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

Due Date	Last edited	Edited By	Status
12/27/2022	12/27/2022	April Burns	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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	Mississippi
A.2a	**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.	April Burns
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	april.burns@medicaid.ms.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	April Burns
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	april.burns@medicaid.ms.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/27/2022

Reporting Period

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name** Auto-populated from report dashboard.	Mississippi Coordinated Access Network (MSCAN)

Add plans (A.7)

	Indicator	Response
	Plan name	Magnolia Health Plan, Inc. Molina Healthcare of Mississippi, Inc. UnitedHealthcare of Mississippi, Inc.

Add BSS entities (A.8)

	Indicator	Response
	BSS entity name	Conduent Mississippi Division of Medicaid

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
B.I.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	814,114
B.I.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	367,589

Topic III. Encounter Data Report

Number	Indicator	Response

Number	Indicator	Response
B.III.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. 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.	Other third-party vendor Other, specify Myers & Stauffer LC

Topic X: Program Integrity

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans** 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.	The State Medicaid Agency (SMA) conducted two PI activities during the past year in the MississippiCAN manged care program. Activities were focused on specific payment issues with our three Coordinated Care Organizations (CCOs). 1) The SMA reviewed encounter claims relative to Ordering, Referring, Prescribing (ORP) providers rendering services to Medicaid beneficiaries. The review consisted of encounter data with dates of services ranging over an 8-year span. ORP rules state providers enrolled in the Medicaid program as an ORP provider are only allowed to order, refer and/or prescribe items and services for Medicaid beneficiaries. The SMA determined from its review that the three CCOs improperly paid funds to billing providers for services rendered by ORP providers. 2) The SMA reviewed encounter data relative to Medicaid provider, Mississippi Department of Health (MSDH)-Family Planning Clinic and encounter rates. After review of encounter claims for a review period of five years, the SMA determined that the three CCOs appeared to have been paying the provider less than the encounter rate established for this provider for services that qualify for the rate.
B.X.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
B.X.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Exhibit A MSCAN Contract Amendment 4, Section 12 - Program Integrity

Number	Indicator	Response
B.X.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The Contractor will be responsible for collecting the overpayment for any provider audited when approved by the SMA. The SMA shall conduct investigations related to suspected provider FWA cases and reserve the right to pursue and retain recoveries for any and all types of claims which the Contractor does not have an active investigation. The Contractor shall confer with the SMA before initiating any recoupment or withhold of any program integrity related funds to ensure the recovery recoupment or withod is permissible. If the Contractor obtains funds in cases where recovery recoupment or withhold is prohibited as outlined in Section 12, the Contractor will return the funds to the SMA.
B.X.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 pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Yes, the state tracks compliance through Special Investigations Unit (SIU) regulatory reporting. The Contractor is required to report overpayments annually to the SMA.
B.X.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.
B.X.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 **Changes in provider circumstances: Metrics** Yes **Changes in provider circumstances: Describe metric** The Contractor must notify the SMA of any provider that will be terminated from the program within forty-eight (48) hours. Notification must include the reason for termination, date of termination, and any termination notification to the provider. There is a high-level review of all provider terminations including "for cause" terminations. DOM will be ensuring that future monitoring efforts include a detailed review of the "for cause" termination requirements as outlined in the contract.

Number	Indicator	Response
B.X.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 the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
B.X.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	"Myers & Stauffer Encounter Validation Report https://medicaid.ms.gov/programs/managed-care/measuring-managed-care-performance/ The state is assuming that overpayments referred to in this question are for overpayments initially paid to providers. State requires the return of overpayments.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	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-UnitedHealthcare of Mississippi, Inc. d/b/a UnitedHealthcare Community Plan of Mississippi; Molina Healthcare of MS, Inc.; Magnolia Health Plan
		07/01/2017
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medicaid.ms.gov/mississippican-resources/
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)

Number	Indicator	Response
C1.I.4a	**Special program benefits** 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. 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.	Behavioral health Dental Transportation
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1.I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	367,589
C1.I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	During the Public Health Emergency (PHE), regular Medicaid members have not been terminated unless the member is deceased, moved out of state, or voluntarily termed. However, based on member redetermination outcomes, the number of members enrolled in managed care has decreased, and these members have transitioned to regular Medicaid.

Topic III: Encounter Data Report

Number	Indicator	Response
C1.III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. 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)).	Rate setting Monitoring and reporting Contract oversight Program integrity

Number	Indicator	Response
C1.III.2	**Criteria/measures to evaluate MCP performance** 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. 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).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1.III.3	**Encounter data performance criteria contract language** 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.	Exhibit A MSCAN Contract Amendment 4, Section 11 - Reporting Requirements, S. Member Encounter Data
C1.III.4	**Financial penalties contract language** 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.	Exhibit A MSCAN Contract Amendment 4, Section 16 - Default and Termination, E. Liquidated Damages
C1.III.5	**Incentives for encounter data quality** 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.	N/A
C1.III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	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.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
C1.IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** 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.	N/A
C1.IV.2	**State definition of "timely" resolution for standard appeals** 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.	Timely resolution for standard appeals is "within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires. Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c).
C1.IV.3	**State definition of "timely" resolution for expedited appeals** 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.	Timely resolution for expedited appeals is "no longer than 72 hours after the Contractor receives the request for an Expedited Resolution of an Appeal."
C1.IV.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.	Timely resolution for grievances is "within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as the Member's health condition requires. Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)."

Topic V. Availability, Accessibility and Network Adequacy

Number	Indicator	Response

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	"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 health care 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.
C1.V.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.

Topic V. Availability, Accessibility and Network Adequacy

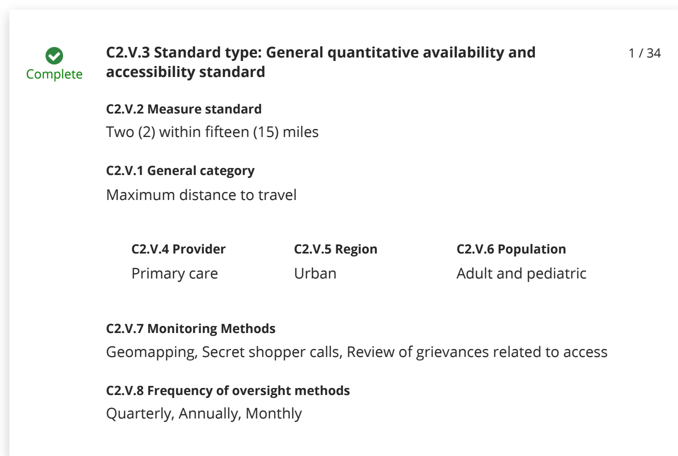
Access Measures

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.

Find in the Excel Workbook
C2_Program_State



Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 1 / 34

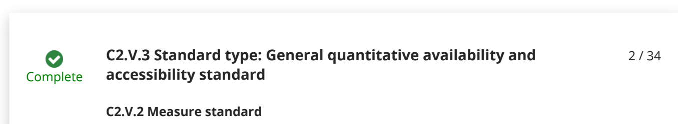
C2.V.2 Measure standard
Two (2) within fifteen (15) miles

C2.V.1 General category
Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly



Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 2 / 34

C2.V.2 Measure standard

Two (2) within thirty (30) miles

C2.V.1 General category
Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 3 / 34

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 4 / 34

C2.V.2 Measure standard
One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 5 / 34

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialists	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 6 / 34

C2.V.2 Measure standard
One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 7 / 34

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dental Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 8 / 34

C2.V.2 Measure standard
One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dental Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Review of grievances related to access, Secret shopper calls

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 9 / 34

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Subspecialty Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 10 / 34

C2.V.2 Measure standard

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

C2.V.1 General category

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Subspecialty Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

11 / 34

C2.V.2 Measure standard

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

C2.V.1 General category

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

12 / 34

C2.V.2 Measure standard

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

C2.V.1 General category

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

13 / 34

C2.V.2 Measure standard

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

C2.V.1 General category

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
One (1) within thirty (30) minutes or thirty (30) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Durable Medical Equipment Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
One within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Durable Medical Equipment Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacies	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacies	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard
One (1) within sixty (60) minutes or sixty (60) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dialysis Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard
One within ninety (90) minutes or ninety (90) miles

C2.V.1 General category
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dialysis Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard
Well Care Visit-No to exceed thirty (30) calendar days

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Biannually

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

25 / 34

C2.V.2 Measure standard
Routine Sick Visit-Not to exceed seven (7) calendar days

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Biannually

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

26 / 34

C2.V.2 Measure standard
Urgent Care Visit-Not to exceed twenty-four (24) hours

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Biannually

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard
Not to exceed seven (7) calendar days

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

28 / 34

C2.V.2 Measure standard
Routine Visit-Not to exceed forty-five (45) calendar days

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental (Routine Visit)	Statewide	Pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

29 / 34

C2.V.2 Measure standard
Urgent Visit-Not to exceed forty-eight (48) hours

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental (Urgent Visit)	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
Routine Visit-Not to exceed twenty-one (21) calendar days

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Statewide

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
Urgent Visit-Not to exceed twenty-four (24) hours

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard
Urgent Care Providers-Not to exceed twenty-four (24) hours

C2.V.1 General category
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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
Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Care Providers	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods
Quarterly, Annually, Monthly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1.IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	Mississippi Envision (ms-medicaid.com) https://www.ms-medicaid.com/msenvision/mscanInfo.do Conduent staff at 1-800-884-3222 This is the fiscal agent for the reporting period. Due to the transition of our fiscal agent from Conduent to Gainwell, the link is no longer valid. This is the fiscal agent for the reporting period. Effective 10/1/2022, DOM transitioned to MESA: Medicaid Enterprise System Assistance.
C1.IX.2	**BSS auxiliary aids and services** 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.	The DOM website details these services as follows: "Beneficiaries may contact Conduent and/or the Mississippi Division of Medicaid (DOM), Office of Coordinated 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."
C1.IX.3	**BSS LTSS program data** 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).	N/A
C1.IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Requires weekly reporting that captures the number of MSCAN calls; number of calls by type; number of calls transferred to the respective CCOs; and the number of enrollment change forms returned, processed, and received. In evaluation of the data collected, DOM requires performance improvement efforts be made to address any areas identified as needing improvement.

Topic X: Program Integrity

Number	Indicator	Response

Number	Indicator	Response
C1.X.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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Magnolia Health Plan, Inc.** 150,585 **Molina Healthcare of Mississippi, Inc.** 73,604 **UnitedHealthcare of Mississippi, Inc.** 143,400
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Magnolia Health Plan, Inc.** 18.5% **Molina Healthcare of Mississippi, Inc.** 9% **UnitedHealthcare of Mississippi, Inc.** 17.6%
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Magnolia Health Plan, Inc.** 41% **Molina Healthcare of Mississippi, Inc.** 20% **UnitedHealthcare of Mississippi, Inc.** 39%

Topic II. Financial Performance

Number	Indicator	Response

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)** 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.	**Magnolia Health Plan, Inc.** 91% **Molina Healthcare of Mississippi, Inc.** 94% **UnitedHealthcare of Mississippi, Inc.** 91%
D1.II.1b	**Level of aggregation** 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.	**Magnolia Health Plan, Inc.** Program-specific statewide **Molina Healthcare of Mississippi, Inc.** Program-specific statewide **UnitedHealthcare of Mississippi, Inc.** Program-specific statewide
D1.II.2	**Population specific MLR description** 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.	**Magnolia Health Plan, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A
D1.II.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, Inc.** No **Molina Healthcare of Mississippi, Inc.** No **UnitedHealthcare of Mississippi, Inc.** No

Topic III. Encounter Data

Number	Indicator	Response

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** 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.	**Magnolia Health Plan, Inc.** The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 30th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider. **Molina Healthcare of Mississippi, Inc.** The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 30th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider. **UnitedHealthcare of Mississippi, Inc.** The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 30th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider.
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the 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 period.	**Magnolia Health Plan, Inc.** 86% **Molina Healthcare of Mississippi, Inc.** 94% **UnitedHealthcare of Mississippi, Inc.** 95%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) 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 period.	**Magnolia Health Plan, Inc.** 99.94% **Molina Healthcare of Mississippi, Inc.** 99.96% **UnitedHealthcare of Mississippi, Inc.** 99.85%

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of 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.	**Magnolia Health Plan, Inc.** 578 **Molina Healthcare of Mississippi, Inc.** 267 **UnitedHealthcare of Mississippi, Inc.** 467
D1.IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 18 **UnitedHealthcare of Mississippi, Inc.** 31
D1.IV.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, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A

Number	Indicator	Response
D1.IV.4	**Number of critical incidents filed during the reporting period 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 period 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 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.	**Magnolia Health Plan, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Magnolia Health Plan, Inc.** 469 **Molina Healthcare of Mississippi, Inc.** 264 **UnitedHealthcare of Mississippi, Inc.** 342
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Magnolia Health Plan, Inc.** 109 **Molina Healthcare of Mississippi, Inc.** 3 **UnitedHealthcare of Mississippi, Inc.** 117

Number	Indicator	Response
D1.IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** 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).	**Magnolia Health Plan, Inc.** 493 **Molina Healthcare of Mississippi, Inc.** 259 **UnitedHealthcare of Mississippi, Inc.** 494
D1.IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** 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.	**Magnolia Health Plan, Inc.** 37 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.6c	**Resolved appeals related to payment denial** 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.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 8 **UnitedHealthcare of Mississippi, Inc.** 4
D1.IV.6d	**Resolved appeals related to service timeliness** 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).	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** 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.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0

Number	Indicator	Response
D1.IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** 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).	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 249 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.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, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.7a	**Resolved appeals related to general inpatient services** 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".	**Magnolia Health Plan, Inc.** 9 **Molina Healthcare of Mississippi, Inc.** 5 **UnitedHealthcare of Mississippi, Inc.** 18
D1.IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. 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".	**Magnolia Health Plan, Inc.** 58 **Molina Healthcare of Mississippi, Inc.** 45 **UnitedHealthcare of Mississippi, Inc.** 116

Number	Indicator	Response
D1.IV.7c	**Resolved appeals related to inpatient behavioral health services** 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".	**Magnolia Health Plan, Inc.** 74 **Molina Healthcare of Mississippi, Inc.** 14 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Magnolia Health Plan, Inc.** 99 **Molina Healthcare of Mississippi, Inc.** 25 **UnitedHealthcare of Mississippi, Inc.** 43
D1.IV.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, Inc.** 144 **Molina Healthcare of Mississippi, Inc.** 31 **UnitedHealthcare of Mississippi, Inc.** 172
D1.IV.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, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 4 **UnitedHealthcare of Mississippi, Inc.** 4
D1.IV.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".	**Magnolia Health Plan, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A
D1.IV.7h	**Resolved appeals related to dental services** 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".	**Magnolia Health Plan, Inc.** 29 **Molina Healthcare of Mississippi, Inc.** 60 **UnitedHealthcare of Mississippi, Inc.** 106

Number	Indicator	Response
D1.IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** 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".	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 1 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.7j	**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-i, enter "N/A".	**Magnolia Health Plan, Inc.** 165 **Molina Healthcare of Mississippi, Inc.** 82 **UnitedHealthcare of Mississippi, Inc.** 39

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Magnolia Health Plan, Inc.** 31 **Molina Healthcare of Mississippi, Inc.** 3 **UnitedHealthcare of Mississippi, Inc.** 11
D1.IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Magnolia Health Plan, Inc.** 2 **Molina Healthcare of Mississippi, Inc.** 1 **UnitedHealthcare of Mississippi, Inc.** 2
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Magnolia Health Plan, Inc.** 1 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 1
D1.IV.8d	**State Fair Hearings retracted prior to reaching a decision** 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) prior to reaching a decision.	**Magnolia Health Plan, Inc.** 3 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 2

Number	Indicator	Response
D1.IV.9a	**External Medical Reviews resulting in a favorable 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 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).	**Magnolia Health Plan, Inc.** 8 **Molina Healthcare of Mississippi, Inc.** 1 **UnitedHealthcare of Mississippi, Inc.** 1
D1.IV.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, Inc.** 4 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 1

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Magnolia Health Plan, Inc.** 1,009 **Molina Healthcare of Mississippi, Inc.** 411 **UnitedHealthcare of Mississippi, Inc.** 606
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 63 **UnitedHealthcare of Mississippi, Inc.** 48
D1.IV.12	**Grievances filed on behalf of LTSS users** 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.	**Magnolia Health Plan, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A

Number	Indicator	Response
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period 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 - 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.	**Magnolia Health Plan, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Magnolia Health Plan, Inc.** 1,009 **Molina Healthcare of Mississippi, Inc.** 411 **UnitedHealthcare of Mississippi, Inc.** 603

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
D1.IV.15a	**Resolved grievances related to general inpatient services** 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".	**Magnolia Health Plan, Inc.** 2 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 8
D1.IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. 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".	**Magnolia Health Plan, Inc.** 1 **Molina Healthcare of Mississippi, Inc.** 21 **UnitedHealthcare of Mississippi, Inc.** 72
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services** 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".	**Magnolia Health Plan, Inc.** 1 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that 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".	**Magnolia Health Plan, Inc.** 1 **Molina Healthcare of Mississippi, Inc.** 3 **UnitedHealthcare of Mississippi, Inc.** 4
D1.IV.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, Inc.** 4 **Molina Healthcare of Mississippi, Inc.** 70 **UnitedHealthcare of Mississippi, Inc.** 16

Number	Indicator	Response
D1.IV.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, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.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, Inc.** N/A **Molina Healthcare of Mississippi, Inc.** N/A **UnitedHealthcare of Mississippi, Inc.** N/A
D1.IV.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, Inc.** 13 **Molina Healthcare of Mississippi, Inc.** 9 **UnitedHealthcare of Mississippi, Inc.** 16
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** 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".	**Magnolia Health Plan, Inc.** 490 **Molina Healthcare of Mississippi, Inc.** 44 **UnitedHealthcare of Mississippi, Inc.** 530
D1.IV.15j	**Resolved grievances related to other service types** 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-i, enter "N/A".	**Magnolia Health Plan, Inc.** 497 **Molina Healthcare of Mississippi, Inc.** 275 **UnitedHealthcare of Mississippi, Inc.** 8

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or provider customer service** 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.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 46 **UnitedHealthcare of Mississippi, Inc.** 3
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management** 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.	**Magnolia Health Plan, Inc.** 2 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 5
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider** 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.	**Magnolia Health Plan, Inc.** 6 **Molina Healthcare of Mississippi, Inc.** 124 **UnitedHealthcare of Mississippi, Inc.** 9
D1.IV.16d	**Resolved grievances related to quality of care** 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.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 16 **UnitedHealthcare of Mississippi, Inc.** 123

Number	Indicator	Response
D1.IV.16e	**Resolved grievances related to plan communications** 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.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 2
D1.IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Magnolia Health Plan, Inc.** 555 **Molina Healthcare of Mississippi, Inc.** 229 **UnitedHealthcare of Mississippi, Inc.** 61
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated 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.	**Magnolia Health Plan, Inc.** 5 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved 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).	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0

Number	Indicator	Response
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved 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.	**Magnolia Health Plan, Inc.** 0 **Molina Healthcare of Mississippi, Inc.** 0 **UnitedHealthcare of Mississippi, Inc.** 0
D1.IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Magnolia Health Plan, Inc.** 32 **Molina Healthcare of Mississippi, Inc.** 7 **UnitedHealthcare of Mississippi, Inc.** 451

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.

Find in the Excel Workbook
D2_Plan_Measures

Complete

D2.VII.1 Measure Name: Adult Body Mass Index Assessment 1 / 57

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
State-specific

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

D2.VII.8 Measure Description
Magnolia numerator-11490 Magnolia denominator-24549 Molina numerator-1944 Molina denominator-4288 United numerator-10270 United denominator-19329

Measure results

Magnolia Health Plan, Inc.
46.80%

Molina Healthcare of Mississippi, Inc.
45.34%

UnitedHealthcare of Mississippi, Inc.
53.13%

Complete

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

2 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
2372

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
50.90%

Molina Healthcare of Mississippi, Inc.
33.30%

UnitedHealthcare of Mississippi, Inc.
44.70%

Complete

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

3 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
32

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
57.20%

Molina Healthcare of Mississippi, Inc.
52.30%

UnitedHealthcare of Mississippi, Inc.
48.90%

Complete

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

4 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
33

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
57.20%

Molina Healthcare of Mississippi, Inc.
62.10%

UnitedHealthcare of Mississippi, Inc.
61.34%

Complete

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

5 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
33

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
48.69%

Molina Healthcare of Mississippi, Inc.
47.70%

UnitedHealthcare of Mississippi, Inc.
45.73%

Complete

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

6 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
0418/0418e

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
.74%

Molina Healthcare of Mississippi, Inc.
.54%

UnitedHealthcare of Mississippi, Inc.
.63%

Complete

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

7 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
0418/0418e

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
.88%

Molina Healthcare of Mississippi, Inc.
.79%

UnitedHealthcare of Mississippi, Inc.
.92%

Complete

D2.VII.1 Measure Name: Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)

8 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
39

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
40.80%

Molina Healthcare of Mississippi, Inc.
34.70%

UnitedHealthcare of Mississippi, Inc.
39.70%

Complete

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

9 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
1516

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
41.00%

Molina Healthcare of Mississippi, Inc.
34.90%

UnitedHealthcare of Mississippi, Inc.
39.16%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30-CH) 10 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
1392

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
62.40%

Molina Healthcare of Mississippi, Inc.
62.70%

UnitedHealthcare of Mississippi, Inc.
60.50%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months of Life (W15-CH) 11 / 57

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
State-specific

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

D2.VII.8 Measure Description
Magnolia numerator-3511 Magnolia denominator-6291 Molina numerator-3260 Molina denominator-5962 United numerator-3808 United denominator-6672

Measure results

Magnolia Health Plan, Inc.
55.81%

Molina Healthcare of Mississippi, Inc.
54.68%

UnitedHealthcare of Mississippi, Inc.
57.10%

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) 12 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
24

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
49.90%

Molina Healthcare of Mississippi, Inc.
54.30%

UnitedHealthcare of Mississippi, Inc.
68.37%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS-CH) Combo 10

13 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
38

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
24.10%

Molina Healthcare of Mississippi, Inc.
20.70%

UnitedHealthcare of Mississippi, Inc.
23.60%

Complete

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

14 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
1407

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
20.20%

Molina Healthcare of Mississippi, Inc.
10.95%

UnitedHealthcare of Mississippi, Inc.
19.00%

Complete

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

15 / 57

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
1448

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
3.69%

Molina Healthcare of Mississippi, Inc.
32.68%

UnitedHealthcare of Mississippi, Inc.
36.43%

Complete

D2.VII.1 Measure Name: PC-01 Elective Delivery (PC01-AD)

16 / 57

D2.VII.2 Measure Domain
Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number
0469/0469e

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
4.79%

Molina Healthcare of Mississippi, Inc.
0.00%

UnitedHealthcare of Mississippi, Inc.
0.00%

Complete

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

17 / 57

D2.VII.2 Measure Domain
Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number
1517

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
74.70%

Molina Healthcare of Mississippi, Inc.
63.50%

UnitedHealthcare of Mississippi, Inc.
74.70%

Complete

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

D2.VII.2 Measure Domain
Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number
2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
11.24%

Molina Healthcare of Mississippi, Inc.
12.47%

UnitedHealthcare of Mississippi, Inc.
11.50%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) Most or Moderately Effective Contraception - 60 days

D2.VII.2 Measure Domain
Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number
2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
41.06%

Molina Healthcare of Mississippi, Inc.
43.44%

UnitedHealthcare of Mississippi, Inc.
43.33%

Complete

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

D2.VII.2 Measure Domain
Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number
2902

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.

.44%

Molina Healthcare of Mississippi, Inc.

.45%

UnitedHealthcare of Mississippi, Inc.

.61%

Complete

D2.VII.1 Measure Name: Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD) LARC - 60 days

21 / 57

D2.VII.2 Measure Domain

Maternal and perinatal health

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

2902

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.

7.65%

Molina Healthcare of Mississippi, Inc.

7.68%

UnitedHealthcare of Mississippi, Inc.

8.37%

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21 to 44 (CCW-AD) Most Effective

22 / 57

D2.VII.2 Measure Domain

Maternal and perinatal health

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

2903/2904

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.

23.41%

Molina Healthcare of Mississippi, Inc.

19.04%

UnitedHealthcare of Mississippi, Inc.

24.55%

Complete

D2.VII.1 Measure Name: Contraceptive Care – All Women Ages 21 to 44 (CCW-AD) LARC

D2.VII.2 Measure Domain
Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number
2903/2904

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
2.38%

Molina Healthcare of Mississippi, Inc.
1.97%

UnitedHealthcare of Mississippi, Inc.
2.75%

Complete

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

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
18

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
49.39%

Molina Healthcare of Mississippi, Inc.
50.12%

UnitedHealthcare of Mississippi, Inc.
57.42%

Complete

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

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
58

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
56.30%

Molina Healthcare of Mississippi, Inc.
70.50%

UnitedHealthcare of Mississippi, Inc.
58.40%

Complete

D2.VII.1 Measure Name: (CDC) HbA1c Testing

26 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
57

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
88.32%

Molina Healthcare of Mississippi, Inc.
82.00%

UnitedHealthcare of Mississippi, Inc.
90.51%

Complete

D2.VII.1 Measure Name: (CDC): Patients with Diabetes received Statin Therapy (SPD)

27 / 57

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
HEDIS

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

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
60.86%

Molina Healthcare of Mississippi, Inc.
51.36%

UnitedHealthcare of Mississippi, Inc.
57.70%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)

28 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
59

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
52.80%

Molina Healthcare of Mississippi, Inc.
62.53%

UnitedHealthcare of Mississippi, Inc.
45.26%

Complete

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

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
272

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
25.15%

Molina Healthcare of Mississippi, Inc.
27.84%

UnitedHealthcare of Mississippi, Inc.
22.47%

Complete

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

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
275

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
54.06%

Molina Healthcare of Mississippi, Inc.
54.18%

UnitedHealthcare of Mississippi, Inc.
44.25%

Complete

D2.VII.1 Measure Name: Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroid

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
State-specific

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

D2.VII.8 Measure Description
Magnolia numerator-295 Magnolia denominator-573 Molina numerator-36 Molina denominator-124 United numerator-230 United denominator-461

Measure results

Magnolia Health Plan, Inc.
51.48%

Molina Healthcare of Mississippi, Inc.
60.48%

UnitedHealthcare of Mississippi, Inc.
49.89%

Complete

D2.VII.1 Measure Name: Heart Failure Admission Rate (PQI-08-AD)

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
277

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
48.75%

Molina Healthcare of Mississippi, Inc.
37.25%

UnitedHealthcare of Mississippi, Inc.
46.94%

Complete

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

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
283

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
2.62%

Molina Healthcare of Mississippi, Inc.
4.52%

UnitedHealthcare of Mississippi, Inc.
1.45%

Complete

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

34 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
1768

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
11.85%

Molina Healthcare of Mississippi, Inc.
8.87%

UnitedHealthcare of Mississippi, Inc.
13.34%

Complete

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

35 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
1800

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
55.58%

Molina Healthcare of Mississippi, Inc.
43.99%

UnitedHealthcare of Mississippi, Inc.
57.39%

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression (HVL-AD)

36 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality

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

Forum (NQF) number
2082/3210e

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
31.60%

Molina Healthcare of Mississippi, Inc.
15.92%

UnitedHealthcare of Mississippi, Inc.
19.13%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Initiation Total

37 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
4

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
35.11%

Molina Healthcare of Mississippi, Inc.
40.87%

UnitedHealthcare of Mississippi, Inc.
40.11%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Engagement Total

38 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
4

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
6.63%

Molina Healthcare of Mississippi, Inc.
6.08%

UnitedHealthcare of Mississippi, Inc.
7.85%

Complete

D2.VII.1 Measure Name: Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
27

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
78.00%

Molina Healthcare of Mississippi, Inc.
71.20%

UnitedHealthcare of Mississippi, Inc.
77.65%

Complete

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

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
105

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
49.45%

Molina Healthcare of Mississippi, Inc.
75.31%

UnitedHealthcare of Mississippi, Inc.
48.82%

Complete

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

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
105

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
Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
31.65%

Molina Healthcare of Mississippi, Inc.
61.18%

UnitedHealthcare of Mississippi, Inc.
31.22%

Complete

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

42 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
576

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
57.69%

Molina Healthcare of Mississippi, Inc.
51.68%

UnitedHealthcare of Mississippi, Inc.
51.80%

Complete

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

43 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
576

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
34.32%

Molina Healthcare of Mississippi, Inc.
23.32%

UnitedHealthcare of Mississippi, Inc.
29.49%

Complete

D2.VII.1 Measure Name: SSD-AD Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
1932

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
71.30%

Molina Healthcare of Mississippi, Inc.
70.60%

UnitedHealthcare of Mississippi, Inc.
69.50%

Complete

D2.VII.1 Measure Name: HPCMI-AD Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
2607

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
52.80%

Molina Healthcare of Mississippi, Inc.
62.50%

UnitedHealthcare of Mississippi, Inc.
45.30%

Complete

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

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
2940

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
1.20%

Molina Healthcare of Mississippi, Inc.
3.40%

UnitedHealthcare of Mississippi, Inc.
.80%

Complete

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

47 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
3389

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
3.30%

Molina Healthcare of Mississippi, Inc.
4.80%

UnitedHealthcare of Mississippi, Inc.
3.80%

Complete

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

48 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
3400

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
22.80%

Molina Healthcare of Mississippi, Inc.
49.60%

UnitedHealthcare of Mississippi, Inc.
33.60%

Complete

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

49 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
576

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
68.40%

Molina Healthcare of Mississippi, Inc.
59.30%

UnitedHealthcare of Mississippi, Inc.
61.70%

Complete

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

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
56

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
41.20%

Molina Healthcare of Mississippi, Inc.
37.10%

UnitedHealthcare of Mississippi, Inc.
37.30%

Complete

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

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
2801

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
65.50%

Molina Healthcare of Mississippi, Inc.
59.40%

UnitedHealthcare of Mississippi, Inc.
61.80%

Complete

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

52 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
3489

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
50.50%

Molina Healthcare of Mississippi, Inc.
59.00%

UnitedHealthcare of Mississippi, Inc.
52.50%

Complete

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

53 / 57

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
3489

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
38.50%

Molina Healthcare of Mississippi, Inc.
27.90%

UnitedHealthcare of Mississippi, Inc.
33.00%

Complete

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

54 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
1800

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
Yes

D2.VII.8 Measure Description

Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
81.00%

Molina Healthcare of Mississippi, Inc.
77.10%

UnitedHealthcare of Mississippi, Inc.
82.00%

Complete

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

55 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
1800

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
70.30%

Molina Healthcare of Mississippi, Inc.
65.30%

UnitedHealthcare of Mississippi, Inc.
73.40%

Complete

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

56 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
108

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
61.80%

Molina Healthcare of Mississippi, Inc.
38.50%

UnitedHealthcare of Mississippi, Inc.
59.30%

Complete

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

57 / 57

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
108

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
Yes

D2.VII.8 Measure Description
Part of standardized national measure sets

Measure results

Magnolia Health Plan, Inc.
47.90%

Molina Healthcare of Mississippi, Inc.
30.60%

UnitedHealthcare of Mississippi, Inc.
44.50%

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. Include any pending or unresolved actions.

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.

Find in the Excel Workbook
D3_Plan_Sanctions

Complete

D3.VIII.1 Intervention type: Withholding of Capitation Payment until Compliance

1 / 4

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Molina Healthcare of Mississippi, Inc.

D3.VIII.4 Reason for intervention

Inappropriate Pattern of Claim Denials and Excessive Denial Rates of Provider Payments- Reporting indicated that Molina's entire denied claims percentage exceeded the allowed 6%-8% range. Also, Molina failed to provide a detailed explanation of denials in excess of 2% by individual denial category and 6% in the aggregate.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/25/2021

D3.VIII.8 Remediation date non-compliance was corrected
06/01/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 4

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Molina Healthcare of Mississippi, Inc.

D3.VIII.4 Reason for intervention

Inaccurate Reporting-Annual MLR Report-The report contained subcontractor administrative expenses that were not properly calculated and classified.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
03/28/2022

D3.VIII.8 Remediation date non-compliance was corrected
01/31/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages 3 / 4

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Molina Healthcare of Mississippi, Inc.

D3.VIII.4 Reason for intervention

Call Center reporting exceeded the monthly average abandonment rate percentage allowed (5%) for the Pharmacy call line during January and February of 2021; and the Providers' call lines during January, February, March, April, May, June, and July of 2021.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 90,000

D3.VIII.7 Date assessed
03/29/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/30/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages 4 / 4

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Magnolia Health Plan, Inc.

D3.VIII.4 Reason for intervention

Call center reporting exceeded the monthly average abandonment rate percentage allowed (5%) for the Member Services Call Center during April, May and July of 2021; and Nurse call lines during January, March, June, and July of 2021.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 70,000

D3.VIII.7 Date assessed
03/29/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/30/2023

D3.VIII.9 Corrective action plan
Yes

Topic X. Program Integrity

Number	Indicator	Response

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff** 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).	**Magnolia Health Plan, Inc.** 13 **Molina Healthcare of Mississippi, Inc.** 2 **UnitedHealthcare of Mississippi, Inc.** 2
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Magnolia Health Plan, Inc.** 8 **Molina Healthcare of Mississippi, Inc.** 46 **UnitedHealthcare of Mississippi, Inc.** 59
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Magnolia Health Plan, Inc.** 0.05:1,000 **Molina Healthcare of Mississippi, Inc.** 0.62:1,000 **UnitedHealthcare of Mississippi, Inc.** 0.41:1,000
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Magnolia Health Plan, Inc.** 25 **Molina Healthcare of Mississippi, Inc.** 30 **UnitedHealthcare of Mississippi, Inc.** 29
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Magnolia Health Plan, Inc.** 0.16:1,000 **Molina Healthcare of Mississippi, Inc.** 0.41:1,000 **UnitedHealthcare of Mississippi, Inc.** 0.2:1,000

Number	Indicator	Response
D1.X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Magnolia Health Plan, Inc.** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 42 **Molina Healthcare of Mississippi, Inc.** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 18 **UnitedHealthcare of Mississippi, Inc.** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 8
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Magnolia Health Plan, Inc.** 0.28 **Molina Healthcare of Mississippi, Inc.** 0.24 **UnitedHealthcare of Mississippi, Inc.** 0.05
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Magnolia Health Plan, Inc.** Period: 7/1/2021-6/30/2022 Total overpayments recovered: $14,099,203.99 Ratio of Collections to Total Premium Payments: less than 1.5% **Molina Healthcare of Mississippi, Inc.** Period: 7/1/2021-6/30/2022 Total overpayments recovered: $12,819,040.00 Ratio of Collections to Total Premium Payments: 2.2% **UnitedHealthcare of Mississippi, Inc.** Period: 7/1/2021-6/30/2022 Total overpayments recovered: $22,355,857.12 Ratio of Collections to Total Premium Payments: 2.14%
D1.X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Magnolia Health Plan, Inc.** Weekly **Molina Healthcare of Mississippi, Inc.** Weekly **UnitedHealthcare of Mississippi, Inc.** Weekly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Number	Indicator	Response

Number	Indicator	Response
E.IX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Conduent** Enrollment Broker Subcontractor **Mississippi Division of Medicaid** State Government Entity
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Conduent** Enrollment Broker/Choice Counseling **Mississippi Division of Medicaid** Other, specify OCC will need to provide.