements, and Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Plan provides an overview of the Compliance Committee's purpose, functions, and composition. Committee responsibilities include but are not limited to advising the Compliance Officer, assisting in maintaining the compliance program, analyzing legal requirements and areas of risk, determining strategies to promote compliance and detect potential violations, and ensuring Magnolia maintains a system to solicit, evaluate, and respond to complaints and problems. The Compliance Committee's composition consists of a cross-functional team with varying responsibilities in the health plan, including employees, managers of key

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						operating units, senior leadership, and members of the Board. The committee meets quarterly and as needed and reports directly to the Board of Directors. The Compliance Committee Charter defines: • the purpose and objectives of the committee • meeting frequency (quarterly and as needed) • the committee's chairperson (Compliance Officer) • attendance requirement (75% of meetings) • quorum (50% of voting members) (note 5 voting members establish a quorum) • voting membership Minutes for the meetings from September 2024 through June 2025 were reviewed. The minutes reflected a quarterly cadence for meetings, the presence of a quorum for each meeting, and appropriate attendance by voting members. Attendance documentation clearly indicated if a proxy was attending for a voting member.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					ISCA documentation, the corporate FWA Plan, the Magnolia FWA Plan, and a host of related policies and procedures address processes to prevent and detect potential or suspected fraud, waste, and abuse.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Magnolia Health Plan FWA Plan and associated policies and procedures detail Magnolia's processes for investigating suspected or alleged FWA. Onsite discussion confirmed the designated investigator for Magnolia is a Certified Fraud Examiner.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The Magnolia Health Plan FWA Plan and associated policies and procedures address provider payment suspensions and recoupments of overpayments. No issues were identified in the documentation.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Processes and requirements for Magnolia's Pharmacy Lock-In Program, also known as the Beneficiary Health Management Program, are found in Policy MS.PHAR.15, Pharmacy Lock-In Program. The program involves collaboration among Magnolia Health Plan, DOM, and the pharmacy benefit manager, Gainwell Technologies. The policy addresses the goals of the program and that when included in the program, members are restricted to one pharmacy and one controlled substance provider to address overutilization and misuse of pharmacy benefits. The policy addresses member identification for potential inclusion in the program, member notification of their lock-in status, member appeal rights related to inclusion in the program, referrals to case management and education on appropriate medication use, ongoing monitoring of members in the program, members who are excluded from the program, etc.
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy CC.COMP.04, Confidentiality Policy, outlines responsibilities and procedures for maintaining the confidentiality of sensitive information, including protected health information (PHI) and applies to all directors, officers, and employees of Centene

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corporation and its affiliates. The policy details permitted and prohibited uses and disclosures of PHI, security protocols, guidelines for verbal communication of PHI, the execution of agreements with business associates to ensure the protection of PHI, member rights and responsibilities regarding PHI, and employee training about confidentiality policies, compliance monitoring, and consequences of violations. Additional policies, program descriptions, training documents, the Compliance Plan, and the Code of Conduct provide information about confidentiality requirements.

B. Provider Services

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

The Provider Services review encompasses initial and ongoing provider education, clinical practice and preventive health guidelines, the provider satisfaction survey, practitioner medical record documentation standards and provider compliance with those standards, and network adequacy.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

As noted in policy, Magnolia conducts initial provider orientation within 30 days of network enrollment to ensure providers receive essential information about the health plan's business practices. Although the Provider Manual indicated that the Provider Relations Department is responsible for providing ongoing education to providers and their staff, onsite discussion confirmed that ongoing provider education is not addressed in a formal policy. The Provider Orientation and/or Provider Manual comprehensively cover various topics that providers will need to understand to operate effectively within Magnolia's network. It was noted that discrepancies were noted in member benefits for behavioral health services and orthotics/prosthetics when comparing the Provider Manual to the Member Handbook.

Magnolia educates providers on medical record documentation standards through the Provider Manual, which outlines requirements for compliance, and conducts annual medical record audits using a Medical Record Audit Tool, aiming for at least 90% compliance. Providers scoring below 90% are re-audited within six months, and persistent non-compliance may prompt review by the Chief Medical Director, referral to the Quality Improvement or Peer Review Committees, or termination from the network. For 2024, five clinics were audited, all scoring 100%, an improvement over 2023 results. Magnolia reported that 2025 audits are still in progress, with final results to be submitted to the QIC in December 2025.

DOM implemented centralized credentialing in 2022. However, the review of Policy MS.QI.13, Medical Record Review, reflected incorrect information that "Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re- credentialing." Although a recommendation was given to revise this information during the 2024 EQR, the statement remains in the policy.

Practice Guidelines

§ 438.236, § 457.1233

Magnolia adopts evidence-based clinical practice guidelines and preventive health guidelines from recognized sources, with review and input from board-certified practitioners and specialists. If no recognized source exists, guidelines are developed through Centene committees. Updates occur annually or when significant new evidence or national standards emerge, followed by Quality Committee review. Magnolia's adopted guidelines include a range of topics relevant to Magnolia's membership. Dissemination methods include Magnolia's website, Provider Manual (with links or availability notices), new practitioner orientation materials, newsletters, and special mailings. The Provider Manual confirms that providers can access a full list of guidelines on Magnolia's website and review confirmed that a downloadable document listing adopted guidelines and sources is available on the website. However, as with the 2024 EQR, the current EQR found hyperlink issues, including incorrect or inaccessible links preventing access to specific guidelines regarding antipsychotic prescribing, schizophrenia treatment, and substance abuse training resources.

Provider Satisfaction Survey Validation

Magnolia's 2024 Provider Satisfaction Survey was conducted by Press Ganey, an NCQA certified survey vendor. 105 valid surveys were completed out of the total sample of 2,250, equating to a 4.7% response rate. This is lower than the previous year's response rate of 5.2%. The overall provider satisfaction score was 79.8%, an improvement over the previous year (75.5%). Results were presented to the Quality Improvement Committee during the December 2024 meeting.

Table 9 offers the section of the worksheet that needs improvement, the reasons, and the recommendations.

Table 9: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	There were 105 valid surveys completed out of the total sample of 2,250 equating to a 4.7% response rate which is lower than the previous year's response rate of 5.2%.	Continue efforts to improve the response rate to ensure the results better represent the provider population.

Network Adequacy Validation

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

Constellation conducted a validation review of Magnolia's provider network following CMS's *EQR Protocol 4: Validation of Network Adequacy*, which validates the health plan's provider

network to determine if the CCO is meeting network standards defined by the State. To validate Magnolia's network, Constellation requested and reviewed:

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

A desk review of these documents was conducted to assess network adequacy. The following is an overview of the results for each activity.

Provider Network File Questionnaire

The Provider Network File Questionnaire confirmed Magnolia maintains complete and usable provider and member data which allows ongoing monitoring of network adequacy. Data submitted through the provider network file supports accurate tracking of provider types, locations, and appointment access. The information is reliable for assessing compliance.

Availability of Services

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

PCP panel listings are updated within five business days of receiving the monthly enrollment file from DOM. PCPs can access their panel listings at any time via the secure provider web portal and can verify panel assignments by contacting the Provider Services Call Center. Printed copies of the panel listing can be requested from Provider Relations. Magnolia monitors provider panel limitations through quarterly geographic access reports but confirmed this process is not addressed in a policy. Participating providers can verify member eligibility and enrollment at any time via the secure provider portal. All providers may verify enrollment and eligibility by using the IVR system or contacting a Provider Services Representative.

The geographic access standards for PCPs, specialists, and other provider types are documented in a policy and are compliant with contractual requirements. Magnolia

monitors the geographic adequacy of its network through quarterly geographic access reports that evaluate the network by county. Magnolia provided copies of Network Analysis (geographic access) reports dated July 26, 2025, which confirmed access is evaluated by county using appropriate urban and rural parameters. Additionally, Magnolia provided a geographic analysis dated October 1, 2025, for general and specialty dental providers. This report confirmed that the deficiency from the 2024 EQR related to dental access parameters was corrected. Magnolia staff confirmed that although the Indian Health Care Providers within Mississippi declined to contract with the health plan, they are treated as in-network providers regarding authorization requirements and claim payments.

In addition to quarterly geographic access reports, Magnolia conducts annual analyses to identify opportunities for improving the availability of primary care, specialty, and behavioral health practitioners. Magnolia also considers member experience data (e.g., surveys, complaints, appeals, out-of-network service utilization) to identify gaps in geographic access and/or practitioner types. Barrier analyses are conducted to address gaps in practitioner availability, and interventions are implemented to address deficiencies.

Policy MS.PRVR.10, Evaluation of the Accessibility of Services, and the Provider Manual outline appointment access standards in compliance with the *2025 DOM Contract*, *Section 6.2.2* for all provider types. The Policy and Provider Manual define the timeframe for routine behavioral health/substance use disorder visits as within 14 calendar days; however, the Member Handbook lists the timeframe as 21 days. Magnolia staff reported that the policy and Provider Manual have been updated but that the Member Handbook has not yet been revised to include the new standard.

Magnolia measures appointment accessibility for primary care, behavioral health, and high-volume/high-impact specialty services at least annually, while also considering member satisfaction survey results and grievance/appeal data. Providers must maintain 90% compliance with appointment access standards; those below this threshold must implement a CAP, followed by re-audit. Persistent non-compliance is escalated to the QIC.

Magnolia's Q1 2025 audit showed compliance rates ranging from 92.8% for pediatric sick visits to 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 and provision of written information regarding appointment access requirements. In addition, Magnolia reported that it is working to develop a quick reference source for provider scheduling staff and expansion of telehealth services.

Magnolia's printed and online Provider Directories include the required elements, which confirms that Magnolia implemented the corrective action from the previous EQR to ensure the printed Provider Directory includes all required information. Magnolia conducts

accuracy audits at least monthly to verify accuracy of provider demographics and conducts usability testing at least every 36 months. The health plan has recently contracted with a vendor to perform routine Provider Directory cleanses to aid in identifying inaccurate provider data, allowing Magnolia to make corrections.

Overall, Magnolia met the requirements of the Network Adequacy Validation. Details of the Network Adequacy Validation can be found in *Attachment 3*.

Magnolia ensures its network can meet the cultural, ethnic, racial, and linguistic needs of members by conducting annual assessments which include collecting and comparing member and provider data. The health plan develops interventions, such as recruiting culturally aligned practitioners and requiring cultural competency training, to address identified gaps. The 2025 Medicaid Cultural Needs and Preferences Analysis identified a low cultural competency training completion rate (26.7%) among network practitioners. Magnolia implemented interventions including adding training resources and an attestation form to its website and conducting live corporate-led training sessions. Magnolia plans to conduct targeted outreach to noncompliant providers by Q1 2026.

Provider Access and Availability Study

Constellation conducts Telephonic Provider Access Studies twice yearly for each CCO. Full details of these call studies are reported to DOM separately. For the most recent study conducted in Q3 2025, a decrease was noted in the overall successful contact rate from the previous study conducted in Q1 2025, as shown in *Table 10*.

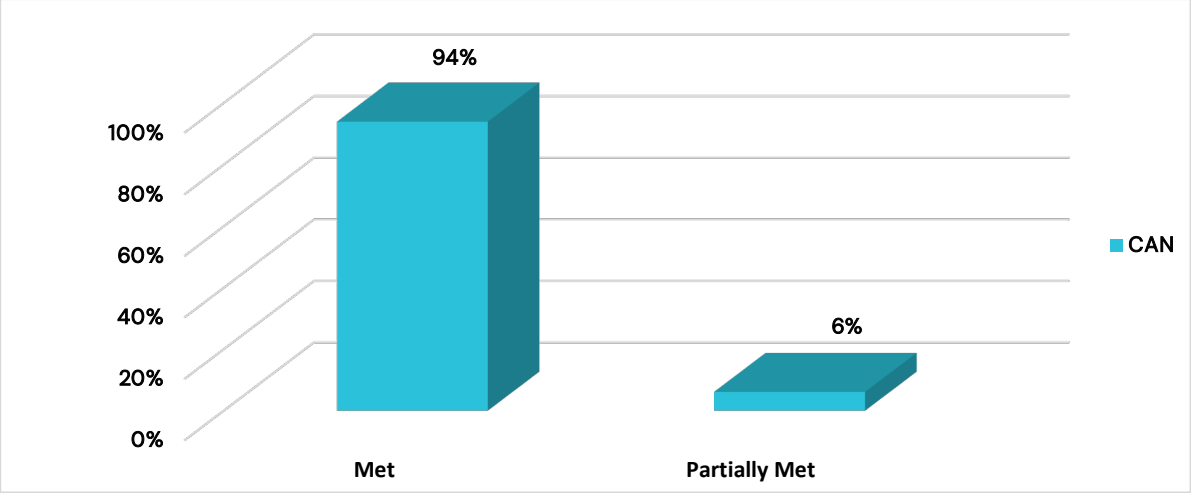
Table 10: Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate
Q3 2025	25 of 94	27%
Q1 2025	53 of 96	55%

For Q3 2025, Magnolia submitted a total of 2,598 unique PCPs and a random sample of 102 was drawn for Phase 1. Of 102 PCPs contacted, eight were answered by voicemail and omitted from the denominator in the success rate formula. After accounting for the voicemail-answered calls, the Phase 1 success rate was 27% (25 of 94). The success rate decreased by 28% from Q1 2025 to Q3 2025. There were 25 attempted PCP provider directory verifications, and the accuracy rate was 32%. The next call study will take place in Q1 2026.

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

Figure 3: Provider Services Findings



Scores were rounded to the nearest whole number.

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

Table 11: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for notifying primary care providers of the members assigned and for providers to verify member enrollment.			✓
Magnolia monitors the status of providers' panels to ensure there are enough providers with open panels to provide appropriate member access.			✓
Geographic access standards for all provider types are appropriately documented in policy, and Magnolia conducts routine monitoring to ensure network adequacy.			✓
Magnolia conducts an annual assessment of members' cultural, ethnic, racial, and linguistic needs and has implemented interventions to increase provider participation in cultural competency training.	✓		✓
Magnolia conducts routine audits of provider compliance with appointment and after-hours access standards and implements interventions to improve compliance with the standards.			✓
Magnolia has recently contracted with a vendor to assist in improving Provider Directory accuracy. Additionally, corporate Provider Directory accuracy audits are conducted and two data coordinators dedicated to Provider Directory accuracy activities were hired.			✓
Magnolia adopts CPGs and PHGs from nationally recognized sources to guide healthcare decision-making.	✓		✓

Table 12: Provider Services Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Magnolia's processes for monitoring provider panel limitations are not addressed in a policy.	*Recommendation: Include the process used for monitoring and tracking provider limitations on panel size in either a newly created policy or in an existing policy.*	✓		✓
Policy MS.PRVR.10, Evaluation of the Accessibility of Services, and the Provider Manual list the provider appointment access standard for routine behavioral health/substance use disorder visits as within 14 calendar days; however, the Member Handbook, page 38, states the timeframe is within 21 calendar days.	*Recommendation: Revise the Member Handbook to reflect the correct timeframe for routine behavioral health/substance use disorder visits, as documented in Policy MS.PRVR.10 and the Provider Manual.*	✓		✓
When comparing documentation of benefits in the Provider Manual and Member Handbook, discrepancies were noted in the benefits information listed for behavioral health services and orthotics and prosthetics.	*Corrective Action Plan: Correct the discrepancies noted above to ensure the Provider Manual and Member Handbook provide correct information about member benefits and related limitations.*			✓
The 2024 EQR found that several hyperlinks to CPGs/PHGs on Magnolia's website did not allow providers to access the specific guidelines. The current review continues to reflect that providers are unable to access several guidelines, specifically: • Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents • Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (second hyperlink) • Practitioner Training (for Substance Abuse Treatment)	*Corrective Action Plan: Revise the hyperlinks to the specified guidelines to ensure providers can access the information.*	✓		✓
Policy MS.QI.13, Medical Record Review, states, "Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re- credentialing."	*Corrective Action Plan: Revise Policy MS. QI.13, Medical Record Review, to remove the incorrect statement that medical record review results are shared with the Credentialing Department to be considered at recredentialing.*	✓		

PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)*						
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						See standards below.
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Magnolia provides PCPs with access to a current panel listing through the secure provider web portal. The panel listing is updated and made available within five business days of receiving the monthly enrollment file from DOM and can be accessed by PCPs at any time. Providers can also verify member eligibility and their member panel by contacting the Provider Services Call Center. Printed copies of the panel listing can be requested from Provider Relations staff. Policy MS.PRVR.01, PCP Member Panel Reports, details the process for ensuring PCPs are informed of the members assigned to their panels.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MS.PRVR.09, Verification of Member Eligibility, outlines processes for providers to verify member eligibility. As noted in the policy, Magnolia must enable verification of member enrollment for both network and out-of-network providers within five business days of receiving the member list. Participating providers can verify member eligibility and enrollment at any time via the secure provider portal. All providers may verify enrollment and eligibility by using the interactive voice response system at any time or

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						contacting a Provider Services Representative during business hours.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Onsite discussion revealed Magnolia monitors provider panel limitations through quarterly geographic access reports that evaluate the network based on both open and closed panels. This was evidenced in the geographic access reports dated 7/26/25 that Magnolia provided for review. Magnolia staff confirmed this process is not addressed in a policy, however. *Recommendation: Include the process used for monitoring and tracking provider limitations on panel size in either a newly created policy or in an existing policy.*
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					The geographic access standard for PCPs documented in Policy MS.CONT.01, Provider Network is compliant with contractual requirements. The Network Analysis (geographic access report) dated 7/26/25 confirms PCP access is evaluated by county using appropriate urban and rural parameters. Magnolia staff confirmed that although the Indian Health Care Providers within Mississippi decline to contract with the health plan, these providers are treated as in-network providers regarding authorization requirements and claim payment.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					The geographic access standards for specialists and other non-PCP providers are documented in Policy MS.CONT.01, Provider Network and are compliant with contractual requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The geographic access report dated 7/26/25 confirms access is evaluated by county using appropriate urban and rural parameters for hospitals, specialists, OB/GYNs, urgent and emergency care providers, DME providers, behavioral health providers, and dialysis providers. Magnolia provided the Dental network analysis dated 10/1/25 which confirms access is evaluated by county using appropriate urban and rural parameters for general and specialty dental providers. This confirms the deficiency from last year's EQR related to dental access parameters was corrected. Policy MS.CONT.01 addresses coverage for services from out-of-network providers and states that if Magnolia cannot satisfy the standard for Federally Qualified Health Centers and Rural Health Centers access, the Plan will allow its Medicaid members to seek care from non-contracted Federally Qualified Health Centers and Rural Health Centers and will reimburse these providers at Medicaid fees. Additionally, the document mentions ensuring access to out-of-state providers for medically necessary services that are not readily available either in the Plan's network or within Mississippi.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					As noted in Policy CC.PRVR.47, Evaluation of Practitioner Availability, Magnolia conducts an annual analysis to identify opportunities for improving the availability of primary, specialty, and behavioral health practitioners. Results are compared against established standards, and deficiencies are analyzed to identify causes. A barrier analysis is conducted to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						address gaps in practitioner availability. Opportunities are identified and prioritized for measures not meeting performance goals, and interventions are implemented to address deficiencies. Examples of interventions include expanding the network, improving scheduling systems, targeting specific specialties or geographic areas for recruitment, and addressing provider dissatisfaction to improve retention. Interventions are evaluated for effectiveness annually and reported separately or as part of the Quality Improvement Program evaluation. Magnolia monitors overall network adequacy annually by analyzing member experience data (e.g., surveys, complaints, appeals, out-of-network service utilization) to identify gaps in geographic access and/or practitioner types. The 2025 Medicaid Practitioner Availability Report for measurement year 2024 states on page 12, "The health plan will continue to recruit, contract with, and credential all available primary care Family/General Medicine, primary care Internal Medicine, and specialty care high-impact Oncology practitioners as new practices enter the service areas." However, Magnolia has not conducted credentialing activities since 2022. This discrepancy was discussed during the onsite review, at which time Magnolia clarified that the 2025 Practitioner Availability Report is produced at the corporate level using standard, templated language and does not reflect Magnolia-specific credentialing activities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability details Magnolia's annual assessment of cultural, ethnic, racial, and linguistic needs, and indicates that Magnolia: • Collects practitioner and member demographic data through various sources to identify gaps. • Links members with practitioners who meet cultural and linguistic preferences and reviews surveys and complaints for improvement opportunities. • Implements interventions such as recruiting culturally aligned practitioners and requiring cultural competency training. The 2025 Medicaid Cultural Needs and Preferences Analysis (June 2025) reported a rising Diversity Index in Mississippi, adequate availability of multilingual providers (primarily Spanish), active use of interpretation services, and minimal related grievances. It identified a low cultural competency training completion rate among network practitioners (26.7%) as an improvement opportunity. The Opportunity Analysis cited limited practitioner language data as a barrier and an opportunity to improve the accuracy of the Find-a-Provider tool. Interventions included launching a Provider Demographic Tool to update language and demographic data and conducting ongoing outreach. During the onsite discussion, Magnolia reported that training resources and an attestation form were recently added to the website, live corporate-led trainings are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						underway, and targeted outreach to non-compliant providers is planned by Q1 2026.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					As noted in Policy CC. PRVR.47, Evaluation of Practitioner Availability, Magnolia implements targeted interventions to improve availability when deficiencies in the network are identified. Interventions can include: • Focusing on specialties or geographic areas with identified gaps by recruiting additional practitioners. • Working with individual practices to enhance appointment availability. • Monitoring provider satisfaction and addressing dissatisfaction to strengthen retention. • Analyzing member experience data to identify gaps and prioritize improvement opportunities. • Measuring and reporting the success of interventions annually.
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					Magnolia maintains complete and usable provider and member data which allows ongoing monitoring of network adequacy. Data submitted through the provider network file supports accurate tracking of provider types, locations, and appointment access. The information is reliable for assessing compliance.
1.10 The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's	X					Policy CC.QI.17, Potential Quality of Care Incidents, describes processes for identifying, investigating, and managing Potential Quality of Care incidents in a confidential manner by clinical personnel. It addresses

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
affiliation with the CCO for serious quality of care or service issues.						methods of identifying potential quality of care incidents, investigation and documentation procedures, assessment of severity levels, Medical Director review, and determination of next steps. Policy MS.PRVR.23, Provider Termination, addresses the provider termination process for serious issues such as fraud, integrity, or quality concerns, and when notified by DOM of a provider's termination. As noted, Magnolia must notify the provider in writing of the reasons for termination and the effective date and send a copy of the notification to DOM within 24 hours.
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy MS.PRVR.10, Evaluation of the Accessibility of Services, and the Provider Manual list the provider appointment access standards in compliance with the *2025 DOM Contract, Section 6.2.2* for all provider types. These documents specify the timeframe for routine behavioral health/substance use disorder visits as within 14 calendar days; however, the Member Handbook, page 38, states the timeframe is within 21 calendar days. During onsite discussion of this finding, Magnolia staff reported that they have updated Policy MS.PRVR.10 and the Provider Manual to reflect the new contract requirement, but the Member Handbook has not yet been revised. *Recommendation: Revise the Member Handbook to reflect the timeframe for routine behavioral health/substance use disorder visits that is documented in Policy MS.PRVR.10 and the Provider Manual.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					Magnolia's process for assessing practitioner compliance with appointment access standards is found in Policy MS.PRVR.10, Evaluation of the Accessibility of Services. As noted, Magnolia "measures appointment accessibility to primary care services, behavioral health providers, high volume and high impact specialty care services at least annually." Magnolia also considers Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results related to appointment access and member grievance and appeal data in the assessment of appointment access. Providers who fail to meet the minimum compliance of 90% with state-defined standards are required to comply with a written CAP. After implementing the CAP and allowing sufficient time for improvement, another audit is conducted to monitor progress. If the provider remains below 90% compliance after the second audit, the case is referred to the QIC for review and recommendations for further action. Magnolia submitted the "MS Magnolia Medicaid Availability Audit Report_Q1_2025" for review. This document includes appointment access standards for PCPs/pediatrics providers, specialists, OBGYNs, and behavioral health providers. Compliance rates for the study ranged from a high of 92.8% for pediatric sick visits to a low of 16% for behavioral health emergent visits. During discussion, Magnolia reported current and ongoing interventions to improve provider compliance with the appointment access standards, including continuous in-person and/or virtual provider education

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and provision of written information regarding appointment access requirements. In addition, Magnolia reported that they are working to develop a quick reference source for provider office scheduling staff and expansion of telehealth services.
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					Magnolia's printed Provider Directory (dated June 2025) includes PCPs, FQHCs, RHCs, specialists, clinics, hospitals, urgent care providers, skilled nursing facilities, behavioral health providers, ancillary providers, dental providers, and vision providers. Both the printed and online Provider Directories include the required elements. This confirms that Magnolia implemented the corrective action from the previous EQR to ensure the printed Provider Directory includes all required information. Policy MS.PRVR.19, Provider Directory, indicates Magnolia updates the web-based directory within 5 business days of changes to the provider network by refreshing the web-based data nightly from the Enterprise Data Warehouse system. The policy also indicates Magnolia ensures accuracy of content by conducting accuracy audits at least monthly to verify accuracy of provider demographics and conducting usability testing at least every 36 months. Additionally, the policy confirms that Provider Directories are available in "State Medicaid Regional offices, in the Plan's office, WIC offices, upon member request, and other areas as directed by the Division."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Policy MS.PRVR.19, Provider Directory, indicates Magnolia ensures Provider Directory accuracy by conducting accuracy audits at least monthly. Onsite discussion revealed Magnolia has contracted with a vendor, Veda, which conducts provider directory cleanses every 60 days using an algorithm to aid in identifying inaccurate provider data, allowing Magnolia to make corrections. Additionally, internal Provider Directory accuracy audits are conducted at the corporate level. Magnolia reported that two data coordinators have been hired and are dedicated to Provider Directory accuracy activities. During the previous EQR, Magnolia mentioned that a website enhancement was under development that would allow providers to update panel sizes and/or limitations, physical and billing addresses, etc. Magnolia reported that this enhancement has been implemented and is currently in use.
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The plan meets adequacy standards. Appointment scheduling timeframes are consistent with state requirements, and supporting documents show valid time, distance, and directory accuracy assessment methods. Combined with high confidence validation from the review, the provider network appears adequate for members' needs.
II B. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Magnolia conducts initial provider orientation within 30 days of joining the network to ensure newly contracted providers receive essential information about the health

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						plan's business practices. Topics included in the orientation are outlined in an attachment to this policy. Magnolia makes provider tool kits available to all newly contracted providers. These are distributed electronically, via email and/or mail and include the Provider Orientation document, Provider Manual and website links, training materials, Provider Representative contact information, etc.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					The 2024 - June 2025 Provider Orientation PowerPoint (Provider Orientation) and the Provider Manual provider information about Care Management and Care Coordination. The Provider Manual comprehensively addresses the Care Management Program and related initiatives, includes information about the 24-Hour Nurse Advice Line and the My Health Pays® Rewards Program, and includes contact information for providers to make referrals to any of these programs.
2.2 Billing and reimbursement practices;	X					The Provider Orientation and Provider Manual cover billing and reimbursement, providing detailed information on clean claims, claim rejection, submission timeframes, dispute processes, balance billing policies, payment policies, coding guidelines, and common billing errors. It also includes contact information for claims submissions, electronic payments, and support for billing-related inquiries.
2.3 Member benefits, including covered services, excluded services, and services		X				The Provider Orientation provides an overview of member benefits, including some covered services and excluded services. For more specific information,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provided under fee-for-service payment by DOM;						providers are encouraged to consult the Medicaid Fee Schedule or contact Magnolia's Provider Services. The Provider Manual includes information about medical, behavioral health, dental, vision, and pharmacy service coverage. The manual also lists non-covered services and information that certain services are provided under fee-for-service payment by DOM. The Provider Manual includes a grid that lists member benefits and any related limitations. When comparing documentation of benefits in the Provider Manual and Member Handbook, discrepancies were noted in the benefits information listed for the following: • Behavioral Health Services – The Member Handbook, page 19, states, "A comprehensive range of services are covered, including substance use disorder treatment, MYPAC services, CSP care management services and PRTF." The Provider Manual, page 21, does not include "CSP care management services." • Orthotics and Prosthetics – The Member Handbook, page 20 states, "No Limit" but the Provider Manual, page 22 states, "Limited to children under 21 years." *Corrective Action Plan: Correct the discrepancies noted above to ensure the Provider Manual and Member Handbook provide correct information about member benefits and related limitations.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					The 2024 - June 2025 Provider Orientation covers the procedure for referral to a specialist and states referrals are not required for CAN members to see a specialist.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual covers the procedure for referral to a specialist and the use of specialists as PCPs.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					The Provider Orientation and/or Provider Manual cover accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments.
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					Both the Provider Orientation and Provider Manual include information about recommended standards of care, including EPSDT screening requirements and services, the My Health Pays Program, and information that providers are required to render medically necessary and appropriate levels of care to members.
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					The responsibility to follow-up with members who are non-compliant with EPSDT screenings and services is addressed in the Provider Manual.
2.8 Medical record handling, availability, retention, and confidentiality;	X					The Provider Orientation addresses medical record handling, availability, retention, and confidentiality under the "Provider Responsibilities" section. The Provider Manual covers medical record handling, availability, retention, confidentiality, and requirements for member and Magnolia access to medical records. It also informs that Magnolia conducts random medical record audits to monitor compliance with documentation standards and assess the quality and appropriateness of services rendered.
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					The Provider Orientation provides information about provider complaints and grievances, claim disputes and State Administrative Hearings for claim appeals, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member appeals/State Fair Hearings. Information about member complaint, grievance, and appeal procedures is included in the Provider Manual. The manual also covers provider complaints and grievances, claim appeals, and State Administrative Hearings.
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The 2024 - June 2025 Provider Orientation informs that Magnolia Health uses Express Scripts as its Pharmacy Benefit Manager and informs that certain drugs require prior authorization for payment approval. It explains how to submit pharmacy prior authorization requests, the availability of an emergency supply of medication, etc. When discussing this finding during the onsite, Magnolia confirmed that the newly updated Provider Orientation correctly indicates Gainwell Technologies is the Pharmacy Benefit Manager. The Provider Manual informs that as of 7/1/24, Gainwell Technologies is the Pharmacy Benefit Manager and that Magnolia follows DOM's Preferred Drug List. The manual addresses requirements for prior authorization of medications and methods to request prior authorization. It informs that a 72-hour emergency supply of medication is available in certain circumstances to avoid interruption or delay in therapy.
2.11 Prior authorization requirements including the definition of medically necessary;	X					Both the Provider Orientation and the Provider Manual address prior authorization requirements and processes and include the definition of medically necessary services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					The Provider Orientation and the Provider Manual cover the roles and responsibilities of PCPs. The Provider Manual covers reassignment of a member to another PCP.
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					As noted in the Provider Orientation, providers are required to notify Magnolia if they can no longer accept new patients or are leaving the network. The Provider Manual informs that providers have the right to limit the number of members included in their panels and that if a PCP wishes to change their declared panel capacity, they must contact Magnolia Provider Services. It states providers must notify Magnolia in writing at least 45 calendar days in advance if they are unable to accept additional members due to reaching their maximum panel size. It further states that providers cannot refuse to treat established patients who become covered under Magnolia, as they are not considered new patients.
2.14 Medical record documentation requirements;	X					Medical record documentation standards are included in the Provider Manual.
2.15 Information regarding available translation services and how to access those services;	X					Information about available translation services and how to access them is included in the Provider Orientation. The Provider Manual provides detailed information about available translation services and how to access them.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					The Provider Orientation addresses provider performance expectations, including an overview of provider responsibilities, obtaining prior authorizations when necessary, coordinating care when referrals are made to Care Management, proper billing and coding, avoiding intentional and unintentional billing errors, complying with appointment access standards, etc. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Manual outlines the responsibilities of providers, including adherence to preventive health and clinical practice guidelines, compliance with UM requirements, and participation in QI activities.
2.17 A description of the provider web portal;	X					The Provider Orientation and Provider Manual include detailed information about accessing the provider web portal, functions available through the portal, and contact information for Provider Services.
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					The Provider Manual states, "Magnolia adheres to the DOM's stipulation that a provider cannot be required to agree to a non-exclusivity requirement, nor can the provider be required to participate in Magnolia's other lines of business, in order to participate in Magnolia's MississippiCAN network."
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					The Provider Manual indicates the Provider Relations Department is responsible for providing ongoing education to providers and their staff. This includes providing updates and training, clarifying policies and procedures, educating providers on claim denial trends, network performance profiling, and individual provider performance profiling, and offering tutorials on using electronic solutions for web authorizations, claims submissions, and checking member eligibility. It notes that providers can contact the Provider Relations Department to schedule training or request additional education. Onsite discussion confirmed that ongoing provider education is not addressed in a policy. Magnolia staff

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reported that they use an internal training guide to ensure training requirements are met. *Recommendation: Create a policy or revise an existing policy to describe processes for ongoing provider education.*
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, and that are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, describes procedures for adopting CPGs and PHGs. The guidelines are research evidence-based guidelines adopted from recognized sources. Board-certified practitioners review and provide advice on the guidelines, with specialist input documented in meeting minutes. If no recognized source is available, Centene's committees assist in sourcing or developing guidelines. Guidelines are updated annually or upon significant new scientific evidence or changes in national standards, followed by review by the Quality Committees.
2. The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members.		X				Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, states the guidelines are distributed to all practitioners who are likely to use them, and that revised guidelines are shared promptly, including with new practitioners if the original distribution has already occurred. New and updated guidelines are disseminated to providers via Magnolia's website, and the Provider Manual either includes links to the full guidelines or notes that they are available on the Plan website or as hard copies upon request. Additional mechanisms for notifying and distributing guidelines include new

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						practitioner orientation materials, provider newsletters, and special mailings. The 2025 Quality Management Program Description states Magnolia distributes the guidelines to providers through multiple channels and makes them available to members upon request. The Provider Manual states providers can access the full list of guidelines on Magnolia's website under the "Practice Guidelines" section. Review confirmed the website allows providers to download a document titled, "2025 Adopted MS Coordinated Care Organization Clinical Practice Guidelines for Physical and Behavioral Health" The document lists specific guidelines related to health conditions/diagnoses along with links to access the guidelines and the guidelines' sources. During the 2024 EQR, the review found that multiple hyperlinks did not allow providers to access the specific guidelines for various reasons, and a corrective action was given to "Revise the hyperlinks to the CPGs and PHGs on Magnolia's website to ensure providers can access the information." The current review continues to reflect that providers are unable to access the specific guidelines as follows: • For "Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents," the hyperlink returns a page that does not include the specified guideline. Instead, the website includes guidelines for medications for alcohol use and opioid use disorders.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The second hyperlink provided for the "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia" returns a different guideline ("Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders"). • For Substance Abuse Treatment, the hyperlink indicated for "Practitioner Training link https://www.samhsa.gov/practitioner-training" returns a message of "Access denied" – "You are not authorized to access this page." *Corrective Action Plan: Revise the hyperlinks to the guidelines specified above to ensure providers can access the information.*
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						Magnolia's adopted guidelines address all of the categories specified in the standards below.
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					Guidelines include the following: • Recommendations for Preventive Pediatric Health Care • Preventive Pediatric Care: 0-21 Years of Age • U.S Preventive Services Task Force Recommendations Pediatric and Adolescent Services Recommendations
3.2 Recommended childhood immunizations;	X					Guidelines include the following: • Immunizations: 0-18 Years of Age Immunization Schedule
3.3 Pregnancy care;	X					Maternal Care, Perinatal Care, and Postpartum Care guidelines are available.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.4 Adult screening recommendations at specified intervals;	X					Guidelines include the following: • Immunizations: ≥19 Years of Age Immunization Schedule
3.5 Elderly screening recommendations at specified intervals;	X					Guidelines include the following: • Immunizations: ≥19 Years of Age Immunization Schedule
3.6 Recommendations specific to member high-risk groups;	X					Guidelines include topics of: • HIV/AIDS • Lead Toxicity • Opioids & Opioid Prescribing • Sickle Cell Disease • Suicide Risk
3.7 Behavioral health.	X					Guidelines include: • Antipsychotic Prescribing for Children and Adolescents • Anxiety/Panic Disorder • Attention Deficit Hyperactivity Disorder, Pediatrics • Autism • Bipolar Disorder • Depression • Opioid Management - Treatment of Opioid Use Disorder • Oppositional Defiant Disorder • Schizophrenia • Substance Abuse Treatment
II D. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.		X				An attachment to Policy MS.QI.13, Medical Record Review, and the Provider Manual define medical record documentation elements. During the 2024 EQR, it was noted that Policy MS.QI.13, Medical Record Review, stated, "Medical record review results are filed in the QI Department and shared with

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Credentialing Department to be considered at the time of re-credentialing." As a result, a recommendation was given to remove this statement, as Magnolia no longer conducts credentialing activities. However, the current review confirmed the statement remains in the policy (page 3, item 13). *Corrective Action Plan: Revise Policy MS. QI.13, Medical Record Review, to remove the incorrect statement that medical record review results are shared with the Credentialing Department to be considered at recredentialing.*
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					As described in Policy MS.QI.13, Medical Record Review, and the Provider Manual, Magnolia assesses provider compliance with medical record documentation standards annually. The goal is for physicians to meet 90% of the requirements for medical record-keeping. Qualified Magnolia employees or contractors conduct the audit using a Medical Record Audit Tool. Preliminary results are reviewed with the provider's office staff, and the provider is notified of final scoring within 15 days of the audit. This notification includes the overall score and any identified areas of deficiency along with a copy of the completed audit tool. Providers scoring below 90% on medical record compliance are re-audited within six months. Cases of continued non-compliance are escalated to determine recommended actions, which may include additional medical record reviews by the Chief Medical Director, referral to the Quality Improvement Committee or Peer Review Committee, and/or termination from Magnolia's network.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						An aggregate summary of medical record audits is presented annually to Magnolia's Quality Improvement Committee. Trends are analyzed to identify plan-wide areas needing improvement, and network-wide or provider-specific education is provided to address these issues. For the 2024 Medical Record Review, 5 clinics were audited. All the clinics had overall scores of 100%. This is an improvement over the 2023 results. Results were reported to the QIC in December 2024. Magnolia reported that Medical Record Reviews are still in progress for 2025. Final analysis and report will be submitted to the Quality Improvement Committee in December 2025 after completion of audits.
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Magnolia's 2024 Provider Satisfaction Survey was conducted by Press Ganey, a NCQA certified survey vendor. A total of 105 valid surveys were completed out of the total sample of 2,250, equating to a 4.7% response rate. This is lower than the previous year's response rate of 5.2%. This is a low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. The overall provider satisfaction score was 79.8%, an improvement over the previous year (75.5%). *Recommendation: Continue efforts to improve the response rate to ensure the results better represent the population of providers.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Survey results were analyzed and summarized in the final report. Magnolia reviewed response patterns, identified limitations, and identified areas for improvement. The plan recommended continued outreach to improve provider engagement, showing that survey data were used to identify potential quality concerns.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					The final report included a full summary of findings, analysis, and recommendations, indicating the survey results are shared internally to support quality monitoring. The documentation demonstrates that results and follow-up actions were compiled and available for leadership review. Results were presented to the Quality Improvement Committee during the December 2024 meeting.

C. Member Services

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

The Member Services functions encompass oversight of policies and procedures, member rights and responsibilities, member education initiatives, preventive health and chronic disease management, grievance processes, and member enrollment and disenrollment activities.

Magnolia's member rights and responsibilities are formally outlined in Policy MS.MBRS.25, Member Rights and Responsibilities. Members are informed of their rights and responsibilities through multiple channels, including the New Member Packet, the Member Handbook, and Magnolia's website. The review confirmed that member rights and responsibilities are consistently and accurately reflected across all materials.

Members receive a comprehensive New Member Packet within 14 days of enrollment. The packet includes required documents such as the Member Handbook, member ID card and Welcome Letter, Benefit Booklet, health plan contact information, website details, required forms, and educational brochures. In addition to required content, Magnolia includes supplemental materials designed to educate members about covered services, available benefits, health incentive programs, enhanced benefits, and how to access care effectively. All member materials are written at or below a sixth grade reading level, as verified by the Flesch-Kincaid Readability Scale, and are formatted using appropriate font size and plain language to promote comprehension and accessibility.

Members are provided with clear instructions on how to establish a relationship with a PCP and a designated Medical Home. New members are directed to select a PCP and schedule an initial preventive care visit before seeking care for illness, reinforcing the importance of preventive services, continuity of care, and appropriate use of the health care system.

The Member Handbook explains how to access the Magnolia Provider Directory, choose or change a PCP, understand covered benefits, request second opinions, and obtain out-of-network services. Definitions and access information for urgent and emergent care are included, along with details regarding pharmacy benefits, limitations, and the Preferred Drug List. Member materials also outline the hours of operation for the Member Services Call Center, which meet contractual requirements, and confirm that the Nurse Advice Line is available 24 hours a day, seven days a week. Members are advised that changes to benefits, services, or providers will be communicated through written notices, Magnolia's website, addendums to the Member Handbook, new member orientations, and other appropriate methods.

The Magnolia Provider Directory is a comprehensive listing of all participating providers and hospitals within Magnolia's network and includes provider addresses, telephone numbers,

and languages spoken. Members may obtain a provider directory by contacting Member Services, picking up a copy at Regional DOM offices, local WIC offices, or the Magnolia Health office. Members may also access the most current version of the provider directory on Magnolia's website.

The Member Services Department serves as a central resource to help members understand how Magnolia operates and how to obtain needed care. Representatives assist members with locating and selecting a PCP, scheduling appointments, replacing member ID cards, requesting new member materials, obtaining information about covered and non-covered services, Care Management, transportation assistance, emergency support, and reporting potential fraud, waste, or abuse.

The Member Services Call Center is accessible by phone or Relay 711 and operates extended business hours, including evenings and weekends, in compliance with contractual requirements. Calls received after normal business hours are automatically routed to Magnolia's 24-hour Nurse Advice Line, which is staffed by registered nurses and available 24 hours a day, seven days a week, including holidays.

Member Services call activity is routinely collected, reviewed, and analyzed to identify trends and opportunities for improvement. When opportunities are identified, corrective action plans are developed and implemented as appropriate.

Magnolia maintains an active Member Advisory Committee, which provides members with an opportunity to share feedback, concerns, and recommendations directly with Member Services staff. Input from this committee supports ongoing improvements to member communications and service delivery.

Both the New Member Packet and the Member Handbook describe PCP selection and emphasize the PCP's role as the primary source of care coordination. Disenrollment procedures are outlined in Policy MS.ELIG.05, Disenrollment, which details required timeframes, points of contact, and specifies that disenrollment requests must be submitted directly to DOM.

Grievances

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

Comprehensive documentation of procedures for receiving, documenting, acknowledging, investigating, and resolving member grievances, including applicable timeframes, is included in a health plan policy. The policy, Member Handbook, Provider Manual, and Magnolia's website appropriately define grievance terminology. The policy outlines who may file a grievance; however, per DOM, a policy revision is needed to align policy language regarding who may file an appeal with federal language in *42 CFR §438.402 (c)*. Magnolia ensures impartial decision-making and requires clinical expertise for grievances involving medical

issues. A grievance tracking system is used to monitor grievances and provides alerts for approaching deadlines. Grievance data and trends are reported quarterly to the Quality Improvement Committee for review and improvement opportunities.

A sample of grievance files was reviewed and for most, no issues were noted. However, findings for the remaining files included:

- In several files, typographic errors related to dates were found in acknowledgement and/or resolution letters. Magnolia staff reported that letters are reviewed prior to mailing.
- In one file, the grievance intake notes did not include specific information about the member's grievance.
- In one file, the member's grievance was related to billing. Grievance staff made three attempts to contact provider to investigate but the attempts were unsuccessful. The grievance was closed as unable to process rather than implementing an extension and continuing attempts to investigate. The member was notified that a provider relations team member would reach out to the facility after closure of the grievance.
- In one file, the member's grievance included three separate issues, but the investigation and resolution only addressed one of the three issues.

Magnolia staff confirmed that PCP changes are handled as if they are complaints and are closed within 24 hours after Call Center Representatives assist the member with selecting a new PCP. If dissatisfaction with the provider is an element, the grievance process is initiated. Magnolia staff reported that practitioner changes due to dissatisfaction are logged and included in grievance analysis and reporting.

Member Satisfaction Survey Validation

Magnolia contracts with Press Ganey, a certified vendor, to conduct the CAHPS adult and child member surveys. Surveys were fielded from March 2025 to May 2025.

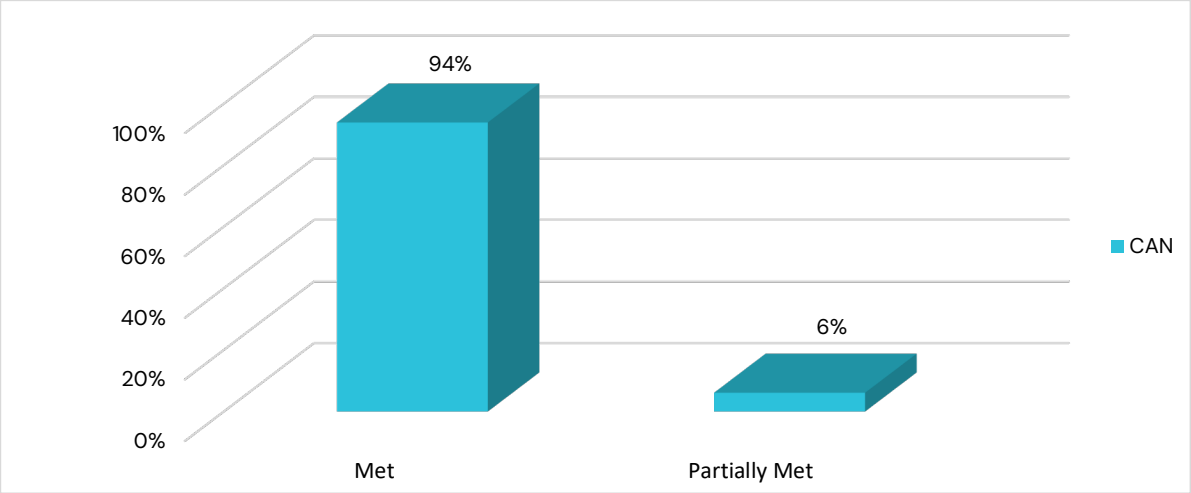
For MY 2024, the adult CAHPs survey had a response rate of 15.5%, which is lower than last year's rate of 16.1%. The largest improvement was in Customer Service, and the largest decline was in Rating of Personal Doctor.

The MY 2024 child CAHPS survey showed an improvement in the response rate to 12.4%, compared to 10.1% the previous year. The largest improvement was in Coordination of Care and the largest decline was in Rating of Specialist.

The child with chronic conditions survey had a response rate of 10.1%, which is higher than last year's rate of 9.3%. The largest increase was for Customer Service, and the largest decline was in Rating of Specialist.

As illustrated in *Figure 4*, Magnolia met 94% of the standards for Member Services for the current EQR.

Figure 4: Member Services Findings



Scores were rounded to the nearest whole number.

Table 13: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members receive a comprehensive New Member Packet within 14 days of enrollment that includes the Member Handbook, ID card, covered services/benefit information, and educational materials about health incentive programs, enhanced benefits, and how to access health care services.	✓	✓	✓
Member materials are written at or below a sixth grade reading level, verified using the Flesch-Kincaid Readability Scale, and formatted with appropriate font and plain language to promote understanding.	✓		✓
Magnolia has an active Member Advisory Committee that allows members an opportunity to share their feedback and thoughts with Member Services staff.	✓	✓	✓
A health plan policy clearly outlines processes for receiving, documenting, acknowledging, investigating, and resolving grievances, including related timeframes.	✓	✓	
Grievance terminology is appropriately defined in policy, the Member Handbook, Provider Manual, and on Magnolia's website.	✓		
Magnolia uses a grievance tracking system that monitors cases from receipt through resolution and provides alerts for approaching deadlines.	✓	✓	
Grievance data, trends, and root causes are summarized and reported quarterly to the Quality Improvement Committee for review and discussion.	✓		

Table 14: Member Services Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MS.MBRS.07, Member Grievance and Complaints Process, defines who can file a grievance. However, DOM staff reported that the policy language should align with the language in *42 CFR §438.402 (c)* and language that legal guardians for minors or incapacitated adults can file a grievance must be removed from the policy.	*Corrective Action Plan: Revise information in Policy MS.MBRS.07, Member Grievance and Complaints Process, to align with in 42 CFR §438.402 (c) by removing language that legal guardians for minors or incapacitated adults can file a grievance.*	✓		
Issues identified during review of sample grievance files were related to typographic errors related to dates in acknowledgement and/or resolution letters, insufficient documentation of the member's grievance at intake, premature closure of a grievance without resolution, and failure to investigate and resolve all issues included in the member's grievance.	*Corrective Action Plan: Conduct training for grievance staff related to reviewing letters for errors prior to mailing, clearly documenting specific information regarding the member's dissatisfaction at intake, use of extensions when appropriate to resolve grievances, and ensuring all issues are included in the investigation and resolution of grievances.*	✓	✓	✓

MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MS.MBRS.025, Member Rights and Responsibilities and Addendum, appropriately detail member rights and responsibilities and the mechanism of communicating these to members.
2. Member rights include, but are not limited to, the right:	X					Magnolia lists the rights members are entitled to receive in the member handbook and on the Magnolia website
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						CC.COMP.04, Confidentiality Policy, defines Magnolia's policies and responsibilities with respect to the use, disclosure, and maintenance of hard copy, electronic or oral communication of confidential information to protect the confidentiality of and to guard against unauthorized access to or disclosure of the same.
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Member responsibilities are outlined in Policy MS.MBRS.25, Member Rights and Responsibilities, and are communicated to members through the New Member Packet, Member Handbook, and the organization's website.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						The Member Handbook explains that certain life changes may affect a member's eligibility with Magnolia. Members are instructed to notify the appropriate eligibility source—such as the local Social Security Administration office, Mississippi Department of Human Services county office, or Regional DOM office—within 10 days of the change or when they become aware of it. Members are also advised to contact Member Services to report the change.
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment	X					Magnolia contracts with a third-party vendor to mail the New Member packet to all new members within 14 calendar days from receipt of enrollment data.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
starts, of all benefits to which they are entitled, including:						
1.1 Full disclosure of benefits and services included and excluded in coverage;						The New Member Packet, which includes the Member Handbook, contains all required components along with additional materials developed by Magnolia to educate members about covered services and available benefits. Members are informed about health incentive programs, enhanced benefits, and how to access health care services.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						Magnolia ensures that female members have direct access to women's health specialists, in addition to access to a Primary Care Provider.
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						The Member Handbook and Magnolia website inform members how to obtain second opinions at no cost from network providers and explain that prior authorization may be required for second opinions from out-of-network providers.
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						New members receive a Welcome to Magnolia Health packet that includes important forms, a quick reference benefits booklet, and the member's MississippiCAN ID card. Covered services and maximum allowable benefits are outlined, and members may contact Magnolia's Member Services department for additional information or clarification.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The Member Handbook and Magnolia website detail requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						Magnolia includes the procedures and restrictions on obtaining out-of-network medical care in the Member Handbook. Members can contact Member Services for assistance if needed.
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook informs that prior authorization is not required for emergent care, urgent care, or post stabilization services. Members may access emergency services 24 hours a day, 7 days a week when the member perceives such services are needed. Member materials also note that the Nurse Advice Line is available 24 hours per day, seven days per week.
1.6 Policies and procedures for accessing specialty/referral care;						Members are informed of policies and procedures for accessing specialists and when such specialists require referrals. The Member Handbook directs Members to contact their PCP or Member Services for additional information.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						Magnolia details the Pharmacy Program, Preferred Drug List, and Emergency Drug Supply within the Member Handbook. The process for obtaining medical equipment and limitations are listed in the benefits grid section of the Member Handbook.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The Member Handbook states that every attempt will be made to inform Members within 30 days of any changes in benefits, services, and/or the provider network as they occur. Members are directed to visit Magnolia's website or call 1-866-912-6285 for the most up-to-date information.
1.9 A description of the member's identification card and how to use the card;						The Member Handbook contains an example of the MississippiCAN ID Card, with an explanation of the information contained on the front and back of the card.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						New members receive an ID card within 14 days of enrollment. Members are asked to always keep their card with them and to show their card when going in for a service covered by Magnolia. Members can obtain a replacement card by contacting member services.
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						The Member Handbook provides contact information and hours of operation for Member Services, along with examples of how Member Services can help members access care. Services include assistance with selecting and scheduling appointments with a PCP, obtaining information on covered and non-covered benefits, and support with emergency issues.
1.13 A description of EPSDT services;						EPSDT services, screenings, and frequencies are listed in the Member Handbook. Members are encouraged to contact the EPDST Coordinator for assistance in accessing these services.
1.14 Procedures for disenrolling from the CCO;						Open enrollment information, including the mechanism for choosing another CCO, is provided in the Member Handbook.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						The Member Handbook describes the availability of and processes for filing grievances, appeals, and State Fair Hearings.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						Information about reporting instances of suspected fraud or abuse is provided in the Member Handbook and on the Magnolia website. Members can contact Magnolia's Waste, Fraud and Abuse Hotline by calling 1-866-685-8664.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						The Member Handbook provides information regarding care management services including how to contact the care management team to receive assistance. Any member who wants a Care Manager will be assigned one.
1.19 Information about advance directives;						Members can complete the Mississippi Advance Health Care Directive Form, found on the Mississippi State Department of Health's website, www.msdh.state.ms.us. Members can also call Member Services at 1-866-912-6285 for assistance in finding the form. Members are encouraged to talk to their PCP about advanced directives.
1.20 Additional information as required by the contract and by federal regulation.						The Member Handbook contains all the required components. New members receive a Welcome to Magnolia Health packet that includes important forms, a quick reference benefits booklet and the member's MississippiCAN ID Card.
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Magnolia provides each of its members with 30 calendar days' written notice of any material change to the MississippiCAN Program before its intended effective date. Magnolia sends a written notice within 15 calendar

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						days of notice or issuance of termination of a provider to members who receive primary care from the provider, who are treated on a regular basis from the provider, or who are affected by the loss of the provider for other reasons. The written notice shall include information about selecting a new provider, and a date after which members who are receiving an ongoing course of treatment cannot use the terminated provider.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Magnolia follows Policy MS.MBRS.06, Member Materials Readability and Translation, when developing member educational materials. This policy is to ensure that member educational materials are written in a clear and concise manner. This includes ensuring material is written at appropriate reading levels and ensuring availability of alternate language translation for threshold and prevalent non-English languages as required by CMS and the Mississippi Division of Medicaid's Limited English Proficiency Policy.
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					The Member Handbook contains information about Magnolia's 24-hour Nurse Advice Line. It is a free service available every day, any time. Experienced nurses can answer health questions, give medical advice, guide care for a sick child, and help schedule PCP appointments.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, details the procedure of summarizing complaint and grievance actions, trends, and root causes and reporting of the analysis quarterly to the QIC. Member reeducation occurs as needed.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					Magnolia confirmed during onsite review that all marketing materials are provided to DOM in accordance with the contract specifications.
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					The Member Services Department is available Monday through Friday from 7:30 a.m. to 5:30 p.m. This department is also available during extended hours every Monday from 5:00 p.m. to 8:00 p.m., and the second weekend of every month from 8:00 a.m. to 5:00 p.m. Member Service Representatives assist members with questions regarding benefits, claims inquiries, eligibility verifications, PCP changes, and requests for new or replacement identification cards.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Call center staff receive training in various tasks including making initial welcome calls, conducting outbound calls to new members, assisting members with selecting a PCP, and responding to general member inquiries.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					The 2024 Quality Management Program Evaluation reported that the call center consistently met or exceeded all key performance metrics, demonstrating a high level of operational efficiency and customer service. The call center's performance throughout the year reflected a strong commitment to meeting contractual obligations and ensuring customer satisfaction.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Members are encouraged to contact Member Services for assistance with selecting a PCP and to obtain a list of network providers.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					The Member Handbook outlines the process for disenrollment. Magnolia will not disenroll members due to health changes, use of medical services, mental capacity, or behavior related to special needs. Some members are required to be in a CCO under MississippiCAN and can switch CCOs within 90 days. Members in an optional category may disenroll from Magnolia with or without cause within 90 days of joining. After 90 days, members stay enrolled until the next open enrollment period.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					The Member Handbook provides detailed information about preventive health services, including preventive health guidelines and EPSDT services. It also addresses the availability of chronic disease management services, such as programs for diabetes, asthma, obesity, hypertension, heart problems, smoking cessation, etc. Members are encouraged to utilize preventive health and chronic disease management services to maintain health.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					The periodic well baby/well child health visit, also known as Early and Periodic Screening, Diagnostic, and Treatment, is the federally funded Medicaid preventive program designed for "at-risk" children. Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System, states the purpose of the program is to ensure that at-risk children have access to early and comprehensive preventive care and treatment. Magnolia monitors a list of children with abnormal findings to ensure follow up action is taken.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Policy MS.CM.05, Population Health Management and Clinical Operations, details how Magnolia promotes member medical self-management through education. Education to members includes modifiable behaviors to improve health outcome, signs of exacerbation or negative change in their condition, when to call the doctor, appropriate condition monitoring and preventive care and the importance of adhering to a prescribed treatment plan.
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					Magnolia contracts with Press Ganey, a certified vendor, to conduct the CAHPS adult and child member surveys. Surveys were fielded from March 2025 to May 2025.
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Magnolia CAHPS results were analyzed to identify performance trends and potential QI opportunities. The final report included analysis of results, discussion of findings and identification of areas for improvement. QIC

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						minutes from August 2025 included documentation of CAHPS improvement strategies.
3. The CCO reports results of the member satisfaction survey to providers.	X					Survey results were communicated to providers through established reporting mechanisms. Documentation supports that member experience findings are shared to promote provider awareness and support QI efforts. The 2025 CAHPS results are available on Magnolia's website.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					Results of the 2025 surveys were reported and discussed during the August 2025 QIC meeting.
III G. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, addresses processes for receiving and responding to member grievances. It includes information about receiving, documenting, and acknowledging grievances, the investigation process, resolution attempts, related timeframes, etc.
1.1 Definition of a grievance and who may file a grievance;		X				Policy MS.MBRS.07, Member Grievance and Complaints Process, appropriately defines the term "grievance" as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The term is also appropriately defined in the Member Handbook, Provider Manual, and on Magnolia's website. Policy MS.MBRS.07, Member Grievance and Complaints Process, states the following parties have the right to file

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						a grievance: members, legal guardians for minors or incapacitated adults, authorized representatives designated in writing by the member, and service providers acting on behalf of the member with the member's written consent. However, the Member Handbook, the Provider Manual, and the website do not mention legal guardians of minors or incapacitated adults. During onsite discussion of this, DOM staff reported that the policy language should align with the language in *42 CFR §438.402 (c)* and that the policy should be revised to remove language that legal guardians for minors or incapacitated adults can file a grievance. *Corrective Action Plan: Revise information in Policy MS.MBRS.07, Member Grievance and Complaints Process, to align with in 42 CFR §438.402 (c) by removing language that legal guardians for minors or incapacitated adults can file a grievance.*
1.2 The procedure for filing and handling a grievance;	X					The review found that Policy MS.MBRS.07, the Member Handbook, the Provider Manual, and Magnolia's website provide correct and appropriate information about grievance filing timeframes, methods, and acknowledgement, and that assistance will be provided in the process as needed.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					Policy MS.MBRS.07, the Member Handbook, the Provider Manual, and Magnolia's website correctly document grievance resolution timeframes and provide appropriate information about extensions of the resolution timeframe.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, states, "Magnolia shall ensure that individuals who make decisions on grievances are not involved in any previous level of review or decision-making. Magnolia shall also ensure that healthcare professionals with appropriate clinical expertise shall make decisions on grievances that involve clinical issues."
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, indicates Magnolia uses a grievance tracking system. Onsite discussion confirmed Magnolia uses Prime, a system that tracks grievances from receipt through resolution and prompts staff when resolution timeframes are approaching. Magnolia staff reported that system-generated logs can be produced and that the grievance staff also use an Excel spreadsheet day-to-day tracking. Magnolia provided an example of the information included in a grievance tracking log that evidenced all required information is captured.
2. The CCO applies the grievance policy and procedure as formulated.		X				A sample of grievance files was reviewed, and for most, no issues were noted. However, findings for the remaining files included: • For several files, typographic errors related to dates were found in acknowledgement and/or resolution letters. Magnolia staff reported that letters are reviewed prior to mailing. • For one file, the grievance intake notes did not include specific information about the member's grievance.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• For one file, the member's grievance was related to billing. Grievance staff made 3 attempts to contact provider to investigate, but the attempts were unsuccessful. The grievance was closed as unable to process rather than implementing an extension and continuing attempts to investigate. The member was notified that a provider relations team member would reach out to the facility after closure of the grievance. • For one file, the member's grievance included three separate issues, but the investigation and resolution only addressed one of the three issues. *Corrective Action Plan: Conduct training for grievance staff related to reviewing letters for errors prior to mailing, clearly documenting specific information regarding the member's dissatisfaction at intake, use of extensions when appropriate to resolve grievances, and ensuring all issues are included in the investigation and resolution of grievances.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, specifies that grievances will be categorized according to NCQA standards, the current CCO Contract, and the current CCO Reporting manuals. It states that summaries of complaint and grievance actions, trends, and root causes are reported quarterly to the Quality Improvement Committee, which reviews them for opportunities to improve the quality of service and care. Review of submitted QIC minutes confirmed review and discussion of grievance data, trends, and actions.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					No issues were identified regarding confidentiality of grievance records.
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					Magnolia staff confirmed that PCP changes are handled as if they are complaints and are closed within 24 hours after Call Center Representatives assist the member with selecting a new PCP. If dissatisfaction with the provider is an element, the grievance process is initiated.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					Magnolia staff reported that practitioner changes due to dissatisfaction are logged and included in grievance analysis and reporting.

D. Quality Improvement

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

The 2025 Quality Management Program Description highlights Magnolia's commitment to providing high-quality, equitable care that meets the diverse needs of its members. It defines the program's goals and objectives, which include improving health outcomes, reducing disparities, enhancing the member experience, supporting providers, and promoting patient safety. The QI Program uses systematic methodologies and advanced data analytics to drive continuous improvement. Its scope encompasses both the quality and safety of clinical care as well as the services delivered to members. The QI Program Description is reviewed and approved by Quality Senior Leadership, the Quality Improvement Committee, and the Board of Directors.

Magnolia has mechanisms to assess the quality and appropriateness of care provided to all members, including those with special health care needs. These activities address physical health, behavioral health, and social health services. Analysis of utilization data is conducted using various sources, such as medical service encounter data and pharmacy reporting, to identify patterns of inappropriate utilization of services. Utilization data is used to support population-based initiatives aimed at improving adherence to preventive health guidelines, such as screenings, immunizations, and early diagnosis of diseases.

Magnolia Quality Work Plan is an annual document that outlines the activities and objectives to be completed by various departments and committees. It is developed based on the previous year's Quality Program Evaluation and includes measurable goals for improving clinical care, service quality, member experience, and cultural responsiveness. The plan specifies accountable individuals, target dates, data collection methods, and evaluation timelines. It is updated quarterly to reflect progress and is reviewed regularly by the QIC. The Work Plan is a dynamic document that ensures alignment with the health plan's needs, accreditation standards, and regulatory requirements.

Magnolia's Board of Directors has ultimate authority and oversight of the Quality Program. It is accountable for ensuring the quality of care and services provided to members. The Board delegates operational authority to the QIC. The QIC oversees all clinical, physical, and behavioral health quality service functions. The QIC is responsible for implementing the QI Program and ensuring continuous enhancement of services. The Chief Medical Director chairs the QIC and oversees the quality activities. Other members of the QIC include the health plan's senior management and clinical staff. Network providers specializing in pediatrics, family medicine, and psychiatry serve as voting members. The committee charter outlines the attendance requirement for voting members as 75% of scheduled meetings. A quorum requires at least five members including three plan staff and two

external physicians. Committee meeting minutes demonstrated the committee met at quarterly intervals.

Magnolia increases provider performance awareness through the Provider Profiling Program and Provider Analytics. These tools use claims data to generate dashboards that give insights into provider performance, including cost, utilization data, peer group comparisons, patient engagement analysis, quality measure trends, and readmissions by disease state. The dashboards are updated monthly and made available electronically via the Provider Web Portal. Providers review these dashboards with a qualified designee to identify barriers, develop improvement strategies, and track progress. Policy MS.QI.23, Provider Profiling Program, documents the process by which Magnolia develops, implements, monitors, and distributes provider profiling reports to providers.

Magnolia tracks provider compliance with EPSDT service provision requirements. Policy MS.QI.20, Early and Periodic Screening, Diagnosis & Treatment (EPSDT) and Well Child Visit Services, includes specific CPT codes for initial hospital or birthing center care for normal newborn infants. These codes are part of the preventive medicine codes used for EPSDT services. Additionally, the policy mentions the "Start Smart Postpartum Packet Mailings," which includes information and schedules for newborn EPSDT visits. The policy includes procedures for monitoring compliance, educating employees, providers, and members, and implementing interventions to improve screening rates. It also details reporting requirements, provider agreements, and follow-up processes for diagnosis and treatment after EPSDT screenings.

The Magnolia Health Quality Management Program Evaluation summarizes the organization's ongoing efforts to enhance healthcare quality, member satisfaction, and health outcomes. Covering activities from January 1 through December 31, 2024, the report highlights key accomplishments, challenges, and recommendations for 2025. The evaluation assesses the quality and safety of clinical care and services provided to members and providers. It offers a comprehensive review of QI activities, including trend analyses, barriers, and outcomes, to identify opportunities for improvement. Recommendations for 2025 emphasize Magnolia's commitment to refining interventions, strengthening provider networks, and expanding member education to address identified challenges and further improve results in the coming year.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation conducted a validation review of the HEDIS, CMS Adult, and CMS Child Core Set measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. Constellation contracts with Aqurate to evaluate the accuracy of the PMs. Aqurate applies the three

activities to support the auditing process per *42 CFR §438.330 (c)* and *§457.1240 (b)*. PM validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS measures and the CMS Adult and Child Core Set measures when calculating the PM rates.

Performance Measure Validation Documentation Requested

Per the contract between Magnolia and DOM, Magnolia was required to submit HEDIS data to NCQA. To ensure the HEDIS rates were accurate and reliable, DOM required Magnolia to undergo an NCQA HEDIS Compliance Audit. Magnolia contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Magnolia 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 and Interactive Data Submission System (IDSS) files, the 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 Magnolia.

Data management process review:

- Review of the health plan's measurement policies and procedures.
- Review of the table and field definitions to ensure the correct data was used to calculate the selected measures.
- Review of the health plan’s standard code mapping used in the calculation of measures.
- Review of the health plan’s policies and procedures for safeguarding confidential information.
- Assessment of compliance with HEDIS technical specifications for calculating and reporting PMs per certified auditor report.

Algorithmic compliance evaluation:

- 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 Magnolia's final audit reports, information systems compliance tools, and IDSS files approved by the NCQA-licensed organizations. In addition, Aqurate conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Aqurate reviews several aspects crucial to the calculation of PM data: data integration, data control, and documentation of PM calculations. The main steps in the validation process include:

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

A scoring worksheet was used to evaluate and validate the HEDIS measures in accordance with CMS's *EQR Protocol 2: Validation of Performance Measures*. This ensures that CCOs accurately calculate and report performance measures in alignment with standardized specifications outlined in the *HEDIS Volume 2 Technical Specifications*.

The validation process includes multiple components—General Measure Elements, Denominator and Numerator Elements, Sampling Methods, and Reporting Standards—using

a structured set of audit elements. Each audit element is assigned a weighted point value based on its importance to overall data validity. Higher-weighted elements (e.g., data source accuracy, documentation, and programming adherence) are worth 10 points, while supporting or supplementary elements (e.g., sampling methodology or hybrid integration techniques) are assigned five points. Scoring is determined based on the criteria in *Table 15*.

Table 15: Audit Element Scoring

Audit Element Scoring	
MET (Fully Met)	Full point value awarded.
PARTIALLY MET	Partial credit awarded—5 points for 10-point elements and 3 points for 5-point elements.
NOT MET	Zero points awarded.

The overall validation score is calculated as a percentage, using the formula: (Total Points Earned ÷ Total Possible Points) × 100. This percentage score determines the Audit Designation. *Table 16* offers an overview of the audit categories and corresponding percentage ranges.

Table 16: Audit Designations based on Performance Measure Validation Results

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.

This scoring framework offers a consistent, transparent, and quantitative method for assessing the accuracy and reliability of reported HEDIS performance measures.

HEDIS Performance Measure Validation

All relevant HEDIS PMs for the current measurement year (MY 2024) and the change from the current to previous year are reported in *Table 17*. Rates shown in green indicate a

substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%).

Table 17: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA)	62.05%	81.70%	19.65%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	56.20%	69.10%	12.90%
Counseling for Nutrition	44.28%	48.91%	4.63%
Counseling for Physical Activity	45.50%	49.88%	4.38%
Childhood Immunization Status (CIS)			
DTaP	71.29%	82.24%	10.95%
IPV	85.40%	92.94%	7.54%
MMR	85.89%	92.70%	6.81%
HiB	81.27%	91.00%	9.73%
Hepatitis B	87.10%	91.00%	3.89%
VZV	85.40%	92.46%	7.06%
Pneumococcal Conjugate	70.07%	82.00%	11.92%
Hepatitis A	78.35%	82.00%	3.65%
Rotavirus	71.29%	75.43%	4.14%
Influenza	19.71%	19.22%	-0.49%
Combination #3	63.26%	77.13%	13.87%
Combination #7	54.74%	62.04%	7.30%
Combination #10	16.30%	15.33%	-0.97%
Immunizations for Adolescents (IMA)			
Meningococcal	53.28%	59.12%	5.84%
Tdap/Td	82.97%	81.51%	-1.46%
HPV	20.68%	22.14%	1.46%
Combination #1	53.04%	58.88%	5.84%
Combination #2	19.95%	20.68%	0.73%
Lead Screening in Children (LSC)	66.63%	72.29%	5.66%
Cervical Cancer Screening (CCS)	47.69%	53.77%	6.08%
Chlamydia Screening in Women (CHL)			
16-20 Years	47.88%	49.02%	1.14%
21-24 Years	58.14%	57.32%	-0.82%
Total	49.41%	50.89%	1.48%
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	18.92%	21.60%	2.68%
Oral Evaluation, Dental Services (3-5)	60.52%	61.30%	0.78%
Oral Evaluation, Dental Services (6-14)	62.75%	63.06%	0.31%

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Oral Evaluation, Dental Services (15-20)	45.77%	46.71%	0.94%
Oral Evaluation, Dental Services (Total)	52.50%	53.61%	1.11%
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	10.06%	10.95%	0.89%
Topical Fluoride for Children (3-4)	19.62%	20.85%	1.23%
Topical Fluoride for Children (Total)	14.56%	15.59%	1.03%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
3-17 Years	82.34%	86.96%	4.62%
18-64 Years	73.55%	79.89%	6.34%
65+ Years	NA	NA	NA
Total	81.37%	86.13%	4.76%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	47.99%	41.79%	-6.20%
Bronchodilator	76.42%	73.80%	-2.62%
Asthma Medication Ratio (AMR)			
5-11 Years	86.69%	86.28%	-0.41%
12-18 Years	74.01%	76.64%	2.63%
19-50 Years	66.89%	69.30%	2.41%
51-64 Years	54.96%	61.46%	6.50%
Total	76.52%	78.40%	1.88%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	54.50%	63.75%	9.25%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	NA
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy - 21-75 years (Male)	75.37%	73.87%	-1.50%
Statin Adherence 80% - 21-75 years (Male)	54.26%	49.84%	-4.42%
Received Statin Therapy - 40-75 years (Female)	72.83%	71.71%	-1.12%
Statin Adherence 80% - 40-75 years (Female)	51.35%	48.45%	-2.90%
Received Statin Therapy - Total	74.05%	72.76%	-1.29%
Statin Adherence 80% - Total	52.77%	49.13%	-3.64%
Cardiac Rehabilitation (CRE)			
Initiation - 18-64 Years	1.78%	3.55%	1.77%
Engagement1 - 18-64 Years	2.37%	5.67%	3.30%
Engagement2 - 18-64 Years	0.59%	3.55%	2.96%
Achievement - 18-64 Years	0.00%	0.00%	0.00%
Initiation - 65+ years	NA	NA	NA
Engagement1 - 65+ Years	NA	NA	NA
Engagement2 - 65+ Years	NA	NA	NA
Achievement - 65+ Years	NA	NA	NA
Initiation – Total	1.76%	3.55%	1.79%

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Engagement1 – Total	2.35%	5.67%	3.32%
Engagement2 - Total	0.59%	3.55%	2.96%
Achievement - Total	0.00%	0.00%	0.00%
Effectiveness of Care: Diabetes			
Glycemic Status Assessment for Patients With Diabetes (GSD) ◇			
*PoorHbA1cControl**	50.85%	35.04%	-15.81%
AdequateHbA1cControl	42.09%	56.93%	14.84%
Eye Exam for Patients With Diabetes (EED) ◇	59.37%	66.67%	7.30%
Blood Pressure Control for Patients With Diabetes (BPD) ◇	61.07%	63.02%	1.95%
Kidney Health Evaluation for Patients With Diabetes (KED) ◇			
Kidney Health Evaluation for Patients With Diabetes (18-64)	19.24%	28.11%	8.87%
Kidney Health Evaluation for Patients With Diabetes (65-74)	18.60%	39.39%	20.79%
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	19.24%	28.19%	8.95%
Statin Therapy for Patients with Diabetes (SPD) ◇			
Statin Therapy for Patients With Diabetes - Received Statin Therapy	62.06%	61.89%	-0.17%
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	52.36%	48.47%	-3.89%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (DMH)			
1-17	29.91%	32.78%	2.87%
18-64	38.80%	40.79%	1.99%
65+	32.62%	26.38%	-6.24%
Total	32.51%	35.08%	2.57%
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	51.80%	54.59%	2.79%
Effective Continuation Phase Treatment	31.52%	34.34%	2.82%
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	68.53%	66.92%	-1.61%
6-17 years - 7-Day Follow-Up	41.96%	41.33%	-0.63%
18-64 years - 30-Day Follow-Up	51.67%	55.46%	3.79%
18-64 years - 7-Day Follow-Up	32.38%	33.89%	1.51%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	62.46%	63.46%	1.00%
7-Day Follow-Up	38.53%	39.08%	0.55%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
6-17 years - 30-Day Follow-Up	64.64%	57.89%	-6.75%
6-17 years - 7-Day Follow-Up	46.41%	42.11%	-4.30%
18-64 years - 30-Day Follow-Up	37.26%	45.79%	8.53%
18-64 years - 7-Day Follow-Up	23.89%	32.66%	8.77%

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	47.27%	50.51%	3.24%
Total- 7-Day Follow-Up	32.12%	36.34%	4.22%
Diagnosed Substance Use Disorders (DSU)			
Alcohol (Total)	1.36%	1.29%	-0.07%
Opioid (Total)	1.14%	1.13%	-0.01%
Other (Total)	2.88%	2.93%	0.05%
Any (Total)	4.52%	4.51%	-0.01%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
30 days (13-17)	NA	NA	NA
7 Days (13-17)	NA	NA	NA
30 days (18-64)	38.34%	43.75%	5.41%
7 Days (18-64)	27.98%	33.13%	5.15%
30 days (65+)	NA	NA	NA
7 Days (65+)	NA	NA	NA
7 days (Total)	36.27%	41.14%	4.87%
30 days (Total)	26.47%	30.29%	3.82%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
30-Day Follow-Up: 13-17 Years	20.59%	20.63%	0.04%
7-Day Follow-Up: 13-17 Years	13.24%	11.11%	-2.13%
30-Day Follow-Up: 18+ Years	23.90%	26.45%	2.55%
7-Day Follow-Up: 18+ Years	14.47%	19.57%	5.10%
30-Day Follow-Up: Total	23.32%	25.37%	2.05%
7-Day Follow-Up: Total	14.25%	17.99%	3.74%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	24.70%	20.44%	-4.26%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	24.70%	20.44%	-4.26%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD) ◇	74.63%	75.97%	1.34%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) ◇	73.22%	79.95%	6.73%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	76.79%	85.11%	8.32%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) ◇	55.43%	56.65%	1.22%
Effectiveness of Care: Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 Months-17 Years	73.31%	72.97%	-0.34%
18-64 Years	58.67%	58.87%	0.20%
65+ Years	NA	NA	NA

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Total	71.67%	71.28%	-0.39%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
3 Months-17 Years	51.59%	52.64%	1.05%
18-64 Years	41.22%	40.69%	-0.53%
65+ Years	NA	NA	NA
Total	49.99%	50.85%	0.86%
Use of Imaging Studies for Low Back Pain (LBP) ◇	70.82%	68.22%	-2.60%
Use of Opioids at High Dosage (HDO) *	0.98%	0.79%	-0.19%
Use of Opioids from Multiple Providers (UOP) *			
Multiple Prescribers	12.44%	13.05%	0.61%
Multiple Pharmacies	2.15%	1.08%	-1.07%
Multiple Prescribers and Multiple Pharmacies	1.06%	0.50%	-0.56%
Risk of Continued Opioid Use (COU) *			
18-64 years - >=15 Days covered	6.16%	8.34%	2.18%
18-64 years - >=31 Days covered	2.32%	2.95%	0.63%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	6.16%	8.35%	2.19%
Total - >=31 Days covered	2.32%	2.97%	0.65%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20-44 Years	81.07%	84.68%	3.61%
45-64 Years	88.06%	89.22%	1.16%
65+ Years	72.32%	67.24%	-5.08%
Total	83.89%	86.38%	2.49%
Initiation and Engagement of AOD Dependence Treatment (IET)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	65.96%	72.50%	6.54%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%	0.00%	0.00%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	65.96%	64.92%	-1.04%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.26%	5.90%	1.64%
Total: Initiation of AOD Treatment: 13-17 Years	66.17%	65.63%	-0.54%
Total: Engagement of AOD Treatment: 13-17 Years	3.56%	5.11%	1.55%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	42.93%	38.76%	-4.17%
Alcohol abuse or dependence:	3.26%	6.59%	3.33%

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Engagement of AOD Treatment: 18+Years			
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	36.54%	34.71%	-1.83%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	14.29%	16.94%	2.65%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	42.83%	38.88%	-3.95%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.85%	7.52%	2.67%
Total: Initiation of AOD Treatment: 18+ Years	41.82%	38.25%	-3.57%
Total: Engagement of AOD Treatment: 18+ Years	5.93%	8.58%	2.65%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	44.67%	41.19%	-3.48%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	3.00%	6.12%	3.12%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	37.54%	35.34%	-2.20%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	13.92%	16.47%	2.55%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	48.08%	45.31%	-2.77%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.71%	7.12%	2.41%
Total: Initiation of AOD Treatment: Total	45.63%	42.97%	-2.66%
Total: Engagement of AOD Treatment: Total	5.55%	7.99%	2.44%
Prenatal and Postpartum Care (PPC) ◇			
Timeliness of Prenatal Care Under 21 (Admin only rate)	80.75%	83.41%	2.67%
Postpartum Care Under 21 (Admin only rate)	52.62%	57.21%	4.59%
Timeliness of Prenatal Care Over 21 (Admin only rate)	81.38%	85.76%	4.38%
Postpartum Care Over 21 (Admin only rate)	52.62%	59.08%	6.46%
Timeliness of Prenatal Care (Total per IDSS)	92.46%	95.62%	3.16%
Postpartum Care (Total per IDSS)	75.18%	73.48%	-1.70%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) ◇			
1-11 years	58.94%	63.60%	4.66%
12-17 years	63.06%	64.76%	1.70%
Total	61.46%	64.31%	2.85%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	58.08%	61.44%	3.36%
15 Months-30 Months	70.23%	72.21%	1.98%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	46.15%	49.84%	3.69%
12-17 Years	40.67%	43.98%	3.31%
18-21 Years	21.06%	23.28%	2.22%

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Total	41.92%	45.38%	3.46%
Antibiotic Utilization for Respiratory Conditions (AXR)			
3m–17	40.29%	43.27%	2.98%
18–64	33.49%	37.21%	3.72%
65+	13.95%	17.50%	3.55%
Total	39.18%	42.30%	3.12%
Plan All-Cause Readmissions (PCR-AD) ◇◇			
Observed Readmission Rate	13.62%	12.95%	-0.68%
Expected Readmission Rate	11.14%	9.20%	-1.94%
*Observed/Expected (O/E) Ratio **	1.22%	1.41%	0.18%
Outlier Rate	67.13	78.37	11.24
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%	-
The percentage of children and adolescents on antipsychotics who received cholesterol testing.	-	30.38%	-
The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	-	28.04%	-
Colorectal Cancer Screening (COL-E)			
46–50	-	29.75%	-
51–75	-	49.34%	-
Total	-	45.16%	-
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)			
Initiation	-	57.37%	-
Continuation	-	66.37%	-
Breast Cancer Screening (BCS-E)	51.34%	54.20%	2.86%
Adult Immunization Status (AIS-E)			
Influenza 19–65	11.12%	11.83%	0.71%
Influenza 65+	13.10%	12.12%	-0.97%
Influenza Total	11.12%	11.83%	0.71%
TdTdap 19–65	24.50%	30.27%	5.77%
TdTdap 65+	14.29%	16.67%	2.38%
TdTdap Total	24.47%	30.24%	5.76%
Zoster 50–65	1.50%	3.02%	1.52%
Zoster 66+	3.57%	4.55%	0.97%
Zoster Total	1.52%	3.03%	1.51%
Pneumococcal 66+	13.10%	25.76%	12.66%
Postpartum Depression Screening and Follow-Up (PDS-E) ◇			
Screening: Under 21∞	-	3.09%	-
Follow-up: Under 21∞	-	NA	-
Screening: Over 21∞	-	3.01%	-

Measure/Data Element	HEDIS MY 2023 CAN Rates	HEDIS MY 2024 CAN Rates	Change
Follow-up: Over 21∞	-	NA	-
Screening: As reported in IDSS∞	-	3.02%	-
Follow-up: As reported in IDSS∞	-	51.43%	-
Prenatal Immunization Status (PRS-E) ⋄			
Influenza: Under 21∞	-	6.48%	-
Tdap: Under 21∞	-	26.08%	-
Combination: Under 21∞	-	3.55%	-
Influenza: Over 21∞	-	8.32%	-
Tdap: Over 21∞	-	26.35%	-
Combination: Over 21∞	-	5.31%	-
Influenza: As reported in IDSS	6.89%	7.97%	1.09%
Tdap: As reported in IDSS	22.28%	26.30%	4.03%
Combination: As reported in IDSS	3.56%	4.97%	1.42%

NA: 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 year rate for health plan was not reported.

As shown in *Table 17*, the following measures showed a substantial improvement for the CAN population:

- Adult BMI Assessment (ABA)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI Percentile indicator
- Childhood Immunization Status (CIS): the DTaP, Pneumococcal Conjugate, and Combination #3 indicators
- Glycemic Status Assessment for Patients With Diabetes (GSD): Poor HbA1c Control and Adequate HbA1c Control indicators
- Kidney Health Evaluation for Patients With Diabetes (KED): 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. 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.

No measures showed a substantial decrease in the rate.

CMS Core Set Measure Validation – CAN

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2024 and the previous year (MY 2023). The change from 2023 to 2024 is reported in the following table. Rate changes shown in green indicate a substantial (>10%) improvement, and rate changes shown in red indicate a substantial (>10%) decline.

Table 18: CAN CMS Core Set Measure Rates

Measure	MY 2023 CAN Rate	MY 2024 CAN Rates	Change
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	-
Ages 65 +	-	150.04	-
Total	-	238.85	-
Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD) ∞	-	0.86%	-
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception – 3 days	12.66%	12.72%	0.06%
Most or moderately effective contraception – 90 days	51.64%	53.83%	2.20%
LARC - 3 Days	0.61%	0.67%	0.06%
LARC - 90 Days Reported	11.35%	12.01%	0.66%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception rate	24.69%	30.90%	6.21%
LARC rate	2.92%	4.67%	1.75%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *			
Ages 18 - 64	27.16	26.67	-0.49
Ages 65+	NA	NA	NA
Total	27.07	26.60	-0.47
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) *			
Ages 40 - 64	57.01	48.84	-8.17
Ages 65+	106.72	75.02	-31.70
Total	57.43	49.02	-8.41
HEART FAILURE ADMISSION RATE (PQI-08) *			
Ages 18 - 64	45.82	46.68	0.86
Ages 65+	0	225.06	225.06
Total	45.66	47.14	1.48
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) *			

Measure	MY 2023 CAN Rate	MY 2024 CAN Rates	Change
Ages 18 - 39	1.87	0.94	-0.93
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	39.30%	40.77%	1.47%
Ages 65+	NA	NA	NA
Total	38.94%	40.23%	1.29%
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) *			
Ages 18 - 64	1.01%	0.78%	-0.23%
Ages 65+	NA	NA	NA
Total	1.01%	0.78%	-0.22%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) *			
Ages 18 - 64	3.24%	2.92%	-0.32%
Ages 65+	NA	NA	NA
Total	3.22%	2.91%	-0.31%
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-64	0.64%	0.74%	0.09%
Ages 65+	3.63%	3.09%	-0.54%
Total	0.67%	0.75%	0.08%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *			
Ages 18 - 64	73.20%	56.58%	-16.62%
Ages 65+	NA	NA	NA
Total	73.21%	56.63%	-16.59%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	45.78%	44.59%	-1.19%
Prescription for Buprenorphine	40.25%	38.77%	-1.48%
Prescription for Oral Naltrexone	0.97%	0.97%	0.00%
Prescription for Long-acting, injectable naltrexone	0.14%	0.00%	-0.14%
Prescription for Methadone	4.98%	5.65%	0.68%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	NR	NR	NR
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	NR	NR	NR
Discussed or Recommended Cessation Medications: Ages 18 to 64	NR	NR	NR
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	NR	NR	NR
Percentage of Current Smokers and Tobacco Users: Age 65 and Older	NR	NR	NR
Advising Users to Quit: Age 65 and Older	NR	NR	NR
Discussing Cessation Medications: Age 65 and Older	NR	NR	NR
Discussing Cessation Strategies: Age 65 and Older	NR	NR	NR
Percentage of Current Smokers and Tobacco Users: Total	NR	NR	NR
Advising Users to Quit: Total	NR	NR	NR

Measure	MY 2023 CAN Rate	MY 2024 CAN Rates	Change
Discussing Cessation Medications: Total	NR	NR	NR
Discussing Cessation Strategies: Total	NR	NR	NR
Percentage of Current Smokers and Tobacco Users: Total	NR	NR	NR
Child Core Set Measures			
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	1.58%	1.32%	-0.26%
Primary Care Access and Preventative Care			
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	6.33%	5.23%	-1.10%
Age 2 Screening	6.61%	5.64%	-0.97%
Age 3 Screening	4.95%	5.33%	0.38%
Total Screening	6.06%	5.36%	-0.70%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	1.67%	3.78%	2.12%
Most or moderately effective contraception – 90 days	57.62%	60.28%	2.66%
LARC - 3 Days	0.48%	1.89%	1.42%
LARC - 90 Days Reported	15.95%	13.95%	-2.00%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	28.66%	28.95%	0.29%
LARC Rate	2.28%	2.45%	0.16%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	51.56%	52.01%	0.45%
Numerator 2 All Four Molars Sealed	35.41%	36.97%	1.57%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.77%	1.53%	0.76%
Ages 1-2	21.89%	25.42%	3.52%
Ages 3-5	57.69%	59.31%	1.63%
Ages 6-7	63.32%	64.23%	0.91%
Ages 8-9	63.51%	64.67%	1.16%
Ages 10-11	62.12%	62.91%	0.79%
Ages 12-14	56.85%	57.08%	0.23%
Ages 15-18	45.81%	46.81%	1.00%
Ages 19-20	27.24%	27.86%	0.62%
Total Ages <1-20	49.66%	51.47%	1.82%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			

Measure	MY 2023 CAN Rate	MY 2024 CAN Rates	Change
Ages 1-2	11.42%	12.72%	1.30%
Ages 3-5	27.25%	28.48%	1.23%
Ages 6-7	31.40%	32.59%	1.19%
Ages 8-9	30.69%	32.69%	2.00%
Ages 10-11	29.29%	30.88%	1.59%
Ages 12-14	25.91%	26.07%	0.16%
Ages 15-18	18.22%	18.60%	0.38%
Ages 19-20	7.39%	6.82%	-0.57%
Total Ages 1-20	23.87%	24.96%	1.09%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	6.06%	7.47%	1.40%
Ages 3-5	25.56%	27.29%	1.73%
Ages 6-7	30.62%	32.33%	1.71%
Ages 8-9	30.16%	32.58%	2.41%
Ages 10-11	28.94%	30.77%	1.83%
Ages 12-14	25.33%	25.90%	0.57%
Ages 15-18	17.81%	18.47%	0.67%
Ages 19-20	7.06%	6.82%	-0.24%
Total Ages 1-20	22.70%	24.16%	1.46%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	4.02%	3.90%	-0.12%
Ages 3-5	0.42%	0.32%	-0.09%
Ages 6-7	0.01%	0.01%	0.00%
Ages 8-9	0.00%	0.02%	0.02%
Ages 10-11	0.00%	0.01%	0.01%
Ages 12-14	0.00%	0.05%	0.05%
Ages 15-18	0.00%	0.01%	0.01%
Ages 19-20	0.00%	0.00%	0.00%
Total Ages 1-20	0.47%	0.45%	-0.02%
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	-	27.60%	-

NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not Required; BR: Biased Rate; NR: Not Reported
**: 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.

For the CAN CMS Core Set measures, two measures demonstrated a significant increase in rate. Those include:

- 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.

A substantial decrease in the rate was noted in one measure. This measure was:

- Heart Failure Admission Rate (PQI-08), Ages 65+ indicator. This is an inverse measure where lower rate shows better performance. However, the numerator was 0 for MY 2023 and 3 for MY 2024 and the rate change should be reviewed with caution.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

Each CCO is required to submit the PIPs they have conducted during the preceding 12 months to Constellation for validation. For the 2025 EQR, Magnolia submitted the PIPs listed in *Table 19*.

Table 19: 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.

Technical Methods for Data Collection and Validation

PIP validation was conducted in accordance with CMS's *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

Constellation validates and scores the submitted PIPs using the CMS-designed protocol and proprietary worksheets to evaluate the validity and confidence in the results of each project. The proprietary worksheets were developed based on the requirements included in *Protocol 1*, which include the two activities displayed in *Table 20*.

Table 20: Constellation's PIP Validation Activities per CMS Protocol

Activity One: Assess the PIP Methodology		
Step	**Description**	**Step Questions**
1	Review the Selected PIP Topic(s)	Are the selected PIP topic(s) appropriate?
2	Review the PIP Aim Statement	How appropriate and adequate is the aim statement?
3	Review the Identified PIP Population	Did the Plan clearly identify the population for the PIP in relation to the PIP aim statement?
4	Review Sampling Methods	Are the sampling methods appropriate and will they produce valid and reliable results?
5	Review the Selected PIP Variables and Performance Measures	Do the selected variables identify the Plan's performance on the PIP questions objectively and reliably and use clearly defined indicators of performance?
6	Review Data Collection Procedures	Are the procedures the Plan used to collect the data that inform the PIP measurement valid and reliable?
7	Review Data Analysis and Interpretation of PIP Results	Were appropriate techniques used, and were the analysis and interpretation of PIP results accurate?
8	Assess Improvement Strategies	Did the Plan apply appropriate interventions for achieving improvement?
9	Assess the Likelihood that Significant and Sustained Improvement Occurred	What is the likelihood that significant and sustained improvement occurred as a result of the PIP?
Activity Two: Perform Overall Validation and Reporting of PIP Results		
1	Perform Validation	Using the worksheet, score steps in Activity 1 to answer: Were the steps considered met, partially met, or not met? Which category does the overall PIP validation score fall into: High Confidence, Confidence, Low Confidence, or Not Credible?
2	Report Results	Are recommendations and/or corrective actions documented in the PIP validation worksheet and the CCO's annual report?

The PIP validation process follows a structured, nine-step methodology designed to ensure accuracy, reliability, and meaningful healthcare improvements. Each PIP is systematically reviewed to assess topic selection, aim statement clarity, population identification, sampling

methods, PMs, data collection, analysis, intervention strategies, and sustainability of improvement. This comprehensive approach evaluates the methodological soundness of each project, ensuring that findings are free from bias and capable of supporting data-driven decision-making.

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

The final validation score determines the level of confidence in the reported findings (refer to *Table 21*). Projects scoring 90 to 100% are classified as High Confidence, indicating strong methodological integrity with minimal documentation concerns. A Confidence rating between 70 and 89% suggests minor issues that introduce slight bias but do not compromise overall results. A Low Confidence rating between 60 to 69% signals major deviations from established methods that may impact data integrity, while projects scoring below 60% are deemed Not Credible, indicating significant flaws that prevent validation of the reported outcomes.

Table 21: 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.*

Overview of PIP Validation Results

The following tables provide a summary of the validation results, project performance over time, and interventions for each of the PIPs. An arrow pointing up (↑) indicates that project's performance on the measure is improving. A down arrow (↓) indicates the project's performance on the measure is declining. Green cells indicate a statistically significant improvement in

performance. Yellow cells indicate a statistically significant decline in performance. Cells without highlighting indicate the change was not statistically significant.

PIP VALIDATION RESULTS

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

Table 22: PIP Performance Findings

PIP Topic	Validation Score	Performance Measure	Performance Measure Results							
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)	R5 (MY)	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 appropriate spirometry testing to confirm the diagnosis.	28.4% (2019)	36.8%	26.5% ↓ (2020)	21.8% ↓ (2021)	22.3% ↑ (2022)	24.5% ↑ (2023)	N/A	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)
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)	NA	NA	NA	NA	NA	NA	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; R6 – Remeasurement 6; N/A = not applicable as no measurement has been conducted

Table 23: PIP Interventions

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 robo-calls to non-adherent members • Care management outreach for high-risk members
FUH – Mental Health Hospitalization Follow-up
• Transition of care (TOC) 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

Details of the validation activities for the performance measures and PIPs, and specific outcomes related to each activity, may be found in *Attachment 3*.

For the 2025 EQR, 100% of the standards received a "Met" score in the Quality Improvement section of the review, as noted in *Figure 5*. Strengths, weaknesses, and recommendations are noted in the tables that follow.

Figure 5: Quality Improvement Findings

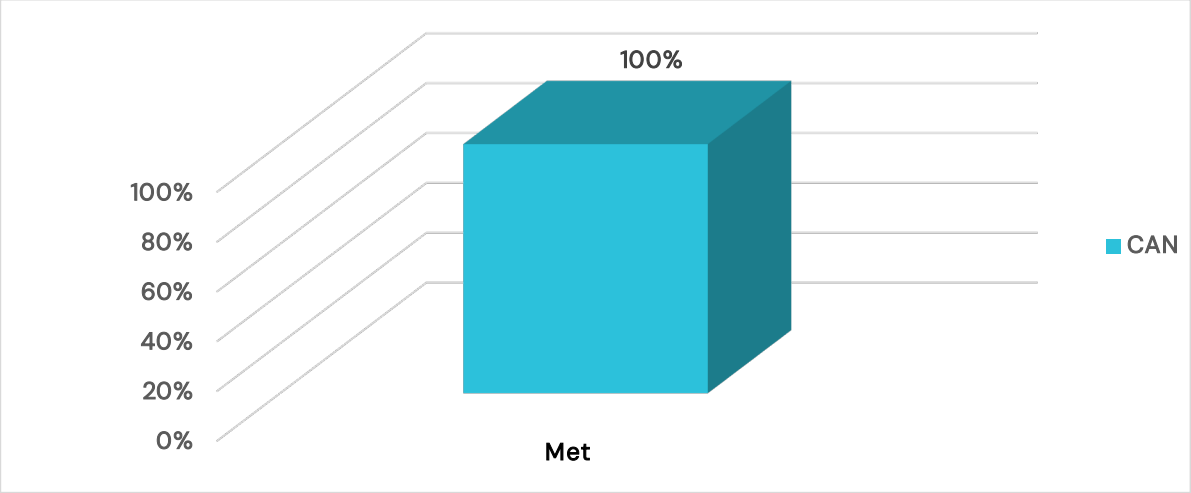


Table 24: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Magnolia's QI Program is designed to improve health outcomes, reduce disparities, enhance member experience, support providers, and promote patient safety.	✓		
The program includes 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.	✓		
Magnolia Health's Quality Work Plan is a dynamic, annually updated document that outlines measurable goals, accountable individuals, target dates, data collection methods, and evaluation timelines.	✓		
Providers actively participate in QI activities through the Provider Profiling Program and Provider Analytics, which offer insights into performance and support improvement strategies.	✓		
The QI Program undergoes annual evaluation to assess its effectiveness, identify opportunities for improvement, and refine interventions to enhance healthcare quality and member satisfaction.	✓		
Magnolia was fully compliant with all IS Standards and it was determined that Magnolia submitted valid and reportable rates for all measures in scope of the audit.	✓		

Table 25: Quality Improvement Weaknesses, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) was not reported administratively as required by DOM. The plan reported it using only the survey method.	*Recommendation: Plan must review requirements and report measures as required for submission by DOM.*	✓		

QUALITY IMPROVEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The 2025 Quality Management Program Description highlights Magnolia's commitment to providing high-quality, equitable care that meets the diverse needs of its members. It defines the program's goals and objectives, which include improving health outcomes, reducing disparities, enhancing the member experience, supporting providers, and promoting patient safety. The QI Program uses systematic methodologies and advanced data analytics to drive continuous improvement. Its scope encompasses both the quality and safety of clinical care as well as the services delivered to members. The QI Program Description is reviewed and approved by Quality Senior Leadership, the Quality Improvement Committee, and the Board of Directors.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Magnolia has mechanisms to assess the quality and appropriateness of care provided to all members, including those with special health care needs. These activities address physical health, behavioral health, and social health services.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Data analysis of utilization data is conducted using various sources, such as medical service encounter data and pharmacy reporting, to identify patterns of inappropriate utilization of services. Utilization data is used to support population-based initiatives aimed at improving

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						adherence to preventive health guidelines, such as screenings, immunizations, and early diagnosis of diseases.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					Magnolia Health's Quality Work Plan is an annual document that outlines the activities and objectives to be completed by various departments and committees. It is developed based on the previous year's Quality Program Evaluation and includes measurable goals for improving clinical care, service quality, member experience, and cultural responsiveness. The plan specifies accountable individuals, target dates, data collection methods, and evaluation timelines. It is updated quarterly to reflect progress and is reviewed regularly by the Quality Improvement Committee. The Work Plan is a dynamic document that ensures alignment with the health plan's needs, accreditation standards, and regulatory requirements.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia's Board of Directors has ultimate authority and oversight of the Quality Program. It is accountable for ensuring the quality of care and services provided to members. The Board delegates operational authority to the QIC. The QIC oversees all clinical, physical, and behavioral health quality service functions. The QIC is responsible for implementing the QI Program and ensuring continuous enhancement of services.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Director chairs the QIC and oversees the quality activities. Other members of the QIC include the health plan's senior management staff, and clinical staff. Network providers specializing in pediatrics, family

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medicine, and psychiatry serve as voting members. The committee charter outlines the attendance requirements for voting members as members must attend 75% of scheduled meetings. A quorum requires at least five members including three plan staff and two external physicians.
3. The QI Committee meets at regular intervals.	X					Committee meeting minutes demonstrated the committee met at quarterly intervals.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes of committee meetings are drafted and distributed within 30 business days.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the PM rates. Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) was not reported administratively as required by DOM. The plan reported it using only the survey method. *Recommendation: Plan must review requirements and report measures as required for submission by DOM.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					Four PIPs were submitted. The rationale for measures selected was discussed and showed that they were aimed at addressing priority health issues pertinent to the population.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					The study designs adhered to CMS protocol with clear aims, baseline data, interventions, and ongoing measurements, which include statistical testing of improvements.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					The provider agreement requires providers to participate in and comply with Magnolia's QI program.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Magnolia increases provider performance awareness through the Provider Profiling Program and Provider Analytics. These tools use claims data to generate dashboards that provide insights into provider performance, including cost, utilization data, peer group comparisons, patient engagement analysis, quality measure trends, and readmissions by disease state. The dashboards are updated monthly and made available electronically via the Provider Web Portal. Providers review these dashboards with a qualified designee to identify barriers, develop improvement strategies, and track progress. Policy MS.QI.23, Provider Profiling Program, documents the process by which Magnolia develops, implements, monitors, and distributes provider profiling reports to providers.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines, addresses the development, adoption, revision, and performance monitoring conducted for the clinical and preventive practice guidelines. Annually, Magnolia monitors practitioner adherence to these guidelines through review of HEDIS measures.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					Policy MS.QI.20, Early and Periodic Screening, Diagnosis & Treatment (EPSDT) and Well Child Visit Services, includes specific CPT codes for initial hospital or birthing center care for normal newborn infants. These codes are part of the preventive medicine codes used for EPSDT services. Additionally, the policy mentions the "Start Smart Postpartum Packet Mailings," which include information and schedules for newborn EPSDT visits.
4.2 EPSDT screenings and results;	X					Policy MS.QI.20, Early and Periodic Screening, Diagnosis & Treatment (EPSDT), and Well Child Visit Services outlines Magnolia Health's process for providing EPSDT and Well Child Visit services to Medicaid recipients. The policy includes procedures for monitoring compliance, educating employees, providers, and members, and implementing interventions to improve screening rates. It also details reporting requirements, provider agreements, and follow-up processes for diagnosis and treatment after EPSDT screenings.
4.3 Diagnosis and/or treatment for children.	X					Included in policy MS.QI.20, Early and Periodic Screening, Diagnosis & Treatment (EPSDT), and Well Child Visit Services.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					The Magnolia Health Quality Management Program Evaluation summarizes the organization's ongoing efforts to enhance healthcare quality, member satisfaction, and health outcomes. Covering activities from January 1 through December 31, 2024, the report highlights key

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						accomplishments, challenges, and recommendations for 2025. The evaluation assesses the quality and safety of clinical care and services provided to members and providers. It offers a comprehensive review of QI activities, including trend analyses, barriers, and outcomes, to identify opportunities for improvement. Recommendations for 2025 emphasize Magnolia's commitment to refining interventions, strengthening provider networks, and expanding member education to address identified challenges and further improve results in the coming year.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The QI Program Evaluation was approved by the QIC in July 2025 and reported to the Board of Directors.

E. Utilization Management

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

Constellation reviewed Magnolia's UM Program, examining the UM Program Description, UM Program Evaluation, Member Handbook, Provider Manual, and related policies and procedures.

The UM Program is designed to ensure fair, consistent, and impartial utilization decisions while coordinating medical and behavioral care for members. It is overseen by senior executives, including the Chief Medical Officer, Vice President of Population Health and Clinical Operations, and the Behavioral Health Medical Director, with approval from the UMC and the QIC. The program applies to all eligible members across various product types, age groups, and diagnoses, covering a wide range of care settings such as preventive, emergency, primary, specialty, acute, behavioral health, community-based services, skilled nursing, and ancillary care. Key activities include screening, intake, assessment, utilization management, discharge planning, case management, crisis management, referrals, disease management, and psychiatric medication utilization review.

The UM process includes components like 24-hour nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning, and care coordination. All services must meet medical necessity criteria, which are based on nationally recognized, evidence-based standards such as InterQual and the American Society of Addiction Medicine guidelines.

The program undergoes annual evaluations to ensure effectiveness, identify issues, and recommend improvements. These evaluations are reviewed by the UMC, QIC, or the Board of Directors. The Chief Medical Officer and other senior executives are responsible for implementing the program, overseeing cost containment, quality improvement, and utilization review activities. A pharmacist manages pharmacy services, while medical directors may assist in guiding best practices. The program aims to balance efficiency, cost-effectiveness, and patient-specific needs.

Coverage and Authorization of Services

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

The UM Department manages service authorization reviews for both medical and behavioral health care. Medical service requests are handled by medical nurse reviewers, while behavioral health requests, including mental health and substance use disorder cases, are managed by behavioral utilization managers. If a request involves both medical and behavioral health services, it is assigned separately to the respective reviewers.

The department follows specific timelines for decision-making. Standard requests are processed within three calendar days or two business days, whichever is longer. Urgent requests are reviewed and resolved within 24 hours. Providers can submit expedited requests if they believe that the standard timeframe could seriously jeopardize a member's health. Magnolia reviews these urgent requests and, if deemed appropriate, ensures they are processed within 24 hours.

All UM decisions comply with Policy MS.UM.05, Timeliness of UM Decisions and Notifications. In 2024, the UM Department successfully achieved or exceeded its timeliness goals, reflecting its dedication to providing prompt and efficient service. Two levels of UM medical necessity review are available for all authorization requests. Notification of the availability of an appropriate practitioner reviewer to discuss any UM adverse benefit determination, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse benefit determination.

Staff that perform UM application of criteria are tested annually. In 2024, team members were tested on all inter-rater reliability domains applicable to their position. All staff members are allowed two attempts to pass the tests. Additional training must be completed before retesting, and remediation is completed for any tests that are not passed after the second attempt. The initial pass rate was 95% and the final pass rate was 99%, exceeding the goal of 90%.

Constellation's review of sample approval and denial files revealed the criteria used to make the determination was identified and procedures for the evaluation of medical necessity of services for members were applied consistently.

Appeals

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

Magnolia's appeal process is clearly outlined across several resources, including the Utilization Management Program Description, relevant policies, the Member Handbook, the Provider Manual, and the health plan's website. Collectively, these documents provide a clear definition of an adverse benefit determination, the information required to initiate an appeal, and guidance on how to file a State Fair Hearing request.

Policies MS.UM.01, Utilization Management Program Description, MS.UM.08, Appeal of Utilization Management Decisions, and related resources specify that appeals are reviewed by a practitioner with appropriate medical training who was not involved in the original decision. Policy MS.UM.08, Appeal of Utilization Management Decisions, further outlines that if an expedited appeal request is denied, the case is automatically transferred to the standard timeframe, and reasonable efforts are made to provide oral notification.

Timeliness requirements are also addressed in Policy MS.UM.08, Appeals of Utilization Management Decisions, the Member Handbook, and the Provider Handbook, which specify that standard appeals must be resolved within 30 days and expedited appeals within 72 hours. Magnolia demonstrated strong monitoring practices by using multiple systems including the Prime system, which tracks turnaround times using color-coded alerts.

Magnolia conducts ongoing monitoring of appeal trends across medical, behavioral health, and pharmacy services. Findings are reviewed by the QIC and incorporated into the Quality Management Program Evaluation, which includes barriers, interventions, and recommendations. One identified barrier was the high volume of pharmacy appeals and to address this, the Pharmacy Director and Pharmacy Appeals Team formed a dedicated group to assess pharmacy appeal drivers and provide education and support. Finally, a review of Magnolia's Quality Improvement meeting minutes and appeals log confirmed that appeals are managed confidentially and in accordance with organizational policies and procedures.

The sample appeal file review 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)

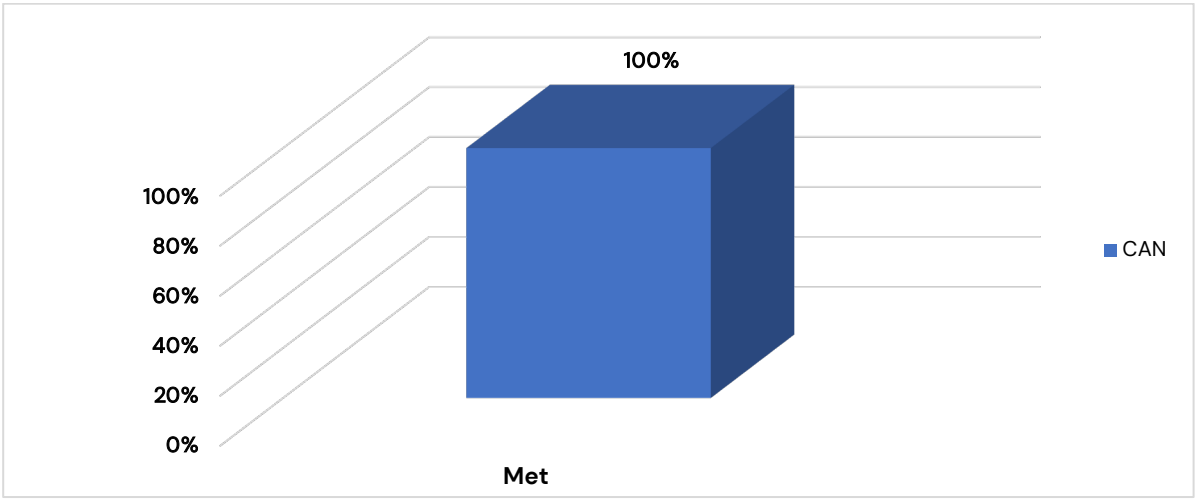
Magnolia's Care Management and Disease Management Program provides an integrated, whole-person, patient-centered approach for members. Various policies and the Member Handbook outline the program's purpose, scope, and objectives. Members are identified for care management through multiple sources, including provider and self-referrals, community agencies, predictive modeling, etc. Once identified, members receive a Health Risk Assessment to evaluate their health status, comorbidities, social determinants of health, and current needs. A qualified health professional develops a treatment plan within 30 days, and coordinated care activities: including member education, discharge planning, appointment scheduling, and community resource connections are initiated according to the member's risk level. Magnolia uses multiple strategies to engage high-risk or hard-to-reach members and provides targeted disease management support for conditions such as asthma, behavioral health, diabetes, weight management, and tobacco cessation. The My Health Pays Incentive Program further promotes preventive health through financial incentives and multi-channel education.

Transition of care and continuity of services are guided by various policies and are described in the Member Handbook. These policies ensure safe, coordinated transitions when members move between care settings, change providers, or experience benefit changes. Magnolia's multidisciplinary Transitional Care Management team, including RN care

managers, social service specialists, medical directors, program coordinators, and behavioral health staff, supports members through these transitions. Although the *CAN Contract* requires continuation of services without prior authorization when a new member transfers to the health plan, the Member Handbook stated that prior authorization is required. Review of the sample care management files yielded that assessment and care management activities are provided to members based on their assigned risk level.

As shown in *Figure 6*, 100% of the UM standards were scored as "Met."

Figure 6: Utilization Management Findings



Scores were rounded to the nearest whole number.

Table 26: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Review of a sample of denial files determined that all were processed timely, reviewed by appropriate health care professionals, and contained clearly documented rationales for the denial determinations. Documentation confirmed that denial decisions with rationales were communicated to members and providers within required timeframes.	✓	✓	
All physical and behavioral health turnaround time metric goals were met/exceeded (urgent concurrent, non-urgent pre-service, urgent pre-service, and post-service review).		✓	
Staff applying UM criteria are tested annually on applicable IRR domains. In 2024, staff were allowed two attempts to pass, with additional training required before retesting and remediation completed if the second attempt was unsuccessful. The initial pass rate was 95%, and the final pass rate was 99%.	✓		✓
Magnolia's Member Handbook presents the appeals process in clear, easy-to-understand language, supporting accessibility and encouraging member engagement in the appeals process.	✓		

Strengths	Quality	Timeliness	Access to Care
Due to a barrier identified for pharmacy appeals, Magnolia's Pharmacy Director and Pharmacy Appeals Team formed a dedicated group to review pharmacy appeals, analyze key drivers, and provide guidance on required documentation and additional support.	✓		
Magnolia's use of the Prime system provides color-coded alerts to help staff maintain timely closure of appeals.	✓	✓	
Magnolia's My Health Pays Incentive Program promotes member engagement in preventive health through financial incentives and multi-channel education, including provider outreach, in-person events, flyers, and motion graphic videos.	✓		✓
Magnolia noted that they employ multiple strategies to engage high-risk or hard-to-contact members, including up to three telephone attempts, home visits by resource coordinators, written correspondence, and other outreach methods.	✓		✓

Table 27: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The Member Handbook describes Magnolia's transition of care process. While the *CAN Contract, Section 8(B)(5)* requires continuation of medically necessary services without prior authorization, the Member Handbook (page 41) incorrectly states that prior authorization is required within fifteen business days.	*Recommendation: Update the Member Handbook to clearly describe the transition of care process, ensuring it reflects Magnolia's current policy and aligns with contractual requirements.*	✓		

UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					
1.1 Structure of the program;	X					The structure of the UM program is detailed in the UM Program Description.
1.2 Lines of responsibility and accountability;	X					The Vice President of Population Health and Clinical Operations, Chief Medical Director, and Behavioral Health Medical Director oversee the UM Program's development, implementation, and evaluation.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Policy CC.UM.02, Clinical Decision Criteria and Application, outlines the standards to be used when making UM decisions. Providers are made aware of standards and are updated when there are changes.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					The file review confirmed that all UM decisions and required notifications are provided within the timeframes as noted in Policy MS.UM.05, Timeliness of UM Decisions and Notifications.
1.5 Consideration of new technology;	X					The minutes from the Clinical Policy Committee meetings demonstrate that Magnolia reviews and evaluates new technologies for inclusion as medical necessity criteria.
1.6 The appeal process, including a mechanism for expedited appeal;	X					Policy MS.UM. 08, Appeal of UM Decisions, explains the standard and expedited appeal process.
1.7 The absence of direct financial incentives and/or quotas to provider	X					Policy CC.UM.64, Affirmative Statement About Incentives, states UM decision making is based only on appropriateness of care and service and existence of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
or UM staff for denials of coverage or services.						coverage. Magnolia does not compensate any individual or entity to deny, limit, or discontinue medically necessary services to members.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The Chief Medical Officer oversees the UM program. The Chief Medical Officer is a physician currently licensed (without restrictions) to practice medicine in Mississippi.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					The annual review and approval of InterQual Medical Necessity and American Society of Addiction Medicine Criteria was completed by the Utilization Management Committee and the QIC in December 2024. Guidelines are reviewed more often, as needed.
V B. Medical Necessity Determinations *42 CFR § 438.210(a–e), 42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					Policy CC.UM.02, Clinical Decision Criteria and Application, states that Magnolia and delegated vendors (as applicable) use written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness of medical, behavioral health, and pharmacy services that require approval. The medical necessity criteria and the procedures for applying them are reviewed annually and updated as appropriate.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					All UM approval and denial files that were reviewed contained relevant information to make a determination. All decisions were consistent with criteria and met definition of Medical Necessity.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					The Plan utilizes medical necessity criteria as an objective screening guide not intended as a substitute for physician judgment. Utilization review decisions are made in accordance with the currently accepted medical and/or behavioral health care practices, taking into consideration the individual member needs and characteristics at the time of the request, such as: age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, as reference in Policy CC.UM.02.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Departmental training is provided to associates who utilize the approved medical review criteria. Consistency of staff and medical director use and decision making when determining authorization determinations is evaluated according to Policy CC.UM.32, Interrater Reliability – Associates, Medical Directors, and Therapists.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Magnolia uses the most current version of the Mississippi Medicaid Preferred Drug List . The member handbook directs members to contact Member Services or to visit the Magnolia website to access the Preferred Drug List. For additional medications that may be covered, members can also visit DOM's website.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					The 2024 UM Program Evaluation details the procedure for prior authorization of medications. The goal of the Coverage Determination Review Program (also known as prior authorization) is to ensure that

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. Pharmacy coverage determination reviews were delegated to DOM's pharmacy benefit administrator, Gainwell, effective July 1, 2024. Prior authorization protocols are developed and reviewed at least annually by DOM. Magnolia provides input to DOM on proposed prior authorization criteria. These protocols indicate the criteria that must be met for the drug to be authorized.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The member handbook addresses emergency and post-stabilization services. Members are informed that these services are needed to stabilize a member's condition after an emergency and do not require prior authorization. Magnolia does not require members to receive emergency care and post-stabilization services within the Magnolia network.
7. Utilization management standards/criteria are available to providers.	X					Policy CC.UM.02 details how providers are informed of UM criteria. Providers are notified through provider orientation, the Provider Manual, Magnolia's website, and provider newsletters of the criteria used for medical necessity determinations. The Provider Manual, newsletters, clinical policies, and other provider information are also available in the provider tool kit on Magnolia's website. These communications include notification that treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting Population Health and Clinical Operations

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or may discuss the UM decision with the medical director.
8. Utilization management decisions are made by appropriately trained reviewers.	X					Policy CC.UM.04, Appropriate UM Professionals, details the credentials and training of UM decision makers. Appropriately licensed, qualified health professionals supervise the utilization management process and all medical necessity decisions. A provider or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials and appeals of healthcare services offered under the medical benefits. Appropriate practitioners include: • Physicians – for all types of denials and appeals. • Behavioral health practitioners, including psychiatrists, doctoral- level clinical psychologists or certified addiction medicine specialists – for behavioral healthcare denials and appeals. • Pharmacists – for pharmaceutical denials. Appropriate staffing is determined based on membership and requirements. Personnel employed by or under contract to perform utilization review are appropriately trained, qualified, and currently licensed in the state as applicable.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					The sample of files reviewed demonstrated that Magnolia's utilization decisions met the contract standards for timeliness and notification requirements. 100% of files reviewed exhibited consistency with the approval process, including notification to the member and provider. Additional information was requested and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						considered when it was determined necessary to make appropriate decisions.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					In the sample denial files reviewed, all contained documentation that Magnolia UM staff attempted to obtain all pertinent information necessary prior to the denial of services.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Magnolia uses appropriate physician specialists to review medical necessity determinations and issue denials.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					A sample of denial files was reviewed and all contained documentation of timely communications with providers and members, including the basis for the determination and the process to appeal the decision.
V C. Appeals *42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					Magnolia's Utilization Management Program Description and Policy MS.UM.07, Adverse Determinations and Notifications, provide a descriptive overview of the appeals process. Additionally, the appeals process is outlined in the Member Handbook, Provider Manual, and on the website.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Policy MS.UM.08, Appeal of UM Decisions, the Provider Manual, Member Handbook, and the health plan's website clearly define an adverse benefit determination as the denial or limited authorization of a requested service. These resources outline the process for filing an appeal, including the ability for a member, their representative, or a service provider to initiate the appeal on the member's behalf. Notably, the Member Handbook presents this information in language that is clear and easy for members to understand, which supports accessibility and promotes member engagement in the appeals process.
1.2 The procedure for filing an appeal;	X					The health plan's policies, Provider Manual, and Member Handbook outline the appeals process, stating that a member may file an oral or written appeal within 60 calendar days of the Adverse Benefit Determination. Additionally, Magnolia will confirm receipt of a verbal appeal within 10 calendar days of receiving it, unless the appeal is expedited.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Policy MS.UM.01, Utilization Management Program Description, and Policy MS.UM.08, Appeal of Utilization Management Decisions, describe that appeal reviews are performed by a practitioner with the appropriate medical experience who was not previously involved in the case.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy MS.UM.08, Appeal of UM Decisions, indicates that if Magnolia denies a request for an expedited appeal, the appeal will automatically be transferred to the standard timeframe. A reasonable attempt will be made to provide oral notification of the expedited request denial. Also, during onsite discussion, Magnolia explained that if an appeal is not eligible for expedited review, the health plan sends an appeal letter to the provider and mails the member a copy of the downgrade decision.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy MS.UM.08, Appeal of Utilization Management Decisions, the Member Handbook, and Provider Manual provide a descriptive outline of the requirements and timeframes for resolution of standard appeals within 30 days and expedited appeals within 72 hours. During the onsite discussion, Magnolia explained that they use multiple systems to monitor and ensure timeliness of appeal resolution. One system, Prime, tracks turnaround times and provides alerts: items remain green for the first 20 days, turn yellow on day 21, and turn red on day 28 to signal the need for closure to maintain timeliness.
1.6 Written notice of the appeal resolution as required by the contract;	X					The appeal resolution notice provides a detailed overview of the right to request a State Fair Hearing and guidelines such as indicating the member may be held liable for the cost of the benefits if the hearing decision upholds the denial, as described in Policy MS.UM.08, Appeal of Utilization Management Decisions, the Member Handbook, and Magnolia's letter template. Constellation's review of the sample appeal files demonstrated that members were provided with written notice of appeal

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resolution as well as information on how to request a State Fair Hearing.
1.7 Other requirements as specified in the contract.	X					Policy MS.UM.08, Appeal of Utilization Management Decisions, along with the Member Handbook, Provider Manual, and letter templates outline the continuation of benefits process and State Fair Hearing procedures.
2. The CCO applies the appeal policies and procedures as formulated.	X					The sample appeal files reviewed reflected that appeals were processed timely, included appropriate physician review, and provided clear explanations for upheld or reversed decisions along with the relevant clinical criteria.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Magnolia tracks and analyzes appeal trends across medical, behavioral health, and pharmacy services. These findings are submitted to the QIC for review and recommendations. Additionally, an overall trend analysis is included in the Quality Management Program Evaluation, which outlines identified barriers, implemented interventions, and proposed recommendations. One barrier identified was the high volume of pharmacy appeals with providers submitting limited clinical information. To address this, Magnolia's Pharmacy Director and Pharmacy Appeals Team formed a dedicated group to review these appeals, analyze key drivers, update website guidance on required documentation, and provide additional technical support.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					A review of Magnolia's QIC meeting minutes and appeals log indicates that appeals are handled confidentially, in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						accordance with the organization's policies and procedures.
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Policy MS.CM.01, Care Management Program and Program Description, and the Health Coaching Disease Management Program Overview outline the purpose, scope, and objectives of the Care Management Program. Included are details about the program's integration with other health plan initiatives and key components of the care coordination process.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					As outlined in Policy MS.CM.01, Care Management Program and Program Description, Policy CC.CM.02, Care Coordination/Care Management Services, and Policy MS.PHARM.17, Case Management Referral Process, members are identified for care management services through various data and referral sources such as family referrals, community agencies, health care providers, pharmacy, hospital staff, emergency department utilization reports, self-referrals, and predictive modeling software. In addition, as part of the overall Population Health Management strategy, data from multiple sources are integrated to identify members who may benefit from care management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Once a member is identified as a potential candidate for care management services, a referral is initiated within 30 days to complete an initial assessment as outlined in Policy MS.CM.01, Care Management Program and Program

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description, and Policy CC.CM.02, Care Coordination/Care Management Services.
4. The detailed health risk assessment includes all required elements:						Magnolia conducts a Health Risk Assessment with members to evaluate their current needs, health conditions, demographic information, and other relevant factors, as outlined in various policies.
4.1 Identification of the severity of the member's conditions/disease state;	X					Policy MS.CM.01, Care Management Program and Program Description, and Policy CC.CM.02, Care Coordination/Care Management Services, state that the Health Screening Assessment and Comprehensive Assessment assess the severity of the member's conditions/disease state.
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					Policy MS.CM.01, Care Management Program and Program Description, and Policy CC.CM.02, Care Coordination/Care Management Services, state that the Health Screening Assessment and Comprehensive Assessment are used to evaluate members for potential co-morbidities and multiple complex health conditions.
4.3 Demographic information;	X					Policy MS.CM.01, Care Management Program and Program Description, and Policy CC.CM.02, Care Coordination/Care Management Services, state that the initial assessment is also used to identify issues related to social determinants of health, such as lack of financial resources, demographic factors, and limited social, family, or caregiver support.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.4 Member's current treatment provider and treatment plan, if available.	X					During the assessment process, when available, the member's current treatment plan or treatment information is reviewed to support the collection of updated clinical information, as outlined in Policy MS.CM.01, Care Management Program and Program Description, and Policy CC.CM.02, Care Coordination/Care Management Services.
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					The health risk assessment is reviewed by a qualified health professional, and a treatment plan is completed within 30 days of completion of the Health Risk Assessment, as described in Policy MS.CM.01, Care Management Program and Program Description.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					As described in Policy CC.CM.02, Care Coordination/Care Management Services, and Policy MS.CM.01, Care Management Program and Program Description, the risk level assignment is periodically updated as the member's health status or needs change.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					As outlined in Policy CC.CM.02, Care Coordination/Care Management Services, Policy MS.CM.01, Care Management Program and Program Description, Policy MS.CM.25, Management and Continuity of Care, Policy UM.24, Continuity and Coordination of Services, and the Member Handbook, Magnolia delivers an integrated, whole-person, patient-centered approach to care management. During onsite discussion, Magnolia highlighted that integrated care is facilitated through activities such as Integrated Care Team meetings, weekly

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Behavioral Health rounds, and leadership focus group meetings. Once a treatment plan is established, coordinated care activities; including member education, discharge planning, connection to community resources, and appointment scheduling are initiated. The type and frequency of services are determined by the member's assigned risk level, and all care management activities are documented in a centralized system to ensure continuity, quality, and oversight. Review of sample care management files confirmed that assessments, treatment planning, and care management activities were appropriately provided based on each member's risk level.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						Members are provided with information on how to contact their assigned team members as outlined in Policy MS.CM.01, Care Management Program and Program Description.
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						As outlined in Policy MS.CM.01, Care Management Program and Program Description, Policy MS. CM.25, Management and Continuity of Care, referral and scheduling assistance are provided to members.
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						Policy CC.CM.02, Care Coordination/Care Management Services, describes that referral services and care management activities are documented in the member's medical record. Review of the sample care management files confirmed that care management activities are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appropriately documented in the member's medical record.
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						Policy CC.CM.02, Care Coordination/Care Management Services, describes that all emergency encounters, urgent care, and follow-up are documented in the member's medical record.
7.5 Coordination of discharge planning;						Policy MS.CM.01, Care Management Program and Program Description, and Policy MS.CM.25, Management and Continuity of Care, describe that discharge planning coordination is provided to members.
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						Policy MS.CM.01, Care Management Program and Program Description, and Policy MS.CM.25, Management and Continuity of Care, explain that coordination with additional social programs is provided to members.
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are						Policy MS.CM.01, Care Management Program and Program Description, the Member Handbook, Policy MS.CM.18, Transition of Care Policy, and Policy UM.24, Continuity

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						and Coordination of Services, state that members are able to have continued access to a provider for 60 calendar days to not disrupt active treatment.
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						Policy CC.CM.02, Care Coordination/Care Management Services, outlines the process followed when members change physicians. During this process, the care manager ensures that there is no disruption in service.
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						Policy MS.CM.01, Care Management Program and Program Description, states that educational materials and newsletters are provided to members throughout care management processes to promote engagement and prevention.
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					Policy MS.CM.01, Care Management Program and Program Description, describes that members assigned to the medium risk level will receive all services included in the low risk level.
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					Policy MS.CM.01, Care Management Program and Program Description, specifies that members assigned to the high-risk level receive all services provided to medium-risk members. During onsite discussion, Magnolia noted that they employ multiple strategies to engage high-risk or hard-to-contact members, which entails conducting up to three telephone attempts, home visits by resource coordinators, written correspondence, and other outreach methods.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MS.01, Care Management and Program Description, Policy MS.UM.24, Continuity and Coordination of Services, Policy MS.Elig.05, Disenrollment, and the Member Handbook describe the process followed when a member disenrolls from the health plan. The Transitions Coordinator transfers the member's care management history, six months of claims data, and relevant information regarding special needs to DOM.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Several policies, together with the Health Coaching Disease Management Program Overview, provide a comprehensive description of Magnolia's Disease Management Program. The program offers targeted support for conditions such as asthma, behavioral health, diabetes, weight management, and tobacco cessation. Its objectives include promoting adherence to evidence-based treatment and lifestyle guidelines, providing medication education, encouraging medication compliance, encouraging preventive care, fostering healthy lifestyle habits, and improving long-term health outcomes. During onsite discussion, Magnolia highlighted the My Health Pays Incentive Program, which provides financial incentives to encourage member participation in preventive health activities. Members are informed about available resources through multiple channels, including in-person events, flyers, and, most recently, motion graphic videos explaining the My Health Pays process to enhance engagement.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Policy MS.CM.99, Transitional Care Management Process, Policy MS.UM.24, Continuity and Care Coordination of Care, Policy CC.CM.02, Care Coordination/Care Management Services, Policy MS.CM.18, Transition of Care Policy, and Policy MS.CM.25, Management and Continuity of Care, outline the transition of care process for members. These policies collectively define how care managers coordinate transitions of care in situations that may impact members and their care plans, for example, when benefits end, when a member transitions from pediatric to adult care, or when coverage is terminated. The Transition of Care Policy is publicly available through the Member Handbook, member website, and other member-facing materials. It provides guidance to members and potential members on how to access continued services during a transition of care.
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Policy MS.CM.99, Transitional Care Management Process, outlines the care management activities provided to members transitioning from a hospital setting to ensure a safe and successful transition to their home or community setting.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					The Transitional Care Management team is a multidisciplinary group, including RN Care Managers, Social Service Specialists, Medical Directors, Program Coordinators, and Behavioral Health staff that supports members through care transitions in home and community settings.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO meets other Transition of Care requirements.	X					Policy MS.UM.24, Continuity and Coordination of Services, Policy MS.CM.18, Transitions of Care Policy, and the Member Handbook outline Magnolia's transition of care process. Per the *CAN Contract, Section 8(B)(5)*, "In the event a Member entering the Contractor, either as a new Member or transferring from another Contractor, is receiving medically necessary services… the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization…" However, the Member Handbook (page 41) states that continuation of care with a previous provider requires prior authorization within fifteen business days, which is not consistent with contractual requirements. During onsite discussion, Magnolia acknowledged that new members with a previous provider do not require prior authorization for up to 90 days, honoring the existing authorization while assisting to link to an in-network provider or coordinate needed services. *Recommendation: Update the Member Handbook to clearly describe the transition of care process, ensuring it reflects current policy and aligns with contractual requirements.*
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					Magnolia evaluates the effectiveness of the UM Program annually and formulates recommendations based on the review.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					Each year, Magnolia evaluates the UM program, and recommendations are submitted to the UMC/QIC or the Board of Directors for approval.

F. Delegation

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

Policy MS.QI.14, Oversight of Delegated Vendor Services, outlines Magnolia's oversight of delegated vendor services. This policy establishes a framework for delegating certain activities to external entities and ensuring compliance with State requirements. The policy includes the requirements for a delegation agreement, pre-delegation review, ongoing monitoring, annual evaluations, and corrective actions if needed. Magnolia retains ultimate accountability for delegated services and reserves the right to revoke delegation agreements if standards are not met. The policy also includes provisions for handling protected health information and fraud prevention. Prior to executing a delegated services agreement, Magnolia submits a copy of the agreement to DOM for review and approval.

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 this review, Magnolia reported five delegation agreements, as shown in *Table 28*.

Table 28: Delegated Entities and Services

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

Magnolia evaluates the delegated entity's capacity to perform the delegated activities prior to initiating a delegation agreement and annually thereafter. The annual evaluation includes a review of the delegates' policies, procedures, files, and meeting minutes. The policy (MS.QI.14, Oversight of Delegated Vendor Services) indicates an onsite evaluation is preferred but may be conducted via telephone consultation. A summary of the annual evaluation is presented at the next QIC 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.

Magnolia also requires routine reporting of key performance metrics. These monitoring reports are reviewed and analyzed for outliers or inconsistencies and discussed with the vendor during the Joint Oversight Committee meetings. Copies of the annual audits conducted for each delegate were provided.

As noted in *Figure 7*, 100% of the Delegation standards were scored as "Met."

Figure 7: Delegation Findings

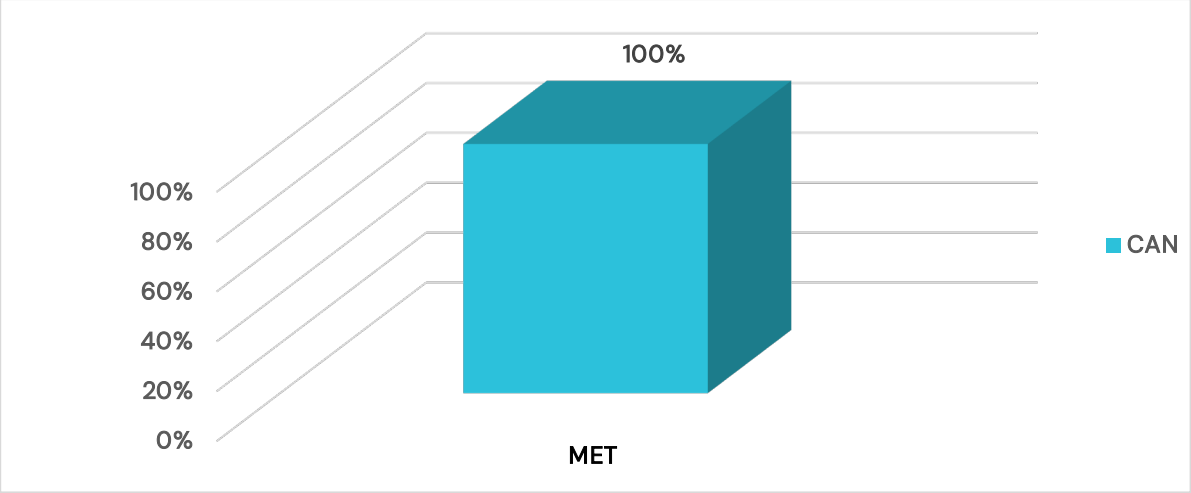


Table 29: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Magnolia 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 30: Delegation Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MS.QI.14, Oversight of Delegated Vendor Services, indicates a summary of the	*Recommendation: Present the summary of the annual evaluation for each*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
annual evaluation is presented at the next QIC meeting for review and comment. The recently completed annual summaries were not found in the committee minutes.	*delegated vendor as mentioned in policy MS.QI.14, Oversight of Delegated Vendor Services.*			

DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The CCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Policy MS.QI.14, Oversight of Delegated Vendor Services, outlines Magnolia's oversight of delegated vendor services. This policy establishes a framework for delegating certain activities to external entities and ensuring compliance with State requirements. The policy includes the requirements for a delegation agreement, pre-delegation review, ongoing monitoring, annual evaluations, and corrective actions if needed. Magnolia retains ultimate accountability for delegated services and reserves the right to revoke delegation agreements if standards are not met. The policy also includes provisions for handling protected health information and fraud prevention. Prior to executing a delegated services agreement, Magnolia submits a copy of the agreement to DOM for review and approval. 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.
2. The CCO has written agreements with all contractors or agencies performing delegated functions that outline	X					The policy includes the requirements for a delegation agreement, pre-delegation review, ongoing monitoring, annual evaluations, and corrective actions if needed.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
responsibilities of the contractor or agency in performing those delegated functions.						Magnolia retains ultimate accountability for delegated services and reserves the right to revoke delegation agreements if standards are not met. The policy also includes provisions for handling protected health information and fraud prevention. Prior to executing a delegated services agreement, Magnolia submits a copy of the agreement to DOM for review and approval. For this EQR, Magnolia submitted copies of the delegation agreement for each delegate.
3. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					Magnolia evaluates the delegated entity's capacity to perform the delegated activities prior to initiating a delegation agreement and annually thereafter. The annual evaluation includes a review of the delegates' policies, procedures, files, and meeting minutes. The policy (MS.QI.14, Oversight of Delegated Vendor Services) indicates an onsite evaluation is preferred but may be conducted via telephone consultation. A summary of the annual evaluation is presented at the next QIC meeting for review and comment. However, there was no documentation for this activity in the committee minutes. Magnolia also requires routine reporting of key performance metrics. These monitoring reports are reviewed and analyzed for outliers or inconsistencies and discussed with the vendor during the Joint Oversight Committee meetings. Copies of the annual audits conducted for each delegate were provided.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Present the summary of the annual evaluation for each delegated vendor as mentioned in policy MS.QI.14, Oversight of Delegated Vendor Services.

ATTACHMENTS

Attachment 1: Initial Notice and Materials Requested for Desk Review

July 3, 2025

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

Dear Mr. Sisk:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2025 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN (MSCAN) Program and will be conducted by Constellation Quality Health Constellation).

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

The virtual onsite visit for the MississippiCAN Program will be conducted on November 5, 2025, and November 6, 2025.

In preparation for the desk review, the items on the enclosed Mississippi CAN Materials Request for Desk Review list should be provided to Constellation no later than August 4, 2025.

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)

cc: DOM

MississippiCAN 2025 External Quality Review

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MississippiCAN (MSCAN) Program, as well as a complete index that includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.
2. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, key managers responsible for the functions, and any vacancies. For all positions required in the MSCAN Contract, Section 1 (M), indicate whether the staff are in-state, the number of FTEs, and any required credentials. For contractually required key positions, provide the percentage of time allocated to the MSCAN contract and the CHIP contract, as well as any other lines of business.
3. Current membership demographics, including total enrollment and distribution by age ranges, gender, and county of residence for the MSCAN Program.
4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base for the MSCAN Program, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. Provider identified limitations on panel size considered in the network assessment
5. The total number of unique specialty providers for MSCAN as well as the total number of unique primary care providers, broken down by specialty, currently in the network.
6. A completed Provider Network File Questionnaire
7. A current provider directory/list as supplied to MSCAN members.
8. A copy of the current Fraud, Waste & Abuse/Compliance Plan for the MSCAN Program, any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.
9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for MSCAN.
10. The Quality Improvement work plans for MSCAN for 2024 and 2025.
11. The most recent reports that summarize the effectiveness of the Quality Improvement, Medical/Utilization Management, Disease/Care Management, and Population Health Programs for MSCAN.
12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN Program that have been planned and completed during the previous year and any interim information available for projects currently in progress. This documentation should include

information from the project that explains and documents all aspects of the project cycle (i.e., analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

a. For all projects with non-HEDIS measures:
    - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.

b. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction.

c. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP.

13. Minutes of all committee meetings within the past year for committees reviewing or taking action on MSCAN related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.
14. Membership lists and a committee matrix for all MSCAN committees, including the professional specialties of any non-staff members. Please indicate which members are voting members and include committee charters if available.
15. Any data collected for the purpose of monitoring utilization (over and under) of health care services for the MSCAN Program.
16. Copies of the most recent physician profiling activities conducted to measure provider performance for the MSCAN Program.
17. Reports of medical record reviews completed in 2024 and 2025 and a copy of the tools used to complete these reviews for MSCAN providers.
18. A complete list of all MSCAN members enrolled in the Care Management Program from July 2024 through June 2025. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis that triggered the need for care management.
19. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for July 2024 to June 2025. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.
20. A copy of the MSCAN member handbook and any statement of the member bill of rights and responsibilities, if not included in the handbook.
21. A report of findings from the most recent member and provider satisfaction surveys for the MSCAN Program along with a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and any other documentation of the requested scope of work.

22. A copy of any member newsletters, educational materials, and/or other mailings. Include any training plans for educating members about the MSCAN Program.
23. A copy of any provider newsletters, educational materials, and/or other mailings. Include any training plans and initial provider orientation materials used for educating providers about the MSCAN Program.
24. A copy of the grievance, complaint, and appeal logs for the MSCAN Program for the months of July 2024 through June 2025.
25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the MSCAN Program.
26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the MSCAN Program. Please include:
    a. Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    b. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.
27. Preventive health guidelines recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.
    a. Copies of the EPSDT tracking reports and follow-up activities from July 2024 through June 2025.
28. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.
29. For the MSCAN Program, a list of physicians currently available for utilization consultation/review and their specialties.
30. A copy of the provider handbook or manual for the MSCAN Program.
31. A sample provider contract for the MSCAN Program.
32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA with updated data for SFY 2025. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and enrollment data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*

d. A copy of the IT Disaster Recovery Plan.

e. A copy of the most recent disaster recovery or business continuity plan test results.

f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

g. A copy of the policies or program description that address the information systems security and access management. Please also include policies with respect to email and PHI.

h. A copy of the Information Security Plan & Security Risk Assessment.

i. A copy of the claims processing monitoring reports covering the period of July 2024 through June 2025.

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

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

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

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

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

Folder	Requested Document	Description
a.	HEDIS® Measurement Year 2024 (MY 2024) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2024 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for all supplemental data sources that are utilized for all measures included under PMV review. If the CCO did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV file and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) CSV file and Excel workbooks for MSCAN for MY 2024.

Folder	Requested Document	Description
c.	HEDIS MY 2024 Final Audit Report (FAR) from the Licensed Organization for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization for MY 2024.
d.	NCQA certification for certified measure code used to generate each of the HEDIS measures	• If your CCO contracted directly with NCQA for automated source code review (ASCR) to have measure logic certified, please provide a copy of your NCQA ASCR final measure certification for the HEDIS measures reported. • If your CCO used [2]HEDIS Certified Measures℠, to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each non-HEDIS measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production.
f.	Numerator positive case listings for the HEDIS and non-HEDIS measures	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health's portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. Constellation Quality Health will select a random sample from this list of 100 compliant records to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the site review.
g.	List of exclusions and numerator compliant records via medical record review (MRR) for the HEDIS measures	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health portal, folder 36 g) a list of all the numerator compliant records and exclusions/valid data errors that are identified through medical record review. Constellation Quality Health will select a random sample to conduct the medical record review validation.
h.	Rate Reporting template populated with data for HEDIS Admin-only rates and non-HEDIS measure rates	Constellation Quality Health will provide the rate reporting template for both the CMS Adult and Child Core Set HEDIS Admin only rates and non-HEDIS measures which must be populated by the CCO with final data (denominators, numerators, and rates) for each measure for the MSCAN population.
1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA. 2. HEDIS Certified Measures ℠ is a service mark of the NCQA.		

37. Provide electronic copies of the following files for MSCAN:
    a. Twenty-five medical necessity denial files for the MSCAN Program for the months of July 2024 through June 2025. Of the 25 requested files, include five behavioral health and five pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used to make the denial determination for each file.

b. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN Program for the months of July 2024 through June 2025, including any medical information and approval criteria used to make the decision.

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

These materials:

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

Attachment 2: Materials Requested for Onsite Review

Magnolia – MississippiCAN

External Quality Review 2025

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied
2. A copy of the written agreement/contract with Turning Point.
3. Copies of the 2024 Joint Operating Committee meeting minutes for Turning Point.
4. The most recent geographic access report for dental providers.
5. Policy MS.PRVR.10, Evaluation of the Accessibility of Services
6. Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines

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

Attachment 3: EQR Validation Worksheets

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

EQR Survey Validation Worksheet

Plan Name	Magnolia Health
Survey Validated	CAHPS MEMBER SATISFACTION – ADULT
Validation Period	2024
Review Performed	2025

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	States the purpose of CAHPS survey. *Documentation:* Press Ganey Adult CAHPS Report MY2024
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	CAHPS is a standardized, validated survey tool.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	The survey meets NCQA reliability requirements.

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan.

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied.

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The adult CAHPs survey had a response rate of 15.5% which is lower than last year's rate of 16.1%. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.

EQR Survey Validation Worksheet

Plan Name	Magnolia Health
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2024
Review Performed	2025

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. Documentation: Press Ganey Child Report MY2024
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	CAHPs is a validated tool and meets NCQA's reliability requirements.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability.

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan.

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied.

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child Medicaid response rate was 12.4% which is an improvement from the previous year's rate of 10.1%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.

EQR Survey Validation Worksheet

Plan Name	Magnolia Health
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD WITH CCC
Validation Period	2024
Review Performed	2025

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2024
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	CAHPS is an NCQA validated tool. Documentation confirms this.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey meets NCQA reliability Standard.

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan.

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied.

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child with CCC response rate was 10.1% which is a slight improvement from the previous year's rate of 9.4%. The response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2025**
Review Performed:	**12/3/2025**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ALL ADULT AND CHILD CMS CORE MEASURES – CAN**
Reporting Year:	**2025**
Review Performed:	**12/3/2025**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PIP Validation Worksheet

Plan Name:	**Magnolia Health**
Name of PIP:	**Improving Follow-Up After Hospitalization for Mental Illness**
Reporting Year:	**2024**
Review Performed:	**2025**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	FUH is a high-priority behavioral health measure. Only 38.5 percent of Mississippi youth meet the 30-day FUH benchmark nationally. Magnolia identified barriers such as limited appointments, poor follow-up scheduling, transportation issues, and inconsistent discharge planning.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined using NCQA HEDIS measure.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted, such as claims and encounter data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	A data analysis plan was described, including quarterly monitoring.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis followed the stated plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Magnolia explained quarterly results and described follow-up actions such as Pseudo-claims, provider education, and post-discharge outreach.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
		barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	FUH improved from 65.34% in 2022 at baseline to 66.92% in 2024.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Although improvements were noted there were no statistically significant improvements.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	75
Project Possible Score	75
Project Rating Score	100%

AUDIT DESIGNATION
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	**Magnolia Health**
Name of PIP:	**Reducing Preterm Births for Pregnant Mothers with HTN/Pre-eclampsia**
Reporting Year:	**2024**
Review Performed:	**2025**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Preterm births remain a high risk in Mississippi. Hypertension and preeclampsia continue to be major drivers of preterm delivery. Magnolia's data supports the need for a PIP.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No Sampling used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No Sampling used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No Sampling used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The indicator is clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data elements are clearly listed.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted, administrative claims and birth outcome data were used.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	The analysis followed the plan documented in the PIP.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Magnolia described reasons for rate changes and identified next steps such as expanded member outreach and provider engagement.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Magnolia provided education calls, mailed materials, case management outreach, and OB provider collaboration. Barriers such as late prenatal care and limited member engagement were identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Preterm birth was 15.44% in 2023 and 15.79% in 2024. Unable to judge if there was a significant improvement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement aligns with intervention
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	79
Project Possible Score	79
Project Rating Score	100%

AUDIT DESIGNATION
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Magnolia Health
Name of PIP:	Respiratory Illness: AMR
Reporting Year:	2024
Review Performed:	2025

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Asthma is a major health need in the Mississippi Medicaid population. AMR remains highly relevant. SPR was retired for MY2024, the plan continued with AMR as the primary focus.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	The aim is clear and focused on improving controller medication use for members with persistent asthma.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The population was defined using HEDIS 2024 criteria and includes all eligible members.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	AMR is clearly defined and follows NCQA specifications.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	The plan clearly identified the required data.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted. Claims and pharmacy data were used
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis followed the documented plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes clear explanations and next steps based on results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	The plan used interventions including outreach calls, letters, and provider education. Barriers such as knowledge gaps and missing contact information were identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement from 74.04% in 2023 to 76.62% in 2024
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement aligns with the intervention implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

AUDIT DESIGNATION
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	**Magnolia Health**
Name of PIP:	**Sickle Cell Disease**
Reporting Year:	**2024**
Review Performed:	**2025**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Hydroxyurea adherence is a major need for members with SCD. Earlier data showed low compliance of 37.5 percent, supporting the need for ongoing improvement
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted. Claims and pharmacy data are used
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was completed according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Provided explanation of results and provided next steps.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions included outreach, education, and coordination with providers. Barriers such as limited engagement and adherence challenges were identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The adherence rate increased from 25.87 percent to 30.53 percent.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
		Improvement was demonstrated, although the rate remains below the goal.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The improvement is consistent with intervention.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Improvement noted from 2020 to 2024.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	85
Project Possible Score	85
Project Rating Score	100%

AUDIT DESIGNATION
High Confidence in Reported Results

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

EQR NETWORK ADEQUACY VALIDATION WORKSHEET

Plan Name:	**Magnolia CAN**
Reporting Year:	**2024**
Review Performed:	**2025**

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

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.1 Are the methods selected by the CCO appropriate for the state? **(10)**	**MET**	Methods aligned with State standards.
2.2 Are the methods selected by the CCO appropriate to the state Medicaid and CHIP population(s)? **(10)**	**MET**	Methods aligned with populations.
2.3 Are the methods selected by the CCO adequate to generate the data needed to calculate the indicators according to the State's expectations? **(10)**	**MET**	The plans approach was according to the State's expectations and produced usable data.

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

ACTIVITY 3: ASSESSMENT OF CCO NETWORK ADEQUACY RESULTS		
3.1 Did the CCO produce valid results? **(10)**	**MET**	Results were consistent with methodology
3.2 Did the CCO produce accurate results? **(10)**	**MET**	Accuracy is supported by complete data and proper calculations.
3.3 Did the CCO produce reliable and consistent results? **(10)**	**MET**	Results hold up across repeated assessments.
3.4 Did the CCO accurately interpret its results? **(10)**	**MET**	Correctly interpreted and explained findings.

ACTIVITY 4: PERFORM OVERALL VALIDATION OF AND REPORTING OF RESULTS

Step	Possible Score	Score
Step 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	NA	NA
1.9	5	5
Step 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Step 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	99	99

Project Score	99
Project Possible Score	99
Project Rating Score	100%

AUDIT DESIGNATION
High Confidence in Reported Results

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
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Attachment 4: Assessment of Corrective Action Plans from Previous EQR

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

Magnolia Health Plan 2024 Corrective Action Plan

2024 EQR Findings	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II B. Provider Education			
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.			
Magnolia submitted the Geo Access Mapping for dental, vision, and pharmacy providers after the onsite. The parameters used to measure access for dental providers were incorrect. The Envolve Dental Network Analysis dated October 1, 2024, indicates the parameters used were: • 1 general/pediatric dentist within 30 miles or 60 minutes (urban) and 1 general/pediatric dentist within 60 miles or 120 minutes (rural) • 1 dental specialist within 30 miles or 60 minutes (urban) and 1 dental specialist within 60 miles or 120 minutes (rural) The *CAN Contract, Section 7 (B)* states the parameters for both general/pediatric dentists and dental subspecialty providers are 1 within 30 minutes or 30 miles (urban) and 1 within 60 minutes or 60 miles (rural). *Corrective Action Plan: Conduct Geo Access mapping for dental providers using the correct parameters and submit to Constellation for review. Ensure Envolve uses correct parameters for all future Geo Access mapping.*	GEO Access mapping for Dental reflecting correct parameters. Uploaded.	✓	
2. Practitioner Accessibility 2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.			

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