

Managed Care Program Annual Report (MCPAR) for Mississippi: Mississippi Coordinated Access Network (MississippiCAN)

Due date	Last edited	Edited by	Status
12/27/2025	05/13/2026	Elizabeth Spencer	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under	No

Indicator

Response

each plan.

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Mississippi
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Lisa C. Shaw
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	lisa.shaw@medicaid.ms.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Elizabeth Spencer
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	Elizabeth.Hartman@medicaid.ms.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	05/13/2026

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	07/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	06/30/2025
A6	Program name Auto-populated from report dashboard.	Mississippi Coordinated Access Network (MississippiCAN)

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Magnolia Health Plan
	Molina Healthcare of MS
	UnitedHealthcare Community Plan of MS

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Gainwell Technologies - Fiscal Agent-Enrollment Broker/Choice Counseling

Add In Lieu of Services and Settings (A.9)



Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	N/A

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	654,906
BI.2	Statewide Medicaid managed care enrollment Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	439,217

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	<p data-bbox="310 100 618 142">Data validation entity</p> <p data-bbox="310 153 716 321">Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs.</p> <p data-bbox="310 321 716 699">Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.</p>	<p data-bbox="760 100 1081 142">Other third-party vendor</p> <p data-bbox="760 174 1222 216">Other, specify – Myers & Stauffer LC</p>

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p data-bbox="313 107 695 180">Payment risks between the state and plans</p> <p data-bbox="313 201 727 863">Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.</p>	<p data-bbox="760 107 1377 1331">The State Medicaid Agency (SMA) conducted three PI activities during the past year in the MississippiCAN and MSCHIP managed care programs. One activity was focused review of the Coordinated Care Organization (CCO) provider investigations to ensure that fraud, waste and or abuse are being correctly identified and correctly reported to the provider. Also, to ensure correct recoupment is occurring. The second activity was an in-depth training conducted by Medicaid's office of Health Benefits and Programs related to Mississippi Department of Mental Health guidelines, policies and licensing requirements, in addition to deep dive into the Mental Health Section of the State Medicaid's Administrative Code. This training was provided to each of the CCOs and staff from Office of Program Integrity and Medicaid Fraud Control Unit. The third activity undertaken involved notification of all provider findings received from the CCOs to the Investigative Division with the Office of Program Integrity for possible investigation for any fee for service claims. This allowed cohesive and coordinated investigations involving the CCOs and the State Medicaid Agency Office of Program Integrity. Note: CCO, Managed Care Plan (MCP) or Managed Care Organization (MCO) may be used interchangeably throughout the questionnaire. All related to the three plans.</p>
BX.2	<p data-bbox="313 1388 618 1461">Contract standard for overpayments</p> <p data-bbox="313 1482 727 1640">Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p data-bbox="760 1388 1247 1415">State has established a hybrid system</p>
BX.3	<p data-bbox="313 1692 634 1808">Location of contract provision stating overpayment standard</p> <p data-bbox="313 1829 727 1976">Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	<p data-bbox="760 1692 1263 1766">Exhibit A MSCAN Contract Amendment 4, Section 12 - Program Integrity</p>

BX.4

Description of overpayment contract standard

Briefly describe the overpayment standard selected in indicator B.X.2.

The procedures must include a provision for prompt reporting to the State, of all overpayments identified or recovered, specifying the overpayments due to potential fraud. When recovering funds on behalf of the Division, the CCOs will retain any overpayments identified and collected because of the audit if the State Medicaid Agency Office of Program Integrity approves the investigation. The CCOs will be responsible for collecting the overpayment for any provider audited. If it is determined that the Office of Program Integrity will conduct an investigation, the State Medicaid Agency will be responsible for collecting the overpayments of providers audited. The CCOs will be required to report to the Office of Program Integrity annually all Overpayments recovered from providers. This information, along with Office of Program Integrity overpayments, will be reported to the entity that is responsible for rate setting.

BX.5

State overpayment reporting monitoring

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?

The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

The State Medicaid Agency (SMA) requires quarterly reporting of all FWA including overpayments in addition to reporting annually all overpayments.

BX.6	Changes in beneficiary circumstances Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	"The Member Listing Report shall be provided to the Contractor sufficiently in advance of the Member's Enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, described in Sections 6.C, Member Identification Card, and 4.B, Choice of a Network Provider, of this Contract, respectively. The Division and the Contractor shall reconcile each Member Listing Report as expeditiously as is feasible but no later than the twentieth (20th) day of each month. The CCOs submit a weekly disenrollment report that includes deceased members."
BX.7a	Changes in provider circumstances: Monitoring plans Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	Changes in provider circumstances: Metrics Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	Changes in provider circumstances: Describe metric Describe the metric or indicator that the state uses.	The SMA requires the CCO to provide a work plan when a provider is being terminated for cause and requires the CCO to provide the provider termination letter that is mailed to the provider being terminated.
BX.8a	Federal database checks: Excluded person or entities During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of	Yes

the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

BX.8b	Federal database checks: Summarize instances of exclusion	The SMA Office of Program Integrity notified the fiscal agent, Office of Enrollment and the CCOs of the providers exclusion. The SMA and the CCOs are required to send a termination notice to the provider with five (5) working days from identification of exclusion. The CCOs must provide the Office of Program Integrity with a copy of the providers termination notice.
BX.9a	Website posting of 5 percent or more ownership control	No
BX.10	Periodic audits	No such audits were conducted during the reporting year. The last one reported was for CY 2022.

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<p>Program contract</p> <p>Enter the title of the contract between the state and plans participating in the managed care program.</p>	<p>CONTRACT BETWEEN THE STATE OF MISSISSIPPI DIVISION OF MEDICAID OFFICE OF THE GOVERNOR AND A COORDINATED CARE ORGANIZATION (CCO) July 1, 2017 - June 30, 2023 + July 1, 2023 - June 30, 2024 Emergency Contract + July 1, 2024 - June 30, 2025 Emergency Contract for UnitedHealthcare of Mississippi, Inc. d/b/a UnitedHealthcare Community Plan of Mississippi Molina Healthcare of MS, Inc. and Magnolia Health Plan</p>
N/A	<p>Enter the date of the contract between the state and plans participating in the managed care program.</p>	07/01/2017
C11.2	<p>Contract URL</p> <p>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.</p>	<p>https://medicaid.ms.gov/programs/managed-care/11081-2/</p>
C11.3	<p>Program type</p> <p>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.</p>	Managed Care Organization (MCO)
C11.4a	<p>Special program benefits</p> <p>Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more.</p> <p>Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.</p>	<p>Behavioral health</p> <p>Dental</p> <p>Transportation</p>
C11.4b	<p>Variation in special benefits</p> <p>What are any variations in the availability of special benefits within the program (e.g. by</p>	N/A

service area or population)?
Enter "N/A" if not applicable.

C11.5	Program enrollment	439,217
	Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	

C11.6	Changes to enrollment or benefits	Managed Care Enrollment Changes 2025: New CCO Health Plan - Mississippi True d/b/a TrueCare will join Molina Healthcare and Magnolia Health Plan as a Coordinated Care Organization (CCO) serving Mississippi Medicaid members, effective July 1, 2025. Provide coverage for Mississippi members (members will be able to select a new CCO). As of July 1, 2025, UnitedHealthcare will no longer provide services for MS Medicaid Managed Care programs. Due to the upcoming transition, UnitedHealthcare no longer received new members March-June 2025. UnitedHealthcare last day of enrolled members was June 30, 2025 due to the end of the SFY25 contract.
	Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.	

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p data-bbox="313 107 634 136">Uses of encounter data</p> <p data-bbox="313 161 695 317">For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p data-bbox="313 321 727 569">Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).</p>	<p data-bbox="760 107 911 136">Rate setting</p> <p data-bbox="760 180 1219 210">Quality/performance measurement</p> <p data-bbox="760 254 1089 283">Monitoring and reporting</p> <p data-bbox="760 327 997 357">Contract oversight</p> <p data-bbox="760 401 987 430">Program integrity</p> <p data-bbox="760 474 1219 504">Policy making and decision support</p>
C1III.2	<p data-bbox="313 625 691 697">Criteria/measures to evaluate MCP performance</p> <p data-bbox="313 722 727 907">What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more.</p> <p data-bbox="313 911 727 1224">Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).</p>	<p data-bbox="760 625 1240 655">Timeliness of initial data submissions</p> <p data-bbox="760 699 1146 728">Timeliness of data corrections</p> <p data-bbox="760 772 1170 802">Timeliness of data certifications</p> <p data-bbox="760 846 1094 875">Use of correct file formats</p> <p data-bbox="760 919 1094 949">Provider ID field complete</p> <p data-bbox="760 993 1349 1056">Overall data accuracy (as determined through data validation)</p>
C1III.3	<p data-bbox="313 1276 716 1348">Encounter data performance criteria contract language</p> <p data-bbox="313 1373 727 1654">Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.</p>	<p data-bbox="760 1276 1360 1434">Exhibit A MSCAN Contract Amendment 4, Section 11 - Reporting Requirements, S. Member Encounter Data and Amendment #14 and SFY 2025 Emergency Contract</p>

C1III.4	<p>Financial penalties contract language</p> <p>Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.</p>	<p>Exhibit A MSCAN Contract Amendment 4 and Amendment 12, Section 16 - Default and Termination, E. Liquidated Damages</p>
C1III.5	<p>Incentives for encounter data quality</p> <p>Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.</p>	<p>N/A</p>
C1III.6	<p>Barriers to collecting/validating encounter data</p> <p>Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.</p>	<p>The state would benefit from CMS standardization of encounter claim guidance, federal regulations and contract language for all encounter claim types, especially pharmacy. Validation of paid amounts on drug claims reported by managed care plans was more challenging and administratively burdensome without the assistance of a vendor. CMS standardization would allow the state to enforce compliance with specific requirements of encounter claim data submissions. The state understands that shadow pricing of the claims is required so the state reprocesses the claims as if FFS instead of only receiving/ingesting the encounter. But the state provides errors/edit codes to the CCO if the encounter processes differently than what the CCO paid.</p>

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p>State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program</p> <p>If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for “critical incidents” within the managed care program? Respond with “N/A” if the managed care program does not cover LTSS.</p>	N/A
C1IV.2	<p>State definition of “timely” resolution for standard appeals</p> <p>Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.</p>	<p>"For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal." 42 C.F.R. §438.408(b)(2). The MCO, PIHP, or PAHP may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. §438.408(c).</p>
C1IV.3	<p>State definition of “timely” resolution for expedited appeals</p> <p>Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.</p>	<p>"For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal." 42 CFR §438.408(b)(3) The MCO, PIHP, or PAHP may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c).</p>

C1IV.4**State definition of “timely” resolution for grievances**

Provide the state’s definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

"For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance." 42 CFR § 438.408(b)(1) Note: Grievances, complaints, and appeals made at the MCO/Plan level are required to be reported to DOM.

Topic V. Availability, Accessibility and Network Adequacy**Network Adequacy**

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	<p>Mississippi is a rural state facing a major shortage of health care professionals, particularly for citizens in small, isolated communities. A slow economy and sparse population base impact many health care providers' decisions to work in these sites. Limited opportunities for continuing education and dialogue with colleagues leave many healthcare professionals feeling isolated. (1) In addition, such rural providers have limited access to medical facilities that are equipped to handle patients needing acute care. Recruiting health care professionals to rural areas is a growing problem, not only within this rural state, but nationally." Hart-Hester, Susan, and Charlotte Thomas. "Access to health care professionals in rural Mississippi. (Original Article)." Southern Medical Journal, vol. 96, no.2, Feb. 2003, pp. 149+. Gale Academic OneFile, link.gale.com/apps/doc/A98828111/AONE?u=anon~abac88e5&sid=googleScholar&xid=cc74c576. Accessed 18 July 2022. DOM is working to improve the review and consistency of the plan reporting and requesting additional information for any possible contract changes needed. Those potential changes include additional specialties (e.g. laboratory), defining urban and rural, defining specialties, etc. With a consistent reporting, it could help DOM understand any potential gaps and shortages better in order to address them. DOM is continuing to request additional information and a presentation of how the plans review and address network adequacy requirements and any challenges.</p>

C1V.2

State response to gaps in network adequacy

How does the state work with MCPs to address gaps in network adequacy?

Monitoring Resources include Quarterly GeoAccess Reporting; EQR Network Validation; Monthly Quality Meetings; and Complaint/Grievance Reporting DOM partners with MCPs for innovative outreach methods for at-risk members. Some of the outreach measures used in remote areas include mobile care units, health fairs, and telehealth. DOM is continuing to review and require ad hoc reports and presentations regarding network adequacy from the plans.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.



Complete

C2.V.3 Standard type: Maximum distance to travel

1 / 34

C2.V.2 Measure standard

Two (2) within fifteen (15) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum distance to travel

2 / 34

C2.V.2 Measure standard

Two (2) within thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls, Encounter Data Analysis

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

3 / 34

C2.V.2 Measure standard

"One (1) within thirty (30) minutes or thirty (30) miles"

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

4 / 34

C2.V.2 Measure standard

"One within sixty (60) minutes or sixty (60) miles"

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

5 / 34

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Adult and
Pediatric

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

6 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Adult and
Pediatric

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

7 / 34

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Dental

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

8 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Dental

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

9 / 34

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Dental

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

10 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Dental

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

11 / 34

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Emergency Care
Providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



C2.V.3 Standard type: Maximum time or distance

12 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Emergency Care
Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



C2.V.3 Standard type: Maximum time or distance

13 / 34

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: Urgent
Care Providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



C2.V.3 Standard type: Maximum time or distance

14 / 34

Complete

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

15 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

16 / 34

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health
Providers (Mental
Health Providers and
Substance Use
Disorder) (Adult and
Pediatric)

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

17 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health
Providers (Mental
Health Providers and
Substance Use
Disorder) (Adult and
Pediatric)

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly

**C2.V.3 Standard type: Maximum time or distance**

18 / 34

Complete

C2.V.2 Measure standard

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Durable Medical
Equipment Providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

19 / 34

C2.V.2 Measure standard

One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Durable Medical
Equipment Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

20 / 34

C2.V.2 Measure standard

One (1) open twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

21 / 34

C2.V.2 Measure standard

One (1) open twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

22 / 34

C2.V.2 Measure standard

"One (1) within sixty (60) minutes or sixty (60) miles"

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Dialysis
Providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

23 / 34

C2.V.2 Measure standard

One within ninety (90) minutes or ninety (90) miles

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Dialysis
Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

24 / 34

C2.V.2 Measure standard

Well Care Visit-Not to exceed thirty (30) calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

Primary care

Statewide

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Biannual



Complete

C2.V.3 Standard type: Appointment wait time

25 / 34

C2.V.2 Measure standard

Routine Sick Visit-Not to exceed seven (7) calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Biannual



Complete

C2.V.3 Standard type: Appointment wait time

26 / 34

C2.V.2 Measure standard

Urgent Care Visit-Not to exceed twenty-four (24) hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Biannual



Complete

C2.V.3 Standard type: Appointment wait time

27 / 34

C2.V.2 Measure standard

Not to exceed seven (7) calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

28 / 34

C2.V.2 Measure standard

Routine Visit-Not to exceed forty-five (45) calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Dental

C2.V.5 Region

Statewide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

29 / 34

C2.V.2 Measure standard

Urgent Visit-Not to exceed forty-eight (48) hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Dental

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly



Complete

C2.V.3 Standard type: Appointment wait time

30 / 34

C2.V.2 Measure standard

Routine Visit-Not to exceed twenty-one (21) calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral health

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method - Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly



Complete

C2.V.3 Standard type: Appointment wait time

31 / 34

C2.V.2 Measure standard

Urgent Visit-Not to exceed twenty-four (24) hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral health

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly



Complete

C2.V.3 Standard type: Appointment wait time

32 / 34

C2.V.2 Measure standard

Post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge-Not to exceed seven (7) calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral health

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly



Complete

C2.V.3 Standard type: Appointment wait time

33 / 34

C2.V.2 Measure standard

Urgent Care Providers-Not to exceed twenty-four (24) hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care: Urgent
Care Providers

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly



Complete

C2.V.3 Standard type: Appointment wait time

34 / 34

C2.V.2 Measure standard

Emergency Providers-Immediately (twenty-four (24) hours a day, seven (7)
days a week) and without Prior Authorization

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Emergency Care
Providers

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of Grievances Related to Access, Custom method -
Secret Shopper Calls

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	<p>BSS website</p> <p>List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.</p>	<p>www.medicaid.ms.gov – DOM’s external website with links to regional office contact information, can call for Regional Office email address. Lots of information for beneficiaries on programs, appeals, medical services. email address –RFI@medicaid.ms.gov (this email will phase out in latter CY 2025); www.access.ms.gov –Common Web Portal with Self Service Portal –members can create an account to apply for benefits, renew benefits, upload requested documents, report change in circumstances, or file appeal. Conduent (eligibility vendor) devised this shared site (DOM/DHS). https://portal.ms-medicaid-mesa.com/ms/member - MESA (MMIS) portal where members can register to create account and see benefits, request and ID card, or call the Gainwell Call Center at 1-800-884-3222</p>
C1IX.2	<p>BSS auxiliary aids and services</p> <p>How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.</p>	<p>The DOM website details these services as follows: Beneficiaries may contact Gainwell and/or the Mississippi Division of Medicaid (DOM), Office of Managed Care, Member Services in multiple ways including by phone, postal mail, and fax. If you speak another language, assistance services, free of charge, are available to you. Call 1-800-421-2408 (Deaf and Hard of Hearing VP: 1-228-206-6062). For more information, read our Notice of Non-Discrimination. Site link: https://medicaid.ms.gov/notice-of-non-discrimination/</p>
C1IX.3	<p>BSS LTSS program data</p> <p>How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).</p>	<p>LTSS is not included in Managed Care with the exception of psychiatric residential treatment facilities (PRTF). Any other long term or nursing home care member are disenrolled from MSCAN and go to Fee for Service (FFS). LTSS programmatic grievances (complaints) and waiver service appeals are tracked in eLTSS (system to electronically track).</p>

C1IX.4 State evaluation of BSS entity performance N/A

What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	<p>Does this program include MCOs?</p> <p>If "Yes", please complete the following questions.</p>	Yes
C1XII.5	<p>Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?</p> <p>(i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)</p>	No
C1XII.6	<p>Did the State or MCOs complete the most recent parity analysis(es)?</p>	MCO
C1XII.7a	<p>Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?</p> <p>(e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)</p>	No
C1XII.8	<p>When was the last parity analysis(es) for this program completed?</p> <p>States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).</p>	05/15/2019
C1XII.9	<p>When was the last parity analysis(es) for this program</p>	12/31/2019

submitted to CMS?

States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).

C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	Yes
C1XII.10b	In the last analysis(es) conducted, describe all deficiencies identified.	Authorization requirements, benefit limits, OON rate discrepancy
C1XII.11a	As of the end of this reporting period, have these deficiencies been resolved for all plans?	Yes
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website?	Yes
	<p>The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.</p>	
C1XII.12b	Provide the URL link(s). Response must be a valid hyperlink/URL beginning with	https://medicaid.ms.gov/wp-content/uploads/2020/01/MHPAEA-Report.pdf

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D11.1	<p>Plan enrollment</p> <p>Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).</p>	<p>Magnolia Health Plan 175,943</p> <p>Molina Healthcare of MS 101,572</p> <p>UnitedHealthcare Community Plan of MS 161,702</p>
D11.2	<p>Plan share of Medicaid</p> <p>What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D11.1) Denominator: Statewide Medicaid enrollment (B.I.1)</p>	<p>Magnolia Health Plan 26.9%</p> <p>Molina Healthcare of MS 15.5%</p> <p>UnitedHealthcare Community Plan of MS 24.7%</p>
D11.3	<p>Plan share of any Medicaid managed care</p> <p>What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? Numerator: Plan enrollment (D11.1) Denominator: Statewide Medicaid managed care enrollment (B.I.2)</p>	<p>Magnolia Health Plan 40.1%</p> <p>Molina Healthcare of MS 23.1%</p> <p>UnitedHealthcare Community Plan of MS 36.8%</p>
D11.4: Parent	<p>Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.</p> <p>If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.</p>	<p>Magnolia Health Plan Centene Corporation</p> <p>Molina Healthcare of MS Molina Healthcare Inc.</p> <p>UnitedHealthcare Community Plan of MS UnitedHealthcare, Inc.</p>

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	<p>Medical Loss Ratio (MLR)</p> <p>What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.</p>	<p>Magnolia Health Plan 96%</p> <p>Molina Healthcare of MS 92%</p> <p>UnitedHealthcare Community Plan of MS 96%</p>
D1II.1b	<p>Level of aggregation</p> <p>What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.</p>	<p>Magnolia Health Plan Program-specific statewide</p> <p>Molina Healthcare of MS Program-specific statewide</p> <p>UnitedHealthcare Community Plan of MS Program-specific statewide</p>
D1II.2	<p>Population specific MLR description</p> <p>Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.</p>	<p>Magnolia Health Plan N/A</p> <p>Molina Healthcare of MS N/A</p> <p>UnitedHealthcare Community Plan of MS N/A</p>

D1II.3

**MLR reporting period
discrepancies**

Does the data reported in item
D1.II.1a cover a different time
period than the MCPAR report?

Magnolia Health Plan

No

Molina Healthcare of MS

No

**UnitedHealthcare Community Plan of
MS**

No

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p data-bbox="313 107 708 176">Definition of timely encounter data submissions</p> <p data-bbox="313 201 708 453">Describe the state’s standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.</p>	<p data-bbox="813 134 1110 165">Magnolia Health Plan</p> <p data-bbox="813 191 1377 579">The Contractor must submit complete and accurate Member Encounter Data that includes: a. All Member Encounter data, b. Member Encounter Data adjustments, c. Encounters reflecting a zero-dollar amount (\$0.00), d. Encounters reflecting claim voids, e. Encounter claims reflecting denied claims, and f. Encounters in which the Contractor has a capitation arrangement with a provider.</p> <p data-bbox="813 621 1154 653">Molina Healthcare of MS</p> <p data-bbox="813 678 1377 1066">The Contractor must submit complete and accurate Member Encounter Data that includes: a. All Member Encounter data, b. Member Encounter Data adjustments, c. Encounters reflecting a zero-dollar amount (\$0.00), d. Encounters reflecting claim voids, e. Encounter claims reflecting denied claims, and f. Encounters in which the Contractor has a capitation arrangement with a provider.</p> <p data-bbox="813 1108 1338 1171">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 1197 1377 1583">The Contractor must submit complete and accurate Member Encounter Data that includes: a. All Member Encounter data, b. Member Encounter Data adjustments, c. Encounters reflecting a zero-dollar amount (\$0.00), d. Encounters reflecting claim voids, e. Encounter claims reflecting denied claims, and f. Encounters in which the Contractor has a capitation arrangement with a provider.</p>
D1III.2	<p data-bbox="313 1640 727 1793">Share of encounter data submissions that met state’s timely submission requirements</p> <p data-bbox="313 1818 727 2100">What percent of the plan’s encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the</p>	<p data-bbox="813 1671 1110 1703">Magnolia Health Plan</p> <p data-bbox="813 1728 911 1759">96.35%</p> <p data-bbox="813 1801 1154 1833">Molina Healthcare of MS</p> <p data-bbox="813 1858 911 1890">99.61%</p> <p data-bbox="813 1932 1338 1995">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 2020 911 2051">96.96%</p>

state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.

D1III.3	Share of encounter data submissions that were HIPAA compliant	Magnolia Health Plan
	What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	100%
		Molina Healthcare of MS
100%		
		UnitedHealthcare Community Plan of MS
		100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	<p data-bbox="313 107 716 180">Appeals resolved (at the plan level)</p> <p data-bbox="313 201 716 642">Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.</p>	<p data-bbox="813 138 1110 170">Magnolia Health Plan</p> <p data-bbox="813 191 883 222">3,118</p> <p data-bbox="813 264 1154 296">Molina Healthcare of MS</p> <p data-bbox="813 317 862 348">485</p> <p data-bbox="813 390 1338 453">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 474 862 506">286</p>
D1IV.1a	<p data-bbox="313 695 521 726">Appeals denied</p> <p data-bbox="313 747 699 905">Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.</p>	<p data-bbox="813 726 1110 758">Magnolia Health Plan</p> <p data-bbox="813 779 862 810">362</p> <p data-bbox="813 852 1154 884">Molina Healthcare of MS</p> <p data-bbox="813 905 862 936">115</p> <p data-bbox="813 978 1338 1041">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 1062 862 1094">208</p>
D1IV.1b	<p data-bbox="313 1157 683 1230">Appeals resolved in partial favor of enrollee</p> <p data-bbox="313 1251 699 1377">Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.</p>	<p data-bbox="813 1188 1110 1220">Magnolia Health Plan</p> <p data-bbox="813 1241 846 1272">55</p> <p data-bbox="813 1314 1154 1346">Molina Healthcare of MS</p> <p data-bbox="813 1367 862 1398">N/A</p> <p data-bbox="813 1440 1338 1503">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 1524 846 1556">10</p>
D1IV.1c	<p data-bbox="313 1619 699 1692">Appeals resolved in favor of enrollee</p> <p data-bbox="313 1713 699 1839">Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.</p>	<p data-bbox="813 1650 1110 1682">Magnolia Health Plan</p> <p data-bbox="813 1703 862 1734">328</p> <p data-bbox="813 1776 1154 1808">Molina Healthcare of MS</p> <p data-bbox="813 1829 862 1860">224</p> <p data-bbox="813 1902 1338 1965">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 1986 846 2018">68</p>

D1IV.2**Active appeals**

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

Magnolia Health Plan

3

Molina Healthcare of MS

0

UnitedHealthcare Community Plan of MS

7

D1IV.3**Appeals filed on behalf of LTSS users**

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

9

D1IV.4**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal

Magnolia Health Plan

N/A

Molina Healthcare of MS

0

UnitedHealthcare Community Plan of MS

N/A

need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	Standard appeals for which timely resolution was provided	Magnolia Health Plan
		620
		Molina Healthcare of MS
Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	433	
	UnitedHealthcare Community Plan of MS	
	214	
<hr/>		
D1IV.5b	Expedited appeals for which timely resolution was provided	Magnolia Health Plan
		123
		Molina Healthcare of MS
Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	52	
	UnitedHealthcare Community Plan of MS	
	31	
<hr/>		
D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service	Magnolia Health Plan
		745
		Molina Healthcare of MS
Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	485	
	UnitedHealthcare Community Plan of MS	
	285	

D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	0
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		0
D1IV.6c	Resolved appeals related to payment denial	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	2,373
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		1
D1IV.6d	Resolved appeals related to service timeliness	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	0
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		0
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	0
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		0
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	Magnolia Health Plan
		0
		Molina Healthcare of MS

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

0

UnitedHealthcare Community Plan of MS

0

D1IV.6g

Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Magnolia Health Plan

0

Molina Healthcare of MS

0

UnitedHealthcare Community Plan of MS

0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	<p data-bbox="316 105 706 178">Resolved appeals related to general inpatient services</p> <p data-bbox="316 199 730 609">Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.</p>	<p data-bbox="820 136 1112 168">Magnolia Health Plan</p> <p data-bbox="820 189 852 220">11</p> <p data-bbox="820 262 1161 294">Molina Healthcare of MS</p> <p data-bbox="820 315 836 346">5</p> <p data-bbox="820 388 1347 451">UnitedHealthcare Community Plan of MS</p> <p data-bbox="820 472 836 504">3</p>
D1IV.7b	<p data-bbox="316 661 706 735">Resolved appeals related to general outpatient services</p> <p data-bbox="316 756 730 1270">Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.</p>	<p data-bbox="820 693 1112 724">Magnolia Health Plan</p> <p data-bbox="820 745 868 777">126</p> <p data-bbox="820 819 1161 850">Molina Healthcare of MS</p> <p data-bbox="820 871 852 903">55</p> <p data-bbox="820 945 1347 1008">UnitedHealthcare Community Plan of MS</p> <p data-bbox="820 1029 852 1060">77</p>
D1IV.7c	<p data-bbox="316 1312 706 1428">Resolved appeals related to inpatient behavioral health services</p> <p data-bbox="316 1449 730 1732">Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.</p>	<p data-bbox="820 1344 1112 1375">Magnolia Health Plan</p> <p data-bbox="820 1396 868 1428">109</p> <p data-bbox="820 1470 1161 1501">Molina Healthcare of MS</p> <p data-bbox="820 1522 852 1554">47</p> <p data-bbox="820 1596 1347 1659">UnitedHealthcare Community Plan of MS</p> <p data-bbox="820 1680 836 1711">4</p>
D1IV.7d	<p data-bbox="316 1785 706 1900">Resolved appeals related to outpatient behavioral health services</p> <p data-bbox="316 1921 730 2079">Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or</p>	<p data-bbox="820 1816 1112 1848">Magnolia Health Plan</p> <p data-bbox="820 1869 852 1900">96</p> <p data-bbox="820 1942 1161 1974">Molina Healthcare of MS</p> <p data-bbox="820 1995 868 2026">195</p>

substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

UnitedHealthcare Community Plan of MS

15

D1IV.7e

Resolved appeals related to covered outpatient prescription drugs

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".

Magnolia Health Plan

8

Molina Healthcare of MS

5

UnitedHealthcare Community Plan of MS

4

D1IV.7f

Resolved appeals related to skilled nursing facility (SNF) services

Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".

Magnolia Health Plan

0

Molina Healthcare of MS

55

UnitedHealthcare Community Plan of MS

1

D1IV.7g

Resolved appeals related to long-term services and supports (LTSS)

Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

D1IV.7h	Resolved appeals related to dental services	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	31
		Molina Healthcare of MS
		195
		UnitedHealthcare Community Plan of MS
		72
<hr/>		
D1IV.7i	Resolved appeals related to non-emergency medical transportation (NEMT)	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	0
		Molina Healthcare of MS
		2
		UnitedHealthcare Community Plan of MS
		0
<hr/>		
D1IV.7k:	Resolved appeals related to durable medical equipment (DME) & supplies	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	0
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		0
<hr/>		
D1IV.7l:	Resolved appeals related to home health / hospice	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	0
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		0
<hr/>		
D1IV.7m:	Resolved appeals related to emergency services / emergency department	Magnolia Health Plan
	Enter the total number of appeals resolved by the plan	0
		Molina Healthcare of MS

during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.

0

UnitedHealthcare Community Plan of MS

0

D1IV.7n: Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.

Magnolia Health Plan

0

Molina Healthcare of MS

0

UnitedHealthcare Community Plan of MS

0

D1IV.7o Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.

Magnolia Health Plan

364

Molina Healthcare of MS

88

UnitedHealthcare Community Plan of MS

108

State Fair Hearings

Number	Indicator	Response
D1IV.8a	<p>State Fair Hearing requests</p> <p>Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.</p>	<p>Magnolia Health Plan</p> <p>30</p> <p>Molina Healthcare of MS</p> <p>3</p> <p>UnitedHealthcare Community Plan of MS</p> <p>1</p>
D1IV.8b	<p>State Fair Hearings resulting in a favorable decision for the enrollee</p> <p>Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.</p>	<p>Magnolia Health Plan</p> <p>7</p> <p>Molina Healthcare of MS</p> <p>1</p> <p>UnitedHealthcare Community Plan of MS</p> <p>1</p>
D1IV.8c	<p>State Fair Hearings resulting in an adverse decision for the enrollee</p> <p>Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.</p>	<p>Magnolia Health Plan</p> <p>17</p> <p>Molina Healthcare of MS</p> <p>2</p> <p>UnitedHealthcare Community Plan of MS</p> <p>0</p>
D1IV.8d	<p>State Fair Hearings retracted prior to reaching a decision</p> <p>Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.</p>	<p>Magnolia Health Plan</p> <p>6</p> <p>Molina Healthcare of MS</p> <p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>0</p>
D1IV.9a	<p>External Medical Reviews resulting in a favorable decision for the enrollee</p>	<p>Magnolia Health Plan</p> <p>N/A</p>

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Molina Healthcare of MS

0

UnitedHealthcare Community Plan of MS

0

D1IV.9b

External Medical Reviews resulting in an adverse decision for the enrollee

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Magnolia Health Plan

N/A

Molina Healthcare of MS

0

UnitedHealthcare Community Plan of MS

0

Grievances Overview

Number	Indicator	Response
D1IV.10	<p>Grievances resolved</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.</p>	<p>Magnolia Health Plan</p> <p>952</p> <p>Molina Healthcare of MS</p> <p>1,060</p> <p>UnitedHealthcare Community Plan of MS</p> <p>589</p>
D1IV.11	<p>Active grievances</p> <p>Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>Magnolia Health Plan</p> <p>0</p> <p>Molina Healthcare of MS</p> <p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>56</p>
D1IV.12	<p>Grievances filed on behalf of LTSS users</p> <p>Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.</p>	<p>Magnolia Health Plan</p> <p>N/A</p> <p>Molina Healthcare of MS</p> <p>N/A</p> <p>UnitedHealthcare Community Plan of MS</p> <p>3</p>
D1IV.13	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance</p> <p>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue -</p>	<p>Magnolia Health Plan</p> <p>N/A</p> <p>Molina Healthcare of MS</p> <p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>N/A</p>

they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14	Number of grievances for which timely resolution was provided	Magnolia Health Plan
	Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	952
		Molina Healthcare of MS
		1,060
		UnitedHealthcare Community Plan of MS
		514

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	<p>Resolved grievances related to general inpatient services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.</p>	<p>Magnolia Health Plan 0</p> <p>Molina Healthcare of MS 71</p> <p>UnitedHealthcare Community Plan of MS 14</p>
D1IV.15b	<p>Resolved grievances related to general outpatient services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.</p>	<p>Magnolia Health Plan 0</p> <p>Molina Healthcare of MS 206</p> <p>UnitedHealthcare Community Plan of MS 173</p>
D1IV.15c	<p>Resolved grievances related to inpatient behavioral health services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.</p>	<p>Magnolia Health Plan 7</p> <p>Molina Healthcare of MS 15</p> <p>UnitedHealthcare Community Plan of MS 3</p>
D1IV.15d	<p>Resolved grievances related to outpatient behavioral health services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that</p>	<p>Magnolia Health Plan 4</p> <p>Molina Healthcare of MS</p>

were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

30

UnitedHealthcare Community Plan of MS

10

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Magnolia Health Plan

0

Molina Healthcare of MS

55

UnitedHealthcare Community Plan of MS

6

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

D1IV.15g

Resolved grievances related to long-term services and supports (LTSS)

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Magnolia Health Plan

N/A

Molina Healthcare of MS

N/A

UnitedHealthcare Community Plan of MS

N/A

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

Magnolia Health Plan

17

Molina Healthcare of MS

56

UnitedHealthcare Community Plan of MS

D1IV.15i	<p>Resolved grievances related to non-emergency medical transportation (NEMT)</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Magnolia Health Plan</p>
		487
		<p>Molina Healthcare of MS</p>
		186
		<p>UnitedHealthcare Community Plan of MS</p>
		320
D1IV.15k	<p>Resolved grievances related to durable medical equipment (DME) & supplies</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Magnolia Health Plan</p>
		0
		<p>Molina Healthcare of MS</p>
		48
		<p>UnitedHealthcare Community Plan of MS</p>
		7
D1IV.15l	<p>Resolved grievances related to home health / hospice</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Magnolia Health Plan</p>
		0
		<p>Molina Healthcare of MS</p>
		6
		<p>UnitedHealthcare Community Plan of MS</p>
		3
D1IV.15m	<p>Resolved grievances related to emergency services / emergency department</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Magnolia Health Plan</p>
		0
		<p>Molina Healthcare of MS</p>
		18
		<p>UnitedHealthcare Community Plan of MS</p>
		18

<p>D1IV.15n</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Resolved grievances related to therapies</p>	<p>Magnolia Health Plan</p> <p>0</p> <p>Molina Healthcare of MS</p> <p>30</p> <p>UnitedHealthcare Community Plan of MS</p> <p>2</p>
<p>D1IV.15o</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".</p>	<p>Resolved grievances related to other service types</p>	<p>Magnolia Health Plan</p> <p>437</p> <p>Molina Healthcare of MS</p> <p>441</p> <p>UnitedHealthcare Community Plan of MS</p> <p>10</p>

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	<p>Resolved grievances related to plan or provider customer service</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.</p>	<p>Magnolia Health Plan 3</p> <p>Molina Healthcare of MS 51</p> <p>UnitedHealthcare Community Plan of MS 11</p>
D1IV.16b	<p>Resolved grievances related to plan or provider care management/case management</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.</p>	<p>Magnolia Health Plan 1</p> <p>Molina Healthcare of MS 0</p> <p>UnitedHealthcare Community Plan of MS 37</p>
D1IV.16c	<p>Resolved grievances related to network adequacy or access to care/services from plan or provider</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.</p>	<p>Magnolia Health Plan 456</p> <p>Molina Healthcare of MS 433</p> <p>UnitedHealthcare Community Plan of MS 44</p>
D1IV.16d	<p>Resolved grievances related to quality of care</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.</p>	<p>Magnolia Health Plan 0</p> <p>Molina Healthcare of MS 29</p> <p>UnitedHealthcare Community Plan of MS 71</p>
D1IV.16e	<p>Resolved grievances related to plan communications</p>	<p>Magnolia Health Plan</p>

	<p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.</p>	<p>0</p> <p>Molina Healthcare of MS</p> <p>8</p> <p>UnitedHealthcare Community Plan of MS</p> <p>4</p>
<p>D1IV.16f</p>	<p>Resolved grievances related to payment or billing issues</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.</p>	<p>Magnolia Health Plan</p> <p>448</p> <p>Molina Healthcare of MS</p> <p>327</p> <p>UnitedHealthcare Community Plan of MS</p> <p>103</p>
<p>D1IV.16g</p>	<p>Resolved grievances related to suspected fraud</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.</p>	<p>Magnolia Health Plan</p> <p>2</p> <p>Molina Healthcare of MS</p> <p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>2</p>
<p>D1IV.16h</p>	<p>Resolved grievances related to abuse, neglect or exploitation</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.</p>	<p>Magnolia Health Plan</p> <p>0</p> <p>Molina Healthcare of MS</p> <p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>0</p>
<p>D1IV.16i</p>	<p>Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)</p>	<p>Magnolia Health Plan</p> <p>0</p> <p>Molina Healthcare of MS</p>

	<p>Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).</p>	<p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>0</p>
<p>D1IV.16j</p>	<p>Resolved grievances related to plan denial of expedited appeal</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.</p>	<p>Magnolia Health Plan</p> <p>0</p> <p>Molina Healthcare of MS</p> <p>0</p> <p>UnitedHealthcare Community Plan of MS</p> <p>0</p>
<p>D1IV.16k</p>	<p>Resolved grievances filed for other reasons</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.</p>	<p>Magnolia Health Plan</p> <p>42</p> <p>Molina Healthcare of MS</p> <p>212</p> <p>UnitedHealthcare Community Plan of MS</p> <p>317</p>

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.



Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS-AD)

1 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

54.19

Molina Healthcare of MS

42.65

UnitedHealthcare Community Plan of MS

46.02



Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS-AD)

2 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

51.73

Molina Healthcare of MS

50.75

UnitedHealthcare Community Plan of MS

48.32



Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women Ages 21-24 (CHL-AD)

3 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

55.84

Molina Healthcare of MS

58.45



Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women Ages 16-20 (CHL-CH)

4 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

48.39

Molina Healthcare of MS

50.55

UnitedHealthcare Community Plan of MS

45



Complete

D2.VII.1 Measure Name: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)

5 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

N/A

D2.VII.6 Measure Set
Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

0.08

Molina Healthcare of MS

0.82

UnitedHealthcare Community Plan of MS

0.09



Complete

D2.VII.1 Measure Name: Screening for Depression and Follow-Up Plan: Ages 12 -17 (CDF-CH) 6 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

0.14

Molina Healthcare of MS

0.21

UnitedHealthcare Community Plan of MS

0.09



Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV-CH)

7 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

46.47

Molina Healthcare of MS

43.51

UnitedHealthcare Community Plan of MS

42.57



Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30-CH)

8 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

73.76

Molina Healthcare of MS

70.13

UnitedHealthcare Community Plan of MS

72.55



Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months of Life (W15-CH) 9 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

64.53

Molina Healthcare of MS

61.44

UnitedHealthcare Community Plan of MS

60.83



Complete

**D2.VII.1 Measure Name: WCV-CH: Child and Adolescent Well-Care Visits^{10 / 46}
12-17 year olds**

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

44.75

Molina Healthcare of MS

39.05

UnitedHealthcare Community Plan of MS

40.68



Complete

**D2.VII.1 Measure Name: IMA-CH: Immunizations for Adolescents
Combo 1**

11 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

48.21

Molina Healthcare of MS

37.3

UnitedHealthcare Community Plan of MS

44.18



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA-CH) Combo 2

12 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

17.11

Molina Healthcare of MS

10.28

UnitedHealthcare Community Plan of MS

16.26



Complete

D2.VII.1 Measure Name: Developmental Screening in the First Three Years of Life (DEV-CH) 13 / 46

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

32.95

Molina Healthcare of MS

32.27

UnitedHealthcare Community Plan of MS

32.78



Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care (PPC-AD) 14 / 46

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

54.28

Molina Healthcare of MS

53.07

UnitedHealthcare Community Plan of MS

53.09



Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) Most or Moderately Effective Contraception - 3 days 5 / 46

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

13.33

Molina Healthcare of MS

12.65

UnitedHealthcare Community Plan of MS

12.6



Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 16 / 46 21-44 (CCP-AD) Most or Moderately Effective Contraception - 90 days

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

55.53

Molina Healthcare of MS

52.94

UnitedHealthcare Community Plan of MS

55.77



D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) LARC - 3 days 7 / 46

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

0.67

Molina Healthcare of MS

1

UnitedHealthcare Community Plan of MS

0.77



D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) LARC - 90 days 8 / 46

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

11.94

Molina Healthcare of MS

11.79

UnitedHealthcare Community Plan of MS

11.69



Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21 to 44 ^{19 / 46} (CCW-AD) LARC

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

4.16

Molina Healthcare of MS

4.74

UnitedHealthcare Community Plan of MS

4.65



D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP-AD)

20 / 46

Complete

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

2.51

Molina Healthcare of MS

63.75

UnitedHealthcare Community Plan of MS

2.43



D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB-AD)

21 / 46

Complete

D2.VII.2 Measure Domain

Long-term services and supports

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

33.03

Molina Healthcare of MS

40.69

UnitedHealthcare Community Plan of MS

34.92



Complete

D2.VII.1 Measure Name: HPCMI-AD: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control Ages 18-64 (> 9)

22 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

78.57

Molina Healthcare of MS

85.71

UnitedHealthcare Community Plan of MS

82.02



D2.VII.1 Measure Name: Diabetes Short-Term Complications Admission Rate (PQI-01-AD) 23 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

29.01

Molina Healthcare of MS

19.66

UnitedHealthcare Community Plan of MS

23.5



D2.VII.1 Measure Name: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05-AD) Age 40-64 24 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

97.58 Rate per 100,00 Member Months

Molina Healthcare of MS

92.13 Rate per 100,00 Member Months

UnitedHealthcare Community Plan of MS

89.45 Rate per 100,00 Member Months



Complete

D2.VII.1 Measure Name: Heart Failure Admission Rate (PQI-08-AD) age 18-64 ^{25 / 46}

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

48.96 Rate per 100,00 Member Months

Molina Healthcare of MS

53.7 Rate per 100,00 Member Months

UnitedHealthcare Community Plan of MS

40.2 Rate per 100,00 Member Months



Complete

D2.VII.1 Measure Name: Asthma in Younger Adults Admission Rate (PQI-15-AD) age 18-39

26 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

1.66 Rate per 100,00 Member Months

Molina Healthcare of MS

3.08 Rate per 100,00 Member Months

UnitedHealthcare Community Plan of MS

2.58 Rate per 100,00 Member Months



Complete

D2.VII.1 Measure Name: Plan All-Cause Readmission Rate (PCR-AD)

27 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

9.16

Molina Healthcare of MS

11.07

UnitedHealthcare Community Plan of MS

10.01



Complete

D2.VII.1 Measure Name: Asthma Medication Ratio: Ages 19-64 (AMR-AD) 28 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

55.98

Molina Healthcare of MS

56.67

UnitedHealthcare Community Plan of MS

52.42



Complete

D2.VII.1 Measure Name: IET-AD: Initiation and Engagement of Substance Use Disorder Treatment Initiation total (all ages)

29 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

43.01

Molina Healthcare of MS

49.62

UnitedHealthcare Community Plan of MS

46.29



Complete

D2.VII.1 Measure Name: IET-AD: Initiation and Engagement of Substance Use Disorder Treatment Engagement total (all ages)

30 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

10.01

Molina Healthcare of MS

13.38

UnitedHealthcare Community Plan of MS

12.44



Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM-AD) Acute Phase

31 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

65.96

Molina Healthcare of MS

60.1

UnitedHealthcare Community Plan of MS

64.88



Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM-AD) Continuation Phase

32 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

48.73

Molina Healthcare of MS

42.55

UnitedHealthcare Community Plan of MS

48.27



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) 30 Days

33 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

69.15

Molina Healthcare of MS

60.38

UnitedHealthcare Community Plan of MS

60.61



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) 7 Days

34 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

44.02

Molina Healthcare of MS

33.88

UnitedHealthcare Community Plan of MS

32.96



Complete

D2.VII.1 Measure Name: OHD-AD Use of Opioids at High Dosage in Persons Without Cancer

35 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

0.83

Molina Healthcare of MS

0.18

UnitedHealthcare Community Plan of MS

0.93



Complete

D2.VII.1 Measure Name: COB-AD Concurrent Use of Opioids and Benzodiazepines

36 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

2.94

Molina Healthcare of MS

2.83

UnitedHealthcare Community Plan of MS

3.41



Complete

D2.VII.1 Measure Name: OUD-AD Use of Pharmacotherapy for Opioid Use Disorder

37 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

44.1

Molina Healthcare of MS

58.09

UnitedHealthcare Community Plan of MS

39.58



Complete

D2.VII.1 Measure Name: FUH-CH Follow-Up After Hospitalization for Mental Illness 30 Days ages 6-17 38 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

76.57

Molina Healthcare of MS

71.91

UnitedHealthcare Community Plan of MS

76.15



D2.VII.1 Measure Name: FUH-CH Follow-Up After Hospitalization for Mental Illness 7 Days ages 6-17 39 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

47.74

Molina Healthcare of MS

42.44

UnitedHealthcare Community Plan of MS

49.91



D2.VII.1 Measure Name: APP-CH Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics Total 40 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

63.68

Molina Healthcare of MS

61.41

UnitedHealthcare Community Plan of MS

59.52



Complete

D2.VII.1 Measure Name: FUM-CH Follow-Up After Emergency Department Visit for Mental Illness 30 Days ages 6-17

41 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

57.69

Molina Healthcare of MS

50.65

UnitedHealthcare Community Plan of MS

61.59



**D2.VII.1 Measure Name: FUM-CH Follow-Up After Emergency
Department Visit for Mental Illness 7 Days ages 6-17**

42 / 46

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

42.31

Molina Healthcare of MS

33.77

UnitedHealthcare Community Plan of MS

46.38



D2.VII.1 Measure Name: AMR-CH Asthma Medication Ratio Ages 5-11

43 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

82.4

Molina Healthcare of MS

76.58

UnitedHealthcare Community Plan of MS

81.58



Complete

D2.VII.1 Measure Name: AMR Asthma Medication Ratio Ages 12-18

44 / 46

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

75.03

Molina Healthcare of MS

70.23

UnitedHealthcare Community Plan of MS

73.16



Complete

D2.VII.1 Measure Name: ADD-CH Follow-Up Care for Children Prescribed ADHD Medication Condition and Maintenance Initiation Phase

45 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan

59.71

Molina Healthcare of MS

52.85

UnitedHealthcare Community Plan of MS

54.84



Complete

D2.VII.1 Measure Name: ADD-CH Follow-Up Care for Children Prescribed ADHD Medication Condition and Maintenance Continuation Phase

46 / 46

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results**Magnolia Health Plan**

64.68

Molina Healthcare of MS

68.88

UnitedHealthcare Community Plan of MS

60.97

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.



Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 5

D3.VIII.2 Plan performance **D3.VIII.3 Plan name**

issue

Magnolia Health Plan

Financial issues

D3.VIII.4 Reason for intervention

"Rescinding what was reported in prior year: Third party liability coverage-failure to identify members enrolled in both Medicaid and Marketplace plans (CY 2014- 2021)"

Sanction details**D3.VIII.5 Instances of non-compliance**

-18,566

D3.VIII.6 Sanction amount

-\$6,498,100

D3.VIII.7 Date assessed

03/14/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/14/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 5

D3.VIII.2 Plan performance **D3.VIII.3 Plan name**

issue

Molina Healthcare of MS

Financial issues

D3.VIII.4 Reason for intervention

Failure to pay full 3% state premium taxes by use of tax credits (CY 2023)

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

\$638,956.47

D3.VIII.7 Date assessed

01/29/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/29/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 5

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

Molina Healthcare of MS

D3.VIII.4 Reason for intervention

Failure to pay full 3% state premium taxes by use of tax credits (CY 2023)

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

\$43,492

D3.VIII.7 Date assessed

11/07/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/07/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 5

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

UnitedHealthcare Community Plan of MS

D3.VIII.4 Reason for intervention

Failure to pay full 3% state premium taxes by use of tax credits (CY 2023)

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

\$1,906,804.29

D3.VIII.7 Date assessed

01/29/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/29/2025

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 5

D3.VIII.2 Plan performance

issue

Financial issues

D3.VIII.3 Plan name

UnitedHealthcare Community Plan of MS

D3.VIII.4 Reason for intervention

Failure to pay full 3% state premium taxes by use of tax credits (CY 2024)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$3,163,105

D3.VIII.7 Date assessed

07/17/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 07/07/2025

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<p data-bbox="313 107 711 176">Dedicated program integrity staff</p> <p data-bbox="313 201 711 390">Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).</p>	<p data-bbox="813 136 1110 168">Magnolia Health Plan</p> <p data-bbox="813 191 829 222">5</p> <p data-bbox="813 262 1154 294">Molina Healthcare of MS</p> <p data-bbox="813 317 829 348">3</p> <p data-bbox="813 388 1338 457">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 480 829 512">2</p>
D1X.2	<p data-bbox="313 569 672 638">Count of opened program integrity investigations</p> <p data-bbox="313 663 711 789">How many program integrity investigations were opened by the plan during the reporting year?</p>	<p data-bbox="813 598 1110 630">Magnolia Health Plan</p> <p data-bbox="813 653 841 684">61</p> <p data-bbox="813 724 1154 756">Molina Healthcare of MS</p> <p data-bbox="813 779 841 810">22</p> <p data-bbox="813 850 1338 919">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 942 841 974">20</p>
D1X.4	<p data-bbox="313 1031 683 1100">Count of resolved program integrity investigations</p> <p data-bbox="313 1125 711 1251">How many program integrity investigations were resolved by the plan during the reporting year?</p>	<p data-bbox="813 1060 1110 1092">Magnolia Health Plan</p> <p data-bbox="813 1115 841 1146">48</p> <p data-bbox="813 1186 1154 1218">Molina Healthcare of MS</p> <p data-bbox="813 1241 841 1272">24</p> <p data-bbox="813 1312 1338 1381">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 1404 841 1436">28</p>
D1X.6	<p data-bbox="313 1493 672 1602">Referral path for program integrity referrals to the state</p> <p data-bbox="313 1627 711 1749">What is the referral path that the plan uses to make program integrity referrals to the state? Select one.</p>	<p data-bbox="813 1522 1110 1554">Magnolia Health Plan</p> <p data-bbox="813 1577 1305 1646">Makes referrals to the SMA and MFCU concurrently</p> <p data-bbox="813 1715 1154 1747">Molina Healthcare of MS</p> <p data-bbox="813 1770 1297 1839">Makes referrals to the State Medicaid Agency (SMA) only</p> <p data-bbox="813 1913 1338 1982">UnitedHealthcare Community Plan of MS</p> <p data-bbox="813 2005 1297 2074">Makes referrals to the State Medicaid Agency (SMA) only</p>

D1X.7	Count of program integrity referrals to the state	Magnolia Health Plan
	Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	Not applicable
		Molina Healthcare of MS
		0
		UnitedHealthcare Community Plan of MS
		16

D1X.7	Count of program integrity referrals to the state	Magnolia Health Plan
	Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	19
		Molina Healthcare of MS
		Not applicable
		UnitedHealthcare Community Plan of MS
		Not applicable

D1X.9a:	Plan overpayment reporting to the state: Start Date	Magnolia Health Plan
	What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	07/01/2024
		Molina Healthcare of MS
		07/01/2024
		UnitedHealthcare Community Plan of MS
		07/01/2024

D1X.9b:	Plan overpayment reporting to the state: End Date	Magnolia Health Plan
	What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	06/30/2025
		Molina Healthcare of MS
		06/30/2025
		UnitedHealthcare Community Plan of MS
		06/30/2025

D1X.9c:	Plan overpayment reporting to the state: Dollar amount	Magnolia Health Plan
	From the plan's latest annual overpayment recovery report,	\$14,058,270

what is the total amount of overpayments recovered?

Molina Healthcare of MS

\$100,509.91

UnitedHealthcare Community Plan of MS

\$68,514.69

D1X.9d: Plan overpayment reporting to the state: Corresponding premium revenue

What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))

Magnolia Health Plan

\$14,058,270

Molina Healthcare of MS

\$433,111,033

UnitedHealthcare Community Plan of MS

\$1,294,613,286.99

D1X.10 Changes in beneficiary circumstances

Select the frequency the plan reports changes in beneficiary circumstances to the state.

Magnolia Health Plan

Weekly

Molina Healthcare of MS

Daily

UnitedHealthcare Community Plan of MS

Weekly

Topic XI: ILOS



Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	Magnolia Health Plan No ILOSs were offered by this plan Molina Healthcare of MS No ILOSs were offered by this plan UnitedHealthcare Community Plan of MS No ILOSs were offered by this plan

Topic XIII. Prior Authorization



Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage



Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	<p>Are you reporting data prior to June 2026?</p> <p>If “Yes”, please complete the following questions under each plan.</p>	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	<p>BSS entity type</p> <p>What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).</p>	<p>Gainwell Technologies - Fiscal Agent-Enrollment Broker/Choice Counseling</p> <p>Subcontractor</p>
EIX.2	<p>BSS entity role</p> <p>What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).</p>	<p>Gainwell Technologies - Fiscal Agent-Enrollment Broker/Choice Counseling</p> <p>Enrollment Broker/Choice Counseling</p>

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to "Review & submit."

Number	Indicator	Response
F1	Notes (optional)	<p>The MississippiCAN contracts ended June 30, 2025 for Magnolia Health Plan, Molina Healthcare and UnitedHealthcare. New contracts operationally began July 1, 2025 for Magnolia Health Plan, Molina Healthcare and Mississippi True D/B/A TrueCare. During SFY 2025, the Division worked on the implementation phase of the new contracts effective August 12, 2024. During the wind down of the SFY25 contracts, the outgoing managed care plan, UnitedHealthcare, no longer was assigned new enrollees beginning in March 2025. UnitedHealthcare and the Division worked on a transition plan during the end of SFY 2025 to ensure a smooth transition for members out of UnitedHealthcare. Another change during SFY 2025 was the implementation of the Pharmacy Benefit Administrator (PBA), Gainwell Technologies, effective July 1, 2024 as the PBA for managed care. Previously, each plan subcontracted with a PBA or PBM. Please note that this questionnaire may use Coordinated Care Organization (CCO), Managed Care Plan (MCP) and Managed Care Organization (MCO) interchangeably as it relates to the three plans.</p>