CCME

2022 External Quality Review

MAGNOLIA HEALTH PLAN

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Prepared on behalf of the
Mississippi Division of Medicaid

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Magnolia Health Plan (Magnolia). This report contains a description of the process and the results of the 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) Program.

The goals of the review were to:

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

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

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

Summary and Overall Findings

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

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

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Sub-contractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess Magnolia's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration

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

Magnolia has developed policies and procedures to guide health plan operations and to ensure compliance with contractual requirements, applicable laws, and regulations. Policies are reviewed and revised as needed at least annually. Staff can access policies on an intranet site, and departmental leadership ensures staff are informed of policy revisions and educated about new policies.

All key positions are filled, and overall, staffing appears to be sufficient to ensure that all required services are provided to members. CCME recommends that on the Organizational Chart, Magnolia differentiate staff who work on lines of business outside of Medicaid (by color-coding, creating a key, etc.).

Magnolia's Compliance Committee advises the Compliance Officer and assists maintaining the Compliance Program. The Compliance Committee is chaired by the Compliance Officer, meets quarterly and as needed, and the quorum is defined as the presence of 50% of voting members. Committee members are expected to attend 75% of the meetings, as noted in the Compliance Committee Charter. One voting member did not meet this requirement. The Compliance and Ethics Program Description (2021-2022) (Compliance Plan) and the Centene Business Ethics and Code of Conduct are comprehensive and address elements of the Compliance Program, expectations for ethical and appropriate business behavior, training, and consequences of Compliance violations and inappropriate conduct. Related policies and procedures provide additional, detailed information. Compliance training is provided at employment and annually through multiple forums. Additionally, information about compliance topics is conveyed through group and department meetings, emails, intranet articles, workplace posters, the Provider Manual, the Member Handbook, and on Magnolia's website.

Magnolia provided appropriate documentation to demonstrate its information systems infrastructure is capable of meeting contractual requirements as well as information system requirements. Magnolia's resiliency strategies address its diverse infrastructure that is comprised of both cloud and traditional data centers. Magnolia exceeds the State's

timeliness requirements by averaging greater than 99% of clean claims being paid in 30 days and 100% being paid in 90 days. Magnolia performs regular risk assessments to identify potential risks to its infrastructure and to aid in implementing preventative measures. Revision timestamps indicate Magnolia regularly reviews and updates its documentation.

Provider Services

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

Magnolia documents credentialing and recredentialing processes and requirements in policies, and additional policies address maintaining confidentiality of provider information, non-discrimination in the credentialing process, etc. Magnolia's Credentialing Committee makes credentialing decisions using a peer review process, is chaired by the Medical Director, and meets monthly. Committee minutes confirmed the presence of a quorum for each meeting and revealed three voting members of the committee did not meet the requirement for attendance for at least 75% of the meetings. This is the third consecutive year this finding was noted.

Review of initial credentialing and recredentialing files for practitioners confirmed the files were compliant with all requirements. Magnolia corrected the previously identified issue related to the collection of complete collaborative agreements between nurse practitioners and collaborating physicians.

Magnolia policy appropriately documents geographic access standards for network providers and Magnolia evaluates the geographic access standards for network providers through quarterly geographic access studies.

Policy MS.PRVR.10, Evaluation of the Accessibility of Services, lists incorrect appointment access standards for routine and post-discharge appointments with behavioral health/substance use disorder providers and does not include other appointment access standards that are found in the *CAN Contract, Section 7 (B) 2*. Magnolia measures provider compliance with appointment access standards through telephonic access studies and by monitoring member satisfaction survey results, grievance data, and appeal data.

Activities are in place to evaluate the network's ability to provide culturally appropriate care to all members. The Cultural Competency Plan addresses employee, provider, and subcontractor training regarding cultural competency. Magnolia evaluates the effectiveness of the Cultural Competency Plan annually, tracks and trends any identified issues, and implements interventions as needed.

Appropriate processes are in place for conducting new provider orientation and ongoing education for all providers. The Provider Manual is a comprehensive resource for

information providers need to operate effectively within Magnolia's network. Review of the Provider Manual revealed issues with documentation of member benefits for flu, pneumonia, and COVID-19 vaccines, as well as plastic surgeon services, when comparing it to the Member Handbook. Providers are educated about requirements for medical record maintenance and documentation standards, and Magnolia monitors provider compliance with those standards. The 2022 Medical Record Audit was being finalized at the time of the onsite. Documentation of the 2021 Medical Record Review was submitted, and results were reported to the Quality Improvement Committee (QIC) in October 2021.

Magnolia maintains both a print and web-based version of the Provider Directory, and all required elements are included. However, the Provider Directory policy includes incorrect information about requirements to include completed cultural competence training in Provider Directories. The review of the printed Provider Directory revealed language information was listed in the field for "Cultural Competence Training."

Appropriate processes are in place for adoption and ongoing review of preventive health and clinical practice guidelines. Magnolia distributes the guidelines to applicable practitioners and to others upon request, and the guidelines are available on the website. The Provider Manual directs the reader to the website to view the full list of guidelines, however, the hyperlink is non-functional.

The 2021 Provider Satisfaction Report by SPH Analytics noted that the response rate was 9.2%, which was also the 2020 response rate. This rate is below the National Committee for Quality Assurance (NCQA) target rate and may introduce bias into the generalizability of the findings. Survey results were presented to the QIC in June 2022 and included in the Mississippi Coordinated Access Network (MSCAN) Quality Management Program Evaluation 2021.

Member Services

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

Magnolia members are guaranteed all required member rights, and newly enrolled members are educated about their rights and responsibilities. Additionally, members may access information about rights and responsibilities on Magnolia's website.

Magnolia's Member Handbook is comprehensive and includes information to educate members about the health plan, pertinent processes and requirements, and additional information that members need to understand health plan processes. One minor issue was noted with documentation of member benefits regarding coverage of pneumonia vaccines. In addition to education provided through the Member Handbook and website, Magnolia provides additional education about Early and Periodic Screening, Diagnostic,

and Treatment services and other preventive health services and encourages members to obtain recommended services through newsletters and birthday reminder cards. An incentive program provides rewards for completing healthy activities such as yearly wellness exams, annual screenings, and tests.

Member materials are developed in compliance with contractual requirements to ensure member understanding of the materials. Oral interpretation of written member materials is available upon request, and member materials can be provided in alternate formats and languages.

Magnolia's Member Services Call Center is available for members during the required hours of operation, and the toll-free Nurse Advice Line is available 24 hours a day, seven days a week. Call Center staff utilize interactive call center scripts during member interactions, and routine training is conducted for Call Center staff. Magnolia monitors Call Center statistics and performance at least monthly and reports to the QIC. For 2021, Magnolia met the Call Center performance goals for each quarter.

Magnolia has established processes for notifying members in writing by mail of changes in benefits, services, and the provider network. To ensure members receive the notification, an additional notice may be provided by email and/or the website. Magnolia assists members who are affected by a provider's termination to select another provider.

Member Satisfaction Survey validation for Magnolia revealed low response rates may introduce bias into the generalizability of the findings.

Magnolia's Policy MS.MBRS.07, Member Grievance and Complaints Process provides a summary of the process used to respond to member grievances and complaints. Members are instructed in the Member Handbook and on Magnolia's website. The policy mentions that Magnolia may extend this timeframe and will give the member written notice of the reason for the extension. However, this policy and the notice sent to the member regarding the need for the extension does not include the member's right to file a grievance related to the extension.

CCME reviewed a sample of grievance files. All the files demonstrated the grievances were processed in a timely manner, and appropriate notifications were provided.

Quality Improvement

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

Magnolia's 2022 MississippiCAN Quality Management Program Description describes the health plan's primary goal as to improve members' health status through a variety of activities across all care settings. The QI Program Description was complete and included all requirements.

Magnolia focuses on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sex, primary language, etc. and by key populations through their Health Equity Program. The Health Equity Program Description and the Health Equity Governance Committee has been established to focus on improving health disparities.

The Quality Work Plan is developed annually after completing the QI Program Evaluation for the previous year. Magnolia's Work Plan reflects the ongoing progress of the quality activities. The status of the QI activities reflected on the work plan is reviewed by the QIC on a regular basis. The 2021 and 2020 QI work plans were provided for review and contained all requirements.

Magnolia's network providers receive feedback regarding their performance data through the Primary Care Provider Profile report and the Patient Care Opportunities report. Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines addresses the development, adoption, revision, and performance monitoring conducted for the clinical and preventive practice guidelines. Magnolia chose two physical health and two behavioral health clinical practice guidelines to monitor in 2021. The guidelines monitored are Diabetes Care, Prenatal Care, Attention Deficit and Hyperactivity Disorder, and Depression. Magnolia also specifically targeted one provider (Jackson Hinds Comprehensive Health Center).

Annually, Magnolia assesses the effectiveness of the QI Program and documents that assessment in the Quality Program Evaluation. The 2021 Quality Management Program Evaluation was reviewed for this EQR. This program evaluation included the results of activities and studies underway or completed in 2021. A barrier analysis and recommendations for 2022 to overcome those barriers were also included.

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted the validation following the CMS developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1 through December 31, 2021.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files provided by Magnolia. Aqurate found that Magnolia's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2021

All relevant HEDIS performance measures for the CAN population were compared for the current review year (MY 2021) to the previous year (MY 2020) and the change from 2020 to 2021 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have a substantial increase or decrease in rate from 2020 to 2021. A substantial increase or decrease is a change in rate greater than 10%.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	60.00%	75.00%	15.00%
Substantial Decrease in Rate (>10% decrease)			
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	59.25%	47.87%	-11.38%
Continuation and Maintenance (C&M) Phase	72.68%	61.81%	-10.87%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	33.85%	22.83%	-11.02%
Pharmacotherapy for Opioid Use Disorder (Total)	34.18%	22.83%	-11.35%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2021 and MY 2020. The changes from 2020 to 2021 are reported in the tables below. The rate changes shown in green indicate a substantial (>10%) improvement, and the rate changes shown in red indicate a substantial (>10%) decline.

Table 2: CAN Non-HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	12.43%	31.30%	18.87%
Total	12.19%	31.60%	19.41%
Substantial Decrease in Rate (>10% decrease)			

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	87.85	53.10	-34.75
Total	88.21	53.64	-34.57
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	59.86	48.86	-11
Ages 65+	160.77	0	-160.77
Total	60.07	48.75	-11.32

In the prior year, Magnolia did not report one non-HEDIS measure as required by DOM. For MY 2021, Magnolia did not report the three new Adult and Child core set measures until repeated requests were made.

The MY 2021 Final Audit Report identified many concerns that the HEDIS Compliance Auditor experienced with Magnolia regarding Magnolia's timeliness for responding, providing appropriate data and responses when requested, and meeting the HEDIS Compliance Audit timelines. The Aqurate team had similar concerns with regards to the receipt of rates data for the non-HEDIS CMS Core Set measures.

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

DOM requires the CCOs to conduct PIPs that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child - Asthma and Adult - COPD). Magnolia provided PIP documents for four PIPs. Topics included Asthma/COPD, Behavioral Health Readmissions, Sickle Cell Disease, and Reducing Preterm Births. All the PIPs scored in the "High Confidence in Reported Results" range as noted in tables below. A summary of each PIP's status and the interventions are also included.

Table 3: Asthma/COPD PIP

Asthma/COPD	
The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and who had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year. This indicator uses the HEDIS measure, Asthma Medication Ratio (AMR). The documentation provided showed no change with an AMR rate of 70.24% for 2020 and 70.25% for 2021 with a goal of 76.86%. The COPD spirometry testing indicator declined from 26.49% in 2020 to 21.84% in 2021.The goal is 36.82%.	
Previous Validation Score	**Current Validation Score**
73/74= 99% High Confidence in Reported Results	73/74= 99% High Confidence in Reported Results
Interventions	
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the Asthma Medication Ratio (AMR) and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Education on the AMR & SPR measures in provider newsletters by the QI Team.	

Table 4: Behavioral Health Readmission PIP

Behavioral Health Readmission	
The Behavioral Health Readmission PIP is focused on reducing 30-day readmissions for members discharged from a behavioral health facility and to increase case management enrollment for those that are readmitted. Magnolia tracks data quarterly and annually for this PIP. The 2021/2022 rate was 19.73% which reduced slightly in the Q2 2022 rate to 19.7%. The enrollment rate improved from Q1 2022 at 35.7% to Q2 2022 at 37.5%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Telephonic outreach by the Clinical Provider Trainer for Behavioral Health to all Hinds County Behavioral Health facilities to provide education, resources, and address any barriers. • Direct outreach to members discharged from Hinds County BH facilities by the Behavioral Health Team to complete the TOC Assessment.	

Table 5: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
The Sickle Cell Disease PIP focuses on increasing compliance with Hydroxyurea for eligible members throughout the treatment period. The most recent rate improved from 20.6% in 2020/2021 to 25.8% in 2021/2022. The goal is 47%.	
Previous Validation Score	**Current Validation Score**
73/74= 99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and on the importance of medication adherence. • Pharmacy Team mailed letters to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment. • Pharmacy Team outreached all members who received letters to provide education and to address any barriers/concerns. • Referrals to Care Management as needed.	

Table 6: Reducing Preterm Births PIP

Reducing Preterm Births	
The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with HTN/preeclampsia. The baseline rate was 14.47% which increased to 15.84% in the 2021-2022 measurement period. The goal is to reduce the preterm birth rate to 11.4%.	
Previous Validation Score	**Current Validation Score**
70/70=100% High Confidence in Reported Results	72/73= 99% High Confidence in Reported Results
Interventions	
• Complete Notification of Pregnancy (NOP) as applicable. • Enrolling member in the Start Smart for Baby program. • Refer to Care Management for continuous follow-up. • Identify various methodologies to enhance patient education and engagement to increase early intervention. Develop materials on controlling hypertension during pregnancy and distribute to members as needed. • Develop a plan and criteria to distribute blood pressure cuffs to member.	

The Asthma COPD PIP and the OB Hypertension PIP demonstrated no quantitative improvement in process or care.

Utilization Management

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

The Utilization Management Program Description 2022 outlines and describes the Utilization Management (UM) Program. Policies and procedures are established to support the implementation and operation of the program. Magnolia's UM Program's aim is to provide services that are covered benefits, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Prior authorization is required for specific procedures and services and not required for emergency or urgent care services. Two levels of UM medical necessity review are available for all authorization requests. Level 1 review is conducted on covered benefits by a Prior Authorization Nurse or Concurrent Review Nurse. If criteria are met, the review nurse issues an authorization. If criteria are not met, the case is sent for a Level II review by an appropriately licensed practitioner.

At least annually, Magnolia assesses the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. Policy CC.UM.32, Interrater Reliability - Associates, Medical Directors, and Therapists describes the process for conducting interrater reliability for all clinical staff and medical directors.

Review of approval files reflects medical and behavioral health utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours, and standard requests are communicated within three calendar days/two business days.

CCME reviewed a sample of denial decisions made by Magnolia and found all Adverse Benefits Notices incorrectly mentions that an oral request for an appeal by members must be followed up in writing unless the request is for an expedited appeal.

Also, the Adverse Benefit Notice letter template incorrectly mentions that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.

Magnolia's procedures for filing an appeal are included in Policy MS.UM08, Appeal of UM Decisions, in the UM Program Description, Member Handbook, Provider Manual, and on Magnolia's website. These documents incorrectly mention an oral request for an appeal

must be followed up in writing unless the request is for an expedited appeal. Also, the appeal policy includes information that is contained in the acknowledgement letter. However, some of this information was not included in the acknowledgement letter.

Magnolia's appeal policy correctly documents the timeframes for resolving a standard and expedited appeal. The policy further explains Magnolia will notify the member of the need to extend the timeframe for resolution and the member has a right to file a grievance if he or she disagrees with the extension. However, the notice sent to the member regarding the extension does not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website.

A sample of appeal files were reviewed. The following issues were identified:

- In one file, the resolution notice was sent to the member prior to the date of the decision.
- There were two files where the appeal was requested as expedited and the member was not notified of the decision to deny the request for expedited resolution.
- One appeal was not resolved within the required timeframe, and one acknowledgement letter was not sent.

Magnolia has Care and Disease Management Programs in place. Departmental policies, procedures, and program descriptions provide detailed information about processes and requirements for conducting Care Management activities. Care Management activities are conducted by an interdisciplinary team consisting of Registered Nurses, Program Coordinators, Behavioral Health and Social Services staff, departmental leadership, and Medical Directors. The Population Health Program includes programs to manage chronic health conditions, including Chronic Obstructive Pulmonary Disease, Asthma, Diabetes, Heart Failure, Coronary Artery Disease, Hypertension and/or Hyperlipidemia, as well as and lifestyle management programs related to exercise, nutrition, stress management, weight management, and tobacco cessation.

Policies and procedures describe processes for identifying members as potential candidates for Care Management; conducting assessments and reassessments; developing, monitoring, and revising Care Plans; and more. Magnolia conducts initial assessments and develops Care Plans within the required timeframes and in collaboration with the member/caregiver and the interdisciplinary care team to ensure agreement with the changes.

Care Management files reflect appropriate care management activities for members' acuity levels and needs.

Delegation

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

CCME's External Quality Review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials. For this review, Magnolia reported 20 delegation agreements.

The Oversight of Delegated Vendor Services Policy and the Oversight of Delegated Credentialing Policy describe processes for delegation of health plan activities and oversight of delegated entities. Documentation of annual oversight and ongoing monitoring was provided for 19 of the 20 delegates. Reports of the monitoring and oversight included documentation of any identified deficiencies, the delegates' responses to any corrective action, and follow-up by the health plan. The annual oversight monitoring for Rush Health Systems was not provided. Also, the files reviewed for the annual monitoring of Mississippi Health Partners incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable."

Quality Improvement Plans and Recommendations from Previous EQR

For the previous EQR, one standard was scored as "Partially Met" and zero standards were scored as "Not Met." The following is a high-level summary of the deficiency identified in the 2021 EQR:

- The review of credentialing and recredentialing files revealed an issue related to collecting complete collaborative agreements for nurse practitioners.

Following the 2021 EQR, Magnolia submitted its response to the Corrective Action Plan on January 13, 2022. CCME reviewed and accepted the Corrective Action Plan on January 18, 2022. A quarterly CAP follow-up was conducted in April 2022.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Corrective Action Plan was implemented.

Conclusions

Magnolia met some of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 7: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Magnolia's compliance scores relative to each of the 11 Subpart D and QAPI standards above. A discussion of identified issues follows the table.

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

Category	Report Section	Total Number of Standards	Magnolia CAN	
			Number of Standards Scored as "Met"	2022 Overall Score
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)	Provider Services, Section II. B	9	8	89%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	18	17	94%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	13	12	92%
Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	38	37	97%
Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	16	80%
Sub-contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	1	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	11	9	82%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	19	100%

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

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

- For Availability of Services and Assurances of Adequate Capacity and Services, the deficiency was due to incorrect appointment access standards documented in policy and failure to include all required appointment access standards in policy.
- For Coordination and Continuity of Care, two policies listed an incorrect timeframe for continued access to providers who are no longer available through the CCO's network.

- For Coverage and Authorization of Services, Adverse Benefit Determination Notices and the Adverse Benefit Determination Notice template incorrectly indicate an oral appeal request must be followed with a written appeal request unless the request is for an expedited appeal.
- For Provider Selection, the identified issue was related to inadequate member attendance at the Credentialing Committee meetings.
- For Grievance and Appeal Systems:
    - The Member Grievance and Complaints Process policy and the notice sent to members regarding the need for the extension does not offer the right to file a grievance related to the extension.
    - The Appeal of UM Decisions, UM Program Description, Member Handbook, Provider Manual, and website incorrectly mention an oral request for an appeal must be followed by a written request unless the request is for an expedited appeal. Appeal acknowledgement letters were missing the member's right to submit comments, documents, or other information relevant to the appeal and the right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired. Appeal extension notices do not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, Provider Manual, and on Magnolia's website. Appeal files reflected a resolution notice sent to the member prior to the date of the decision, failure to notify members of the decision to process appeals as standard rather than expedited, untimely appeal resolution, and failure to send an appeal acknowledgement letter.
- For Sub-contractual Relationships and Delegation, Magnolia did not provide documentation of annual oversight monitoring for one delegate, and files reviewed for the annual monitoring of credentialing delegate incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable."
- For Practice Guidelines, the link in the Provider Manual to access the preventive health and clinical practice guidelines on Magnolia's website was nonfunctional.

Table 8, Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2021 review. For 2022, 210 out of 223 standards received a score of "Met." There were 13 standards scored as "Partially Met."

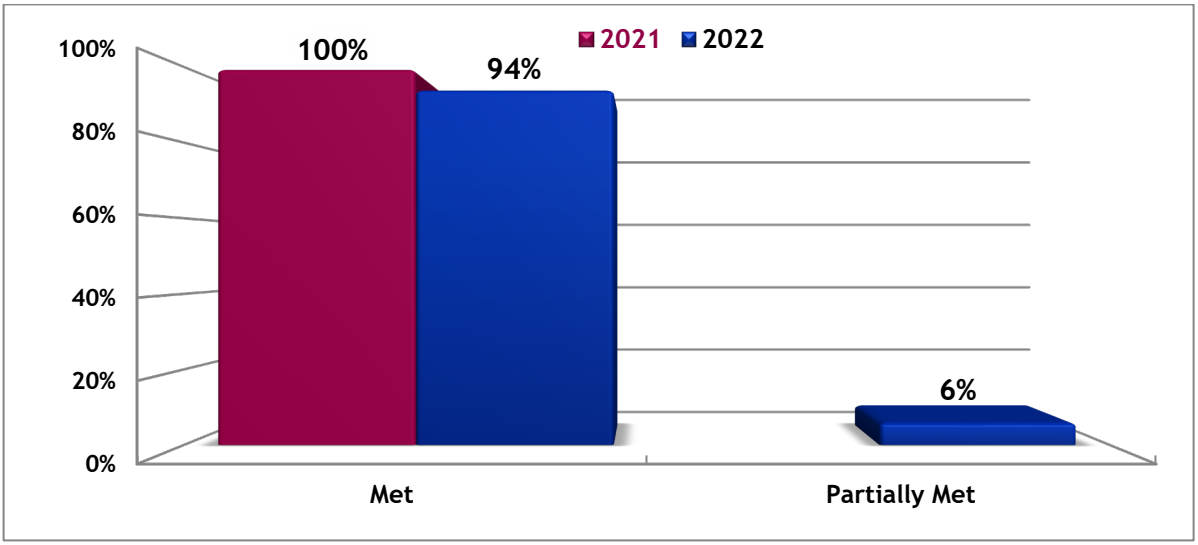
Table 8: Scoring Overview—CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	31	0	0	0	0	31	100%
2022	30	1	0	0	0	31	97%
Provider Services							
2021	83	1	0	0	0	84	99%
2022	79	5	0	0	0	84	94%
Member Services							
2021	33	0	0	0	0	33	100%
2022	32	1	0	0	0	33	97%
Quality Improvement							
2021	19	0	0	0	0	19	91%
2022	19	0	0	0	0	19	91%
Utilization Management							
2021	55	0	0	0	0	55	100%
2022	49	5	0	0	0	54	91%
Delegation							
2021	2	0	0	0	0	2	100%
2022	1	1	0	0	0	2	50%
TOTALS:							
2021	**223**	**1**	**0**	**0**	**0**	**224**	**99.5%**
2022	**210**	**13**	**0**	**0**	**0**	**223**	**94%**

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

The 2022 Annual EQR shows that Magnolia achieved "Met" scores for 94% of the standards reviewed. As the following chart indicates, 6% of the standards were scored as "Partially Met." No standards were scored as "Not Met." The chart below provides a comparison of the current review results to the 2021 review results.

Figure 1: 2022 Annual EQR Review Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvement

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of Strengths, Weaknesses, and Recommendations can be found in the sections that follow.

Table 9: Evaluation of Quality

Strengths Related to Quality
• Appropriate processes are in place for policy development, management, and annual review. Staff are educated about new and revised policies and are given access to policies through an intranet site.
• All contractually required key positions are filled, and overall staffing appears to be sufficient.
• Information systems infrastructure is monitored for both security and regulatory compliance.
• Disaster recovery and business continuity plans are thorough and address the variances in cloud and data center infrastructure.
• Initial and ongoing Compliance training covers Federal and State statutes, regulations, and guidelines and is provided through a variety of forums.
• Credentialing and recredentialing processes are thoroughly documented in policies, and practitioner and organizational provider credentialing and recredentialing files were compliant with all requirements.
• Provider Satisfaction survey results are presented and addressed in QIC meetings.
• Member rights are guaranteed to all members, and members are educated about member rights and responsibilities in a variety of ways.
• Magnolia provides education for new members through the new member packet, the Member Handbook, welcome calls, etc.

Strengths Related to Quality

• Call center scripts are used to guide Member Services Call Center staff during member interactions, and routine training is provided to Call Center staff.
• Magnolia was fully compliant with all Information Systems Standards, and it was determined that Magnolia submitted valid and reportable rates for all HEDIS measures in scope of the audit.
• There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Magnolia followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.
• The following HEDIS MY 2021 measure rates and non-HEDIS Adult Core Set measure rates were strengths for Magnolia since their rates had a greater than 10% improvement:
  ○ Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) improved by 15 percentage points.
  ○ HIV Viral Load Suppression (HVL-AD) measure, the Ages 18 - 64 indicator improved by 18.87 percentage points and the Total indicator improved by 19.41 percentage points.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• The Organizational Chart lists the Member Services Manager twice on different pages and with different employee names. Onsite discussion revealed one is for the Medicaid line of business and the other is for a different line of business.	• Recommendation: Consider color coding the Organizational Chart to clarify the line of business for staff members outside of the Medicaid line of business.
• Review of the Compliance Committee meeting minutes revealed that one voting member did not meet the attendance expectation.	• Corrective Action Plan: Reinforce attendance expectations with members of the Compliance Committee.
• Three voting members of the Credentialing Committee did not meet the attendance requirement. One member attended only 64% of meetings, one attended only 55% of the meetings, and a third attended only 18% of the meetings. This is the third consecutive year this finding was noted for the Credentialing Committee.	• Corrective Action Plan: Reinforce attendance expectations with Compliance Committee members and take action to replace members who do not comply with the attendance requirements.
• Policy MS.PRVR.19, Provider Directory, page one, states Provider Directories will include "whether the provider has completed cultural competence training." This requirement to include completed cultural competence training is no longer applicable for Provider Directories. Also, when reviewing the printed Provider Directory, some provider listings included various languages in the field for "Cultural Competence Training."	• Recommendation: Revise Policy MS.PRVR.19, Provider Directory, to remove the requirement to include Cultural Competency Training. Determine the cause for provider languages being listed in the Provider Directory under "Cultural Competence Training" and resolve as necessary.
• The Provider Manual directs the reader to the website to view the full list of preventive health guidelines and clinical practice guidelines. However, the hyperlink provided is non-functional, returning an error message. This is a finding originally	• Corrective Action Plan: Revise the Provider Manual to include the correct hyperlink to the list of preventive health and clinical practice guidelines on Magnolia's website or remove the hyperlink and provide detailed information about where to locate the guidelines.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
noted during the previous EQR. A recommendation was given to correct this issue.	
• Response rates for provider satisfaction surveys are low and may affect generalizability of the results.	• Recommendation: Continue reminders for satisfaction survey to providers.
• Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System, incorrectly states Magnolia sends birthday reminder cards to one and two year-old members during the birth month. However, onsite discussion revealed the birthday reminder cards are sent to all members up to age 18.	• Recommendation: Correct the age range for the "EPSDT services reminder Happy Birthday" cards in Policy MS.QI.01.
• Response rates for all Member Satisfaction Surveys were lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.	• Recommendation: Continue to determine ways to advertise surveys and increase response rates.
• Minutes for the Quality Improvement Committee meeting did not document which members are considered voting members.	• Recommendation: Document in the Quality Improvement Committee minutes which members are considered voting members.
• The following HEDIS MY 2021 measure rates and non-HEDIS Adult Core Set measure rates were determined to be areas of opportunities for Magnolia since their rates had a greater than 10% decline: o Follow-Up Care for Children Prescribed ADHD Medication (add) measure, both the Initiation Phase indicator and the Continuation and Maintenance (C&M) Phase declined by over 10 percentage points. o Pharmacotherapy for Opioid Use Disorder (POD) measure, the Pharmacotherapy for Opioid Use Disorder (16-64) indicator and the Pharmacotherapy for Opioid Use Disorder (Total) indicator both had a greater than 11 percentage point decline. o Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission Rate (PQI-05) measure, the Ages 40 - 64 indicator and the Total indicator declined by over 34 member months per 100,000 member months. o Heart Failure Admission Rate (PQI-08) measure, the Ages 18 - 64 indicator and the Total indicator declined by over 11 member months per 100,000 member months and the Ages 65+	• Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
indicator declined by over 160 member months per 100,000 member months.	
• Magnolia did not report the three new Adult and Child core set measures until repeated requests were made. There seemed to be a lack of oversight provided by the Magnolia team to Magnolia's corporate teams that are responsible for producing the DOM required measure rates.	• Recommendation: Work proactively with DOM regarding clarification on measures that are required to be reported.
• The MY 2021 Final Audit Report identified many concerns that the HEDIS Compliance Auditor experienced regarding Magnolia's responsiveness. The Aqurate team had similar concerns with regards to receipt of rates data for the non-HEDIS CMS Core Set measures.	• Recommendation: Communicate to Magnolia's corporate teams the measures that are required to be reported to ensure the team understands the measures required for reporting. • Recommendation: Improve processes around the calculation, reporting, and verification of the Adult and Child Core set measure rates reported to DOM.
• The Asthma COPD PIP and the OB Hypertension PIP demonstrated no quantitative improvement in process or care.	• Recommendation: Continue moving forward with the newly implemented interventions such as the pilot for the blood pressure monitoring devices and any support services enhancements.
• Documentation of annual oversight monitoring was not provided for four of the delegates.	• Corrective Action Plan: Develop a process to ensure that the annual monitoring for all delegates is conducted timely.
• The files reviewed for the annual monitoring of Mississippi Health Partners incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable".	• Corrective Action Plan: The files reviewed for the annual monitoring of Mississippi Health Partners incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable".

Table 10: Evaluation of Timeliness

Strengths Related to Timeliness	
• The sample of grievance files reviewed demonstrated that grievances were processed timely and appropriate notifications were provided. • Review of approval files reflect physical and behavioral health utilization decisions are determined within required timeframes	
Weaknesses Related to Timeliness	**Quality Improvement / Recommendations Related to Timeliness**
• Policy MS.MBRS.07, Member Grievance and Complaints Process includes the process if Magnolia requests an extension of the timeframe for resolving a grievance. However, this policy and the notice sent to the member regarding the need for the extension does not offer the member's right to file a grievance related to the extension.	• Corrective Action Plan: Include in the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing a grievance in Policy MS.MBRS.07, Member Grievance and Complaints Process and in the member notice.

Table 11: Evaluation of Access to Care

Strengths Related to Access to Care
• Geographic access standards are correctly documented in policies, and Magnolia routinely monitors its network for compliance with geographic access standards. • Magnolia has established processes to ensure its network can provide culturally appropriate care to all members, including those with diverse cultural and ethnic backgrounds, diverse health beliefs and practices, limited English proficiency, and physical disabilities. • Appropriate processes are in place for notifying members of changes in benefits, services, and the provider network. • Magnolia has implemented a Social Determinants of Health screening tool to assist in identifying members' needs related to food, housing, transportation, utilities, public benefits, internet access, etc.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Policy MS.PRVR.10, Evaluation of the Accessibility of Services, incorrectly lists the appointment access standards for routine appointments and post-discharge appointments with Behavioral Health/Substance Use Disorder providers. Also, the policy does not specify timeframes for dental appointments for routine and urgent care visits and it does not specify the timeframes for Urgent Care or Emergency Care Providers. Refer to the *CAN Contract, Section 7 (B) 2.*	• Corrective Action Plan: Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include the correct timeframes for routine BH/SUD appointments and for BH/SUD appointments post-discharge from an acute psychiatric hospital (when the CCO is aware of the discharge). Add the timeframes for routine and urgent care dental appointments, general urgent care providers, and emergency care providers.

• The Provider Manual includes information about member benefits- however, discrepancies were noted in the information when comparing it to information in the Member Handbook.
  ○ Page 28 of the Provider Manual addresses Flu and Pneumonia vaccines and states limitations of one flu shot per 12 months and two pneumonia shots per lifetime. The Provider Manual does not include Covid-19 vaccines, which are included in the Member Handbook, page 19.
  ○ Page 30 of the Provider Manual addresses Plastic Surgeon services and states, "All services must be in office settings…" However, the Member Handbook, page 20, does not include this limitation.
	• Corrective Action Plan: Revise the Provider Manual to correct the issues noted with vaccine coverage and plastic surgeon services.

• The Member Handbook does not reference the limitation of two pneumonia shots per lifetime, which is noted in the Provider Manual.	• Recommendation: Update the Member Handbook to include the limitation on the number of pneumonia vaccines.
• CCME reviewed a sample of denial decisions made by Magnolia and found all of the Adverse Benefits Notices incorrectly mentions that an oral request for an appeal by members must be followed up in writing unless the request is for an expedited appeal.	• Corrective Action Plan: Correct the Adverse Benefit Notices and remove the requirement that a member must follow an oral request for appeal with a written request.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• The Adverse Benefit Notice letter template, Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, Member Handbook, Provider Manual and on Magnolia's the website incorrectly mentions an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.	• Corrective Action Plan: Correct Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, the Provider Manual, and Magnolia's website and remove the requirement that a member must follow-up an oral request for an appeal with a written request.
• Policy MS.UM08, Appeal of UM Decisions includes information that's contained in the acknowledgement letter. However, the following was missing in the acknowledgement letter: ○ The member's right to submit comments, documents or other information relevant to the appeal. ○ The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.	• Corrective Action Plan: Correct the Acknowledgement Letter and include all the requirements listed in Policy MS.UM08, Appeal of UM Decisions.
• Policy MS.UM08, Appeal of UM Decisions explains Magnolia will notify the member of the need to extend the timeframe for resolution of an appeal and the member has a right to file a grievance if he or she disagrees with the extension. However, the notice send to the member regarding the extension does not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website.	• Corrective Action Plan: Include the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing an appeal in the member notice, the Member Handbook, Provider Manual and on Magnolia's website.
• A sample of appeal files were reviewed. The following issues were identified: ○ In one file, the resolution notice was sent to the member prior to the date of the decision. ○ There were two files where the appeal was requested as expedited and the member was not notified of the decision to deny the request for expedited resolution. ○ One appeal was not resolved within the required timeframe and one acknowledgement letter was not sent.	• Corrective Action Plan: Initiate a process to monitor appeals to ensure all requirements are met.
• Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, incorrectly state the timeframe for continued access to providers who are no longer available through the CCO's network is 90 calendar days.	• Revise Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, to reflect the correct timeframe for allowing a continuing course of treatment when a provider is no longer in Magnolia's network.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On June 23, 2022, CCME sent notification of the initiation of the annual EQR to Magnolia (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN Program.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for purposes of providing Magnolia an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials CCME requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on July 25, 2022, for review at the CCME offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on October 5, 2022, and October 6, 2022. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Magnolia's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*, and the Contract requirements between Magnolia and DOM. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

I. Administration

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

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

Magnolia has developed policies and procedures to guide health plan operations and to ensure compliance with contractual requirements, applicable laws, and regulations. Processes for overall policy development, review, and ongoing management are found in Policy CC.COMP.22, Policy Management. Policy management processes include annual review, revision, and approval of all policies. Staff can access policies on an intranet site, and departmental leadership ensures staff are informed of policy revisions and educated about new policies.

Review of Magnolia's Organizational Chart, along with onsite discussion, confirmed all key positions are filled. Most Information Technology functions are conducted at the corporate level, but there are two local staff in Mississippi. Claims adjudication functions are conducted at the corporate level, but local claims staff work with corporate staff for claims processing functions. The Organizational Chart lists the Member Services Manager twice on different pages and with different employee names. Onsite discussion revealed one is for the Medicaid line of business, and the other is for a different line of business. Onsite discussion included a recommendation to differentiate staff who work under other lines of business (by color-coding, creating a key, etc.) on the Organizational Chart. Overall staffing appears to be sufficient to ensure that all required services are provided to members.

Magnolia's Compliance Committee advises the Compliance Officer and assists maintaining the Compliance Program. The Compliance and Ethics Program Description (2021-2022) (Compliance Plan) and the Compliance Committee Charter describe the committee's functions and operations. The Compliance Committee is chaired by the Compliance Officer, meets quarterly and as needed, and the quorum is defined as the presence of 50% of voting members. Committee members are expected to attend 75% of the meetings as noted in the Compliance Committee Charter. However, review of meeting minutes revealed one voting member attended only 50% of the meetings.

Magnolia's Compliance Plan addresses program elements (such as policies, procedures, and standards of conduct), training, communication, auditing and monitoring, and investigations of suspected and/or actual offenses. Related policies and procedures provide additional, detailed information. The Centene Business Ethics and Code of Conduct (Code of Conduct) applies to all employees and addresses expectations for ethical business conduct and practices. The Code of Conduct covers a variety of topics relating to appropriate business behavior, including, but not limited to fraud, waste, and abuse (FWA), confidentiality, and conflicts of interest.

As noted in the Compliance Plan, initial employee compliance training is conducted within 30 days of hire, and all employees and subcontractors are required to complete annual compliance training that covers Federal and State statutes, regulations, and guidelines. Training is conducted through a variety of methods, such as interactive in-service sessions, online training, and newsletters. Staff are educated about appropriate

lines of communication for compliance topics and issues, methods for reporting compliance issues and suspected or actual FWA, assurances of confidentiality and anonymity for anyone reporting issues, and the prohibition of retaliation against those who report issues. Information about reporting mechanisms and other compliance topics is also disseminated internally through group and department meetings, emails, intranet articles, workplace posters, etc., and externally through the Provider Manual, Member Handbook, and Magnolia's website.

Magnolia conducts ongoing monitoring and auditing of the Compliance Program and provides regular reports to the Compliance Officer and Compliance Committee. Monitoring activities allow for the identification and review of variations in operations, compliance issues, vulnerabilities, etc. An annual review is conducted to determine if program elements have been satisfied, to identify issues, and to develop implementations to address those issues.

A Pharmacy Lock-In Program is in place to detect and prevent abuse of pharmacy benefits. Processes to identify and evaluate members as candidates for the program, conduct ongoing monitoring, etc. are found in Policy MS.PHAR.15, Pharmacy Lock-In Program.

Health Information Systems

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

Magnolia provided appropriate documentation to demonstrate its infrastructure is capable of meeting contractual requirements as well as information system requirements. Magnolia's resiliency strategies address its diverse infrastructure that is comprised of both cloud and traditional data centers. Magnolia exceeds the State's timeliness requirements by averaging greater than 99% of clean claims being paid in 30 days, and 100% being paid in 90 days. Magnolia performs regular risk assessments to identify potential risks to its infrastructure and to aid in implementing preventative measures. Revision timestamps indicate Magnolia regularly reviews and updates its documentation.

Confidentiality

§ 438.224

Multiple policies, program descriptions, training documents and the Compliance Plan and Code of Conduct provide information about Magnolia's processes for maintaining confidentiality of protected information. Employee training includes principles and expectations for maintaining the confidentiality of applicable information.

In the Administration section of the review, Magnolia received "Met" scores for 97% of the standards reviewed, as illustrated in *Figure 2: Administration Findings*.

Figure 2: Administration Findings

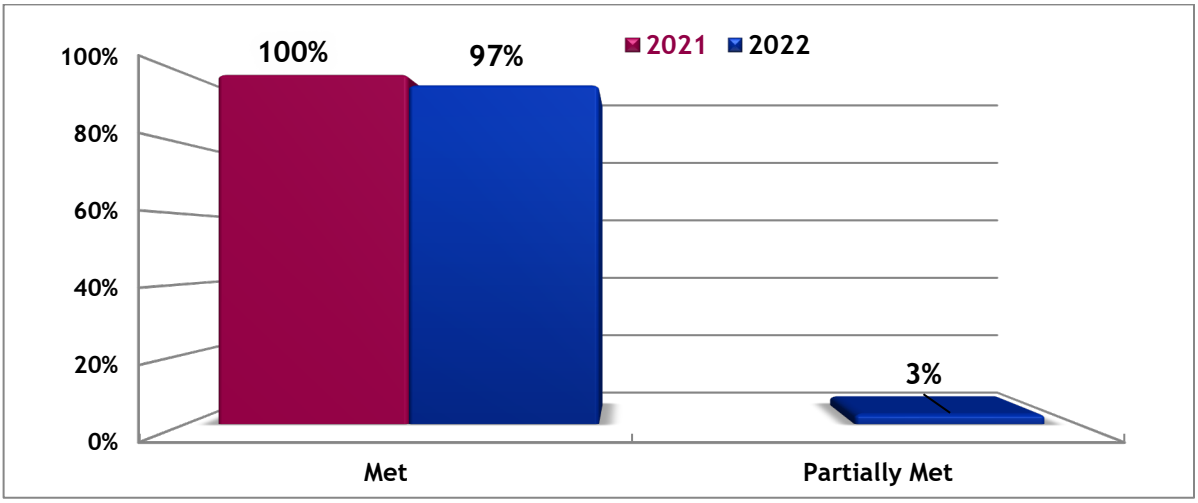


Table 12: Administration

Section	Standard	2022 Review
Compliance/ Program Integrity	The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Partially Met

Strengths

- Appropriate processes are in place for policy development, management, and annual review. Staff are educated about new and revised policies and are given access to policies through an intranet site.
- All contractually required key positions are filled, and overall staffing appears to be sufficient.
- Information systems infrastructure is monitored for both security and regulatory compliance.
- Disaster recovery and business continuity plans are thorough and address the variances in cloud and data center infrastructure.
- Initial and ongoing Compliance training covers Federal and State statutes, regulations, and guidelines and is provided through a variety of forums.

Weaknesses

- The Organizational Chart lists the Member Services Manager twice on different pages and with different employee names. Onsite discussion revealed one is for the Medicaid line of business and the other is for a different line of business.

- The Compliance Committee Charter states committee members are expected to attend 75% of the meetings. Review of the submitted Compliance Committee meeting minutes revealed that one voting member attended only 50% of the meetings.

Corrective Actions

- Reinforce attendance expectations with members of the Compliance Committee.

Recommendations

- Consider color coding the Organizational Chart to clarify the line of business for staff members outside of the Medicaid line of business.

II. Provider Services

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

The review of Provider Services includes credentialing and recredentialing processes, network adequacy, processes for initial and ongoing provider education, processes for reviewing, adopting, and disseminating preventive health and clinical practice guidelines, practitioner medical record requirements, and the provider satisfaction survey.

Provider Selection and Credentialing

42 CFR § 438.214, 42 CFR § 457.1233(a)

Magnolia documents credentialing and recredentialing processes and requirements in policies, including Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, and Policy CC.CRED.09, Organizational Assessment and Reassessment. Additional policies address maintaining confidentiality of provider information, non-discrimination in the credentialing process, etc.

A Credentialing Committee has been delegated to make credentialing decisions using a peer review process for credentialing applications in which issues were found. The Medical Director chairs the committee, and the committee meets monthly. The committee quorum is established as the presence of 50% of voting members. Review of submitted Credentialing Committee minutes confirmed the quorum was established for each of the meetings. However, three voting members of the committee did not meet the requirement to attend at least 75% of the meetings. One member attended only 64% of meetings and another attended only 55%. A third member attended only 18% of the meetings, and this is the third consecutive year this finding was noted for this specific committee member. Her attendance has decreased year over year. CCME discussed the issue with committee member attendance with Magnolia during the previous EQR, and Magnolia reported that if a committee member does not meet the attendance requirement, the health plan engages with the committee member to discuss the attendance expectations and will take action to replace or remove the member if necessary.

Review of initial credentialing and recredentialing files for practitioners confirmed the files were compliant with all credentialing and recredentialing requirements. Magnolia corrected the issue identified during the 2021 EQR related to collection of complete collaborative agreements between nurse practitioners and collaborating physicians. See *Table 13: Previous Provider Selection and Credentialing CAP Items* for the previous year's finding and Magnolia's response to the finding. Review of organizational provider credentialing and recredentialing files confirmed all files were compliant with requirements.

Table 13: Previous Provider Selection and Credentialing CAP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing – CAN	
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians. Onsite discussion confirmed the complete collaborative agreement is collected at initial credentialing for nurse practitioners. However, one nurse practitioner file included only a print-out from the Mississippi Board of Nursing Licensee Gateway. *Corrective Action: Ensure credentialing files contain the complete collaborative agreement for nurse practitioners.*
Magnolia's Response: Magnolia will ensure the appropriate collaborative agreement form is collected during credentialing and recredentialing. A refresher training regarding this requirement will be completed before the end of Q1 2022.	

Availability of Services and Assurances of Adequate Capacity and Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), § 438.207, § 457.1230, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Geographic access standards for network providers are documented in Policy CC.PRVR.47, Evaluation of Practitioner Availability and are compliant with contractual requirements. The policy also defines processes for evaluating the geographic access standards for network providers. Magnolia conducts quarterly geographic access measurements of practitioner types and availability.

Policy MS.PRVR.10, Evaluation of the Accessibility of Services, addresses appointment access standards for various provider types. However, incorrect appointment access standards were included in the policy for routine appointments and post-discharge appointments with behavioral health/substance use disorder providers, and the policy did not include appointment access standards for urgent care providers, emergency care providers, and routine and urgent appointments with dental providers. Appointment access standards are found in the *CAN Contract, Section 7 (B) 2.*

Magnolia measures appointment accessibility to primary care, behavioral health, and specialty care services annually through a variety of methods, including telephonic access studies and monitoring results of member satisfaction surveys, and grievance and appeal data. As noted in the policy, if providers are not compliant with appointment access standards, a written corrective action plan is implemented, and the provider is reaudited. Continued noncompliance results in the provider being presented to the Credentialing Committee for review and recommendations for additional corrective action. The MHP_MSCAN Provider Appointment Availability document for Q1 2022 showed successful contact rates were low and that appropriate standards were used to assess provider compliance. Goals were met for compliance for Primary Care Providers, OBGYNs, and Behavioral Health providers. Results were presented to the Quality Improvement Committee on June 23, 2022.

Magnolia evaluates its network's ability to provide culturally appropriate care to members, including those with diverse cultural and ethnic backgrounds, diverse health beliefs and practices, limited English proficiency, disabilities, and differential abilities. To accomplish this, Magnolia identifies the cultural, linguistic, disparity, and accessibility needs of members as well as provider linguistic and cultural diversity. The Cultural Competency Plan addresses providing training related to cultural competency to all new Magnolia employees as part of new employee orientation and to all staff at least annually. Providers and subcontractors receive training through quarterly training sessions or onsite visits upon request. Magnolia evaluates the effectiveness of the Cultural Competency Plan annually, tracks and trends any identified issues, and implements interventions as needed. This evaluation, including implemented interventions and recommendations for 2022, was noted in the Mississippi Coordinated Access Network (MSCAN) Quality Management Program Evaluation 2021.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

New provider orientation is conducted within 30 days of the contract effective date for all provider types. Topics covered in the orientation include an overview of the CCO and Centene, information about member eligibility, cultural awareness and sensitivity, fraud, waste, and abuse, member benefits, utilization management processes, claims, appeals and grievances, and Magnolia's website and provider portal. A document titled "Magnolia Provider Training Plan" lists methods used for initial and ongoing provider education, including in-service trainings, web-based trainings, workshops, one-on-one virtual or onsite trainings, and written communications, such as weekly provider e-blasts, provider newsletters, educational postcards and letters, the Provider Manual, website, and provider portal. Monitoring of training effectiveness is ongoing, and educational materials are reviewed quarterly for accuracy and updates.

The Provider Manual is a comprehensive resource for information providers need to operate effectively within Magnolia's network. Review of the Provider Manual revealed

issues with documentation of member benefits for flu, pneumonia, and COVID-19 vaccines, as well as plastic surgeon services, when comparing it to the Member Handbook:

- Page 28 of the Provider Manual addresses vaccines but does not include COVID-19 vaccines, which are included on page 19 of the Member Handbook.
- Page 30 of the Provider Manual addresses Plastic Surgeon services and states, "All services must be in office settings…" However, page 20 of the Member Handbook does not include this limitation.

Providers are educated about requirements for medical record maintenance and documentation standards at orientation and through the Provider Manual. Policy MS.QI.13, Medical Record Review, addresses Magnolia's processes for monitoring and evaluating provider compliance with medical record documentation standards and maintenance. Qualified Magnolia staff or contractors conduct annual assessments of provider medical recordkeeping practices, and providers must meet 90% of the requirements for medical recordkeeping. Detailed processes for conducting the audits, addressing identified deficiencies with the applicable providers, and conducting follow-up audits for those providers are addressed in the policy. Magnolia reported that the 2022 Medical Record Audit final analysis was submitted to the QIC in October 2022. Documentation of the 2021 Medical Record Review was submitted to CCME. Results were reported to the QIC in October 2021.

Magnolia maintains both printed and searchable, web-based Provider Directories listing all network providers, including physicians (including specialists), hospitals, pharmacies, and behavioral health providers. Policy MS.PRVR.19, Provider Directory, defines elements that must be included in the Provider Directory, and review of the submitted hardcopy Provider Directory and the online "Find a Provider" tool confirmed all required elements are included. Page one of the Provider Directory policy states Provider Directories will include "whether the provider has completed cultural competence training." However, the requirement to include completed cultural competence training is no longer applicable for Provider Directories. Also, when reviewing the printed Provider Directory, some provider listings included various languages in the field for "Cultural Competence Training." Onsite discussion revealed this may be an issue with how the information is pulled into the file from which the Provider Directory is developed.

Practice Guidelines

§ 438.236, § 457.1233

Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, describes Magnolia's process for adopting preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) from recognized sources that are relevant to the member population. The PHGs and CPGs are reviewed by the QIC to ensure appropriate physician input and are updated at least annually and when there is significant new scientific evidence or changes in national standards. Board-certified practitioners provide input through Magnolia's QIC.

As noted in Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Magnolia distributes the PHGs and CPGs to applicable practitioners and, upon request, to members, potential members, and other providers. New and revised guidelines are available on the website. Additional dissemination methods include practitioner orientation/educational materials, newsletters, and mailings. The Provider Manual includes information about the PHGs and CPGs and directs the reader to the website to view the full list of PHGs and CPGs. However, the hyperlink provided is non-functional, returning an error message.

Provider Satisfaction Survey Validation

The provider satisfaction survey was administered by SPH Analytics on behalf of Magnolia. The 2021 Provider Satisfaction Report by SPH Analytics noted that, similar to the previous year, the total sample size was 2500 and 229 providers responded, for a 9.2% response rate (this was also the 2020 response rate). This response rate is below the National Committee for Quality Assurance (NCQA) target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.2% (65 out of 357).

Compared to the SPH Medicaid Book of Business, 16 of the questions and composites met the goal, and 18 did not meet the goal. The "Health Plan Customer Service Staff" composite scored the highest at 36.40%. The "Pharmacy" composite scored the lowest. Of the 39 composites and questions, 10 improved over the prior year, and 29 decreased from prior year rates. The report indicates that overall satisfaction with Magnolia was 75.1%.Results of the survey were presented to the QIC in June 2022 and included in the 2021 QI Program Evaluation.

Table 14 offers a recommendation based on the low response rate for the Provider Satisfaction Survey.

Table 14: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Similar to the previous year, the total sample size was 2500 and 229 responded for a 9.2% response rate (this was also the 2020 response rate). This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.2% (65 out of 357).	Continue reminders for satisfaction survey to providers.

As noted in *Figure 3: Provider Services Findings*, Magnolia received "Met" scores for 94% of the Provider Services standards.

Figure 3: Provider Services Findings

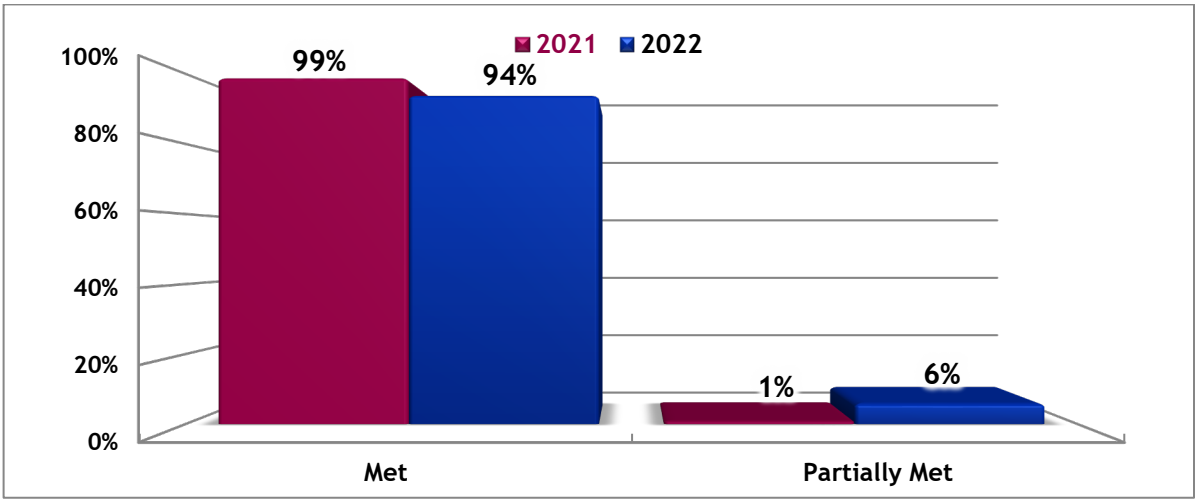


Table 15: Provider Services

Section	Standard	2022 Review
Credentialing and Recredentialing	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO	Partially Met
Adequacy of the Provider Network	The CCO formulates and ensures that practitioners act within policies and procedures	Partially Met

Section	Standard	2022 Review
	that define acceptable access to practitioners and that are consistent with contract requirements	
Provider Education	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Partially Met
Primary and Secondary Preventive Health Guidelines	The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members	Partially Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers	Partially Met

Strengths

- Credentialing and recredentialing processes are thoroughly documented in policies, and practitioner and organizational provider credentialing and recredentialing files were compliant with all requirements.
- Geographic access standards are correctly documented in policies, and Magnolia routinely monitors its network for compliance with geographic access standards.
- Magnolia has established processes to ensure its network can provide culturally appropriate care to all members, including those with diverse cultural and ethnic backgrounds, diverse health beliefs and practices, limited English proficiency, and physical disabilities.
- Provider Satisfaction survey results are presented and addressed in QIC meetings.

Weaknesses

- Three voting members of the Credentialing Committee did not meet the attendance requirement. One member attended only 64% of meetings, one attended only 55% of the meetings, and a third attended only 18% of the meetings. This is the third consecutive year this finding was noted for the Credentialing Committee.
- Policy MS.PRVR.10, Evaluation of the Accessibility of Services, incorrectly lists the appointment access standards for routine appointments and post-discharge appointments with Behavioral Health/Substance Use Disorder (BH/SUD) providers. Also, the policy does not specify timeframes for dental appointments for routine and urgent care visits, and it does not specify the timeframes for Urgent Care or Emergency Care Providers. Refer to the *CAN Contract, Section 7 (B) 2*.

- The Provider Manual includes information about member benefits, however, the following discrepancies were noted in the information when comparing it to information in the Member Handbook:
    - Page 28 of the Provider Manual addresses flu and pneumonia vaccines and states limitations of one flu shot per 12 months and two pneumonia shots per lifetime. The Provider Manual does not include COVID-19 vaccines, which are included in the Member Handbook on page 19.
    - Page 30 of the Provider Manual addresses Plastic Surgeon services and states, "All services must be in office settings…" However, the Member Handbook, page 20, does not include this limitation.
- Policy MS.PRVR.19, Provider Directory, page one, states Provider Directories will include "whether the provider has completed cultural competence training." This requirement to include completed cultural competence training is no longer applicable for Provider Directories. Also, when reviewing the printed Provider Directory, some provider listings included various languages in the field for "Cultural Competence Training." Onsite discussion revealed this may be an issue with how the information is pulled into the file from which the Provider Directory is developed.
- The Provider Manual directs the reader to the website to view the full list of PHGs and CPGs. However, the hyperlink provided is non-functional, returning an error message. This is a finding originally noted during the previous EQR. A recommendation was given to correct this issue.
- Response rates for provider satisfaction surveys are low and may affect generalizability of the results.

Corrective Actions

- Reinforce attendance expectations with Compliance Committee members and take action to replace members who do not comply with the attendance requirements.
- Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include the correct timeframes for routine BH/SUD appointments and for BH/SUD appointments post-discharge from an acute psychiatric hospital (when the CCO is aware of the discharge). Add the timeframes for routine and urgent care dental appointments, general urgent care providers, and emergency care providers.
- Revise the Provider Manual to correct the issues noted with vaccine coverage and plastic surgeon services.
- Revise the Provider Manual to include the correct hyperlink to the list of PHGs and CPGs on Magnolia's website or remove the hyperlink and provide detailed information about where to locate the guidelines.

Recommendations

- Revise Policy MS.PRVR.19, Provider Directory, to remove the requirement to include Cultural Competency Training. Determine the cause for provider languages being listed in the Provider Directory under "Cultural Competence Training" and resolve as necessary.
- Continue reminders for satisfaction survey to providers.

III. Member Services

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

The review of Member Services encompasses member rights and responsibilities, general member education and education about preventive health and chronic disease management, call center activities, enrollment and disenrollment, the member satisfaction survey, grievances, and requests for practitioner changes.

Newly enrolled members are informed of their rights and responsibilities through the new member packet and Member Handbook. Additionally, members may access information about rights and responsibilities on Magnolia's website. The new member packet also includes a Member Handbook and information about how to obtain a Provider Directory.

Magnolia's Member Handbook is comprehensive and includes information to educate members about the health plan, pertinent processes and requirements, and additional information that members need to understand health plan processes. It includes information about member benefits- however, it does not include the limitation for the number of covered pneumonia vaccines. Additionally, it includes information about provider referrals, utilization management, pharmacy processes and processes for obtaining prescription medications. Contact information for, and a description of services provided by, the Member Services area are included in the Member Handbook, as well as information about the secure member portal, mobile application for cell phones, and the 24-Hour Nurse Advice Line. Additional topics covered include Early and Periodic Screening, Diagnosis and Treatment Services, grievance and appeal processes, and information about fraud, waste, and abuse.

In addition to education provided through the Member Handbook and website, Magnolia provides education about Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) services and other preventive health services and encourages members to obtain recommended services through newsletters and "Happy Birthday" reminder cards. An incentive program, "My Health Pays," provides rewards for completing healthy activities such as yearly wellness exams, annual screenings, and tests. Members can use the rewards to pay for utilities, transportation, rent, and other purchases. Members who miss immunizations or EPSDT screenings are contacted by telephone and by mail to

remind of the recommended services, and Member Connections representatives can make home visits to members who do not respond to the reminders.

Member materials are developed in compliance with contractual requirements to ensure member understanding. Written materials do not exceed the sixth grade level of reading comprehension. Oral interpretation of written member materials is available upon request and can be provided through 711 Relay services for the hearing impaired. Documents are available in additional formats, such as Braille and large print, for members with visual impairments.

Magnolia's Member Services Call Center is available for members during the required hours of operation, which are specified in the Member Handbook and on Magnolia's website. The toll-free Nurse Advice Line is available 24 hours a day, seven days a week. Call Center staff utilize interactive call center scripts that have been developed to guide staff during new member welcome calls, member requests for PCP selection and changes, and other inbound member calls. Training is provided to Call Center staff on a variety of topics at least quarterly. Magnolia monitors Call Center statistics and performance at least monthly and reports to the Quality Improvement Committee. Performance elements that are monitored include the number of inbound, outbound, and abandoned calls, the abandoned rate, average speed of answer, and service level. For 2021, documentation indicates performance goals were met for each quarter. Magnolia is focusing on cross-training Call Center staff and using back-up call center staff and/or temporary staff for periods of high call volume. Magnolia reported the Call Center is currently staffed at full capacity.

Magnolia has established processes for notifying members in writing by mail of changes in benefits, services, and the provider network. To ensure members receive the notification, additional notice may be provided by email and/or the website. Magnolia assists members who are affected by a provider's termination to select another provider.

Grievances

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

Magnolia's Policy MS.MBRS.07, Member Grievance and Complaints Process provides a summary of the process used to respond to member grievances and complaints. Members are instructed about the grievance process and requirements in the Member Handbook and on Magnolia's website.

Magnolia's policy defines the timeline for resolving complaints and grievances. Complaints are resolved within one calendar day and grievances are resolved within 30 calendar days. The policy mentions that Magnolia may extend this timeframe and will give the member written notice of the reason for the extension. However, this policy and the notice sent to the member regarding the need for the extension does not offer the member's right to file a grievance related to the extension.

Per policy, all clinical or potential quality of care grievances are routed to the Quality Improvement Department for review and investigation by the appropriate clinical staff. Clinically urgent grievances are resolved within 72 hours of receipt.

CCME reviewed a sample of grievance files. All the files demonstrated that grievances were processed timely and that appropriate notifications were provided.

Member Satisfaction Survey

Member Satisfaction Survey validation for Magnolia was performed based on the CMS Survey Validation Protocol. Magnolia contracts with SPH Analytics Research, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, to conduct a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. The SPH Analytics reports for MY2021 were validated for this annual review.

The Adult CAHPS survey sample size was 1,343 and the total number of completed surveys was 231, lending a response rate of 17.2%. This is higher than the previous year's rate of 15.9%, but lower than the National Committee for Quality Assurance (NCQA) target rate of 40%. The sample size for the Child survey 2794, and the total number of completed surveys was 258, yielding a response rate of 9.2%. This is a slight decline from the previous year's rate of 9.4%. For the Child CCC survey, the sample size was 3,490 for the total sample (all 12-17 year-olds). The total number of completed surveys was 367, for a response rate of 10.6%. This is above the previous year's rate of 10.2%. For the general population subset (members with a chronic conditions), the sample size was 1,637 and the total number of completed surveys was 165, for a 10.1% response rate. This is higher than the previous year's rate of 9.8%.

The response rates for all the surveys were lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.

As noted in *Figure 4: Member Services Findings*, Magnolia achieved "Met" scores for 97% of the Member Services Standards.

Figure 4: Member Services Findings

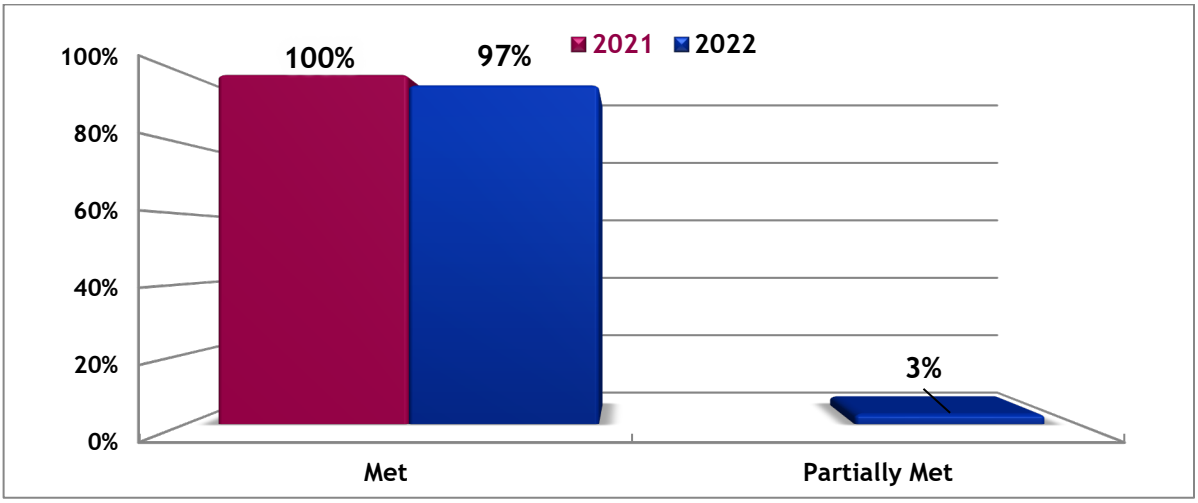


Table 16: Member Services

Section	Standard	2022 Review
Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: Timeliness guidelines for resolution of grievances as specified in the contract	Partially Met

Strengths

- Member rights are guaranteed to all members, and members are educated about member rights and responsibilities in a variety of ways.
- Magnolia provides education for new members through the new member packet, the Member Handbook, welcome calls, etc.
- Grievance files demonstrated that grievances were processed timely and appropriate notifications were provided.
- Appropriate processes are in place for notifying members of changes in benefits, services, and the provider network.
- Call center scripts are used to guide Member Services Call Center staff during member interactions, and routine training is provided to Call Center staff.

Weaknesses

- The Member Handbook does not reference the limitation of two pneumonia shots per lifetime, which is noted in the Provider Manual.

- Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System, incorrectly states Magnolia sends birthday reminder cards to one- and two-year-old members during the birth month. However, onsite discussion revealed the birthday reminder cards are sent to all members up to age 18.
- Response rates for all Member Satisfaction Surveys were lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
- Policy MS.MBRS.07, Member Grievance and Complaints Process includes the process if Magnolia requests an extension of the timeframe for resolving a grievance. However, this policy and the notice sent to the member regarding the need for the extension does not offer the member's right to file a grievance related to the extension.

Corrective Actions

- Include in the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing a grievance in Policy MS.MBRS.07, Member Grievance and Complaints Process and in the member notice.

Recommendations

- Update the Member Handbook to include the limitation on the number of pneumonia vaccines.
- Correct the age range for the EPSDT services birthday reminder cards in Policy MS.QI.01.
- Continue to determine ways to advertise surveys and increase response rates.

IV. Quality Improvement

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

Magnolia's 2022 MississippiCAN Quality Management Program Description describes the health plan's primary goal as to improve members' health status through a variety of activities across all care settings. The Board of Directors has authority, responsibility, and oversight of the development and implementation of the Quality Improvement Program. The Board delegates the operating authority to the Quality Improvement Committee (QIC). The QI Program Description was complete and included all requirements.

Magnolia focuses on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sex, primary language, etc. and by key populations through their Health Equity Program. The Health Equity Program Description and the Health Equity Governance Committee has been established to focus on improving health disparities.

Per the QI Program Description, Magnolia monitors utilization patterns by performing an assessment of utilization data to identify potential over- and under-utilization issues. Various data sources such as medical, behavioral health, pharmacy, dental, and vision

claim/encounter data are used to identify patterns of potential or actual inappropriate utilization of services. Policy CC.UM.01.03, Monitoring Utilization provided an overview of the process followed for detecting and correcting patterns of potential or actual inappropriate under or over utilization. The review of desk materials found several instances of utilization data discussions in meeting minutes and in the QI Program Evaluation.

The Quality Work Plan is developed annually after completing the Quality program evaluation for the previous year. Magnolia's Work Plan reflects the ongoing progress of the quality activities. The status of the QI activities reflected on the work plan is reviewed by the QIC on a regular basis. The 2021 and 2020 QI work plans were provided for review and contained all requirements.

The Quality Improvement Committee is Magnolia's senior leadership committee accountable to the Board of Directors. This committee is responsible for reviewing and monitoring all clinical physical and behavioral health quality and services. This committee also provides oversight of all sub-committees and reports directly to the Board of Directors. The Chief Medical Director chairs the QIC. Other members include senior leaders of the health plan and four network providers specializing in pediatrics, family medicine and behavioral health. A quorum is defined as the presence of a minimum of five members, including three plan staff and two external physicians.

Minutes are maintained for each meeting. A copy of the meeting minutes was provided with the desk materials. In some of the minutes, it was mentioned that materials and reminders would be sent to the voting members of the committee to ensure necessary participants are present. However, it was not clear in the minutes which members were considered voting members.

Magnolia's network providers receive feedback regarding their performance data through the Primary Care Provider Profile report and the Patient Care Opportunities report.

Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines addresses the development, adoption, revision, and performance monitoring conducted for the clinical and preventive practice guidelines. Magnolia chose two physical health and two behavioral health clinical practice guidelines to monitor in 2021. The guidelines monitored are Diabetes Care, Prenatal Care, Attention Deficit and Hyperactivity Disorder, and Depression. Magnolia also specifically targeted one provider (Jackson Hinds Comprehensive Health Center).

Magnolia has a process outlined in policy MS.QI.20, Early and Periodic Screening Diagnostic and Treatment Periodic (EPSDT) Services for monitoring compliance with the EPSDT program requirements and initiate interventions to educate members and providers on timely provisions of services. Magnolia tracks members needing follow-up

care after an EPSDT screening for any abnormal finding. Assistance is provided with follow-up appointments and referrals made to case management.

Annually, Magnolia assesses the effectiveness of the QI Program and documents that assessment in the Quality Program Evaluation. The 2021 Quality Management Program Evaluation was reviewed for this EQR. This program evaluation included the results of activities and studies underway or completed in 2021. A barrier analysis and recommendations for 2022 to overcome those barriers were also included.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Magnolia for the CAN population. DOM has selected a set of PMs to evaluate the quality of care and services delivered by Magnolia to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2021, through December 31, 2021.

Per the contract between the CCOs and DOM, the CCOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, DOM required each CCO to undergo an NCQA HEDIS Compliance Audit. Magnolia contracted with an NCQA licensed organization to conduct the HEDIS Compliance Audit. Aqurate reviewed the CCOs' final audit reports (FARs), information systems compliance tools, and Interactive Data Submission System (IDSS) files approved by Magnolia's NCQA licensed organization. Aqurate found that the CCO's information systems, and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS MY 2021.

In addition, Aqurate conducted additional source code review, medical record review validation and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures.

Aqurate reviewed several aspects crucial to the calculation of PM data: data integration, data control, and documentation of PM calculations. The following are some of the main steps in Aqurate' s validation process:

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by the CCO, which included a review of file consolidations, a comparison of source data to

warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined that the data integration processes for Magnolia was acceptable.

Data Control—The CCO's organizational infrastructure must support all necessary information systems; its quality assurance practices, and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated the CCO's data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by Magnolia. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by the CCO was acceptable.

All relevant CAN HEDIS performance measures were compared for the current review year (MY 2021) to the previous year (MY 2020), and the changes from 2020 to 2021 are reported in *Table 17: CAN HEDIS Performance Measure Results*. The rate changes shown in green indicate a substantial (>10%) improvement, and the rates shown in red indicate a substantial (>10%) decline.

Table 17: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	40.58%	46.80%	6.22%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	53.53%	49.88%	-3.65%
Counseling for Nutrition	46.96%	44.28%	-2.68%
Counseling for Physical Activity	40.63%	42.82%	2.19%
Childhood Immunization Status (cis)			
DTaP	71.53%	75.43%	3.90%
IPV	90.02%	91.73%	1.71%
MMR	89.29%	90.02%	0.73%
HiB	85.89%	86.13%	0.24%
Hepatitis B	86.62%	89.54%	2.92%
VZV	88.81%	89.29%	0.48%
Pneumococcal Conjugate	73.97%	74.94%	0.97%
Hepatitis A	81.02%	77.37%	-3.65%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Rotavirus	75.91%	76.89%	0.98%
Influenza	31.14%	29.68%	-1.46%
Combination #3	65.21%	68.13%	2.92%
Combination #7	55.47%	55.72%	0.25%
Combination #10	24.09%	24.09%	0.00%
Immunizations for Adolescents (ima)			
Meningococcal	59.37%	55.96%	-3.41%
Tdap/Td	79.32%	75.91%	-3.41%
HPV	25.79%	21.65%	-4.14%
Combination #1	58.88%	55.23%	-3.65%
Combination #2	24.82%	20.19%	-4.63%
Lead Screening in Children (lsc)	72.71%	69.62%	-3.09%
Breast Cancer Screening (bcs)	53.86%	50.85%	-3.01%
Cervical Cancer Screening (ccs)	57.18%	57.18%	0.00%
Chlamydia Screening in Women (chl)			
16-20 Years	47.20%	48.69%	1.49%
21-24 Years	60.75%	57.22%	-3.53%
Total	49.23%	49.77%	0.54%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Appropriate Testing for Pharyngitis (3-17)	75.36%	75.14%	-0.22%
Appropriate Testing for Pharyngitis (18-64)	61.36%	60.82%	-0.54%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	73.64%	73.17%	-0.47%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.49%	21.84%	-4.65%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	45.04%	51.48%	6.44%
Bronchodilator	77.56%	80.28%	2.72%
Asthma Medication Ratio (amr)			
5-11 Years	81.52%	81.03%	-0.49%
12-18 Years	70.24%	70.25%	0.01%
19-50 Years	55.41%	59.94%	4.53%
51-64 Years	45.90%	45.70%	-0.20%
Total	71.09%	70.95%	-0.14%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	45.74%	49.39%	3.65%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	60.00%	75.00%	15.00%
Statin Therapy for Patients with Cardiovascular Disease (spc)			

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Received Statin Therapy - 21-75 years (Male)	72.68%	75.00%	2.32%
Statin Adherence 80% - 21-75 years (Male)	57.18%	58.27%	1.09%
Received Statin Therapy - 40-75 years (Female)	71.52%	72.81%	1.29%
Statin Adherence 80% - 40-75 years (Female)	49.32%	50.60%	1.28%
Received Statin Therapy - Total	72.05%	73.84%	1.79%
Statin Adherence 80% - Total	52.97%	54.27%	1.30%
Cardiac Rehabilitation (cre)			
Cardiac Rehabilitation - Initiation (18-64)	1.85%	1.42%	-0.43%
Cardiac Rehabilitation - Engagement1 (18-64)	2.77%	1.77%	-1.00%
Cardiac Rehabilitation - Engagement2 (18-64)	1.23%	1.42%	0.19%
Cardiac Rehabilitation - Achievement (18-64)	0.92%	0.35%	-0.57%
Cardiac Rehabilitation - Initiation (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement2 (65+)	NA	NA	NA
Cardiac Rehabilitation - Achievement (65+)	NA	NA	NA
Cardiac Rehabilitation - Initiation (Total)	1.85%	1.42%	-0.43%
Cardiac Rehabilitation - Engagement1 (Total)	2.77%	1.77%	-1.00%
Cardiac Rehabilitation - Engagement2 (Total)	1.23%	1.42%	0.19%
Cardiac Rehabilitation - Achievement (Total)	0.92%	0.35%	-0.57%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	87.59%	88.32%	0.73%
HbA1c Poor Control (>9.0%)	55.96%	52.80%	-3.16%
HbA1c Control (<8.0%)	38.20%	38.69%	0.49%
Eye Exam (Retinal) Performed	65.94%	67.40%	1.46%
Blood Pressure Control (<140/90 mm Hg)	53.28%	54.74%	1.46%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	15.21%	15.68%	0.47%
Kidney Health Evaluation for Patients With Diabetes (65-74)	NA	15.63%	NA
Kidney Health Evaluation for Patients With Diabetes (75-85) (RATE NA IN MY 2020)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	15.25%	15.68%	0.43%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	59.43%	60.86%	1.43%
Statin Adherence 80%	50.65%	50.84%	0.19%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	46.04%	49.45%	3.41%
Effective Continuation Phase Treatment	28.51%	31.65%	3.14%
Follow-Up Care for Children Prescribed ADHD Medication (add)			

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Initiation Phase	59.25%	47.87%	-11.38%
Continuation and Maintenance (C&M) Phase	72.68%	61.81%	-10.87%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	64.72%	68.36%	3.64%
6-17 years - 7-Day Follow-Up	41.20%	41.16%	-0.04%
18-64 years - 30-Day Follow-Up	59.05%	57.75%	-1.30%
18-64 years - 7-Day Follow-Up	34.60%	34.35%	-0.25%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	62.24%	63.91%	1.67%
7-Day Follow-Up	38.33%	38.31%	-0.02%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	50.00%	50.50%	0.50%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	31.76%	38.50%	6.74%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	43.99%	41.20%	-2.79%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	24.68%	26.91%	2.23%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	45.91%	44.91%	-1.00%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	26.94%	31.54%	4.60%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	26.46%	28.63%	2.17%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	12.45%	16.30%	3.85%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	25.84%	27.20%	1.36%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	11.99%	15.48%	3.49%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	3.13%	0%	-3.13%
7-Day Follow-Up: 13-17 Years	3.13%	0%	-3.13%
30-Day Follow-Up: 18+ Years	5.67%	7.36%	1.69%
7-Day Follow-Up: 18+ Years	3.55%	4.68%	1.13%
30-Day Follow-Up: Total	5.41%	6.65%	1.24%
7-Day Follow-Up: Total	3.5%	4.23%	0.73%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	33.85%	22.83%	-11.02%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	34.18%	22.83%	-11.35%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	66.18%	71.34%	5.16%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	69.76%	70.19%	0.43%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	73.17%	74.51%	1.34%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	57.84%	56.99%	-0.85%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	30.14%	34.04%	3.90%
Cholesterol Testing (1-11)	23.67%	23.30%	-0.37%
Blood Glucose and Cholesterol Testing (1-11)	19.9%	20.81%	0.91%
Blood Glucose Testing (12-17)	41.84%	48.98%	7.14%
Cholesterol Testing (12-17)	28.01%	29.83%	1.82%
Blood Glucose and Cholesterol Testing (12-17)	24.91%	27.52%	2.61%
Blood Glucose Testing (Total)	36.85%	42.89%	6.04%
Cholesterol Testing (Total)	26.16%	27.17%	1.01%
Blood Glucose and Cholesterol Testing (Total)	22.77%	24.78%	2.01%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NQ	NQ	-
Appropriate Treatment for Children with URI (uri)			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	70.98%	71.73%	0.75%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Appropriate Treatment for Upper Respiratory Infection (18-64)	55.77%	56.32%	0.55%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	69.00%	69.88%	0.88%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	43.65%	43.33%	-0.32%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	35.97%	43.74%	7.77%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	42.1%	43.46%	1.36%
Use of Imaging Studies for Low Back Pain (lbp)	72.59%	71.49%	-1.1%
Use of Opioids at High Dosage (hdo)	1.18%	1.15%	-0.03%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	13.00%	11.40%	-1.60%
Multiple Pharmacies	1.92%	1.96%	0.04%
Multiple Prescribers and Multiple Pharmacies	0.93%	0.82%	-0.11%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	2.93%	3.18%	0.25%
18-64 years - >=31 Days covered	1.89%	2.36%	0.47%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	2.95%	3.18%	0.23%
Total - >=31 Days covered	1.90%	2.36%	0.46%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	84.87%	84.81%	-0.06%
45-64 Years	91.10%	91.21%	0.11%
65+ Years	80.18%	80.15%	-0.03%
Total	87.46%	87.48%	0.02%
Annual Dental Visit (adv)			
2-3 Years	41.82%	48.49%	6.67%
4-6 Years	61.08%	66.5%	5.42%
7-10 Years	62.82%	68.29%	5.47%
11-14 Years	61.27%	65.5%	4.23%
15-18 Years	55.3%	58.14%	2.84%
19-20 Years	36.67%	41.27%	4.6%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Total	57.72%	62.51%	4.79%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	67.35%	75.93%	8.58%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	2.04%	3.70%	1.66%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	72.06%	68.46%	-3.6%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	8.10%	4.23%	-3.87%
Total: Initiation of AOD Treatment: 13-17 Years	69.66%	66.33%	-3.33%
Total: Engagement of AOD Treatment: 13-17 Years	7.87%	4.42%	-3.45%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	42.09%	36.88%	-5.21%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	4.27%	4.47%	0.20%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	29.25%	35.43%	6.18%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	10.49%	13.16%	2.67%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	40.50%	37.52%	-2.98%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.25%	5.51%	0.26%
Total: Initiation of AOD Treatment: 18+ Years	37.84%	35.07%	-2.77%
Total: Engagement of AOD Treatment: 18+ Years	6.25%	6.63%	0.38%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	43.55%	39.27%	-4.28%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.14%	4.43%	0.29%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	29.32%	35.79%	6.47%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	10.46%	12.92%	2.46%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	45.27%	41.99%	-3.28%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	5.68%	5.32%	-0.36%
Total: Initiation of AOD Treatment: Total	40.93%	38.25%	-2.68%
Total: Engagement of AOD Treatment: Total	6.41%	6.40%	-0.01%
Prenatal and Postpartum Care (ppc)			

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Timeliness of Prenatal Care	92.21%	93.67%	1.46%
Postpartum Care	74.45%	74.70%	0.25%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	64.21%	63.56%	-0.65%
12-17 years	67.40%	66.80%	-0.60%
Total	66.02%	65.53%	-0.49%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	51.78%	55.81%	4.03%
15 Months-30 Months	66.67%	62.42%	-4.25%
Child and Adolescent Well-Care Visits (WCV)			
3-11 years	41.16%	45.29%	4.13%
12-17 years	35.62%	38.77%	3.15%
18-21 years	20.05%	20.20%	0.15%
Total	37.65%	41.02%	3.37%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.BR: Biased Rate; NR indicates that the rate was not reported; NQ indicates the rate was not required.

As shown, the Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) improved by 15 percentage points. The following HEDIS MY 2021 measure rates had a greater than 10% decline:

- Follow-Up Care for Children Prescribed ADHD Medication (add) measure, both the Initiation Phase indicator and the Continuation and Maintenance (C&M) Phase declined by over 10 percentage points.
- Pharmacotherapy for Opioid Use Disorder (POD) measure, the Pharmacotherapy for Opioid Use Disorder (16-64) indicator and the Pharmacotherapy for Opioid Use Disorder (Total) indicator both had a greater than 11 percentage point decline.

The MY 2021 Final Audit Report, identified many concerns that the HEDIS Compliance Auditor experienced with Magnolia regarding Magnolia's timeliness for responding, providing appropriate data and responses when requested, and meeting the HEDIS Compliance Audit timelines. The Aqurate team had similar concerns with regards to receipt of rates data for the non-HEDIS CMS Core Set measures.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2021 and the previous year (2020). The change from 2020 to 2021 are reported in the tables below. The rate changes shown in green indicate a substantial (>10%) improvement and the rates shown in red indicates a substantial (>10%) decline.

Table 18: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate	MY 2021 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.57%	0.74%	0.17%
Ages 65+	0.00%	0.00%	0.00%
Total	0.57%	0.74%	0.17%
COLORECTAL CANCER SCREENING (COL-AD)			
Ages 50-64	-	42.24%	-
Ages 65-75	-	47.60%	-
Total	-	46.28%	-
Ages 50-64	-	42.24%	-
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception - 3 days	13.75%	11.24%	-2.51%
Most or moderately effective contraception - 60 days	47.02%	41.06%	-5.96%
LARC - 3 Days	0.88%	0.44%	-0.44%
LARC - 60 Days Reported	9.66%	7.65%	-2.01%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception rate	25.58%	23.41%	-2.17%
LARC Rate	3.39%	2.38%	-1.01%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	29.44	25.2	-4.24
Ages 65+	0.00	0	0
Total	29.38	25.15	-4.23
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	87.85	53.10	-34.75
Ages 65+	160.77	151.17	-9.6
Total	88.21	53.64	-34.57
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	59.86	48.86	-11
Ages 65+	160.77	0	-160.77
Total	60.07	48.75	-11.32
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	3.07	2.91	-0.16
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			

Measure	MY 2020 Rate	MY 2021 Rate	Change
Ages 18 - 64	12.43%	31.30%	18.87%
Ages 65+	NA	NA	NA
Total	12.19%	31.60%	19.41%
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	1.28%	1.32%	0.04%
Ages 65+	NA	NA	NA
Total	1.28%	1.32%	0.04%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	3.39%	3.35%	-0.04%
Ages 65+	NA	NA	NA
Total	3.38%	3.35%	-0.03%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	32.73%	33.65%	0.92%
Prescription for Buprenorphine	32.32%	33.17%	0.85%
Prescription for Oral Naltrexone	0.74%	0.57%	-0.17%
Prescription for Long-acting, injectable naltrexone	0.00%	0.10%	0.10%
Prescription for Methadone	0.08%	0.00%	-0.08%
Child Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	0.87%	0.88%	0.01%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	3.09%	3.50%	0.41%
Age 2 Screening	6.03%	4.05%	-1.98%
Age 3 Screening	5.56%	3.59%	-1.97%
Total Screening	4.84%	3.69%	-1.15%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception - 3 days	2.11%	1.81%	-0.30%
Most or moderately effective contraception - 60 days	45.25%	43.01%	-2.24%
LARC - 3 Days	0.79%	0.73%	-0.06%
LARC - 60 Days Reported	12.14%	12.70%	0.56%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	30.66%	28.76%	-1.90%
LARC Rate	2.65%	2.24%	-0.41%

Measure	MY 2020 Rate	MY 2021 Rate	Change
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	NR	46.74%	NA
Numerator 2 All Four Molars Sealed	NR	31.22%	NA
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	-	0.25%	-
Ages 1-2	-	15.46%	-
Ages 3-5	-	47.15%	-
Ages 6-7	-	53.31%	-
Ages 8-9	-	53.59%	-
Ages 10-11	-	51.25%	-
Ages 12-14	-	47.07%	-
Ages 15-18	-	39.12%	-
Ages 19-20	-	24.12%	-
Total Ages <1-20	-	41.91%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	-	4.26%	-
Ages 3-5	-	8.29%	-
Ages 6-7	-	9.29%	-
Ages 8-9	-	8.84%	-
Ages 10-11	-	8.00%	-
Ages 12-14	-	7.06%	-
Ages 15-18	-	4.70%	-
Ages 19-20	-	3.00%	-
Total Ages 1-20	-	6.88%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	-	1.31%	-
Ages 3-5	-	6.54%	-
Ages 6-7	-	8.71%	-
Ages 8-9	-	8.65%	-
Ages 10-11	-	7.90%	-
Ages 12-14	-	6.94%	-
Ages 15-18	-	4.64%	-
Ages 19-20	-	2.95%	-
Total Ages 1-20	-	6.21%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			

Measure	MY 2020 Rate	MY 2021 Rate	Change
Ages 1-2	-	1.78%	-
Ages 3-5	-	0.17%	-
Ages 6-7	-	0.00%	-
Ages 8-9	-	0.00%	-
Ages 10-11	-	0.00%	-
Ages 12-14	-	0.00%	-
Ages 15-18	-	0.00%	-
Ages 19-20	-	0.00%	-
Total Ages 1-20	-	0.19%	-

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate; -: New measure, no prior year or change data available for reporting

The HIV Viral Load Suppression (HVL-AD) measure, the Ages 18 – 64 indicator improved by 18.87 percentage points, and the Total indicator improved by 19.41 percentage points.

The Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission Rate (PQI-05) measure, the Ages 40 – 64 indicator and the Total indicator declined by over 34 member months per 100,000 member months.

The Heart Failure Admission Rate (PQI-08) measure, the Ages 18 – 64 indicator and the Total indicator declined by over 11 member months per 100,000 member months, and the Ages 65+ indicator declined by over 160 member months per 100,000 member months.

In the prior year, Magnolia did not report one non-HEDIS measure as required by DOM. For MY 2021, Magnolia did not report the three new Adult and Child core set measures until repeated requests were made.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

The components assessed are as follows:

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

- Improvement strategies

DOM requires the CCOs to conduct PIPs that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child - Asthma and Adult - COPD).

For the previous EQR, Magnolia submitted four PIPs for validation that addressed the DOM-required topics. All four PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. CCME provided recommendations that focused on revising interventions and generating innovations to achieve goal rates for the Behavioral Health Readmission PIP, the Sickle Cell Disease Outcome PIP, and the HEDIS indicators for the Asthma/COPD PIP.

For the current EQR, Magnolia provided PIP documents for the same PIPs as last year. Topics included Asthma/COPD, Behavioral Health Readmissions, Sickle Cell Disease, and Reducing Preterm Births. All the PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions are also included.

Table 19: Asthma/COPD PIP

Asthma/COPD	
The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and who had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year. This indicator uses the HEDIS measure, Asthma Medication Ratio (AMR). The documentation provided showed no change with an AMR rate of 70.24% for 2020 and 70.25% for 2021 with a goal of 76.86%. The COPD spirometry testing indicator declined from 26.49% in 2020 to 21.84% in 2021.The goal is 36.82%.	
Previous Validation Score	**Current Validation Score**
73/74= 99% High Confidence in Reported Results	73/74= 99% High Confidence in Reported Results
Interventions	
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the Asthma Medication Ratio (AMR) and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Education on the AMR & SPR measures in provider newsletters by the QI Team.	

Table 20: Behavioral Health Readmission PIP

Behavioral Health Readmission	
The Behavioral Health Readmission PIP is focused on reducing 30-day readmissions for members discharged from a behavioral health facility and to increase case management enrollment for those that are readmitted. Magnolia tracks data quarterly and annually for this PIP. The 2021/2022 rate was 19.73% which reduced slightly in the Q2 2022 rate to 19.7%. The enrollment rate improved from Q1 2022 at 35.7% to Q2 2022 at 37.5%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Telephonic outreach by the Clinical Provider Trainer for Behavioral Health to all Hinds County Behavioral Health facilities to provide education, resources, and address any barriers. • Direct outreach to members discharged from Hinds County BH facilities by the Behavioral Health Team to complete the TOC Assessment.	

Table 21: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
The Sickle Cell Disease PIP focuses on increasing compliance with Hydroxyurea for eligible members throughout the treatment period. The most recent rate improved from 20.6% in 2020/2021 to 25.8% in 2021/2022. The goal is 47%.	
Previous Validation Score	**Current Validation Score**
73/74= 99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Pharmacy Team mailed educational letters to members identified with a prescription for Hydroxyurea suggesting ways to be proactive in taking their medication daily (pillbox, daily alarm, auto-refill pharmacy) and on the importance of medication adherence. • Pharmacy Team mailed letters to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment. • Pharmacy Team outreached all members who received letters to provide education and to address any barriers/concerns. • Referrals to Care Management as needed.	

Table 22: Reducing Preterm Births PIP

Reducing Preterm Births	
The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with HTN/preeclampsia. The baseline rate was 14.47% which increased to 15.84% in the 2021-2022 measurement period. The goal is to reduce the preterm birth rate to 11.4%.	
Previous Validation Score	**Current Validation Score**
70/70=100% High Confidence in Reported Results	72/73= 99% High Confidence in Reported Results
Interventions	
• Completing Notification of Pregnancy (NOP) as applicable • Enrolling member in the Start Smart for Baby program • Refer to Care Management for continuous follow up • Identify various methodologies to enhance patient education and engagement to increase early intervention. Develop materials on controlling hypertension during pregnancy, distribute to members as needed. • Develop a plan and criteria to distribute blood pressure cuffs to member	

CCME provided recommendations for the Reducing Preterm Births, and Asthma/COPD PIPs. The recommendations are displayed in *Table 23: Performance Improvement Project Recommendations*.

Table 23: Performance Improvement Project Recommendations

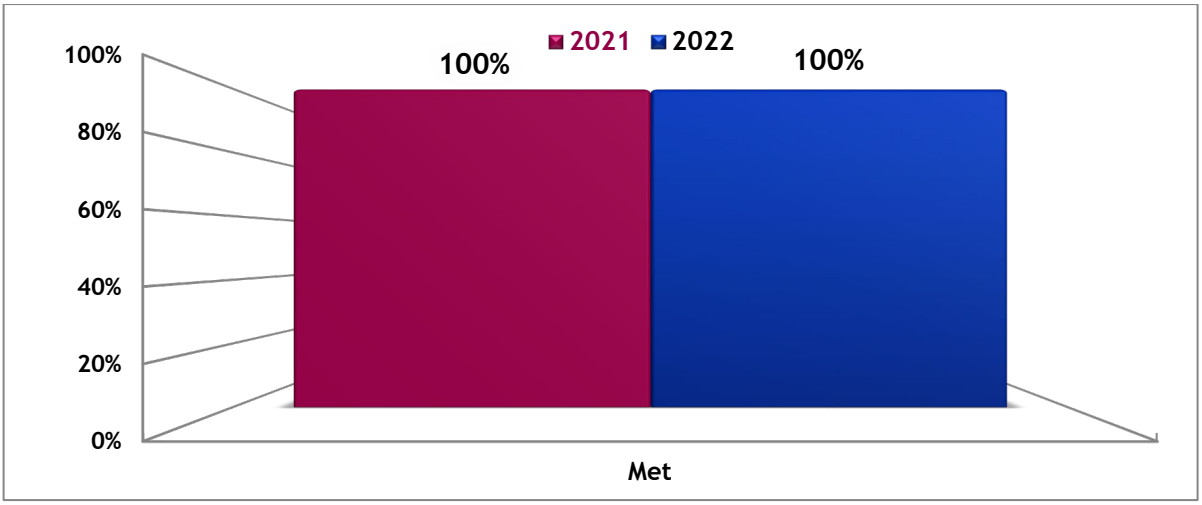
Project	Section	Reason	Recommendation
Reducing Preterm Births	Was there any documented, quantitative improvement in processes or outcomes of care?	The baseline rate was 14.47% which increased to 15.84% in the 2021-2022 measurement period. The goal is to reduce the preterm birth rate to 11.4%.	Continue monitoring newly implemented interventions, including education and enrollment programs to determine if preterm birth rate can be reduced

Project	Section	Reason	Recommendation
Asthma/COPD	Was there any documented, quantitative improvement in processes or outcomes of care?	Asthma medication ratio (12–18-year-olds at 50% or greater) showed no change with an AMR rate of 70.24% for 2020 and 70.25% for 2021. The goal is 76.86%. The COPD spirometry testing indicator declined from 26.49% in 2020 to 21.84% in 2021.The goal is 36.82%.	Initiate enhancements for support services and the Care Management program to improve AMR and COPD rates.

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

For this review period, Magnolia met all the requirements in Quality Improvement section.

Figure 5: Quality Improvement Findings



Strengths

- Magnolia was fully compliant with all Information Systems Standards and determined that Magnolia submitted valid and reportable rates for all HEDIS measures in scope of the audit.
- There were no concerns with Magnolia's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported.

Magnolia followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.

- The following HEDIS MY 2021 measure rates and non-HEDIS Adult Core Set measure rates were strengths for Magnolia since their rates had a greater than 10% improvement:
    - Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) improved by 15 percentage points.
    - HIV Viral Load Suppression (HVL-AD) measure, the Ages 18 - 64 indicator improved by 18.87 percentage points and the Total indicator improved by 19.41 percentage points.

Weaknesses

- Minutes for the Quality Improvement Committee meeting did not document which members are considered voting members.
- The following HEDIS MY 2021 measure rates and non-HEDIS Adult Core Set measure rates were determined to be areas of opportunities for Magnolia since their rates had a greater than 10% decline:
    - Follow-Up Care for Children Prescribed ADHD Medication (add) measure, both the Initiation Phase indicator and the Continuation and Maintenance (C&M) Phase declined by over 10 percentage points.
    - Pharmacotherapy for Opioid Use Disorder (POD) measure, the Pharmacotherapy for Opioid Use Disorder (16-64) indicator and the Pharmacotherapy for Opioid Use Disorder (Total) indicator both had a greater than 11 percentage point decline.
    - Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission Rate (PQI-05) measure, the Ages 40 - 64 indicator and the Total indicator declined by over 34 member months per 100,000 member months.
    - Heart Failure Admission Rate (PQI-08) measure, the Ages 18 - 64 indicator and the Total indicator declined by over 11 member months per 100,000 member months and the Ages 65+ indicator declined by over 160 member months per 100,000 member months.
- Magnolia did not report the three new Adult and Child core set measures until repeated requests were made. There seemed to be a lack of oversight provided by the Magnolia team to Magnolia's corporate teams that are responsible for producing the DOM required measure rates.
- The MY 2021 Final Audit Report identified many concerns that the HEDIS Compliance Auditor experienced regarding Magnolia's responsiveness. The Aqurate team had

similar concerns with regards to receipt of rates data for the non-HEDIS CMS Core Set measures.

Recommendations

- Document in the Quality Improvement Committee minutes which members are considered voting members.
- Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.
- Work proactively with DOM regarding clarification on measures that are required to be reported.
- Communicate to Magnolia's corporate teams the measures that are required to be reported to ensure the team understands the measures required for reporting.
- Improve processes around the calculation, reporting, and verification of the Adult and Child Core set measure rates reported to DOM.

V. Utilization Management

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

The Utilization Management Program Description 2022 outlines and describes the Utilization Management (UM) Program. Established policies and procedures support the implementation and operation of the program. Magnolia's UM Program's aim is to provide services that are covered benefits, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

The Chief Medical Director, who is a Mississippi licensed physician, conducts oversight of UM activities. A behavioral health practitioner participates in the implementation of the behavioral health aspects of the UM program.

Coverage and Authorization of Services

42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114

The UM Program Description mentions that UM criteria and policies for application are reviewed and approved at least annually and updated as needed. Policy MS.UM.02, Clinical Decision Criteria and Application, notes updates and revisions to InterQual, American Society of Addiction Medicine (ASAM), other applicable criteria, state specific service definitions, clinical and pharmacy policies, and procedures for applying criteria, are reviewed at least annually by the Utilization Management Committee (UMC), Clinical Policy Committee (CPC) and/or Quality Improvement Committee (QIC).

Prior authorization is required for specific procedures and services. Prior authorization is not required for emergency or urgent care services. Two levels or UM medical necessity review are available for all authorization requests. Level 1 review is conducted on covered benefits by a Prior Authorization Nurse or Concurrent Review Nurse. If criteria are met, the review nurse issues an authorization. If criteria are not met, the case is sent for a Level II review. Level II reviews are conducted by appropriately licensed practitioners.

At least annually, Magnolia assesses the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. Policy CC.UM.32, Interrater Reliability - Associates, Medical Directors, and Therapists describes the process for conducting interrater reliability for all clinical staff and medical directors.

Policy MS.UM.02, Clinical Decision Criteria and Application, describes that members' individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Approval files reflect that physician reviewers will use manual criteria and their clinical professional judgement to consider the member's individual circumstances when InterQual criteria is not met.

Review of approval files reflect physical and behavioral health utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within three calendar days/two business days.

CCME reviewed a sample of denial decisions made by Magnolia and found all the Adverse Benefits Notices incorrectly mentions that an oral request for an appeal by members must be followed up in writing unless the request is for an expedited appeal.

Also, the Adverse Benefit Notice letter template incorrectly mentions that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.

Appeals

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

The UM Program Description and policies such as Policy MS.UM.08, Appeal of UM Decisions, and Policy MS.UM.01, Utilization Management Program Description, describe Magnolia's approach for handling and processing member appeals. Additionally, information is provided in the Provider Manual, in the Member Handbook, and on the member tab of the website.

Magnolia's procedures for filing an appeal are included in Policy MS.UM08, Appeal of UM Decisions, in the UM Program Description, Member Handbook, Provider Manual and on

Magnolia's website. These documents incorrectly mention an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal. Also, the appeal policy includes information that is contained in the acknowledgement letter. However, some of this information was not included in the acknowledgement letter. The following was missing:

- The member's right to submit comments, documents, or other information relevant to the appeal.
- The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.

Magnolia's appeal policy correctly documents the timeframes for resolving a standard and expedited appeal. This policy also mentions these timeframes can be extended up to 14 calendar days by the member or by the plan. The policy further explains Magnolia will notify the member of the need to extend the timeframe for resolution and the member has a right to file a grievance if he or she disagrees with the extension. However, the notice send to the member regarding the extension does not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website.

A sample of appeal files were reviewed. The following issues were identified:

- In one file, the resolution notice was sent to the member prior to the date of the decision.
- There were two files where the appeal was requested as expedited and the member was not notified of the decision to deny the request for expedited resolution.
- One appeal was not resolved within the required timeframe, and one acknowledgement letter was not sent.

Care Management

42 CFR § 208

Magnolia's UM Program Description 2022 includes an overview of Care and Disease Management programs. Departmental policies and procedures provide detailed information about processes and requirements for staff who conduct Care Management and Population Health Management activities. Magnolia's Care Management team consists of Registered Nurses, Program Coordinators, behavioral health and social services staff, departmental leadership, and Medical Directors.

Optum's Population Health Program Management Operations Program Description describes the chronic condition and lifestyle management programs available to members, including Chronic Obstructive Pulmonary Disease, Asthma, Diabetes, Heart Failure, Coronary Artery Disease, Hypertension and/or Hyperlipidemia, and lifestyle

management programs (exercise, physical activity, nutrition, stress management, tobacco cessation, weight management, and lower back pain).

As noted in the UM Program Description, one key objective of the Care Management Program is early identification of members with the greatest need for care coordination or complex care management. Magnolia uses multiple methods to identify members who are potential candidates for Care Management, including health screenings, internal data sources and reports, reports from the state agency/state enrollment center, predictive modeling, etc. Members are also identified through direct referrals from other CCO departments, providers, vendors, the Nurse Advice Line, and Disease Management. Members may also self-refer.

Magnolia conducts health risk assessments (HRAs) within 30 calendar days of member identification, and members with more urgent needs are prioritized for earlier outreach. Within 30 days of completion of the HRA, member care plans are developed in collaboration with the member, caregivers, and providers. All members enrolled in Care Management are reassessed at least annually and when there are significant changes in condition. Care plans are revised as needed with care plan changes and goal modification based on findings of ongoing evaluations. Significant care plan revisions are shared with the member/caregiver and the interdisciplinary care team to ensure agreement with the changes.

Care Management files reflect appropriate care management activities for members' acuity levels and needs. Health risk assessments are conducted by qualified clinicians, and Magnolia has incorporated a Social Determinants of Health screener to assist in identifying members' needs related to food, housing, transportation, utilities, public benefits, internet access, etc.

As noted in *Figure 6: Utilization Management Findings*, Magnolia achieved a "Met" score for 91% and a score of "Partially Met" for 9% of the Utilization Management standards.

Figure 6: Utilization Management Findings

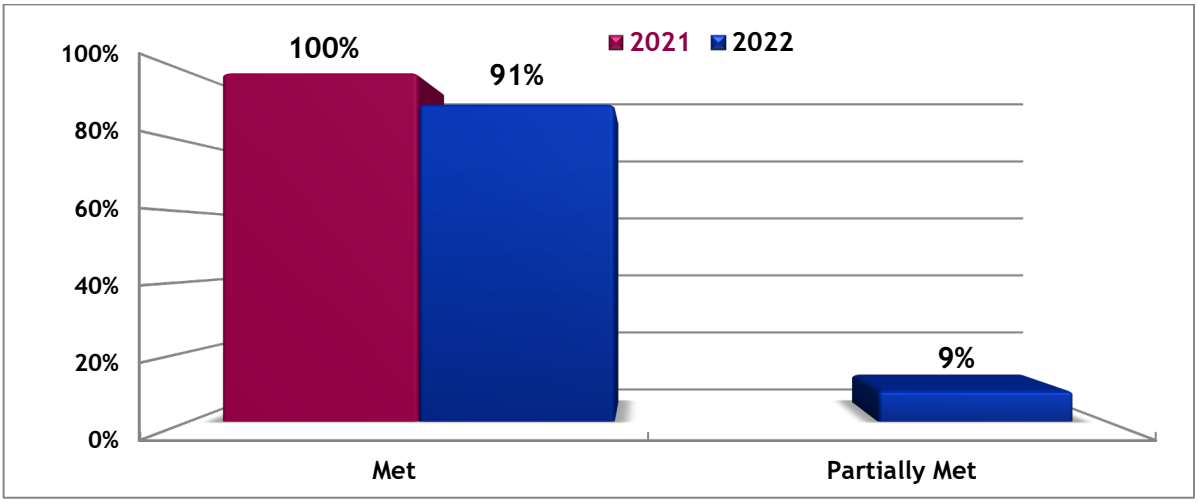


Table 24: Utilization Management

Section	Standard	2022 Review
Medical Necessity Determinations	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Partially Met
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: The procedure for filing an appeal	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met
	The CCO applies the appeal policies and procedures as formulated	Partially Met
Care Management	The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions: Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days	Partially Met

Strengths

- Review of approval files reflect physical and behavioral health utilization decisions are determined within required timeframes.

- Magnolia has implemented a Social Determinants of Health screening tool to assist in identifying members' needs related to food, housing, transportation, utilities, public benefits, internet access, etc.

Weaknesses

- CCME reviewed a sample of denial decisions made by Magnolia and found all the Adverse Benefits Notices incorrectly mention that an oral request for an appeal by members must be followed up in writing unless the request is for an expedited appeal.
- The Adverse Benefit Notice letter template incorrectly mentions that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.
- Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, Member Handbook, Provider Manual and on Magnolia's website incorrectly mentions an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal.
- Policy MS.UM08, Appeal of UM Decisions includes information that is contained in the acknowledgement letter. However, the following information was missing in the acknowledgement letter:
    - The member's right to submit comments, documents, or other information relevant to the appeal.
    - The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.
- Policy MS.UM08, Appeal of UM Decisions explains Magnolia will notify the member of the need to extend the timeframe for resolution of an appeal and the member has a right to file a grievance if he or she disagrees with the extension. However, the notice sent to the member regarding the extension does not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website.
- A sample of appeal files were reviewed. The following issues were identified:
    - In one file, the resolution notice was sent to the member prior to the date of the decision.
    - There were two files where the appeal was requested as expedited, and the member was not notified of the decision to deny the request for expedited resolution.
    - One appeal was not resolved within the required timeframe and one acknowledgement letter was not sent.
- For continued access to providers who are no longer available through the CCO's network, Policy MS.PRVR.23, Provider Termination, and onsite discussion confirmed

the timeframe allowed is up to 60 calendar days. However, Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, incorrectly state the timeframe as 90 calendar days.

Corrective Actions

- Correct the Adverse Benefit Notices and remove the requirement that a member must follow an oral request for appeal with a written request.
- Correct Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, the Provider Manual, and Magnolia's website and remove the requirement that a member must follow-up an oral request for an appeal with a written request.
- Correct the Acknowledgement Letter and include all the requirements listed in Policy MS.UM08, Appeal of UM Decisions.
- Include the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing an appeal in the member notice, the Member Handbook, Provider Manual and on Magnolia's website.
- Initiate a process to monitor appeals to ensure all requirements are met.
- Revise Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, to reflect the correct timeframe for allowing a continuing course of treatment when a provider is no longer in Magnolia's network.

VI. Delegation

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

CCME's External Quality Review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials.

For this review, Magnolia reported 20 delegation agreements, as shown in *Table 25: Delegated Entities and Services*.

Table 25: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve Dental	Dental claims, network, utilization management, credentialing, and quality management
Envolve Vision	Vision services claims, network, utilization management, credentialing, and quality management
Envolve Pharmacy Solutions	Pharmacy claims, network, utilization management, credentialing
Envolve PeopleCare - NurseAdvice Line	24/7 Nurse call center
Medical Transportation Management, Inc. (MTM)	Non-emergency transportation claims, network, utilization management, credentialing, and quality management
National Imaging Associates, Inc. (NIA)	Radiology utilization management
Baptist Memorial Health Care-Baptist Health Services Group Hattiesburg Clinic, PA LSU Healthcare Network (New Orleans) Magnolia Regional Health Center Memorial Hospital at Gulfport Mississippi Health Partners Mississippi Physicians Care Network North Mississippi Medical Clinic/North MS Healthlink Ochsner Clinic Foundation Premier Health, Inc. Rush Health Systems St. Jude Children's Research Hospital University of Mississippi Medical Center	Credentialing
SourceOne	CVO

The Oversight of Delegated Vendor Services policy and the Oversight of Delegated Credentialing Policy describes processes for delegation of health plan activities and oversight of delegated entities. The Joint Oversight Committee oversees delegation processes. The health plan subjects each potential delegate to a pre-delegation assessment to determine its capabilities for conducting functions in compliance with all requirements. Magnolia conducts annual oversight and ongoing monitoring for all delegates. Standardized audit tools that are specific to functional areas are used for pre-delegation and annual assessments.

Documentation of annual oversight and ongoing monitoring were provided for 19 of the 20 delegates. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan. The annual oversight monitoring for Rush Health Systems was not provided. The annual monitoring report provided for this EQR was the same monitoring report provided for the previous (2021) EQR. Also, the files reviewed for the annual monitoring of Mississippi Health Partners incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable."

As indicated in *Figure 7, Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met."

Figure 7: Delegation Findings

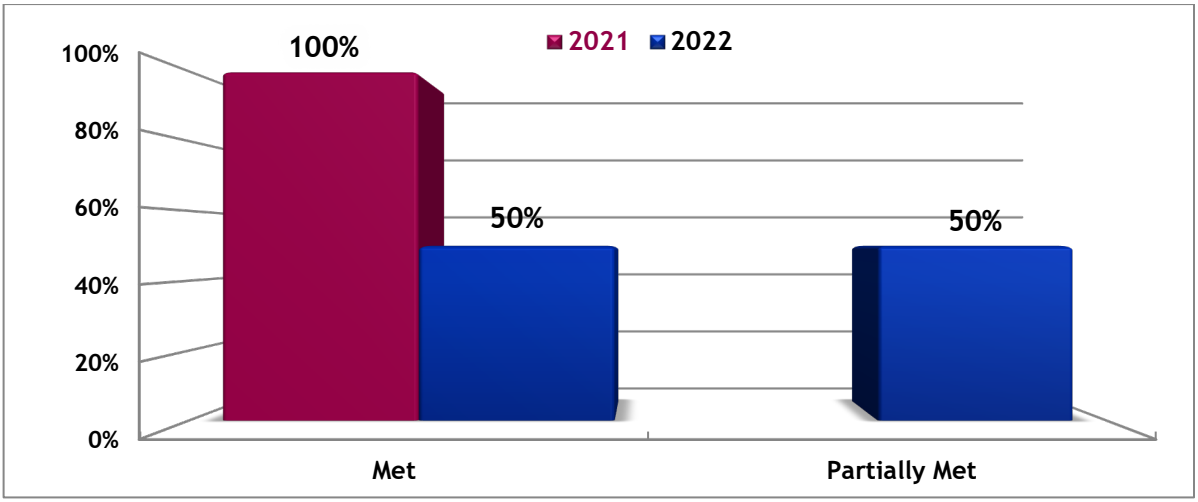


Table 26: Delegation

Section	Standard	2022 Review
Delegation	The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions	Partially Met

Weaknesses

- Documentation of annual oversight monitoring was not provided for one of the delegates.

- The files reviewed for the annual monitoring of Mississippi Health Partners incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable."

Corrective Actions

- Develop a process to ensure that the annual monitoring for all delegates is conducted in a timely manner.
- Re-educate all credentialing delegates to ensure the requirements for checking the Social Security Death Master File and Hospital Admitting Privileges are included in the monitoring.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

I. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
12040 Regency Parkway, Suite 100, Cary, NC 27518-8597 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

June 23, 2022

Mr. Aaron Sisk
Plan President & CEO
Magnolia Health Plan
111 East Capitol Street, Suite 500
Jackson, MS 39201

Dear Mr. Sisk:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2022 External Quality Review (EQR) of Magnolia Health Plan is being initiated. The review will include the MississippiCAN (MSCAN) Program and will be conducted by The Carolinas Center for Medical Excellence (CCME).

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

The virtual onsite visit will be conducted on **October 5, 2022** and **October 6, 2022** for the MississippiCAN Program.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** list should be provided to CCME no later than **July 25, 2022**.

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

Magnolia Health Plan

External Quality Review 2022 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MississippiCAN (MSCAN) Program, as well as a complete index that includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. If applicable, identify staff members who are assigned to only to MSCAN and staff members who are assigned only to CHIP.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence for the MSCAN Program.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the MSCAN Program. Please include any provider identified limitations on panel size considered in the network assessment.

5. The total number of unique specialty providers for MSCAN as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

6. A current provider list/directory as supplied to MSCAN members.

7. A copy of the current Fraud, Waste & Abuse/Compliance Plan for the MSCAN Program, any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

8. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for MSCAN. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

9. The Quality Improvement work plans for MSCAN for 2021 and 2022.

10. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, Disease/Care Management, and Population Health programs for MSCAN.

11. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN Program completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

a. For all projects with non-HEDIS measures:
    - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
b. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction.
c. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP.

12. Minutes of <u>all committee meetings</u> within the past year for committees reviewing or taking action on MSCAN related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

13. Membership lists and a committee matrix for all MSCAN committees including the professional specialty of any non-staff members. <u>Please indicate which members are voting members and include committee charters if available</u>.

14. Any data for the MSCAN Program collected for the purposes of monitoring the utilization (over and under) of health care services.

15. Copies of the most recent physician profiling activities for the MSCAN Program conducted to measure contracted provider performance.

16. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews for MSCAN providers.

17. Provide reports for measuring provider adherence to medical record standards for 2021 and 2022.

18. A complete list of all MSCAN members enrolled in the Care Management program from August 2021 through July 2022. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Include evidence of any training provided to call center staff on the MSCAN Program and changes.

20. A copy of the MSCAN member handbook and any statement of the member bill of rights and responsibilities, if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction surveys for the MSCAN Program with a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and any other documentation of the requested scope of work.

22. A copy of any member newsletters, educational materials, and/or other mailings. Include any training plans for educating providers on MSCAN Program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Include any training plans, including initial provider orientation, for educating providers on the MSCAN Program.

24. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN Program for the months of August 2021 through July 2022.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the MSCAN Program.

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the MSCAN Program. Include copies of the most recent Network Geographic Access Assessment (Geo Access) reports and provider appointment and after-hours access monitoring.

27. Preventive health guidelines recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

28. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

29. For the MSCAN Program, a list of physicians currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual for the MSCAN Program.

31. A sample provider contract for the MSCAN Program.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of August 2021 through July 2022.

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

Date of initial Delegation	Name of Delegated Entity	unctions Delegated	Methods of Oversight

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

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

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

Folder	Requested Document	Description
a.	HEDIS® Measurement Year 2021 (MY 2021) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2021 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for all supplemental data sources that are utilized for all measures included under PMV review. If the CCO did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN for MY 2021.
c.	HEDIS MY 2021 Final Audit Report (FAR) from the Licensed Organization for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.

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

1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
2. HEDIS Certified Measures [SM] is a service mark of the NCQA.

37. Provide electronic copies of the following files for the MSCAN Program:
    a. Credentialing files (<u>including provider office site visits as appropriate</u>) for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and

vi. One file for each additional type of facility in the network.

b. Recredentialing files for:
    i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
    ii. Two OB/GYNs;
    iii. Two specialists;
    iv. Two behavioral health providers
    v. Two network hospitals; and
    vi. One file for each additional type of facility in the network.
c. Twenty-five medical necessity denial files for the MSCAN Program made in the months of August 2021 through July 2022. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of August 2021 through July 2022, including any medical information and approval criteria used in the decision.

    Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

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

II. Attachment 2: Materials Requested for Onsite Review

Magnolia Health Plan
MississippiCAN

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.

2. Copies of the following policies:
    a. CP.CPC.05 – Medical Necessity Criteria
    b. Mississippi addendum to Policy CC.QI.17, Potential Quality of Care Incidents
    c. CP.CPC.03 – Preventive Health and Clinical Practice Guidelines

3. Copy of the EPSDT follow-up report for members needing follow-up care after an EPSDT screening.

4. Results of the most recent Interrater Reliability testing conducted for all clinical staff and medical directors.

5. Please provide the credentials for the reviewers that approved the following approval files:
    a. File 21
    b. File 23
    c. File 24

6. A copy of the MSCAN Geo Access Physical Health Q1.2022 and MSCAN Geo Access Behavioral Health Q1.2022 documents. (The copies originally submitted could not be opened.)

7. For each delegated entity/vendor, documentation of the results of the annual oversight evaluations (including Audit Tools), and any reevaluations conducted between the annual evaluations. We only received the monthly monitoring dashboard reports for Envolve Dental, MTM, NIA, Envolve Pharmacy Solutions, and Envolve Vision.

8. Please provide any predelegation evaluations for new delegates, if applicable.

9. Provide the annual and monthly monitoring for the NurseAdvice Line and all of the credentialing delegates.

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

III. Attachment 3: EQR Validation Worksheets

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

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Similar to the previous year, the total sample size was 2500 and 229 responded for a 9.2% response rate (this was also the 2020 response rate). This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.2% (65 out of 357). *Documentation:* SPH 2021 Provider Satisfaction Survey Report **Recommendation**: Continue reminders for satisfaction survey to providers.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH 2021 Provider Satisfaction Survey Report
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH 2021 Provider Satisfaction Survey Report

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health Plan**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity (updated based on October 2019 version of EQR protocol 6)

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,343, and the total completed surveys was 231, which is a 17.2% response rate. This is higher than the previous year's rate of 15.9% but lower than the National Committee for Quality Assurance target rate of 40%. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid ***Recommendation**: Continue to determine ways to advertise surveys and increase response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* MY2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health Plan**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity (updated based on October 2019 version of EQR protocol 6).

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

	Survey Element	Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

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

	Survey Element	Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3,490 for the total sample. The total completed surveys was 367 for a 10.6% response rate, which is above the rate from last year of 10.2%. The sample size was 1,637 for the general population. The total completed surveys was 165 for a 10.1% response rate, which is higher than last year's rate of 9.8%. Both rates are lower than the National Committee for Quality Assurance target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report ***Recommendation:*** *Continue to determine ways to advertise surveys and increase response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report

CCME EQR Survey Validation Worksheet

Plan Name	**Magnolia Health Plan**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity, this should also be noted since the lack of information is relevant to the assessment of that activity (updated based on October 2019 version of EQR protocol 6).

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 2794 and the total complete surveys was 258 for a 9.2% response rate. This is a slight decline from the rate last year of 9.4% and lower than the NCQA target rate of 40%. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H **Recommendation:** Continue to determine ways to advertise surveys and increase response rates.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

Results Elements		Validation Comments and Conclusions
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* MY2021 SPH Analytics Report Child Medicaid CAHPS 5.1H

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**COLORECTAL CANCER SCREENING (COL-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Magnolia Health MSCAN**
Name of PM:	**TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2022**
Review Performed:	**10/5/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Magnolia**
Name of PIP:	**ASTHMA/COPD**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	AMR and SPR rates are below the target rates for the health plan.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined. Using HEDIS measures: AMR and SPR
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement rates are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of rate in comparison to benchmarks.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The asthma medication ratio (12-18 year olds at 50% or greater) showed no change with an AMR rate of 70.24% for 2020 and 70.25% for 2021. The goal is 76.86%. The COPD spirometry testing indicator declined from 26.49% in 2020 to 21.84% in 2021.The goal is 36.82%. % in 2020 with a goal of 36.82%. ***Recommendation**: Initiate enhancements for support services and the Care Management program to improve AMR and COPD rates.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS (CLINICAL)**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Hinds County has a high rate of readmissions.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement period 1 are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The 2021/2022 rate was 19.73% which reduced slightly in the Q2 2022 rate to 19.7%. The enrollment rate improved from Q1 2022 at 35.7% to Q2 2022 at 37.5%.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions including warm hand-offs, monthly calls for collaboration efforts with Hinds County facilities, prescription transport, and medication reconciliation.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was conducted and interpreted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS (CLINICAL)**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Hinds County has a high rate of readmissions.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement period 1 are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The 2021/2022 rate was 19.73% which reduced slightly in the Q2 2022 rate to 19.7%. The enrollment rate improved from Q1 2022 at 35.7% to Q2 2022 at 37.5%.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions including warm hand-offs, monthly calls for collaboration efforts with Hinds County facilities, prescription transport, and medication reconciliation.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was conducted and interpreted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**80**
Project Possible Score	**80**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**MAGNOLIA**
Name of PIP:	**SICKLE CELL DISEASE (CLINICAL)**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	In 2018, a low percentage of members were compliant with taking their Hydroxyurea.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care and health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using a rate with numerator and denominator.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement 1 are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of results are presented in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent rate improved from 20.6% in 2020/2021 to 25.8% in 2021/2022. The goal is 47%.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Interventions such as direct member outreach from the Pharmacy Team to provide education on the importance of medication adherence appear to be the reason for improvement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical tests and interpretation were provided.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**80**
Project Possible Score	**80**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**Magnolia Health Plan MS CAN**
Review Performed:	2022

ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies and procedures are developed to guide health plan operations and to ensure compliance with contractual requirements and applicable laws and regulations. Processes for overall policy development, review, and ongoing management are found in Policy CC.COMP.22, Policy Management. Policies are reviewed, revised as needed, and approved at least annually. Magnolia uses the RSA Archer platform for policy management, and policies are available to staff on an intranet site. Departmental leadership ensures staff are educated about new and revised policies.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Chief Executive Officer;	X					Aaron Sisk serves as Plan President & Chief Executive Officer (CEO).
1.2 *Chief Operating Officer;	X					Michael Todaro is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Trip Peebles is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Mark Brooks as EVP & Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					Cynthia Douglas is the Vice President, Network Development & Contracting. Lalainya Williamson is the Senior Manager, Contracting & Network Development, and Diandra Lee is the Senior Manager, Provider Relations.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					The Organizational Chart lists the Member Services Manager twice on different pages and with different employee names. Onsite discussion revealed one is for the Medicaid line of business, and the other is for a different line of business. *Recommendation: Consider color coding the Organizational Chart to clarify the line of business for staff members outside of the Medicaid line of business.*
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Utilization Management Coordinator;	X					The Vice President, Utilization Management ion is Dawn Atkin, and the Director, Utilization Management is Amanda Smith.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Carrie Mitchell is the Vice President, Quality Improvement. Jeff Martin is the Director, Quality Improvement. Blair Noble and Suzanne Lindley are Senior Managers, Quality Improvement.
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Dr. Jeremy Erwin is the Chief Medical Director. Medical Directors include Sarah Gantz Pannel, DO (Psychiatry), Bri May, MD (Pediatrics), and Dianna Tate, MD (Pediatrics).
1.13 *Compliance Officer.	X					Nicole Litton is the Senior Director, Compliance and is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia has set an internal benchmark that 99% of clean claims are paid within 30 days and 100% are paid within 90 days. Magnolia provided 12 months of claims processing data for the Information Systems Capabilities Assessment (ISCA) review. The claims data demonstrates that Magnolia regularly exceeds DOM's requirements for timeliness.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia relies on the State's 834 files to collect member data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Quality measure rate reports are stored and processed with National Committee for Quality Assurance (NCQA) certified HEDIS software. Additionally, Magnolia states that all reports are reviewed both by IT and business owners to ensure data accuracy, validate Performance Measures, and to compare historical performance statistics. During the virtual site review, it was discussed that Magnolia should improve monitoring and communication with the corporate team for DOM requirements for measure reporting.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Magnolia has an appropriate disaster recovery and business continuity plan for its IT resources. The organization has implemented strategies to address the differences in its infrastructure which includes the data centers and cloud environments. The recovery and business continuity plans are tested, reviewed, and updated annually.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					Magnolia's Compliance and Ethics Program Description (2021-2022) (Compliance Plan) addresses program elements such as policies, procedures, and standards of conduct; training; communication; auditing and monitoring; and investigations of suspected and/or actual offenses. Related policies and procedures provide additional, detailed information.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 Standards of conduct;						Centene's Business Ethics and Code of Conduct (Code of Conduct) applies to all employees of Centene Corporation and subsidiaries, and addresses expectations for ethical business conduct and practices. The Code of Conduct covers a variety of topics including fraud, waste and abuse (FWA), confidentiality, conflicts of interest, workplace respect and values, etc. As a condition of employment, all employees must provide signature that they have received and understanding the Code of Conduct.
2.2 Identification of the Compliance Officer;						The Compliance Plan describes the roles and responsibilities of the Compliance Officer. The Compliance Officer is a direct report to the health plan's CEO and provides regular reports to Magnolia's governing body, CEO, and compliance committee on the effectiveness of the compliance Program.
2.3 Information about the Compliance Committee;						The Compliance Plan describes the purpose and functions of the Compliance Committee.
2.4 Compliance training and education;						As noted in the Compliance Plan, initial employee compliance training is conducted within 30 days of hire, and all employees and subcontractors are required to complete annual compliance training that covers Federal and State statutes, regulations, and guidelines. Members of the Board of Directors must acknowledge receipt of the Code of Conduct and attest that they will comply. Magnolia uses a variety of training methods and forums for employee training, including interactive in-service sessions, online training, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						newsletters. Attendance and participation in training programs are conditions of continued employment. Failure to comply with training requirements may result in disciplinary action, up to and including termination of employment. Corporate Ethics and Compliance staff evaluate the training and education program to ensure it addresses issues facing employees and that content is kept current. This evaluation is conducted annually.
2.5 Lines of communication;						The Compliance Plan describes lines of communication within the organization for compliance topics and issues. It states confidentiality and anonymity are ensured, and Magnolia prohibits retaliation against anyone who reports suspected misconduct. Information about mechanisms for receiving compliance questions, reports of potential risks, and reports of FWA is disseminated through group and department meetings, emails, mailings, intranet articles, workplace posters, departmental discussions, Provider Manuals, Member Handbooks, and Magnolia's website. Magnolia ensures access to the Compliance Officer, Centene Chief Compliance Officer, CEO, and Board of Directors as well as the Ethics & Compliance Helpline, and CNET. These resources allow employees to report issues in person or anonymously, view policies, find guidance, and obtain additional information.
2.6 Enforcement and accessibility;						All employees receive information about disciplinary guidelines through the intranet, workplace posters, and live presentations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Disciplinary actions may include, but are not limited to oral warnings, suspension, and termination. Disciplinary action is consistently applied to all employees, considering factors including but not limited to, the nature of the violation, direct or indirect involvement of an individual, whether the act was willful or unintentional, whether the act was isolated or a pattern of conduct, and cooperation with the investigation.
2.7 Internal monitoring and auditing;						Magnolia conducts ongoing monitoring and auditing of the Compliance Program as well as providing regular reports to the Compliance Officer and Compliance Committee. Monitoring activities allow for the identification and review of variations in operations, compliance issues, vulnerabilities, etc. An annual review is conducted to determine if the program's compliance elements have been satisfied, to identify issues, and to develop implementations to address any issues. The evaluation may include, unannounced site visits, staff interviews, questionnaires, record reviews, etc.
2.8 Response to offenses and corrective action;						As noted in the Compliance Plan, Magnolia's Compliance Officer (or designee) initiates investigations of reported or suspected noncompliance and takes steps to correct any confirmed issues. Actions may include referral to criminal/civil law enforcement authorities, a corrective action plan, or reporting to appropriate state or federal authorities. Magnolia may include outside counsel, auditors, or managed care experts in investigations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective actions are tailored to address the identified offense, are detailed in writing, and include consequences for failure to implement the corrective action. Ongoing monitoring is conducted of completed corrective action to ensure effectiveness.
2.9 Exclusion status monitoring.						Policy CC.COMP.36, Centene Screening for Exclusions from Federal and State Health Care Programs, addresses exclusion screening requirements for 5% Beneficial Owners, the Board of Directors, employees, contingent workers, and vendors. Magnolia/Centene determines the exclusion status of applicable parties through monthly screening of federal and state databases. Screenings include the OIG List of Excluded Individuals/Entities, General Services Administration's System for Award Management, State exclusion lists, etc.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				As noted in the Compliance Plan, the Compliance Committee advises the Compliance Officer and assists in maintaining the Compliance Program. The Compliance Plan and the Compliance Committee Charter describe the committee's functions and operations. The Compliance Committee Charter states the committee meets quarterly and as needed, is chaired by the Compliance Officer, and defines membership of the committee. Members are expected to attend 75% of the meetings, and the quorum is defined as the presence of 50% of voting members. Review of the submitted Compliance Committee meeting minutes

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						revealed that one voting member only attended 50% of the meetings. *Corrective Action Plan: Reinforce attendance expectations with members of the Compliance Committee.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					As noted in the Compliance Plan, Magnolia's Compliance Officer (or designee) initiates investigations of reported or suspected noncompliance and takes steps to correct any confirmed issues. Actions may include referral to criminal/civil law enforcement authorities, a corrective action plan, or reporting to appropriate state or federal authorities. Magnolia may include outside counsel, auditors, or managed care experts in investigations. Corrective actions are tailored to address the identified offense, are detailed in writing, and include consequences for failure to implement the corrective action. Ongoing monitoring is conducted of completed corrective action to ensure effectiveness. Detailed processes for investigating reported incidents and suspected FWA are included in Policy CC.COMP.16, Compliance, Special Investigations Unit.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes for provider payment suspensions and recoupments are included in Policy CC.COMP.16, Compliance, Special Investigations Unit.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Magnolia's Pharmacy Lock-In Program was established to detect and prevent abuse of pharmacy benefits. Processes to identify and evaluate members as candidates for the program, conduct ongoing monitoring, etc. are found in Policy MS.PHAR.15, Pharmacy Lock-In Program.
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Multiple policies, program descriptions, training documents and the Compliance Plan and Code of Conduct provide information about confidentiality and HIPAA requirements.

Provider Services

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Credentialing processes are documented in Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, and Policy CC.CRED.09, Organizational Assessment and Reassessment. Additional information is found in the following: •Policy CC.CRED.02, Maintaining Confidentiality of Credentialing Information •Policy CC.CRED.04, Nondiscriminatory Credentialing and Recredentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Policy CC.CRED.12, Oversight of Delegated Credentialing
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.		X				Policy CC.CRED.03, Credentialing Committee, indicates Magnolia has a designated Credentialing Committee that makes credentialing decisions using a peer review process. The Medical Director or designee directs and coordinates the credentialing functions for Magnolia and facilitates and chairs the Credentialing Committee. The Credentialing Committee meets monthly, and no less than 10 times a year. The quorum is established as the presence of 50% of voting members, which include network practitioners. Review of submitted Credentialing Committee minutes confirmed the quorum was established for each of the meetings. However, three voting members of the committee did not meet the attendance requirement: •One member attended only 64% of meetings. •One member attended only 55%. •A third member attended only 18% of the meetings, and this is the third consecutive year this was noted for this specific committee member. In 2021, she attended only 45% of the meetings reviewed, and in 2020, she attended only 50% of the reviewed meetings. This is a continued decline in attendance year-over-year for this member. This is the third consecutive year in which some voting members of the Credentialing Committee did not meet the attendance requirements. CCME discussed this issue with Magnolia during

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the previous EQR, and Magnolia reported that if a committee member does not meet the attendance requirement, the health plan engages with the committee member to discuss the attendance expectations and will take action to replace or remove the member if necessary. *Corrective Action Plan: Reinforce attendance expectations with Compliance Committee members and take action to replace members who do not comply with the attendance requirements.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice insurance coverage / claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
3.2 Site assessment.	X					As noted in the previous EQR, due to restrictions related to COVID-19, Magnolia is not conducting site visits for initial credentialing. However, the plan is maintaining a list of providers for whom site visits were postponed and will conduct the site visits when restrictions are lifted.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Provider office site reassessment, when applicable.	X					None of the recredentialing files contained information that a site visit was warranted.
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, documents the process for taking action against a network practitioner for quality reasons. The Quality Improvement and Credentialing Committees monitor network providers for the quality and safety of practitioner services. The Credentialing Committee ultimately determines whether, after investigation, it is necessary to suspend, restrict, or terminate a provider's network participation. When action is taken, the network practitioner is notified in writing and informed of appeal rights. Magnolia reports to the National Practitioner Data Bank, state licensing boards, etc. as required when adverse action is taken against a network practitioner. Procedures for identifying, monitoring, investigating, and analyzing potential or suspected quality of care incidents are addressed in Policy CC.QI.17, Potential Quality of Care Incidents.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy MS.PRVR.01, PCP Member Panel Reports, describes processes for ensuring Primary Care Providers (PCPs) are made aware of members assigned to them via the provider web portal and via hard copy. Magnolia provides a current patient listing to all network PCPs who are registered on the secure provider web portal, which is updated within five business days of receiving the member listing from DOM. Providers who do not have access to the portal or who would like additional copies of the member panel may contact Provider Relations or the Provider Services Call Center to request a copy. The PCP Panel/Patient List will be sent to the provider within five (5) business days of a provider's request.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					As noted on Magnolia's website, all providers may verify member eligibility and enrollment via: •Logging onto DOM's Envision website •Logging onto Magnolia's secure Provider Portal •Calling Magnolia's automated member eligibility Interactive Voice Response (IVR) system •Calling Provider Services

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability, defines processes for evaluating the geographic access standards for network providers. Geographic access to PCPs is measured annually by the Provider Relations Department. Geographic access standards for PCPs are defined in the policy as: 2 within 15 miles (urban) and 2 within 30 miles (rural) and are compliant with contractual requirements. Additionally, member satisfaction with practitioner availability is collected and analyzed annually. Results are reported to and reviewed by the Quality Committee, which makes recommendations to address any identified deficiencies in the number, distribution, or type of practitioners available in the network.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Policy CC.PRVR.47, Evaluation of Practitioner Availability, defines processes for evaluating the geographic access standards for network providers. Geographic access to high-volume (obstetrics/gynecology) and high-impact specialists (oncology) is measured at least annually and analyzed against the required standards. Geographic access to specialists is measured annually by the Provider Relations Department. Geographic access standards for specialists are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						defined in the policy and are compliant with contractual requirements. Additionally, member satisfaction with practitioner availability is collected and analyzed annually. Member complaints and grievances related to provider access is also routinely monitored and considered when assessing network adequacy. Results are reported to and reviewed by the QIC, which makes recommendations to address any identified deficiencies in the number, distribution, or type of practitioners available in the network.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Magnolia conducts quarterly geographic access measurements of practitioner types and availability. Additional factors considered include member satisfaction with the network, complaints and grievances, and the cultural, ethnic, racial, and linguistic needs of members.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					As noted in Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), Magnolia provides culturally appropriate health care services to all members, including those with diverse cultural and ethnic backgrounds, diverse health beliefs and practices, limited English proficiency, and physical/other disabilities. Magnolia identifies the cultural, linguistic, disparity, and accessibility needs of members by collecting and analyzing member demographic information as well as provider linguistic and cultural concordance with its membership. Magnolia also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducts disparity assessments and produces a Cultural Competency Plan. Policy MS.QI.22, Cultural Competency, states Magnolia's Cultural Competency plan describes processes to ensure culturally competent services are provided to all members, including those with limited English proficiency. The Cultural Competency Plan addresses providing training related to cultural competency to all new Magnolia employees receive cultural competency training as part of their new employee orientation process and to all staff annually and as needed. Providers and subcontractors receive training through quarterly training sessions or onsite visits upon request. Member materials are available in alternate languages and formats, as needed. The Cultural Competency Plan is available on Magnolia's website. Magnolia conducts an annual evaluation of the effectiveness of the Cultural Competency Plan, tracks and trends any identified issues, and implements interventions to improve the provision of services as needed. This evaluation, including implemented interventions and recommendations for 2022, was noted in the 2021 Quality Management Program Evaluation.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MS.PRVR.10, Evaluation of the Accessibility of Services, addresses appointment access standards for various provider types. However, the following issues were noted: •For BH/SUD providers, the policy indicates routine appointments should be scheduled within 10 business days. However, the Provider Manual and Member Handbook state these appointments should be scheduled within 21 calendar days, as required by the *CAN Contract, Section 7 (B) 2*. •For BH/SUD appointments post-discharge from an acute psychiatric hospital (when the CCO is aware of the discharge), the policy lists the timeframe as 14 calendar days, while the *CAN Contract, Section 7 (B) 2* lists this timeframe as seven calendar days. The Provider Manual and Member Handbook state the appointment timeframe is seven calendar days. •The policy does not specify timeframes for dental appointments (routine visits and urgent care visits), as noted in the *CAN Contract, Section 7 (B) 2*. •The policy does not specify the timeframes for Urgent Care or Emergency Care Providers as noted in the *CAN Contract, Section 7 (B) 2*. *Corrective Action Plan: Revise Policy MS.PRVR.10, Evaluation of the Accessibility of Services, to include the correct timeframes for routine BH/SUD appointments and for BH/SUD appointments post-discharge from an acute*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	*psychiatric hospital (when the CCO is aware of the discharge). Add the timeframes for routine and urgent care dental appointments, general urgent care providers, and emergency care providers.* According to Policy CC.PRVR.48, Evaluation of the Accessibility of Services, Magnolia measures appointment accessibility to primary care, behavioral health, and specialty care services annually. This is accomplished through a variety of methods, including: results of CAHPS surveys, monitoring grievance and appeal data, and site-specific surveys and audits for primary care, behavioral health, and specialty providers. These audits may be conducted telephonically or onsite. The compliance goal is 90%. If not met, a written corrective action plan will be implemented, and the provider will be allowed enough time to implement changes before being re-audited. If the goal is not met on re-audit, the provider is presented to the Credentialing Committee, or other appropriate committee, for review and recommendations for additional corrective action. The MHP_MSCAN Provider Appointment Availability_Q1 2022 document indicates appointment availability results for: •PCPs—57.54% successful contacts with 100% of PCP providers compliant with well care, sick, and urgent care visits. Appropriate standards were used to assess provider compliance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•OBGYNs—The successful contact rate for OBGYNs was 68.46% with 98% of providers compliant with well care visits and 100% of providers compliant with sick and urgent care visits. Appropriate standards were used to assess provider compliance. •Behavioral Health—44.62% successful contacts with 100% of providers compliant with well care, sick, and urgent care visits. Appropriate standards were used to assess provider compliance. Successful contacts ranged from 68.46% for OBGYN providers to 44.62% for BH providers. To what do you attribute the lower success rates The Quality Committee or a designated subcommittee, analyzes overall results and makes recommendations to address deficiencies as needed. Results were presented to the Quality Improvement Committee on 6/23/22. The required appointment access standards are included in the Member Handbook and Provider Manual.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					The procedure for conducting new provider orientation within 30 days of the contract effective date is found in Policy CC.PRVR.13, Provider Orientations. This process applies to all contracted PCPs, specialists, hospitals, and ancillary providers who are not part of an existing in-network group or facility. Topics covered in the orientation are listed in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Orientation Core Elements attachment to the policy.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					Detailed information about Care Management programs is included in the Provider Manual. The information addresses overall Care Management, as well as Start Smart for Your Baby®, Care Management teams, Community Connections, Disease Management programs, etc.
2.2 Billing and reimbursement practices;	X					The Provider Manual addresses claims and encounters, including timely filing, claims submission processes, information about clean and non-clean claims, claims payments, member billing, claims rejections and claim denials, claim corrections, etc.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;		X				The Provider Manual includes a table listing benefits covered by Magnolia, including notations regarding limitations, coverage requirements, etc. The Provider Manual also includes a listing of value added benefits provided by Magnolia and a table listing non-covered services. Page 28 of the Provider Manual addresses flu and pneumonia vaccines and states limitations of one flu shot per 12 months and two pneumonia shots per lifetime. The Provider Manual does not include COVID-19 vaccines, which are included in the Member Handbook, page 19. Page 30 of the Provider Manual addresses Plastic Surgeon services and states, “All services must

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be in office settings…" However, the Member Handbook, page 20, does not include this limitation. *Corrective Action Plan: Revise the Provider Manual to correct the issues noted with vaccine coverage and plastic surgeon services.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					The Provider Manual addresses Early Periodic Screening Diagnostic Treatment services and lists periodic health screenings that are included. It specifies that providers should follow the American Academy of Pediatrics (AAP) Bright Futures' Periodicity Schedule and the Advisory Committee on Immunization Practices' (ACIP) Recommended Immunization Schedule.
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The Provider Manual includes an overview of the Pharmacy Program and directs the reader to the website for additional information. It references the Preferred Drug List, exception requests, generic substitutions, the Pharmacy Benefit Manager, prior authorizations, the emergency drug supply, etc.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					The Provider Manual informs that PCPs may limit the number of members included in their panels by notifying Provider Services in writing at least 45 calendar days in advance of any panel capacity changes. It also states that PCPs may not refuse to treat members if the provider has not reached their maximum panel size.
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					Key Contact information is found on pages six and seven of the Provider Manual. Page 13 addresses the secure Provider Portal’s functions and capabilities, and how to access the portal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					Magnolia maintains a printed and a searchable, web-based Provider Directory listing all network providers, including physicians (including specialists), hospitals, pharmacies, and behavioral health providers. The Policy defines elements that are included in the Provider Directory. Review of the submitted hardcopy Provider Directory and the online Find a Provider tool confirmed all required elements are included. Policy MS.PRVR.19, Provider Directory, page 1, states Provider Directories will include "whether the provider has completed cultural competence training." This requirement to include completed cultural competence training is no longer applicable for Provider Directories. Also, when reviewing the printed Provider Directory, some provider listings included various languages in the field for "Cultural Competence Training." Onsite discussion revealed this may be an issue with how the information is pulled into the file from which the Provider Directory is developed, and Magnolia staff stated they would research and address the issue. *Recommendation: Revise Policy MS.PRVR.19, Provider Directory, to remove the requirement to include Cultural Competency Training. Determine the cause for provider languages*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						being listed in the Provider Directory under "Cultural Competence Training" and resolve as necessary.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					A document titled "Magnolia Provider Training Plan" was submitted. The stated objective is "to educate providers from their first day and through-out their network participation with Magnolia." Training and education methods referenced in the document include: •In-service staff trainings upon request of a provider or when a need is identified •Web-based trainings that offer multiple training times and can impact a wider audience •Workshops conducted in collaboration with the State and/or in partnership with health systems across the state of Mississippi •One-on-one virtual or onsite trainings at the request of the provider or when a need is identified •Written communications, such as weekly provider e-blasts, provider newsletters, reminder and educational postcards and letters, the Provider Manual, secured and unsecured provider portals, and the Provider Services Cell Center. Monitoring of training effectiveness is ongoing, and educational materials are reviewed quarterly for accuracy and updates. All Training materials are reviewed and approved by the DOM.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, describes Magnolia's process for adopting preventive health guidelines (PHGs) from recognized sources that are relevant to the member population. The PHGs are reviewed by the QIC to ensure appropriate physician input and are updated at least annually and when there is significant new scientific evidence or changes in national standards. Board-certified practitioners provide input through Magnolia's Quality Committee. The guidelines are reviewed at least annually. The Provider Manual includes information about the PHGs and states PHGs "are based on the health needs and opportunities for improvement identified as part of the Quality Assessment Performance Improvement (QAPI) program. Whenever possible, Magnolia Health adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions, as well as statewide collaborative efforts and/or a consensus of healthcare professionals in the applicable field."
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.		X				As noted in Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Magnolia distributes the PHGs to applicable practitioners and, upon request, to members, potential members, and other providers. New and revised guidelines are available on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional dissemination methods include practitioner orientation/educational materials, newsletters, and mailings. The Provider Manual directs the reader to the website to view the full list of PHGs. However, the hyperlink provided is non-functional, returning an error message. This is a finding originally noted during the previous EQR. A recommendation was given to correct this issue. *Corrective Action Plan: Revise the Provider Manual to include the correct hyperlink to the list of guidelines on Magnolia's website or remove the hyperlink and provide detailed information about where to locate the guidelines.*
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, describes Magnolia's process for adopting clinical practice guidelines (CPGs) from recognized sources that are relevant to the member population. The guidelines are reviewed by the QIC to ensure appropriate physician input and are updated at least annually and when there is significant new scientific evidence or changes in national standards. Board-certified practitioners provide input through Magnolia's Quality Committee. The guidelines are reviewed at least annually. The Provider Manual includes information about the CPGs and states CPGs "are based on the health needs and opportunities for improvement identified as part of the Quality Assessment Performance Improvement (QAPI) program. Whenever possible, Magnolia Health adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions, as well as statewide collaborative efforts and/or a consensus of healthcare professionals in the applicable field."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.		X				As noted in Policy CP.CPC.03, Preventive Health and Clinical Practice Guidelines, Magnolia distributes the CPGs to applicable practitioners and, upon request, to members, potential members, and other providers. New and revised guidelines are available on the website. Additional dissemination methods include practitioner orientation/educational materials, newsletters, and mailings. The Provider Manual directs the reader to the website to view the full list of guidelines. However, the hyperlink provided is non-functional, returning an error message. This is a finding originally noted during the previous EQR. A recommendation was given to correct this issue. *Corrective Action Plan: Revise the Provider Manual to include the correct hyperlink to the list of guidelines on Magnolia's website or remove the hyperlink and provide detailed information about where to locate the guidelines.*
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MS.QI.13, Medical Record Review, addresses Magnolia's processes for monitoring and evaluating provider compliance with medical record documentation standards and maintenance. The policy defines the medical record retention timeframe as at least 10 years for adults and at least 13 years for minors. A

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						copy of the Medical Record Audit Tool is attached to the policy and included the medical records documentation standards.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					As noted in Policy MS.QI.13, Medical Record Review, qualified Magnolia staff or contractors conduct annual assessments of provider medical recordkeeping practices. Providers must meet 90% of the requirements for medical recordkeeping and 100% of claim validation or be subject to corrective action. The goal is 100% compliance with all elements. Elements scoring below 90% are considered deficient and in need of improvement. Detailed processes for conducting the audits, addressing identified deficiencies with the applicable providers, and conducting follow-up audits for those providers are addressed in the policy. A summary of the medical record audit is reported to the QIC. Results are trended to identify areas of opportunity and are shared with Credentialing staff for consideration at the time of provider recredentialing. Per information submitted by Magnolia, "Medical Record Reviews are still in progress for 2022. Final analysis and report will be submitted to the Quality Improvement Committee in October 2022 after completion of audits." Documentation of the 2021 Medical Record Review was submitted, indicating the practices audited, the results, issues identified, and recommendations provided. Results were

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reported to the QIC in October 2021 and documented in the meeting minutes.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Similar to the previous year, the total sample size was 2,500 and 229 responded for a 9.2% response rate (this was also the 2020 response rate). This response rate is below the NCQA target rate and may introduce bias into the generalizability of the findings. Behavioral Health providers had the highest response rate at 18.2% (65 out of 357). *Recommendation: Continue reminders for satisfaction survey to providers.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results of the survey were presented to the QIC in June 2022 and included in the 2021 QI Program Evaluation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Per Policy MS.MBRS.25, Member Rights and Responsibilities, all members are provided with a new member packet and Member Handbook at enrollment, and member rights and responsibilities are specified in the Member Handbook. Members may also access information about rights and responsibilities on Magnolia's website. Review of the Member Handbook, Provider Manual, and Magnolia's website confirmed the member rights and responsibilities are included.
2. Member rights include, but are not limited to, the right:	X					Members are guaranteed all required rights, as documented in Policy MS.MBRS.25, the Member Handbook, the Provider Manual, and on Magnolia's website.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Policy MS.MBRS.25 lists member responsibilities and members are informed their responsibilities via the Member Handbook and Magnolia's website.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					Policy MS.MBRS.01, New Member Packet/Member ID card, lists items included in the New Member Packet. The Member Handbook, included in the New Member Packet, instructs members about obtaining a Provider Directory.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						The Member Handbook does not reference the limitation of two pneumonia shots per lifetime, which is noted in the Provider Manual. *Recommendation: Update the Member Handbook to include the limitation on the number of pneumonia vaccines.*
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						Information about PCP referrals to specialists and other providers is included in the Member Handbook. The handbook also informs members of circumstances under which they may self-refer.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						The Member Handbook covers the Pharmacy Program, the Preferred Drug List, 72-hour emergency drug supply, pharmacy copayments and exemptions from copayments, over the counter medications, and vaccines. It also addresses excluded drugs, limitations and other requirements, processes for filling prescriptions, and specialty medications/pharmacies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						Contact information for, and a description of services provided by, the Member Services area are included in the Member Handbook. It also includes information about the secure member portal, mobile application for cell phones, and the 24-Hour Nurse Advice Line.
1.13 A description of EPSDT services;						Information about Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) is found in the Member Handbook. Included are periodic services included in EPSDT, the periodicity schedule, and information about expanded EPSDT services.
1.14 Procedures for disenrolling from the CCO;						Information in the Member Handbook about disenrollment includes circumstances under which a member can request to be disenrolled, processes for requesting disenrollment, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						circumstances under which the health plan can request member disenrollment. Members are informed they must contact DOM by phone or in writing to request disenrollment, and contact information is provided.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						Grievance, complaint, and appeals processes are addressed in the Member Handbook, including definitions of terminology, filing processes and requirements, and associated timeframes.
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						The Member Handbook addresses the Waste, Abuse, and Fraud (WAF) Program, defines terminology, provides examples of fraud, waste, and abuse, and includes information about and contact information for reporting.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Policy MS.MBRS.12, Member Notification of Plan Changes, describes processes for notifying members of benefit changes, provider location and service changes, and any other significant

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						changes. Policy CC.MBRS.27, Member Advisory of Provider Termination, describes processes and requirements for providing advance notice to members of provider terminations and assisting members with selecting a new provider.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Requirements for member materials are found in Policy MS.MBRS.06, Member Materials Readability and Translation. As noted in the policy, vital member materials are translated for non-English threshold languages, and Magnolia provides oral interpretation of member materials upon request, including 711 Relay services for the hearing impaired. Documents are evaluated to ensure they do not exceed the sixth grade level of reading comprehension as determined by Flesch-Kincaid. Document font sizes are no smaller than 12 point and large print materials use a font size no smaller than 18-point. Documents are available in alternative formats for members with special needs, such as visual impairments.
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					Policy MS.MBRS.06, Member Materials Readability and Translation, specifies requirements for marketing materials.
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					Call center requirements are addressed in Policy MS.MBRS.10, Member Service Calls/Hotline. Required hours of operation for the Member Services call center are included in Policy MS.MBRS.10, Member Service Calls/Hotline. The Member Handbook and Magnolia's website specify the Member Services call center hours of operation as: •7:30 a.m. – 8:00 p.m. CST first working day of the week •7:30 a.m. to 5:30 p.m. CST Tuesday – Friday •Second weekend of the month: Saturday and Sunday 8:00 a.m. – 5:00 p.m. CST A nurse advice line is available 24 hours/day, seven days/week via toll free telephone.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Magnolia develops interactive call center scripts for initial welcome calls, outbound calls to new members, inbound member calls for PCP selection, and other inbound member calls. The scripts are reviewed annually. Call Center staff training is conducted at least quarterly. Topics include Medicaid, the MississippiCAN Program, circumstances for transferring members to a Care Manager, and customer service. Additionally, staff receive

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						updated about Medicaid changes, the MississippiCAN Program, etc.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					The 2021 MississippiCAN Quality Management Program Description indicates Call Center statistics are monitored monthly and reported to the QIC. For 2021, Magnolia met the goals for Abandoned Rate, Average Speed of Answer, and Service Level Percentage for each quarter. In 2022, Magnolia is focusing on cross-training for Call Center staff and utilizing backup call center staff and/or temporary staff as needed for periods of high call volume. Magnolia reported that the Call Center is currently staffed at full capacity.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Magnolia allows members to select a PCP at enrollment into the health plan. A PCP is assigned by the health plan when the member does not voluntarily select a PCP within 30 days of enrollment. Factors considered when auto-assigning a PCP including current provider relationships, language needs, age, gender, enrollment of family members, and area of residence.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Policy MS.QI.20.01, Early and Periodic Screening, Diagnostic, and Treatment Periodic (EPSDT) Notification System, addresses educating members about EPSDT and other preventive health services. Methods of providing the education include the new member packet, the Member Handbook, Magnolia's website, and newsletters. Additionally, Magnolia sends "Happy Birthday" reminder cards during the birth month. The policy states these reminder cards are sent to one- and two-year-old members; however, onsite discussion revealed the birthday reminder cards are sent to all members up to age 18. *Recommendation: Correct the age range for the "EPSDT services reminder Happy Birthday" cards in Policy MS.QI.01.* Members may also receive education through the Care Management program. The My Health Pays Rewards program, available for all members, provides rewards when for completing healthy activities such as yearly wellness exams, annual screenings, and tests. Members can use the rewards to help pay for utilities, transportation, rent, and other appropriate purchases.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
participation of pregnant members in recommended care, including participation in the WIC program.						
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					Monthly reports identify new members and members who have missed immunizations and/or EPSDT screenings. Magnolia contacts these members by telephone and by mail to explain benefits and advise of the needed services. Member Connections representatives can make home visits to members who do not respond to the reminders.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					Member Satisfaction Survey validation for Magnolia was performed based on the CMS Survey Validation Protocol. Magnolia contracts with SPH Analytics Research, a certified Consumer Assessment of Healthcare Providers and Systems survey vendor, to conduct a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. The SPH Analytics reports for MY2021 were validated for this annual review. For the Adult survey, the sample size was 1,343 and the total of completed surveys was 231, lending a response rate of 17.2%. This is higher than the previous year's rate of 15.9%, but lower than the NCQA target rate of 40%. For the Child survey, the sample size was 2,794, and the total number of completed surveys was

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						258, yielding a response rate of 9.2%. This is a slight decline from the previous year's rate of 9.4% and lower than the NCQA target rate of 40%. For the Child CCC survey, the sample size was 3,490 for the total sample (all 12-17 year-olds). The total number of completed surveys was 367, which is a response rate of 10.6%. This is above the previous year's rate of 10.2%. For the general population subset (members with a chronic condition), the sample size was 1,637 and the total number of completed surveys was 165, for a 10.1% response rate. This is higher than the previous year's rate of 9.8%. Both rates are lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Recommendation: Continue to determine ways to advertise surveys and increase response rates.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Submitted documentation contained an analysis of the previous response rates for each of the three surveys, as well as comparative rates year over year. The analysis of the most recent surveys will be completed for the next annual review.
3. The CCO reports results of the member satisfaction survey to providers.	X					The Magnolia Health Provider Newsletter from November included a summary of the Members' CAHPS results for the Providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The August 2022 QIC minutes included discussion of CAHPS results from MY2021.
III G. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07, Member Grievance and Complaints Process provides a summary of the process Magnolia uses to respond to member grievances and complaints. Members are instructed in the Member Handbook and on Magnolia's website.
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;		X				Magnolia's policy defines the timeline for resolving complaints and grievances. Complaints are resolved within one calendar day and grievances are resolved within 30 calendar days. The policy mentions that Magnolia may extend this timeframe and will give the member written notice of the reason for the extension. However, this policy and the notice sent to the member regarding the need for the extension does not offer the member's right to file a grievance related to the extension. *Corrective Action Plan: Include in the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						processing a grievance in Policy MS.MBRS.07, Member Grievance and Complaints Process and in the member notice.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Per policy, all clinical or potential quality of care grievances are routed to the Quality Improvement Department for review and investigation by the appropriate clinical staff. Clinically urgent grievances are resolved within 72 hours of receipt.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					CCME reviewed a sample of grievance files. All the files demonstrated the grievances were processed timely and appropriate notifications were provided.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Magnolia's 2022 MississippiCAN Quality Management Program Description describes the health plan's primary goal as to improve members' health status through a variety of activities across all care settings. The Board of Directors has authority, responsibility, and oversight of the development and implementation of the QI Program. The Board delegates the operating authority to the Quality Improvement Committee (QIC). The QI Program Description is submitted to the QIC and the Board of Directors for review and approval.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Magnolia focuses on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sex, primary language, etc. and by key population group through their

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Health Equity Program. The Health Equity Program Description and the Health Equity Governance Committee has been established to focus on improving health disparities.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Per QI Program Description, Magnolia monitors utilization patterns by performing an assessment of utilization data to identify potential over- and under-utilization issues. Various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data are used to identify patterns of potential or actual inappropriate utilization of services. Policy CC.UM.01.03, Monitoring Utilization provided an overview of the process followed for detecting and correcting patterns of potential or actual inappropriate under or over utilization. The review of desk materials found several instances of utilization data discussions in meeting minutes and in the QI Program Evaluation.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					The Quality Work Plan is developed annually after completing the Quality Program Evaluation for the previous year. Magnolia's Work Plan reflects the ongoing progress of the quality activities. The status of the QI activities reflected on the work plan is reviewed by the QIC on a regular basis. The 2021 and 2020 QI work plans were provided for review and contained all requirements.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee is Magnolia's senior leadership committee accountable to the Board of Directors. This

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						committee is responsible for reviewing and monitoring all clinical physical and behavioral health quality and services. This committee also provides oversight of all sub-committees and reports directly to the Board of Directors.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Director chairs the QIC. Other members include three network providers specializing in Pediatrics, Family Practice, one behavioral health provider, one family nurse practitioner, and other senior leaders. A quorum is defined as a minimum of five members, including three plan staff and two external physicians must be present for a quorum.
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are maintained for each meeting. A copy of the meeting minutes was provided with the desk materials. In some of the minutes, it was mentioned that materials and reminders would be sent to the voting members of the committee to ensure necessary participants are present. However, it was not clear in the minutes which members were considered voting members. *Recommendation: Document in the Quality Improvement Committee minutes which members are considered voting members.*
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The performance measure validation found that Magnolia was fully compliant with all information system standards and determined that Magnolia submitted valid and reportable rates for all HEDIS measures in scope of this audit. The MY 2021 Final Audit Report, identified many concerns that the HEDIS Compliance Auditor experienced with Magnolia regarding Magnolia's timeliness for responding, providing appropriate data and responses when requested, and meeting the HEDIS Compliance Audit timelines. The Aqurate team had similar concerns with regards to receipt of rates data for the non-HEDIS CMS Core Set measures. *Recommendations: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.* *Work proactively with DOM regarding clarification on measures that are required to be reported.* *Communicate to Magnolia's corporate teams the measures that are required to be reported to ensure the team understands the measures required for reporting.* *Improve processes around the calculation, reporting, and verification of the Adult and Child Core set measure rates reported to DOM.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					For the current EQR, Magnolia provided PIP documents for the same PIPs as last year. Topics included Asthma/COPD, Behavioral Health Readmissions, Sickle Cell Disease, and Reducing Preterm Births.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All PIPs scored in the "High Confidence in Reported Results" range. The Asthma COPD PIP and the OB Hypertension PIP demonstrated no quantitative improvement in process or care. *Recommendation: Continue moving forward with the newly implemented interventions such as the pilot for the blood pressure monitoring devices and any support services enhancements.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Magnolia's network providers receive feedback regarding their performance data through the Primary Care Provider Profile report and the Patient Care Opportunities report.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Policy CP.CPC.03, Clinical Policy: Preventive Health and Clinical Practice Guidelines addresses the development, adoption, revision, and performance monitoring conducted for the clinical and preventive practice guidelines. Magnolia chose two physical health and two behavioral health clinical practice guidelines to monitor in 2021. The guidelines monitored are Diabetes Care, Prenatal Care, Attention Deficit and Hyperactivity Disorder, and Depression.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Magnolia also specifically targeted one provider (Jackson Hinds Comprehensive Health Center).
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					Magnolia has a process outlined in policy MS.QI.20, Early and Periodic Screening Diagnostic and Treatment Periodic (EPSDT) Services for monitoring compliance with the EPSDT program requirements and initiate interventions to educate members and providers on timely provisions of services. Magnolia tracks members needing follow-up care after an EPSDT screening for any abnormal finding. Assistance is provided with follow-up appointments and referrals made to case management.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Annually, Magnolia assesses the effectiveness of the QI Program and documents that assessment in the Quality Program Evaluation. The 2021 Quality Management Program Evaluation was reviewed for this EQR. This program evaluation included the results of activities and studies underway or completed in 2021. A barrier analysis and any recommendations for 2022 to overcome those barriers were also included.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management Program Description 2022 outlines and describes the Utilization Management (UM) Program. Policies and procedures are established to support the implementation and operation of the program. Magnolia's UM Program's aim is to provide services that are covered benefits, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care. Prior authorization is required for specific procedure and services. Prior authorization is not required for emergency or urgent care services. Two levels or UM medical necessity review are available for all authorization requests. Level 1 review is conducted on covered benefits by a Prior Authorization Nurse or Concurrent Review Nurse. If criteria are met,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the review nurse issues an authorization. If criteria are not met, the case is sent for a Level II review. A level II review is conducted by an appropriately licensed practitioner. Magnolia regularly reviews the prior authorization list to determine if services should be added or removed from the list.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					The lines of accountability are listed in the UM Program Description. It describes responsibilities for the Board of Directors, executive leadership, the Utilization Management Committee (UMC), and other staff.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					The UM Program Description mentions the UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Policy MS.UM.02, Clinical Decision Criteria and Application notes updates and revisions to InterQual, ASAM, other applicable criteria, state specific service definitions, clinical and pharmacy policies, as well as the procedures for applying such criteria, are reviewed at least annually by the UMC, Clinical Policy Committee (CPC) and/or Quality Improvement Committee (QIC).
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Oversight of UM activities is conducted by the Chief Medical Director, who is a Mississippi licensed physician. A behavioral health practitioner participates in the implementation of the behavioral health aspects of the UM program.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114.*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of a sample of utilization approval files demonstrated consistent decision-making using criteria and relevant medical information.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MS.UM.02, Clinical Decision Criteria and Application, describes that members' individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Approval files reflect that physician reviewers will use manual criteria and their clinical professional judgement to consider the member's individual circumstances when InterQual criteria is not met.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					At least annually, Magnolia assesses the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. Policy CC.UM.32, Interrater Reliability - Associates, Medical Directors, and Therapists describes the process for conducting interrater reliability for all clinical staff and medical directors.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Policy MS.PHAR.09, Pharmacy Program, states Envolve Pharmacy Solutions is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Magnolia, including but not limited to prior authorizations and pharmacy network management.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Magnolia's emergency and post stabilization services are covered in policy MS.UM.12 Emergency Services.
7. Utilization management standards/criteria are available to providers.	X					Information regarding requesting the criteria used for the decisions are included in the Adverse Benefit Notification letter.
8. Utilization management decisions are made by appropriately trained reviewers.	X					Per the UM Program Description and Policy CC.UM.04, Appropriate UM Professionals describe the qualifications of staff making UM decisions. Magnolia's Licensed, qualified health care professionals conduct Level I reviews for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medical necessity and have access to an appropriate licensed health care professional for consultation if needed. They apply approved UM criteria while performing reviews for requested services and for concurrent review. Care Managers are prohibited from making adverse medical necessity determinations. When a request for authorization of services does not meet the standard UM criteria, the case is referred to the Medical Director for a Level II medical necessity review. Non-licensed staff may collect non-clinical data and structured clinical data for preauthorization and concurrent review, under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services for which there are explicit criteria. Non-licensed staff do not conduct any activities requiring evaluation or interpretation of clinical information. All non-licensed staff are supervised by licensed staff and have qualified licensed staff available for assistance.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of approval files reflect physical and behavioral health utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within three calendar days/ two business days.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
pertinent information prior to making the decision to deny services.						
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Sample denial files reflect decisions were made by appropriate physician specialists.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.		X				CCME reviewed a sample of denial decisions made by Magnolia and found all the Adverse Benefits Notices incorrectly mentions that an oral request for an appeal by members must be followed up in writing unless the request is for an expedited appeal. Also, the Adverse Benefit Notice letter template incorrectly mentions that an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal. *Corrective Action Plan: Correct the Adverse Benefit Notices and remove the requirement that a member must follow an oral request for appeal with a written request.*
V C. Appeals *42 CFR § 438.228,42 CFR § 438, Subpart F*						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					The UM Program Description and policies such as Policy MS.UM.08, Appeal of UM Decisions, and Policy MS.UM.01, Utilization Management Program Description, describe Magnolia's approach for handling and processing member appeals. Additionally, information is provided in the Provider Manual, in the Member Handbook, and on the member tab of the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definitions of an adverse benefit determination and an appeal and who may file an appeal is included in the policy, Member Handbook, Provider Manual, and on Magnolia's website.
1.2 The procedure for filing an appeal;		X				Magnolia's procedures for filing an appeal are included in Policy MS.UM08, Appeal of UM Decisions, in the UM Program Description (page 25), Member Handbook (page 71), Provider Manual (page 63) and on Magnolia's website. These documents incorrectly mention an oral request for an appeal must be followed up in writing unless the request is for an expedited appeal. Also, the appeal policy includes information that is contained in the acknowledgement letter. However, some of this information was not included in the Acknowledgement Letter. The following were missing: •The member's right to submit comments, documents, or other information relevant to the appeal. •The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired. *Corrective Action Plan: Correct Policy MS.UM08, Appeal of UM Decisions, the UM Program Description, the Member Handbook, the Provider Manual, and Magnolia's website and*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						remove the requirement that a member must follow-up an oral request for an appeal with a written request. Also, correct the Acknowledgement Letter and include all the requirements listed in Policy MS.UM08, Appeal of UM Decisions.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Magnolia's appeal policy correctly documents the timeframes for resolving a standard and expedited appeal. This policy also mentions these timeframes can be extended up to 14 calendar days by the member or the plan. The policy further explains Magnolia will notify the member of the need to extend the timeframe for resolution and the member has a right to file a grievance if he or she disagrees with the extension. However, the notice send to the member regarding the extension does not mention the member's right to file a grievance. This requirement is also missing in the Member Handbook, the Provider Manual, and on Magnolia's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Include the member's right to file a grievance if they disagree with Magnolia's request to extend the timeframe for processing an appeal in the member notice, the Member Handbook, Provider Manual and on Magnolia's website.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					Policy MS.UM.08, Appeal of UM Decisions, and the Member Handbook provide instructions and requirements for the continuation of benefits while an appeal or State Fair Hearing is pending.
2. The CCO applies the appeal policies and procedures as formulated.		X				A sample of appeal files were reviewed. The following issues were identified: In one file, the resolution notice was sent to the member prior to the date of the decision. There were two files where the appeal was requested as expedited and the member was not notified of the decision to deny the request for expedited resolution. One appeal was not resolved within the required timeframe and one acknowledgement letter was not sent. *Corrective Action Plan: Initiate a process to monitor appeals to ensure all requirements are met.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
opportunities, and reported to the Quality Improvement Committee.						
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR § 208*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Magnolia's UM Program Description 2022 includes the purpose, scope, and goals of the program. It addresses integration with other health plan programs, components of the UM process, and provides information about emergency services, pharmaceutical management, behavioral health management, care and disease management, and evaluation of the program. A separate Optum Population Health Program Management Operations Program Description, dated 2020, describes the chronic condition/lifestyle management programs. Departmental policies and procedures provide detailed information about processes and requirements for staff who conduct Care Management and Population Health Management activities.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Policy CC.CM.02, Care Coordination Care Management Services, addresses processes for identifying members as potential candidates for Care Management. Methods of identification include: •Health screenings that may be completed directly by members on the health plan website,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						during new member welcome calls, or by staff during in person contact with members. Members who indicate their health is “poor” are referred for potential enrollment into complex care management. •Direct referrals from Utilization Management, Care Management, Member Connections/Community Health Services Program staff, delegate, vendors, sister organizations such as the Nurse Advice Line and disease management •Self-referrals from members, family members, and/or caregivers and referrals from providers, hospital staff, community/social service agencies, etc. •Internal data sources such as member prioritization reports, members in specific identified population health categories with Risk Score greater than three, CNC BH Risk Score in the top 10% of members, and reports from the state agency/state enrollment center identifying members needing outreach and screening/assessment for potential enrollment into care management, predictive modeling, etc. As noted in the UM Program Description, one key objective of the Care Management Program is early identification of members with the greatest need for care coordination or complex care management. (Examples: children or adults with special healthcare needs; catastrophic, high-cost, high-risk, or co-morbid conditions;

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members who are non-adherent to less intensive programs; frail and elderly, disabled, end of life).
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					As identified in Policy CC.CM.02, Care Coordination Care Management Services, a health risk assessment is completed within 30 calendar days. Additionally, contact is initiated earlier if a member has more urgent needs. Review of the care management files identified that the health risk assessment was completed within 30 days.
4. The detailed health risk assessment includes all required elements:						Policy CC.CM.02, Care Coordination Care Management Services, addresses processes for conducting health risk assessments and elements included in the assessments.
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					Policy MS.CM.01, Care Management Program and Program Description, identifies that a Care Treatment Plan is to be completed within 30 days or earlier after completion of the health risk assessment. The treatment plan development is a collaborative effort with the member, caregivers, and providers as stated in Policy CC.CM.01 and Policy CC.CM.02, Care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Coordination Care Management Services. In review of the care management files, the care treatment plan was completed within 30 days of the health risk assessment.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					As noted in the 2022 Care Management Program Description, reassessments are completed for significant changes of condition, and at least yearly. Member care plans are revised as needed due to progression or regression of condition, meeting goals, etc., with care plan changes and goal modification based on findings of ongoing evaluations. Significant care plan revisions are shared with the member/caregiver and the interdisciplinary care team to ensure agreement with the changes.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:		X				See Standard 7.7 below for the identified issue.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						Policy CM.02 Care Coordination and CM Services, addresses this requirement.
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						Policy CM.02 Care Coordination and CM Services, addresses this requirement.
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						Policy CC.CM.01, Care Management Program Description, address this requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						This requirement is addressed in Policy CC.CM.01, Care Management Program Description; Policy MS.UM.24, Continuity and Coordination of Care; and Policy CC.CM.02, Care Coordination Care Management Services.
7.5 Coordination of discharge planning;						Policy CC.CM.01, Care Management Program Description, address this requirement.
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						Policy CM.02, Care Coordination/Care Management Services, states, "The Care Manager identifies and provides resources and/or referrals for medical care, behavioral healthcare, educational needs, housing, social, other support services and community resources that improve member access to health care, health status, and quality of life."
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						For continued access to providers who are no longer available through the CCO's network, Policy MS.PRVR.23, Provider Termination, states the timeframe allowed is up to 60 calendar days. Onsite discussion confirmed the allowed timeframe is 60 calendar days. Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, incorrectly state the timeframe as 90 calendar days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise Policy CC.MBRS.27, Member Advisory of Provider Termination, and Policy MS.UM.24, Continuity and Coordination of Services, to reflect the correct timeframe for allowing a continuing course of treatment when a provider is no longer in Magnolia's network.
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						Policy CM.02 Care Coordination and CM Services, addresses this requirement.
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						Policy CM.02 Care Coordination and CM Services, addresses this requirement.
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					Policy MS.CM.01, Care Management Program and Program Description, provides guidelines for the implementation of predictive modeling to aid in identifying member's appropriate risk level and members assigned the medium risk level will also receive low risk level services.
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Processes and requirements for overall continuity can coordination of care are documented in Policy MS.UM.24, Continuity and Coordination of Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					The Envolve PeopleCare Population Health Management Program Description indicates the programs include, Chronic Obstructive Pulmonary Disease, Asthma, Diabetes, Heart failure, Coronary artery disease, Hypertension and/or hyperlipidemia, and lifestyle management programs (exercise, physical activity, nutrition, stress management, tobacco cessation, weight management or lower back pain).
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					A descriptive overview and guidelines for managing transitional care for members across healthcare settings are outlined in Policy MS.CM.99, Transitional Care Management Process, and Policy MS.UM.24, Continuity and Coordination of Care.
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Policy MS.CM.99, Transitional CM Process, outlines processes and requirements for conducting transition of care activities and managing transitions of care across healthcare and community settings.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					Policy MS.CM.99, Transitional Care Management Process, states the care management team consists of an integrated team of licensed RN's, program coordinators, behavioral health staff, social services specialists, care management leadership, and medical directors.
4. The CCO meets other Transition of Care requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Oversight of Delegated Vendor Services policy and the Oversight of Delegated Credentialing Policy describes processes for delegation of health plan activities and oversight of delegated entities. The Joint Oversight Committee oversees delegation processes. The health plan subjects each potential delegate to a pre-delegation assessment to determine its capabilities for conducting functions in compliance with all requirements. Magnolia conducts annual oversight and ongoing monitoring for all delegates. Standardized audit tools that are specific to functional areas are used for pre-delegation and annual assessments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				Documentation of annual oversight, and ongoing monitoring were provided for 19 of the 20 delegates. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan. The annual oversight monitoring for Rush Health Systems was not provided. The annual monitoring report provided for this EQR was the same monitoring report provided for the previous (2021) EQR. Also, the files reviewed for the annual monitoring of Mississippi Health Partners incorrectly listed the check of the Social Security Death Master File and Hospital Admitting Privileges as "Not Applicable." *Corrective Action Plan: Develop a process to ensure that the annual monitoring for all delegates is conducted in a timely manner. Also, re-educate all credentialing delegates to ensure the requirements for checking the Social Security Death Master File and Hospital Admitting Privileges are included in the monitoring.*