Constellation Quality Health

Mississippi External Quality Review

Annual Comprehensive Technical Report

Contract Year 2023 – 2024

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Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the Mississippi Division of Medicaid (DOM) contracted with Constellation Quality Health, an external quality review organization (EQRO), to conduct External Quality Reviews (EQR) for all Coordinated Care Organizations (CCOs) participating in the MississippiCAN (CAN) and Mississippi CHIP (CHIP) Medicaid Managed Care Programs. The CCOs include:

- UnitedHealthcare Community Plan – Mississippi (United)
- Magnolia Health Plan (Magnolia)
- Molina Healthcare of Mississippi (Molina)

The goals and objectives of the review were to:

- Determine whether the CCOs were in compliance with service delivery as mandated in Federal Regulations and in the Coordinated Care Organization (CCO) contracts with DOM.
- Assess the degree to which the health plans addressed deficiencies identified during the previous EQR and provide feedback for potential areas of continued improvement.

The purpose of the EQRs is to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and quality of health care services. This was accomplished by conducting the following activities for the CAN and CHIP programs: validation of performance improvement projects, performance measures, surveys, and network adequacy; assessment of compliance with state and federal regulations; and access studies for each health plan. Constellation Quality Health also conducted the Behavioral Health Member Satisfaction Surveys for each of the CCOs. This report is a compilation of the activities conducted in the 2023-2024 review cycle for the CAN and CHIP Programs for each CCO.

Overall Findings for Mandatory EQR Activities

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

- Availability of Services (§ 438.206, § 457.1230)
- Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)
- Coordination and Continuity of Care (§ 438.208, § 457.1230)

- Coverage and Authorization of Services (§ 438.210, § 457.1230, § 457.1228)
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality (§ 438.224)
- Grievance and Appeal Systems (§ 438.228, § 457.1260)
- Subcontractual Relationships and Delegation (§ 438.230, § 457.1233)
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems (§ 438.242, § 457.1233)
- Quality Assessment and Performance Improvement Program (§ 438.330, § 457.1240)
- Disenrollment (§ 438.56)
- Enrollee Rights (§ 438.100)
- Emergency and Post Stabilization Service (§ 438.114)

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

To assess the health plan's compliance with quality, timeliness, and accessibility of services, Constellation Quality Health's review was divided into six areas:

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation

The following is a high-level summary of the review results for each of these areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

Administration

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

Policies and procedures guide staff in conducting required activities. Appropriate processes are followed for reviewing policies annually, updating policies, and educating staff about new and revised policies. Magnolia and Molina incompletely documented committee involvement in policy review and approval processes.

Review of the Organizational Charts and onsite discussion confirmed key positions were filled for each of the CCOs. Overall staffing is sufficient to ensure that all required services are provided to members.

The CCOs have written Compliance Plans, Fraud, Waste, and Abuse (FWA) Plans, and policies that describe processes for ensuring compliance with laws, policies, and contractual requirements, and for preventing, detecting, and responding to FWA. Written Codes of Conduct document expectations for business conduct. No issues were identified related to the processes for educating staff annually about the Compliance Programs and related topics. CCO Compliance Committees assist in developing and implementing the Compliance Programs. Issues with the Compliance Committees were identified related to incomplete documentation of committee meeting attendance (Magnolia) and discrepancies in documentation of who chairs the Compliance Committee (Molina). Confidentiality and privacy of protected health information are appropriately addressed in policies.

Each CCO has a Pharmacy Lock-in Program to detect, prevent, and/or respond to abuse of the pharmacy benefit. Issues were identified related to documentation of the 72-hour limitation for an emergency supply of medication (Magnolia) and the timeframe for notifying members of their inclusion in the Lock-in Program (Molina).

As evidenced by the Information Systems Capabilities Assessment documentation and related policies and procedures, the CCOs' information systems infrastructure was capable of meeting contractual requirements. All CCOs met or exceeded State-required timeframes for clean claim payment. Systems and processes are appropriately maintained and updated in accordance with policies to prioritize data security and system resilience. Disaster Recovery plans are tested and updated annually.

Provider Services

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

The CCOs conduct initial and ongoing provider education to ensure network providers can operate appropriately and effectively within the health plans' networks. Provider Manuals and health plan websites reinforce this education; however, some issues were identified in the documentation related to member benefits, requirements for seeing non-participating providers, well child care, medical record retention requirements, and processes to request member reassignment to another PCP.

Policies define provider medical record documentation standards, processes for assessing provider compliance through routine medical record audits, and follow-up actions when providers do not meet the scoring threshold.

United, Magnolia, and Molina adopt and educate providers about evidence-based clinical practice and preventive health guidelines that are specific to the demographics and health care and service needs of their members. The health plans disseminate the guidelines to providers in various ways, and printed copies are available upon request.

The CCOs' provider networks were found to be adequate and consistent with the requirements of the CMS protocol, "Validation of Network Adequacy." Each of the CCOs has policies regarding geographic access to network providers; however, Magnolia's policy was incomplete. The CCOs monitor quarterly geographic access reports and consider member satisfaction survey results, complaints, grievances, out of network requests, etc. Appointment access standards are documented in policies, Member Handbooks, and Provider Manuals. Magnolia's policy omitted appointment access standards for specialists and Molina's policy and Provider Manuals included incorrect/incomplete information. For Molina, this was an uncorrected deficiency from the previous EQR. The CCOs educate providers about the appointment standards and assess provider compliance through call studies. Molina's policy did not define the frequency of conducting appointment access studies or the department or entity that conducts the audits. This was uncorrected from the previous EQR. Provider Directories include all required elements, and provider information is validated by using automated systems and conducting outreach campaigns to providers.

Each CCO has established a cultural competency program to ensure networks can adequately serve members with special needs. Cultural competency resources are available on plan websites.

Constellation Quality Health conducted and considered the results of Telephone Access Studies and Provider Directory Validations for each CCO. The most recent surveys for all the CCOs identified overall improvement in successful contact and Provider Directory accuracy rates; however, weaknesses continue to include the availability of routine and urgent appointments.

Constellation Quality Health conducted validation reviews of the provider satisfaction surveys using the protocol developed by CMS titled, "Protocol 6: Administration or Validation of Quality of Care Surveys." The survey response rates ranged from 1% to 7.9% and reflected a decrease from the previous year for each CCO. The health plans report results of the provider satisfaction surveys and the impact of measures taken to address identified issues to quality committees.

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 CCOs document member rights and responsibilities in policies; however, Molina's policy did not include all contractually required responsibilities. Members are informed of their rights and responsibilities through Member Handbooks, welcome packets, newsletters, and the CCOs' websites.

Members are educated about health plan processes, covered benefits, applicable copays, programs, and services through new member packets, Member Handbooks, newsletters,

websites, etc. Members are informed in writing of changes in services and benefits 30 days prior to the date of benefit change. Member materials are developed in a manner to ensure they are easily understood and are available in alternate languages and formats. The health plans provide free translation and interpreter services as needed. Members are informed annually that they may request a copy of the Member Handbook and Provider Directory.

Each CCO provides contact numbers and hours of operation for Call Center assistance and member support. Call Center personnel are trained to incorporate interactive scripts which are reviewed annually. Targets for call center performance/call metrics are defined by DOM and analyzed by each CCO.

Member Handbooks include brief information about preventive health services and wellness programs. Members are instructed to contact Member Services for more information or assistance. Members are educated about population health activities and additional recommendations through member newsletters, mailings, automated and live calls, e-mails, text messages, and events such as health fairs and other health promotion events.

Appropriate processes are in place for member enrollment and disenrollment. Members are educated about circumstances under which they may request disenrollment and under which they may be involuntarily disenrolled. Members are instructed to contact DOM in writing or by telephone to request disenrollment and/or a change in health plan.

Each CCO outlines processes for filing and handling grievances in policies. Member Handbooks, Provider Manuals, and CCO websites define grievance terminology, include timeframes for grievance resolution, and include information about extensions of grievance resolution timeframes. A sample of grievance files was reviewed for each CCO for the 2023 EQR and all were found to be acknowledged and resolved timely. Molina was noted to be closing member grievances rather than asking for an extension when additional information was needed to resolve the grievance.

As contractually required, the health plans conducted the Adult, Child and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Constellation Quality Health validated to ensure that the results of the surveys were reliable and valid, and found that the generalizability of the survey results was difficult to discern due to low response rates. The CCOs were advised to work with their survey vendors on strategies to increase the response rates.

Quality Improvement

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

The Quality Improvement (QI) Programs developed by the CCOs focused on the health care and services their members receive and include all aspects of health care quality. The health plans provided a copy of their QI program descriptions, which included the specific goals,

objectives, and priorities to help achieve the overall goals. Information about the QI Program is shared with providers and members through each health plan's website, in Provider Manuals, and in Member Handbooks.

The reduction of health disparities is addressed through each health plan's Health Equity Programs. The goals of these programs are to reduce health disparity and improve culturally and linguistically appropriate services. Specific measures have been chosen to improve the health disparities for the CAN and CHIP populations. Magnolia achieved full Health Equity Accreditation in 2022.

Annually, the health plans develop a QI work plan to identify and track the planned QI activities. Constellation Quality Health received the 2022 and 2023 QI work plans for each health plan. Both work plans included the yearly quality improvement activities, the individual responsible for each task, target dates, quarterly updates, and any previously identified issues. There were several errors and/or missing information in Molina's 2023 QI Work Plan.

The CCOs have established QI committees charged with oversight of their QI programs. The QI committees act as oversight committees and receive regular reports from other departments and/or subcommittees that are accountable to the committee. Members of these committees include the health plans' Chief Medial Officers, quality leads, senior managers, and other staff responsible for key functions within the organization. Participating network providers specializing in a wide variety of specialties serve as voting members.

The CCOs provide coverage for all early and periodic screenings, diagnosis, and treatment (EPSDT) services (Well-Baby/Well-Child screenings for CHIP). The DOM contract requires the CCOs to have a tracking system that provides information on member compliance with EPSDT and Well-Baby/Well-Child services including the diagnosis, treatment, and/or referrals needed. Molina's tracking process indicated staff utilized the Claims Lookup tool to identify all claims received after the original EPSDT or Well-Baby/Well-Child exam to determine potential diagnosis and referral/follow-up. If no claims could be associated as a referral, the list is passed to designated staff to call. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. This was an issue for Molina that was previously identified during the 2020, 2021, and 2023 EQRs and has not been corrected.

Each CCO conducts an annual review of the overall effectiveness of their QI Programs. The results of the annual review are used to develop and prioritize the next year's activities. United, Magnolia, and Molina submitted their 2022 QI Program Evaluations. United and Magnolia's evaluations were complete and included the analysis for each activity as well as identified barriers and opportunities. Molina's was incomplete and did not include the results of all the QI activities conducted in 2022. This continues to be an issue for Molina and was previously identified in the 2020, 2021, and 2022 EQRs.

Performance Measure Validation:

Health plans are required to have an ongoing improvement program and report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. DOM has selected a set of performance measures (PMs) to evaluate the quality of care and services delivered by the plans to its members. To evaluate the accuracy of the PMs reported, Constellation Quality Health contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA Licensed Organization certified to conduct HEDIS Compliance audits, to conduct a validation review. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS® measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2022, through December 31, 2022.

All relevant HEDIS PMs for the CAN and CHIP populations were compared for the current review year (MY 2022) to the previous year (MY 2021). All three CAN CCOs showed more than a 10-percentage point improvement in more measures for MY 2022 than they did for MY 2021. All three CCOs showed improvement in the oral health measures. *Tables 1* and *2* highlight the HEDIS measures for CAN and CHIP that were found to have a substantial increase or decrease in rate.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescents (ima)			
Tdap/Td	76.16%	79.32%	76.40%
Asthma Medication Ratio (amr)			
19-50 Years	61.42%	60.70%	57.83%
51-64 Years	56.25%	56.20%	50.00%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (65-74)	NA	32.26%	NA
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Continuation and Maintenance (C&M) Phase	66.57%	71.08%	59.35%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	41.63%	41.46%	41.28%

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	30.14%	34.76%	28.44%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days (Total)	41.04%	40.83%	40.71%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	29.72%	33.73%	27.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	28.30%	28.26%	NA
7-Day Follow-Up: 13-17 Years	24.53%	15.22%	NA
30-Day Follow-Up: 18+ Years	26.52%	27.72%	24.17%
7-Day Follow-Up: 18+ Years	15.65%	15.79%	12.50%
30-Day Follow-Up: Total	26.78%	27.79%	22.63%
7-Day Follow-Up: Total	16.94%	15.71%	12.41%
Substantial Decrease in Rate (>10% decrease)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	50.76%	47.92%	48.65%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	52.94%	80.43%	NA
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Statin Adherence 80% - 21-75 years (Male)	58.48%	56.54%	39.18%
Statin Adherence 80% - 40-75 years (Female)	47.53%	51.89%	44.26%
Statin Adherence 80% - Total	53.26%	54.26%	41.14%
Statin Therapy for Patients with Diabetes (spd)			
Statin Adherence 80%	52.05%	49.77%	38.46%
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	49.07%	49.53%	59.77%
Effective Continuation Phase Treatment	30.90%	30.85%	37.78%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
18-64 years - 7-Day Follow-Up	24.91%	28.62%	19.26%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	31.64%	28.66%	30.43%
Pharmacotherapy for Opioid Use Disorder (Total)	31.28%	28.93%	30.43%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	17.99%	13.42%	24.18%

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates
Substantial Increase in Rate (>10% improvement)		
Childhood Immunization Status (cis)		
Combination #7	68.13%	69.84%
Follow-up care for children prescribed ADHD Medication (add)		
Initiation Phase	49.83%	43.87%
Continuation and Maintenance (C&M) Phase	69.44%	60.00%
Follow-Up After Hospitalization for Mental Illness (fuh)		
6-17 years - 30-Day Follow-Up	68.00%	68.42%
Total-30-day Follow-Up	67.48%	68.69%
Follow-Up After Emergency Department Visit for Mental Illness (fum)		
6-17 years - 30-Day Follow-Up	72.97%	NA
6-17 years - 7-Day Follow-Up	45.95%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)		
Blood Glucose Testing (1-11)	44.30%	40.00%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)		
12-17 Years	74.16%	63.89%
Substantial Decrease in Rate (>10% decrease)		
Lead Screening in Children (lsc)	64.72%	63.81%
Antidepressant Medication Management (amm)		
Effective Continuation Phase Treatment	24.32%	NA
Appropriate Treatment or Children with URI (uri)		
18-64 Years	52.04%	50.52%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)		
1-11 Years	41.03%	NA
12-17 Years	74.16%	63.89%

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 2022 and the previous year (MY 2021). The changes from MY 2021 to MY 2022 are reported in the tables that follow. Rates shown in green indicate a substantial (>10%) improvement and rates shown in red indicate substantial (>10%) decline.

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

Measure/Data Element	United MY 2022 CAN Rates	Magnolia MY 2022 CAN Rates	Molina MY 2022 CAN Rates
Substantial Increase in Rate (>10% improvement)			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 65+	230.41%	225.56%	0.00%
Total	54.94%	60.72%	55.61%
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	54.46%	51.24%	48.85%
Ages 65+	0.00%	75.19%	0.00%
Total	54.35%	51.30%	48.83%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	40.15%	5.19%	33.06%
Total Screening	46.47%	5.41%	39.48%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	50.73%	54.40%	34.38%
Numerator 2 All Four Molars Sealed	35.24%	37.76%	21.91%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Ages 1-2	22.28%	22.74%	19.74%
Ages 3-5	59.05%	58.72%	48.41%
Ages 6-7	64.66%	64.64%	54.93%
Ages 8-9	65.46%	64.49%	55.01%
Ages 10-11	63.66%	61.41%	52.41%
Ages 12-14	58.42%	55.92%	45.72%
Ages 15-18	48.36%	46.60%	37.24%
Ages 19-20	28.58%	27.74%	20.99%
Total Ages <1-20	50.98%	50.85%	39.25%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 3-5	27.03%	27.51%	21.21%
Ages 6-7	31.47%	31.44%	24.22%
Ages 8-9	31.62%	31.31%	25.88%
Ages 10-11	30.71%	29.16%	21.75%
Ages 12-14	26.51%	25.65%	18.78%
Ages 15-18	19.01%	17.83%	13.26%

Measure/Data Element	United MY 2022 CAN Rates	Magnolia MY 2022 CAN Rates	Molina MY 2022 CAN Rates
Total Ages 1-20	24.11%	24.15%	17.76%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 3-5	25.44%	25.24%	18.91%
Ages 6-7	30.94%	30.75%	23.30%
Ages 8-9	31.27%	30.92%	25.07%
Ages 10-11	30.41%	28.98%	21.35%
Ages 12-14	26.32%	25.44%	18.25%
Ages 15-18	18.85%	18%	12.79%
Total Ages 1-20	23.21%	23.08%	16.04%
Substantial Decrease in Rate (>10% decrease)			
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 65+	0.00%	75.19%	0.00%

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

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates
Substantial Increase in Rate (>10% improvement)		
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)		
Age 1 Screening	51.61%	NA
Age 3 Screening	48.18%	53.24%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)		
Numerator 1 At Least One Sealant	47.09%	26.20%
Numerator 2 All Four Molars Sealed	32.89%	18.36%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)		
Ages 1-2	32.91%	31.95%
Ages 3-5	61.65%	56.14%
Ages 6-7	69.39%	65.24%
Ages 8-9	72.30%	65.75%
Ages 10-11	69.90%	62.55%
Ages 12-14	64.70%	57.65%
Ages 15-18	54.04%	45.66%
Ages 19-20	43.51%	33.99%

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates
Total Ages <1-20	61.17%	54.62%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)		
Ages 3-5	32.20%	28.45%
Ages 6-7	38.29%	36.15%
Ages 8-9	39.33%	36.77%
Ages 10-11	37.08%	33.75%
Ages 12-14	31.39%	27.65%
Ages 15-18	21.68%	19.55%
Total Ages 1-20	30.27%	27.65%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)		
Ages 3-5	30.51%	25.45%
Ages 6-7	37.75%	34.44%
Ages 8-9	39.15%	35.47%
Ages 10-11	36.92%	32.67%
Ages 12-14	31.32%	26.56%
Ages 15-18	21.63%	18.61%
Ages 19-20	14.22%	10.00%
Total Ages 1-20	29.74%	25.92%
Substantial Decrease in Rate (>10% decrease)		
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)		
Ages 18 - 64	0.00%	10.36%
Total	0.00%	10.36%

Performance Improvement Project Validation:

DOM requires each health plan to conduct Performance Improvement Projects (PIPs) for the following topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Each health plan is required to submit PIPs to Constellation Quality Health for validation annually. Constellation Quality Health validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Twenty-three projects were validated for the three health plans. Results of the validation and

status for each project are displayed in the tables that follow. Interventions for each project are included in the Quality Improvement section of this report.

Table 5: Results of the Validation of CAN PIPs

Project	Validation Score	Project Status
United CAN PIPs		
Behavioral Health Readmission	74/75=99% High Confidence in Reported Results	The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest rate from 21.4% in 2021 to 18.7%, with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2021 to 19% in 2022. Individual facility rates were reported as well for each of the five facilities.
Improving Pregnancy Outcomes	80/80=100% High Confidence in Reported Results	The Improved Pregnancy Outcomes PIP goal is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment. This PIP has a DOM goal rate of 94.92% for the HEDIS Timeliness of Prenatal care rate. The baseline rate was 92.21% and the remeasurement number three rate was 96.84%. This rate reflects an improvement in the visit rate and exceeds the goal rate.
Respiratory Illness Management	80/80=100% High Confidence in Reported Results	The Respiratory Illness Management PIP examines the appropriate medications (bronchodilators or systemic corticosteroids) for members with COPD exacerbations based on HEDIS measures, as well as the asthma medication ratio HEDIS measures. For bronchodilators, the baseline was 74.96%. The 2021 rate was 76.36% and the 2022 rate was 78.40%, which demonstrates improvement. Corticosteroids improved from 42.24% at baseline to 49.89% in 2021 and improved again in 2022 to 50.76%. The AMR baseline was 70.7% and increased to 75.79% for 2022.
Sickle Cell Disease Management Decreasing ER Utilization	74/75=99% High Confidence in Reported Results	The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28%, decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%. Thus, the most recent rate did not show improvement in year over year trending.
Magnolia CAN PIPs		

Project	Validation Score	Project Status
Behavioral Health Readmission	80/80 = 100% High Confidence in Reported Results	The Behavioral Health Readmission PIP is focused on reducing 30-day readmissions for members discharged from a behavioral health facility and increasing case management enrollment for those that are readmitted. This PIP showed improvement in the latest rate from 26.88% in 2021 to 25.9% in 2022, with a goal of 6%. Many interventions have been implemented over the five-year PIP period.
Reducing Preterm Births	74/75=99% High Confidence in Reported Results	The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with hypertension/pre-eclampsia who give birth prior to 37 weeks gestation. The baseline rate was 14.47%, and the third remeasurement rate was 15.05%. This rate increased, which reflects a lack of improvement as the goal is to reduce the preterm birth rate.
Sickle Cell Disease Outcomes	74/75=99% High Confidence in Reported Results	The Sickle Cell Disease PIP focuses on increasing compliance with Hydroxyurea for eligible members throughout the treatment period. This PIP measures the rate of members with sickle cell disease that remain compliant with the medication during their treatment period. The baseline rate was 37.5%, decreasing to 25.87% in 2023. The goal is to increase the rate to 47%. Thus, the most recent rate did not show improvement in year over year trending.
Asthma/COPD	74/75=99% High Confidence in Reported Results	The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and the spirometry test for members 40 and older with COPD. This indicator uses the HEDIS measure, AMR. The AMR rate was 71.15% at baseline, which has not changed in 2022 at 71.15%, with a goal of 76.86%. The spirometry testing rate was 28.38% at baseline which has declined to 22.27% for 2022. The goal is 36.82%.
Molina CAN PIPs		
Behavioral Health Readmissions	74/75=99% High Confidence in Reported Results	The Behavioral Health Readmissions PIP is aimed at reducing 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and to determine if the interventions help decrease psychiatric readmissions. The latest report had Q1 2023 data with a readmission rate of 54.2% that increased from the Q4 2022 rate of 10.8%. Case management enrollment for the 13 readmitted members was 100%.
Asthma Medication Ratio	74/75=99% High Confidence in Reported Results	The aim for the Asthma PIP is to increase the compliance rate of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The Asthma PIP focused on the AMR

Project	Validation Score	Project Status
		HEDIS rate for ages 5 to 64. Quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements, with a goal of 72.89%.
Pharmacotherapy Management of COPD Exacerbation	80/80=100% High Confidence in Reported Results	The COPD PIP utilizes the systemic corticosteroid HEDIS measure and the bronchodilator HEDIS measure. For Q1 to Q2 2023, there was an increase from 48.65% to 60.94% for the steroid measure, with a goal of 53.43%, and an improvement from 59.46% to 79.69% for the bronchodilators, with a goal of 81.8%.
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	This PIP assesses 7- and 30-day follow up for members hospitalized for treatment of mental illness. For the 30-day follow up, the rate improved from 34.34% to 44.73%, with a goal of 56.13%. The 7-day rate improved from 21.72% to 27.23%, with a goal of 28.32%.
Obesity	80/80=100% High Confidence in Reported Results	This PIP utilizes the BMI percentile documentation, counseling for nutrition, and counseling for physical activity HEDIS measures. For BMI percentile, there was improvement from Q1 to Q2 with rates of 14.44% increasing to 18.69%, and a goal of 61.31%. Counseling for nutrition improved from 7.41% to 9.86%, with a goal of 52.31%. Counseling for physical activity improved from 7.1% to 9.92%, with a goal of 57.42%.
Prenatal and Postpartum Care	74/75=99% High Confidence in Reported Results	This PIP examines the rate of deliveries that received prenatal care within the first trimester and post-partum care visits within 84 days of delivery. For prenatal visits, the rate declined from 86.19% to 84.72%, with the goal of 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%.
Sickle Cell Disease	74/75=99% High Confidence in Reported Results	This PIP focuses on the percentage of members with Sickle Cell Disease who are enrolled in case management. The rate declined from 6.25% to 4.9%, with a goal of 15.9%.

Results of the validation and project status for each CHIP project are displayed in *Table 6: Results of the Validation of CIP PIPs*. Interventions for each project are included in the Quality Improvement section of this report.

Table 6: Results of the Validation of CHIP PIPs

Project	Validation Score	Project Status
United CHIP		
Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	74/75=99% High Confidence in Reported Results	The Adolescent Well-Child Visits (AWC)/Child and Adolescent Well-Care Visits (WCV) PIP goal is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year. The AWC measure was retired and replaced with the WCV measure. This

Project	Validation Score	Project Status
		measure looks at the percentage of members completing at least one comprehensive wellness visit during the calendar year. The rate for the 12 – 17-year-olds declined from 40.16% to 39.96%. This is below the goal rate of 41.36%. The rate for 18 - 21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%.
Follow Up After Hospitalization for Mental Illness	80/80 = 100% High Confidence in Reported Results	The goal for the Follow-Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7-day and 30-day follow-up visits. The PIP report showed that the 30-day follow up rate improved from 65.8% in 2021 to 67.48% in 2022, exceeding the goal rate of 59.42%. The 7-day follow up rate improved from 35.11% in 2021 to 41.1% in 2022. The goal rate for United is 38.95%.
Reducing Adolescent and Childhood Obesity	94/95=100% Hight Confidence in Reported Results	The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity. The BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93%, with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66%, with a goal rate of 68.61%.
Getting Needed Care CAHPS	94/95=100% High Confidence in Reported Results	For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and to improve the rate to meet the NCQA quality compass percentile rate. The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%.
Molina CHIP		
Asthma Medication Ratio	79/80= 99% High Confidence in Reported Results	The aim for this Asthma PIP is to increase the compliance rate of asthma medication for CHIP members. Quarterly rates show a decline from 93.02% in Q1 2023 to 76.92% in Q2 2023. The rates are above the goal rate of 71.28% (benchmark should be adjusted now that several remeasurements are above it).
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate for 6–17-year-olds improved from 46.43% in Q1 2023 to 59.18% in Q2 2023. The goal is 56.13%. For the 7-day rate, the rate increased from 28.6% in Q1 to 34.7% in Q2. The goal is 28.32%.
Obesity	80/80=100%	The Obesity PIP aims to increase the percentage of CHIP members who had an outpatient visit with their PCP or

Project	Validation Score	Project Status
	High Confidence in Reported Results	OBGYN that includes weight assessment counseling. The BMI documentation rate improved from 11.29% in Q1 to 15.23% in Q2, with a goal of 61.31%. The nutrition counseling rate also improved from 5.68% to 8.96%, with a goal of 52.31%. Counseling for physical activity improved from 4.73% to 8.73%, with a goal of 57.42%.
Well Care/Well Child	85/85=100% High Confidence in Reported Results	The aim for the Well-Care/Well-Child PIP is to increase the number of CHIP members who receive at least six or more well care/well child visits during the first 0-15 months of life. The most recent rates were 59.52% in Q1 and 63.16% in Q2. The goal is 56.13%.

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)

United's CAN and CHIP Utilization Management (UM) Program is integrated within the UnitedHealthcare Clinical Services area. Magnolia's UM Program is structured within the Population Health Management and Clinical Operations Department. Molina's Health Care Services program is structured within the CAN and CHIP UM Program.

The health plans have UM Program Descriptions and policies and procedures that define and describe UM activities. Appropriate clinical staff conduct reviews of service authorization requests using approved clinical guidelines. Magnolia's use of an external review vendor for some clinical determinations was not addressed in policy or the UM Program Description. Annually, inter-rater reliability testing is conducted for both physician and non-physician reviewers to assess consistency in criteria application.

Processes for filing and managing member appeals are outlined the health plans' Member Handbooks, UM Program Descriptions, Provider Manuals, policies, and websites. Appeal terminology is defined, and appeals may be filed verbally or in writing by the member, legal guardian, authorized representative, or service provider. Timeframes for appeal acknowledgment, resolution, and extension are clearly documented by each health plan.

The health plans have Care Management (CM), Disease Management, and Population Health Management Programs according to requirements in the *CAN* and *CHIP Contracts*. Health plans use various resources to identify potential candidates for CM services. Once a member is referred, the health plans provide CM services for members based upon the member's assessed need and risk level. Each health plan also provides transition of care services by an interdisciplinary transitional care team to ensure successful transitions for members across home or community settings.

Overall, documentation of weaknesses was identified for the UM Program. Areas of strength include but are not limited to timely completion of sample approval files, appeal files processed in a timely manner, and reviewers receiving a passing score in Inter- Rater Reliability testing.

Delegation

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

Constellation Quality Health's review of delegation functions included the delegate lists provided by the CCOs, sample delegation contracts, delegation monitoring materials, and documentation of delegation oversight.

United, Magnolia, and Molina had delegation agreements with six different entities. Each of the health plans have policies that define delegation requirements as well as processes for evaluating potential delegates, approval of delegation, implementing written delegation agreements, and conducting ongoing monitoring and annual evaluations for existing delegates.

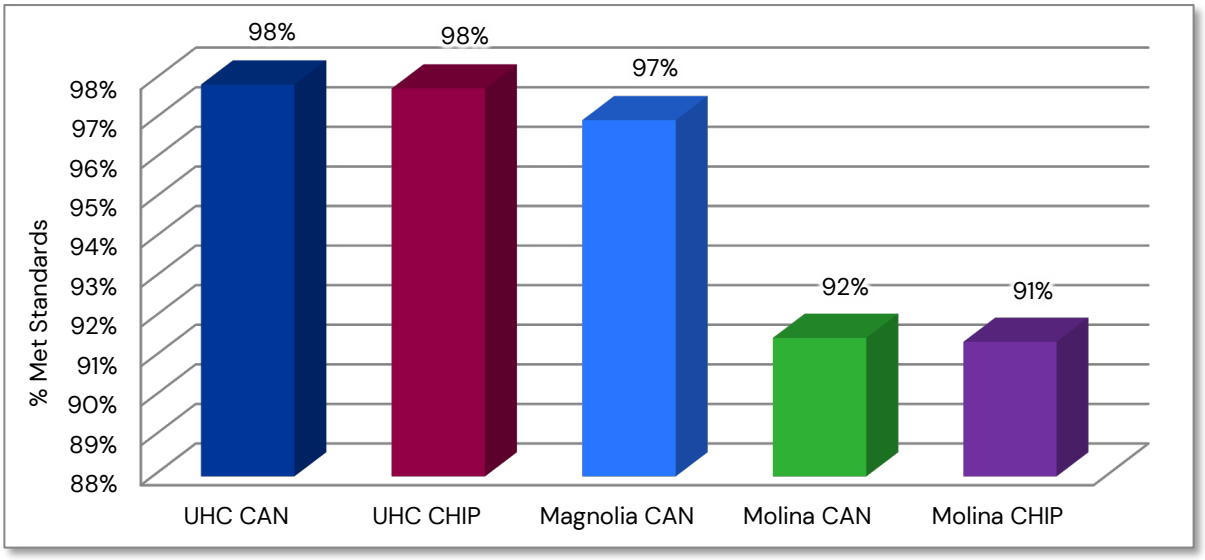
Prior to executing a delegation agreement, the health plans conduct pre-delegation assessments to evaluate potential delegates' abilities to conduct delegated activities in compliance with health plan standards and requirements of the DOM Contract.

Constellation Quality Health reviewed the CCOs documentation of oversight activities conducted for their delegates. United and Magnolia provided the annual evaluation for all entities. Both CCOs measured compliance and performance of all delegated vendors, and no issues were identified. Molina provided a pre-delegation audit and the annual audits for all their delegates except CVS/Caremark. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation audit report was not provided. This was an issue identified during the 2022 EQR.

Conclusions

For the 2023 EQRs, the CCOs met most of the requirements set forth in *42 CFR Part 438 Subpart D,* the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*, and the requirements of the *DOM Contracts*. The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2023 EQRs.

Figure 1: Percentage of Met Standards



Scores were rounded to the nearest whole number

The following tables provide an overall snapshot of the CCOs' CAN and CHIP compliance scores specific to each of the *Subpart D* and QAPI standards.

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

Category	Report Section	Number of CAN Standards	United CAN		Magnolia CAN		Molina CAN	
			Number of Standards Scored as "Met"	2023 Score	Number of Standards Scored as "Met"	2023 Score	Number of Standards Scored as "Met"	2023 Score
Availability of Services *(§ 438.206, § 457.1230)* Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	15	15	100%	13	87%	13	87%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	18	18	100%	18	100%	18	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	12	12	100%	12	100%	11	92%
Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%	1	100%	1	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	18	90%	20	100%	18	90%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%	2	100%	1	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	9	9	100%	9	100%	9	100%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%	4	100%	4	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	19	100%	19	100%	15	79%

Category	Report Section	Number of CAN Standards	United CAN		Magnolia CAN		Molina CAN	
			Number of Standards Scored as "Met"	2023 Score	Number of Standards Scored as "Met"	2023 Score	Number of Standards Scored as "Met"	2023 Score
Disenrollment *(§ 438.56)*	Member Services, Section III. D	1	1	100%	1	100%	1	100%
Enrollee Rights *(§ 438.100)*	Member Services, Section III. A	3	3	100%	3	100%	2	67%
Emergency and Post Stabilization Service *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%	1	100%	1	100%

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

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

Category	Report Section	Number of CHIP Standards	United CHIP		Molina CHIP	
			Number of Standards Scored as "Met"	2023 Overall Score	Number of Standards Scored as "Met"	2023 Overall Score
Availability of Services *(§ 438.206, § 457.1230)* Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	15	15	100%	13	87%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	18	17	94%	18	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	12	12	100%	11	92%
Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%	1	100%

Category	Report Section	Number of CHIP Standards	United CHIP		Molina CHIP	
			Number of Standards Scored as "Met"	2023 Overall Score	Number of Standards Scored as "Met"	2023 Overall Score
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G Utilization Management, Section V. C	20	18	90%	18	90%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%	1	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	7	7	100%	7	100%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	4	4	100%	4	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	19	19	100%	15	79%
Disenrollment *(§ 438.56)*	Member Services, Section III. D	1	1	100%	1	100%
Enrollee Rights *(§ 438.100)*	Member Services, Section III. A	3	3	100%	2	67%
Emergency and Post Stabilization Service *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%	1	100%

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

Overall Recommendations and Opportunities for Improvements

The following is a summary of key findings and recommendations or opportunities for improvement. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

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

Strengths	Quality	Timeliness	Access to Care
Administration			
Key positions are filled, and staffing is sufficient for CCOs to conduct required activities and provide all required services to members.	✓		
Written Compliance Plans, Codes of Conduct, and policies define expectations and processes for ensuring compliance to laws, regulations, and accreditation standards.	✓		
Written Fraud, Waste, and Abuse Plans and related policies describe processes for preventing, detecting, responding to alleged or suspected fraud, waste, and abuse.	✓		
Mandatory compliance training is provided at employment and annually thereafter.	✓	✓	
The CCOs ensure confidentiality when reporting compliance and FWA concerns, provide anonymous reporting options, and ensure there is no retaliation for those making good-faith reports.	✓		
Staff are educated about the possible consequences of non-compliance and FWA.	✓		
The CCOs have established committees with appropriate membership to oversee the Compliance Programs.	✓		
Each health plan has implemented a Pharmacy Lock-in Program to manage inappropriate and/or abuse of pharmacy benefits.	✓		✓
The CCOs provided documentation demonstrating their infrastructure is capable of meeting DOM contractual and information systems requirements.	✓		
All CCOs performed regular risk assessments to identify potential risks to infrastructure and to aid in implementation of preventative measures.	✓		
All CCOs have the ability to perform Medicaid claims and encounter data processing as required by DOM.	✓		
Provider Services			
Policies and procedures define processes for conducting initial provider orientation and education.	✓		✓
Initial provider orientation follows training plans and/or checklists and includes appropriate topics.	✓		✓
Ongoing provider education is provided through a variety of forums.	✓		✓
Appropriate processes are followed for adopting, reviewing, and educating providers about preventive health and clinical practice guidelines.	✓		✓
Policies address routine medical record audit processes to assess provider compliance with medical record documentation standards. The policies indicate appropriate follow-up activities are implemented as needed.	✓		
Geographic access studies are conducted using appropriate access parameters, and provider compliance with appointment access standards is assessed through secret shopper call studies.			✓

Strengths	Quality	Timeliness	Access to Care
Member satisfaction, complaint, and grievance data are considered when assessing network adequacy.			✓
The health plans take action to address any identified network gaps.	✓		✓
Cultural competency programs are in place to ensure health plan networks can serve members with diverse cultural and language needs, accessibility considerations, and other special needs.	✓		✓
Each of the health plans maintains both online and printed Provider Directories that include all required elements.			✓
All three health plans demonstrated appropriate procedures to store, update, verify, and evaluate provider contact information.			✓
Time and distance access reports are conducted quarterly to provide monitoring of member travel requirements for all provider types.	✓	✓	✓
Provider access study successful contact rates and provider directory accuracy rates improved for all the health plans.	✓		✓
Member Services			
The health plans educate members about their rights and responsibilities. The rights and responsibilities are documented consistently across policies, Member Handbooks, Provider Manuals, and the CCOs' websites.	✓		✓
Overall, the Member Handbooks are comprehensive resources for members to understand their benefits, applicable copays, health plan processes, etc.			✓
Call center performance for each CCO is monitored to identify opportunities for improvement, and action is taken to address any identified opportunities.	✓		✓
Review of a sample of grievance files revealed all health plans acknowledged and resolved grievances timely.		✓	
All the health plans use certified survey vendors for member satisfaction survey administration.	✓		
In general, member satisfaction survey response rates improved from the previous year's EQR.	✓		
The three health plans showed assessment of barriers and interventions to address member satisfaction concerns.	✓		✓
Quality Improvement			
The Quality Improvement Programs developed by the CCOs focus on the health care and services their members receive and include all aspects of health care quality.	✓		
The reduction of health care disparities is addressed by each CCO through their Health Equity Programs.	✓		✓
THE CCOs were fully compliant with the HEDIS validation determination standards for the CAN and CHIP HEDIS performance measures.	✓		
Based on the validation of PM rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported.	✓		
The CCOs showed improvement of more than 10 percentage points in MY 2022 for more measures than they did in MY 2021.	✓		
PIP reports included the CMS elements and integrated Corrective Actions from the previous review.	✓		
PIPs were based on analysis of comprehensive aspects of enrollee needs and services and priority topics designated by the Division.	✓		

Strengths	Quality	Timeliness	Access to Care
Utilization Management			
The sample of approval files reflected reviews were completed in a timely manner according to contractual standards for all health plans.		✓	✓
Each health plan conducted inter rater reliability testing. Clinicians and Medical Directors received passing scores.	✓		
The sample of appeal files reflected appeals were processed in a timely manner for all health plans.	✓	✓	
Delegation			
The health plans have policies that define delegation requirements, processes for evaluating potential delegates, approval of delegation, implementing written delegation agreements, and conducting ongoing monitoring and annual evaluations for existing delegates.	✓		
Prior to executing a delegation agreement, the health plans conduct pre-delegation assessments to evaluate potential delegates' abilities to conduct delegated activities in compliance with health plan standards and contractual requirements.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Administration				
Identified issues related to Compliance Committees included meeting minutes that did not reflect attendance by proxy or designee when voting members could not attend (Magnolia) and incorrect documentation of which staff member chairs the committee (Molina).	Ensure Compliance Committee attendance is appropriately documented for meetings and ensure documentation of who chairs the committee is correct.	✓		
Documentation of Pharmacy Lock-in Program requirements was incomplete in policies (Magnolia and Molina).	Ensure Pharmacy Lock-in Program policies completely document all requirements for the program, as detailed in the *CAN* and *CHIP Contracts*.	✓		✓
Provider Services				
Magnolia's policies do not specify geographic access parameters for any providers other than PCPs.	Ensure all required geographic access standards are addressed in health plan policies.	✓		✓
Appointment access standards are incompletely and/or incorrectly documented in Magnolia's and Molina's policies and Provider Manuals.	Ensure policies and Provider Manuals completely and correctly document required appointment access standards.		✓	✓
Molina's policies did not define the frequency of conducting appointment access studies or the department or entity that conducts the studies.	Ensure policies address the frequency of appointment access studies and the department or entity that conducts the studies.	✓		✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
United and Molina incompletely or incorrectly document member benefits information in Provider Manuals and/or websites.	Ensure documentation of member benefits is complete and correct in Provider Manuals and websites.	✓		✓
United did not include information in Provider Manuals that PCPs must contact the health plan regarding assigning a member to an alternate PCP.	Ensure Provider Manuals completely address requirements for PCPs to request a member be assigned to an alternate PCP.			✓
Low provider satisfaction survey response rates may not reflect the population of providers and results should be interpreted with caution.	Devise initiatives to increase provider responses to the survey.	✓		
No improvement was noted in routine and urgent appointment availability for the Access Studies and Provider Directory Validations conducted by Constellation Quality Health.	Implement activities, such as provider re-education, to improve appointment availability compliance.			✓
Member Services				
Molina's policy did not include all contractually required member responsibilities.	Ensure policies address all contractually required responsibilities.	✓		
Issues were found with Molina's documentation of member benefits, including home health visit limitations, emergency ambulance services, and eye care/vision services.	Ensure member benefits are correctly documented.			✓
Molina's policies did not address processes for making members aware of benefit/service changes.	Ensure policies appropriately address processes for notifying members of changes in benefits and services.			✓
Molina incorrectly documented the Member Services Call Center hours of operation in policy.	Ensure policies correctly document the hours of operation for the Member Services Call Center.	✓		✓
For Molina, multiple CAN and CHIP grievance resolution letters indicated steps had been taken to resolve the grievance but did not include the actions taken in the resolution letters. Instead, members were asked to contact the Member Services Department after the grievance was closed.	Ensure processes defined in health plan policy for handling grievances are followed.	✓		✓
Member Satisfaction Survey response rates are below the NCQA target of 40% for all health plans.	Continue to determine ways to advertise member satisfaction surveys and increase response rates. Utilize expertise from survey vendors about strategies to increase response rates.	✓		
Quality Management				
Molina's QI work plan used to track annual QI activities contained several errors regarding	Ensure the QI work plans contain accurate goals and is clear regarding what is being measured and reported	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
the activities' goals and/or what was being measured				
Molina was not measuring provider compliance with clinical practice guidelines as required by Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, and the DOM contract.	Measure provider compliance with the clinical and preventive guidelines as required the *CAN Contract, Section 10 (M)* and the *CHIP Contract, Section 9 (M)* and report the results to the applicable providers.	✓		✓
Molina is not tracking member follow-up treatment and referrals needed for abnormal findings on an EPSDT and Well-Baby/Well-Child exam. This was an issue previously identified during the 2020, 2021, and 2023 EQRs that has not been corrected.	To ensure compliance with the contractual requirements, Molina must follow their process for tracking members identified with an abnormal finding on an EPSDT and Well-Baby/Well-Child exam that includes the diagnosis, treatment, and referrals needed to address the abnormal findings, as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)*.	✓		✓
Molina's 2022 QI Program Evaluation was incomplete and did not include all of the results of the QI activities conducted in 2022. This continues to be an issue and was previously identified in the 2020, 2021, and 2022 EQRs.	To assess the effectiveness of the QI Program, the results of all activities must be analyzed, barriers identified, and recommendations included in the annual QI program evaluation as required by the *CAN Contract, Section 10*, and *Exhibit G* and the *CHIP Contract, Section 9 (D)* and *Exhibit F*.	✓		
During source code review for United, it was identified that the age of the member was calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and United's vendor corrected the source code. United confirmed that the corrected source code was used to calculate the final rates.	It is recommended that the CCOs improve processes around oversight of their software vendors and ensure they are following specifications when calculating the DOM required performance measures.	✓		
There were several HEDIS and non-HEDIS rates that fell by 10 percentage points or more.	The CCOs should monitor and investigate reasons for measure rates that decreased by 10 percentage points or more. The CCOs should continue working toward improvement of non-HEDIS measure rates and ensure that all available data sources are explored to calculate non-HEDIS rates.	✓		
Based on the review of some of Magnolia's HEDIS Compliance Audit Final Audit Reports and onsite discussions, it was identified that there were opportunities for	Improve communication and oversight with the corporate HEDIS team and centralized operations to ensure accuracy, monitoring and tracking for the DOM required PMs.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
improvement in communication and oversight between the corporate HEDIS team, centralized operations, and the CCO.				
All three CAN health plans showed a decline in rates for the sickle cell PIPs. Thirteen of the 23 PIPs across the health plans showed a decline in PIP rates.	Continue interventions to determine if rates can improve wherein most recent trends show a decline. Monitor interim rates to assess for improvement as new interventions are initiated. Modify benchmark if initial benchmark has been exceeded.	✓		
Utilization Management				
For United, some CHIP transitional care management files did not have ongoing documentation of notes that entail a follow up schedule of the members' progress and process for case closure.	Obtain and accurately document a follow up schedule of the members' process while receiving transitional care management services.	✓		✓
Molina's CAN and CHIP Adverse Benefit Determination letters and United's policy incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. Also, an additional United policy and United's website included incorrect information stating that a written request is required when a verbal request is submitted. This is no longer a contractual requirement.	Update the CAN and CHIP Adverse Benefit Determination letters, website, and policies to remove the requirement that a member must follow a verbal appeal request with a written request.			✓
For Molina, some CAN and CHIP appeal files were extended based on the lack of the receipt of a signed Authorized Representative Form, and subsequently closed with no indication of notification to the Division found in the files.	Ensure processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals, and the appropriate notification to the Division when appeal extensions are needed.			✓
Magnolia referenced Turning Point (a vendor) in appeal determination notices. However, use of a vendor for appeal determinations was not referenced in Magnolia's UM policies and Program Description.	Update UM policies and procedures and the Magnolia Health Utilization Management Program Description 2023 to include information about use of vendors for UM and/or appeal determinations.	✓		
Some of United's appeal acknowledgement and resolution letters were addressed to the provider or Appeals Department but appeared to be communicating with the member.	Ensure processes are in place to review the language within the appeal acknowledgement and resolution letters so they accurately address the appellant.			✓
Delegation				
Molina - The annual delegation oversight audit of CVS/Caremark was not conducted	In addition to the monthly and/or quarterly monitoring reports, the CCOs must complete the annual delegation oversight	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
as required by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B).*	audit of for all delegated entities as required by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B).*			

Assessment of DOM's Quality Strategy

DOM requires the CCOs to achieve NCQA accreditation, stipulates the number and priority-based topic choices for performance improvement projects that plans must conduct, and indicates that the State is committed to a higher level of quality monitoring and accountability for its health plans. Constellation Quality Health recommends that DOM continue to use measures from the annual network adequacy reviews, HEDIS audits, and performance improvement project validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its health plans. The 2022- 2023 EQR assessment results, including the identification of health plan strengths, weaknesses, and recommendations, attest to the positive impact of DOM's strategy in monitoring plan compliance, improving quality of care, and aligning healthcare goals with priority topics. The Quality Strategy outlined several DOM goals and standards that align with CMS priority areas. Based on these goals and standards, Constellation Quality Health developed recommendations to allow CCOs to fulfill the goals of the Quality Strategy. *Table 10: DOM Quality Strategy Goals* displays the recommendations for each goal.

Table 10: DOM Quality Strategy Goals

DOM Quality Strategy Goal	Recommendation
Make Care Affordable	• Assess utilization of services to determine appropriate spending and to reduce wasteful spending. • Ensure financial requirements are feasible for members.
Work with Communities to Promote Best Practices of Health Living	• Implement strategies to promote health equity, including targeted outreach and enrollment efforts, culturally competent care, and community-based interventions that address social and economic barriers to health. • Develop community-based programs to align with the ongoing needs and promote programs to members using various modes such as mailings, website announcements, and call center scripts.
Promote Effective Prevention and Treatment of Chronic Disease	• Monitor progress on HEDIS and non-HEDIS measures. • Ensure access to care is sufficient to allow members the ability to visit primary care providers and specialists. • Utilize interdisciplinary care teams comprising physicians,

DOM Quality Strategy Goal	Recommendation
	nurses, pharmacists, and allied health professionals to provide comprehensive and coordinated care to Medicaid patients with chronic diseases.
Make Care Safer by Reducing Harm Caused in the Delivery of Care	• Provide education to members regarding the importance of medication adherence. • Continue prenatal and postpartum care as a priority topic for performance improvement projects.
Strengthen Person and Family Engagement as Partners in their Care	• Retain accurate contact information for members to allow for consistent communication. • Empower Medicaid enrollees and their caregivers to actively participate in their care by providing them with education, resources, and support tools.
Promote Effective Communication and Coordination of Care	• Maintain transition of care processes to ensure efficient care. • Continue advancement of integrated care models by fostering communication and collaboration among providers, to enhance the quality of care.

Optional EQR Activities

The Mississippi Division of Medicaid has requested that Constellation Quality Health conduct optional EQR activities, including Behavioral Health Member Satisfaction Surveys for each of the CCOs.

Behavioral Health Member Satisfaction Survey

Constellation Quality Health contracted with DataStat, Inc. an NCQA Certified CAHPS Survey Vendor, to conduct an Experience of Care and Behavioral Health Outcomes (ECHO) Survey, developed by the Agency for Healthcare Research and Quality (AHRQ), to learn about the experiences of adult and child members who have received counseling or treatment from a provider. The survey addresses key topics such as access to counseling and treatment, provider communication, plan information, and overall rating of counseling and treatment received. For MississippiCAN, attempts were made to survey 2,250 adult Medicaid enrollee households, 2,250 child Medicaid enrollee households. For Mississippi CHIP, attempts were made to survey 1,500 enrollee households. The surveys for both MississippiCAN and Mississippi CHIP were conducted by mail during the period from October 27, 2023, through February 23, 2024, using a standardized survey procedure and questionnaire. See *Attachment 2* for a summary of the 2023 Behavioral Health Member Satisfaction Surveys.

BACKGROUND

As detailed in the *Executive Summary*, Constellation Quality Health, as the EQRO, conducts an EQR of the each CCO participating in the MississippiCAN (CAN) and Mississippi CHIP (CHIP) Medicaid Managed Care Programs on behalf of the Division of Medicaid. Federal Regulations require that EQRs include four mandatory activities: validation of performance improvement projects, validation of performance measures, validation of network adequacy, and an evaluation of compliance with state and federal regulations for each health plan.

In addition to the mandatory activities, Constellation Quality Health conducts a behavioral health member satisfaction survey.

After completing the annual review of the required EQR activities for each health plan, Constellation Quality Health submits a detailed technical report to DOM and to the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addressed the corrective actions from the previous year's review, if applicable. Annually, Constellation Quality Health prepares an annual comprehensive technical report, which is a compilation of the individual annual review findings, for the State. The comprehensive technical report for contract year 2023 through 2024 contains data regarding results of the EQRs conducted for the CAN and CHIP programs for United and Molina and the CAN program for Magnolia.

The report also includes findings of provider access studies and directory validations as well as the behavioral health member satisfaction survey conducted during this reporting period.

METHODOLOGY

The process used by Constellation Quality Health for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plan's office. After completing each annual review, Constellation Quality Health submits a detailed technical report to DOM and to the health plan (covered in the preceding section titled, Background). For a health plan not meeting requirements, Constellation Quality Health requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. Constellation Quality Health provides technical assistance to each health plan until all deficiencies are corrected. Following the initial acceptance of the CAP items, quarterly CAP reviews are completed to evaluate whether the health plan has fully implemented the corrective action items.

The following table displays the dates of the EQRs conducted for each health plan.

Table 11: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Conducted	Report Submitted to DOM
UnitedHealthcare CAN United Healthcare CHIP	7/5/23	10/4/23 – 10/5/23	11/14/23
Magnolia Health Plan CAN	7/5/23	10/18/23 – 10/19/23	11/27/23
Molina Healthcare CAN Molina Healthcare CHIP	7/5/23	11/1/23 – 11/2/23	12/13/23

FINDINGS

The plans were evaluated using the standards developed by Constellation Quality Health and summarized in the tables for each of the sections that follow. Constellation Quality Health scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an up arrow (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score from the previous review.

A. Administration

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

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

Each of the CCOs has established policies and procedures to guide staff in conducting the activities required by the *CAN* and *CHIP Contracts*. The health plans review all policies annually and as needed for changes in contractual requirements, regulations, and/or accreditation standards. New and revised policies are reviewed by appropriate committees for approval prior to implementation. However, Magnolia's Policy Management policy (CC.COMP.22) and Molina's Policy and Procedure Format and Review policy (MHMS-GC-28) incompletely document the committees involved in policy review and approval. Staff are educated about new and revised policies and can access policies on policy storage platforms and sites.

Review of the Organizational Charts and onsite discussions confirmed key positions were filled for each of the CCOs. Overall staffing is sufficient to ensure that all required services are provided to members.

The CCOs have written Compliance Plans, along with Fraud, Waste, and Abuse (FWA) Plans, to describe processes for ensuring compliance with laws, policies, and contractual requirements, and for preventing, detecting, and responding to FWA. Related policies and procedures provide additional, detailed information about these topics. In addition, each plan has written Codes of Conduct to provide staff with information about and expectations for appropriate business conduct.

Each CCO has a Compliance Committee to assist in developing and implementing the Compliance Programs. Charters describe the committees' purpose, functions, responsibilities, etc. and indicate meeting frequency (at least twice a year for United and quarterly for Magnolia and Molina). Issues related to the Compliance Committees were identified. For Magnolia, meeting minutes did not reflect attendance by a proxy/designee when voting members could not attend. For Molina, discrepancies were noted in documentation of the name of the executive-level Compliance Committee, and the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document incorrectly stated who chairs the Compliance Committee.

The CCOs require employees to complete education about the Compliance Program, appropriate business conduct, and FWA at the time of employment and annually. The health plans encourage open communication within the organization and educate staff about methods of reporting suspected compliance issues and/or FWA. Staff are also educated about consequences that may result from noncompliance and FWA. All three health plans have processes that allow anonymous reporting, ensure confidentiality, and they enforce no-retaliation policies for those making good faith reports of issues or concerns.

Pharmacy Lock-in Programs designed to detect, prevent, and/or respond to abuse of the pharmacy benefit are in place for each health plan. No issues with this program were identified for United. For Magnolia, the Pharmacy Lock-In Program policy (MS.PHAR.15) did not address the limitation of 72 hours for the emergency supply of medication. Molina's Pharmacy Lock-In Program policy (MHMS-PH-005) did not define the timeframe for notifying members of their inclusion in the Lock-in Program.,

Confidentiality, privacy, and protected health information (PHI) are addressed in policies that describe processes for the protection, use, and disclosure of PHI for only those purposes permitted or required by law.

Information Systems Capabilities Assessment

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

Review and assessment of each CCO's Information Systems Capabilities Assessment documentation and related policies and procedures indicated each organization's information systems infrastructure was capable of meeting contractual requirements. It was noted that all CCOs met or exceeded timelines for clean claims required by the State. The 2023 EQRs found that systems and processes are appropriately maintained and updated in accordance with policies that prioritize data security and system resilience. Disaster Recovery plans are tested and updated annually to identify risks and protect system data.

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

Table 12: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Key positions are filled, and staffing is sufficient for CCO's to conduct required activities and provide all required services to members.	✓		
Written Compliance Plans, Codes of Conduct, and policies define expectations and processes for ensuring compliance to laws, regulations, and accreditation standards.	✓		
Written Fraud, Waste, and Abuse Plans and related policies describe processes for preventing, detecting, responding to alleged or suspected fraud, waste, and abuse.	✓		
Mandatory compliance training is provided at employment and annually thereafter.	✓	✓	
The CCOs ensure confidentiality when reporting compliance and FWA concerns, provide anonymous reporting options, and ensure there is no retaliation for those making good-faith reports.	✓		
Staff are educated about the possible consequences of non-compliance and FWA.	✓		
The CCOs have established committees with appropriate membership to oversee the Compliance programs.	✓		
Each health plan has implemented a Pharmacy Lock-in Program to manage inappropriate and/or abuse of pharmacy benefits.	✓		✓
All CCOs provided documentation to demonstrate their infrastructure is capable of meeting DOM contractual and information systems requirements.	✓		
All CCOs performed sufficient regular risk assessments to identify potential risks to infrastructure and to aid in implementation of preventative measures.	✓		
All CCOs have the ability to perform Medicaid claims and encounter data processing as required by DOM.	✓		

Table 13: Administration Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Identified issues related to Compliance Committees included meeting minutes that did not reflect attendance by proxy or designee when voting members could not attend (Magnolia) and incorrect documentation of which staff member chairs the committee (Molina).	Ensure Compliance Committee attendance is appropriately documented for meetings and ensure documentation of who chairs the committee is correct.	✓		
Documentation of Pharmacy Lock-in Program requirements was incomplete in policies (Magnolia and Molina).	Ensure Pharmacy Lock-in Program policies completely document all requirements for the program, as detailed in the *CAN* and *CHIP Contracts*.	✓		✓

An overview of the scores for the Administration section is illustrated in *Table 14: Administration Comparative Data*.

Table 14: Administration Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
General Approach to Policies and Procedures					
The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Met	Met	Met
Organizational Chart / Staffing					
The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: Chief Executive Officer	Met	Met	Met	Met	Met
Chief Operating Officer	Met	Met	Met	Met	Met
Chief Financial Officer	Met	Met	Met	Met	Met
Chief Information Officer	Met	Met	Met	Met	Met
Information Systems personnel	Met	Met	Met	Met	Met
Claims Administrator	Met	Met	Met	Met	Met
Provider Services Manager	Met	Met	Met	Met	Met
Provider contracting and education	Met	Met	Met	Met	Met
Member Services Manager	Met	Met	Met	Met	Met
Member services and education	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
CAN: Complaint/Grievance Coordinator CHIP: Grievance and Appeals Coordinator	Met	Met	Met	Met	Met
Utilization Management Coordinator	Met	Met	Met	Met	Met
Medical/Care Management Staff	Met	Met	Met	Met	Met
Quality Management Director	Met	Met	Met	Met	Met
CAN: Marketing, member communication, and/or public relations staff CHIP: Marketing and/or Public Relations	Met	Met	Met	Met	Met
Medical Director	Met	Met	Met	Met	Met
Compliance Officer	Met	Met	Met	Met	Met
Operational relationships of CCO staff are clearly delineated	Met	Met	Met	Met	Met
Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*					
The CCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met
The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met
The CCO information management system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met
The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented	Met	Met	Met	Met	Met
Compliance/Program Integrity					
The CCO has a Compliance Plan to guard against fraud, waste and abuse	Met	Met	Met	Met	Met
The Compliance Plan and/or policies and procedures address requirements	Met	Met	Met	Met	Met
The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Met	Partially Met	Partially Met ↓	Partially Met ↓
The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met	Met
The CCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met
The CCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met	Met
The CCO implements and maintains a Pharmacy Lock-In Program	Met	Met	Partially Met ↓	Met	Met
Confidentiality *42 CFR § 438.224*					
The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met

B. Provider Services

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

The Provider Services review focused on processes for provider education, preventive health and clinical practice guidelines, the provider satisfaction survey, provider medical record documentation and maintenance, and network adequacy.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

The CCOs have policies and procedures for initial provider orientation and education. Initial orientation is conducted within 30 days of the contract effective date or active date. Initial provider education includes pertinent topics to allow providers to understand health plan processes and requirements. Provider Manuals and health plan websites reinforce the orientation and are comprehensive resources for providers. Constellation Quality Health noted issues in information found in the Provider Manuals and/or health plan websites related to:

- Obtaining care from nonparticipating providers (United CAN and CHIP) and exclusions for dental services (United CHIP).
- The limit on the number of home health visits (Molina CAN and CHIP). This was an uncorrected deficiency for Molina.
- An incorrect instruction to refer to the "well-child" section of the Provider Manual, which did not exist (United CHIP).
- Lack of information about medical record retention (United CAN) and requesting reassignment of a member to another primary care provider (United CAN and CHIP).

The CCOs conduct ongoing provider education to update providers about program changes and additions, process changes, member benefits, etc.

Policies define the medical record documentation standards to which network providers are expected to comply. Providers are educated about medical record documentation standards and record-keeping practices through the Provider Manuals, websites, and provider education activities. The CCOs assess provider compliance with the documentation and record-keeping requirements through routine medical record audits. Each CCO sets a scoring threshold for the medical record audits. Additional education is provided and reaudits are conducted for providers who do not meet the scoring threshold.

Practice Guidelines

§ 438.236, § 457.1233

United, Magnolia, and Molina adopt evidence-based clinical practice and preventive health guidelines that are specific to membership demographics and health care and service needs. The guidelines are used to guide quality and health management programs and provide current treatment preventive care information to providers. The guidelines are disseminated to providers through provider orientation, CCO websites, Provider Manuals, newsletters, special mailings, and faxes. Printed copies are available on request.

Provider Satisfaction Survey Validation

Constellation Quality Health conducted validation reviews of the CCOs' provider satisfaction surveys using the protocol developed by the Centers for Medicare and Medicaid Services (CMS) titled, "Protocol 6: Administration or Validation of Quality of Care Surveys." The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol includes seven activities:

1. Review survey purpose(s), objective(s), and intended use.
2. Assess the reliability and validity of the survey instrument.
3. Review the sampling plan.
4. Assess the adequacy of the response rate.
5. Review survey implementation.
6. Review survey data analysis and findings/conclusions.
7. Document evaluation of the survey.

United's survey was administered by Escalent, an independent research company. Magnolia and Molina's surveys were conducted by SPH Analytics/Press Gainey, a National Committee for Quality Assurance Certified Survey Vendor.

Table 15: Provider Satisfaction Survey Validation Results offers the sections of the worksheets that need improvement, the reasons, and the recommendations.

Table 15: Provider Satisfaction Survey Validation Results

Plan	Section	Reason	Recommendation
United CAN and CHIP	Do the survey findings have any limitations or problems with generalization of the results?	The survey had a response rate of 1.0%. This is a decrease from last year's rate of 1.2%.	Devise initiatives to increase provider responses to the survey.
Magnolia CAN	Do the survey findings have any limitations or problems with	The survey had a response rate of 7.9%. This is a decrease from last year's	Devise initiatives to increase provider responses to the survey.

Plan	Section	Reason	Recommendation
	generalization of the results?	rate of 9.2% and may lack external validity.	
Molina CAN and CHIP	Do the survey findings have any limitations or problems with generalization of the results?	The survey had a response rate of 5%. This is a decrease from last year's rate of 10.9% and below the internal goal of 30%.	Devise initiatives to increase provider responses to the survey.

Each of the CCOs' results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified were reported to applicable quality committees.

Network Adequacy Validation

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

Constellation Quality Health conducted a validation review of the CCOs' provider networks following the CMS protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plans' provider networks to determine if the CCOs are meeting network standards defined by the State. To conduct this validation, Constellation Quality Health requested and reviewed the following for each CCO:

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

Desk reviews of these documents were conducted to assess network adequacy. The CCOs' provider networks were found to be adequate and consistent with the requirements of the

CMS protocol, "Validation of Network Adequacy." An overview of the results for each activity conducted to assess network adequacy is found below.

Provider Network File Questionnaire

The purpose of the Provider Network File Questionnaire (PNFQ) is to learn more about each CCO's methods for classifying, storing, and updating provider enrollment data. Constellation Quality Health reviewed the information submitted by each health plan to determine if adequate procedures and processes are in place to maintain an accurate provider file directory. A summary of the findings is displayed in *Table 16*.

Table 16: Overview of Provider Network File Questionnaire Findings

Domain	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Data Management System	CSP Facets	CSP Facets	Portico	QNXT	QNXT
Data Verification	Portal update based on status information from the State	Portal update based on status information from the State	CenProv	Provider Data Team	Provider Data Team
Updates to Provider Directories	Daily except Sunday and Tuesday.	Daily except Sunday and Tuesday.	Daily	Daily	Daily
Geographic Access Reporting	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly

Availability of Services

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

United and Molina policies appropriately defined geographic access standards for primary care providers (PCPs), specialists, and other provider types. Magnolia's policy correctly stated geographic access standards for PCPs but did not include standards for specialty and other providers. The CCOs generate quarterly geographic access reports to evaluate their network against the required geographic access standards. Additional factors, such as results of member satisfaction surveys, complaints, grievances, out of network requests, and provider panel limitations, are considered when assessing network adequacy. The health plans promptly address any identified geographic access gaps.

United appropriately documented network provider appointment access standards for PCPs and specialists in policy, Member Handbooks, and Provider Manuals. Magnolia's policy did not address appointment access standards for specialists and the Member Handbook and Provider Manual included correct information. Molina's policy and Provider Manuals contained incorrect and/or incomplete information. For Molina, these issues were also noted in the previous EQR. The CCOs educate providers about appointment access standards and assess provider compliance through routine call studies. As noted in policies, United conducts quarterly call studies and Magnolia conducts annual call studies. Molina's policy did not define the frequency of conducting appointment access studies or the department or entity that conducts the audits. This was an uncorrected deficiency from the previous EQR.

Health plan Provider Directories include all required elements. The CCOs validate information included in the Provider Directories through automated systems, conducting outreach campaigns to validate provider information, etc.

To ensure their networks can meet the needs of members with hearing or vision impairment, foreign language or cultural requirements, complex medical needs, and accessibility considerations, the CCOs routinely assess member/practitioner race, ethnicity, and languages, monitor member satisfaction with the network, conduct disparity assessments, produce cultural competency plans, and include cultural competency resources on plan websites.

In addition to the activities documented above, Constellation Quality Health conducted and considered the results of Telephone Access Studies and Provider Directory Validations for each CCO. For United and Magnolia, Constellation Quality Health conducted the most recent Telephone Access Study and Provider Directory Validation in Q1 2024. For Molina, Constellation Quality Health conducted the most recent Telephone Access Study in Q4 2023. The most recent surveys for all the CCOs identified overall improvement in successful contact and Provider Directory accuracy rates; however, weaknesses continue to include the availability of routine and urgent appointments. *Table 17* provides an overview of the findings of the most recent studies.

Table 17: Overview of Call Study/Provider Directory Findings

	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Successful Contact Rates	68%	72%	66%	47%	61%
Provider Directory Accuracy Rates	92%	93%	85%	90%	88%
Routine Appointment Availability	79%	20%	49%	17%	6%

	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Urgent Appointment Availability	5%	5%	17%	2%	0%

The results of the most recent Provider Access and Provider Directory Validation studies demonstrated improvement across all five CCOs for successful contact rates and provider directory accuracy rates. The routine and urgent appointment availability rates, however, declined for all five CCOs, indicating an opportunity for improvement regarding timely access to care for enrollees.

Tables 18 and *19* display the strengths, weaknesses, and recommendations for the Provider Services section.

Table 18: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Policies and procedures define processes for conducting initial provider orientation and education.	✓		✓
Initial provider orientation follows training plans and/or checklists and includes appropriate topics.	✓		✓
Ongoing provider education is provided through a variety of forums.	✓		✓
Appropriate processes are followed for adopting, reviewing, and educating providers about preventive health and clinical practice guidelines.	✓		✓
Policies address routine medical record audit processes to assess provider compliance with medical record documentation standards. The policies indicate appropriate follow-up activities are implemented as needed.	✓		
Geographic access studies are conducted using appropriate access parameters, and provider compliance with appointment access standards is assessed through secret shopper call studies.			✓
Member satisfaction, complaint, and grievance data are considered when assessing network adequacy.			✓
The health plans take action to address any identified network gaps.	✓		✓
Cultural competency programs are in place to ensure health plan networks can serve members with diverse cultural and language needs, accessibility considerations, and other special needs.	✓		✓
Each of the health plans maintains both online and printed Provider Directories that include all required elements.			✓
All three health plans demonstrated appropriate procedures to store, update, verify, and evaluate provider contact information.			✓

Strengths	Quality	Timeliness	Access to Care
Time and distance access reports are conducted quarterly to provide monitoring of member travel requirements for all provider types.	✓	✓	✓
Provider access study successful contact rates and provider directory accuracy rates improved for all the health plans.	✓		✓

Table 19: Provider Services Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Magnolia's policies do not specify geographic access parameters for any providers other than PCPs.	Ensure all required geographic access standards are addressed in health plan policies.	✓		✓
Appointment access standards are incompletely and/or incorrectly documented in Magnolia's and Molina's policies and Provider Manuals.	Ensure policies and Provider Manuals completely and correctly document required appointment access standards.		✓	✓
Molina's policies did not define the frequency of conducting appointment access studies or the department or entity that conducts the studies.	Ensure policies address the frequency of appointment access studies and the department or entity that conducts the studies.	✓		✓
United and Molina incompletely or incorrectly document member benefits information in Provider Manuals and/or websites.	Ensure documentation of member benefits is complete and correct in Provider Manuals and websites.	✓		✓
United did not include information in Provider Manuals that PCPs must contact the health plan regarding assigning a member to an alternate PCP.	Ensure Provider Manuals completely address requirements for PCPs to request a member be assigned to an alternate PCP.			✓
Low provider satisfaction survey response rates may not reflect the population of providers and results should be interpreted with caution.	Devise initiatives to increase provider responses to the survey.	✓		
No improvement was noted in routine and urgent appointment availability for the Access Studies and Provider Directory Validations conducted by Constellation Quality Health.	Implement activities, such as provider re-education, to improve appointment availability compliance.			✓

Table 20: Provider Services Comparative Data displays the CCOs' scores for the standards reviewed during the 2023 EQR.

Table 20: Provider Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)*					
The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: The CCO has policies and procedures for notifying primary care providers of the members assigned	Met	Met	Met	Met	Met
The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met	Met	Met	Met
The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Met	Met	Met	Met ↑	Met ↑
Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties	Met	Met	Met	Met	Met
Members have access to specialty consultation from network providers located within the contract specified geographic access standards	Met	Met	Partially Met ↓	Met	Met
The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met	Met	Met	Met
Providers are available who can serve members with special needs, foreign language/cultural requirements, complex medical needs, and accessibility considerations	Met	Met	Met	Met	Met
The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met
The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy	Met	Met	Met	Met	Met
The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues	Met	Met	Met	Met	Met
The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met	Partially Met	Not Met ↓	Not Met ↓

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards	Met	Met	Met	Not Met	Not Met
The CCO regularly maintains and makes available a Provider Directory that that includes all required elements	Met ↑	Met ↑	Met	Met	Met
The CCO conducts appropriate activities to validate Provider Directory information	Met	Met	Met	Met	Met
The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "*Validation of Network Adequacy*"	Met	Met	Met	Met	Met
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*					
The CCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met	Met
Initial provider education includes: A description of the Care Management system and protocols	Met	Met	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met	Met	Met
CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	Met ↑	Met ↑	Met ↑	Not Met ↓	Partially Met
Procedure for referral to a specialist including standing referrals and specialists as PCPs	Met	Met	Met	Met	Met
Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Met ↑	Met	Met	Met
CAN: Recommended standards of care including EPSDT screening requirements and services CHIP: Recommended standards of care including Well-Baby and Well-Child screenings and services	Met	Met	Met	Met	Met
CAN: Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services CHIP: Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services	Met	Met	Met	Met	Met
Medical record handling, availability, retention, and confidentiality	Partially Met ↓	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Provider and member complaint, grievance, and appeal procedures including provider disputes	Met	Met	Met	Met	Met
Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Met	Met	Met	Met	Met
Prior authorization requirements including the definition of medically necessary	Met	Met	Met	Met	Met
A description of the role of a PCP and the reassignment of a member to another PCP	Partially Met ↓	Partially Met ↓	Met	Met	Met
The process for communicating the provider's limitations on panel size to the CCO	Met	Met	Met	Met	Met
Medical record documentation requirements	Met	Met	Met	Met	Met
Information regarding available translation services and how to access those services	Met	Met	Met	Met	Met
Provider performance expectations including quality and utilization management criteria and processes	Met	Met	Met	Met	Met
A description of the provider web portal	Met	Met	Met	Met	Met
A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Met	Met	Met	Met	Met
The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures	Met	Met	Met	Met	Met
Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*					
The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, and that are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met
The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members	Met	Met	Met ↑	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: CAN: Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services CHIP: Pediatric and Adolescent preventive care with a focus on Well-Baby and Well-Child services	Met	Met	Met	Met	Met
Recommended childhood immunizations	Met	Met	Met	Met	Met
Pregnancy care	Met	Met	Met	Met	Met
Adult screening recommendations at specified intervals	Met	N/A	Met	Met	N/A
Elderly screening recommendations at specified intervals	Met	N/A	Met	Met	N/A
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met
Behavioral health	Met	Met	Met	Met	Met
Practitioner Medical Records					
The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians	Met	Met	Met	Met	Met
The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers	Met	Met	Met	Met	Met
Provider Satisfaction Survey					
A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met	Met
The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met	Met	Met	Met
The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified	Met	Met	Met	Met	Met

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

C. Member Services

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

The Member Services review includes 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.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

The CCOs document member rights and responsibilities in policies. Molina's policy did not include all contractually required responsibilities. The health plans inform members of their rights and responsibilities through the Member Handbooks and the CCOs' websites. Additional methods are used by each CCO to educate members about their rights and responsibilities, including welcome letters/packets, member newsletters, and various mailings.

Member CCO Program Education

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

Welcome packets for new members include Member Handbooks, ID cards, welcome letters, benefit booklets, health plan contact information, information about the CCOs' websites, and various forms, and/or brochures. Notification about each health plan's processes for PCP assignment/selection, covered benefits, applicable copays, programs, and services are provided via new member packets, Member Handbooks, newsletters, text platform initiatives, etc. Issues were found with Molina's documentation of member benefits, including home health visit limitations, emergency ambulance services, and eye care/vision services. For Molina, the issue related to documentation of the limited number of home health visits was a repeated finding from the previous EQR. The health plans provide member education through local health fairs and other community events.

Processes are in place to ensure member materials are accessible to members and easily understood, using the contractually required sixth grade reading level and font sizes. The health plans offer member materials in alternate languages and formats and provide free translation and interpreter services when needed. United, Molina, and Magnolia inform members of their right to obtain a copy of the Member Handbook and Provider Directory at least annually. The reviews revealed all the CCOs inform members in writing of changes in services and benefits thirty days prior to the effective date of the benefit change. However, Molina's policies did not address processes for making members aware of benefit/service changes.

Each CCO provides contact numbers and hours of operation to members for Call Center assistance and member support. The review revealed Molina incorrectly documented the Member Services Call Center hours of operation in policy. Call Center personnel are trained to incorporate interactive scripts when speaking with members. These scripts are reviewed annually. Targets for call center performance/call metrics are defined by DOM and analyzed by each CCO.

Preventive Health and Chronic Disease Management Education

Member Handbooks include brief information about preventive health services and wellness programs. Members are instructed to contact Member Services with questions, for assistance, and information. Members are educated about population health activities and additional recommendations through member newsletters, mailings, automated and live calls, e-mails, text messages, and events such as health fairs and other health promotion events.

Member Enrollment and Disenrollment

42 CFR § 438.56

Each CCO has appropriate processes in place for member disenrollment. Circumstances under which members may request "for cause" disenrollment and under which members may be involuntarily disenrolled are described in member materials. Member Handbooks address member disenrollment requirements and instruct members to contact DOM in writing or by telephone to request disenrollment and/or a change in health plan.

Grievances

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

Processes for filing and handling grievances are outlined in policies. The CCO's Member Handbooks, Provider Manuals, and websites define grievance terminology and provide the associated timeframes for resolving or extending grievances. A sample of grievance files was reviewed for each CCO for the 2023 EQR and all were found to be acknowledged and resolved timely. For Molina, multiple CAN and CHIP grievance resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no steps were provided in the letters. Instead, the members were asked to contact the Member Services Department after the grievance was closed.

Member Satisfaction Survey Validation

As contractually required, the health plans conducted the Adult, Child and Child with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Using "Protocol 6: Administration or Validation of Quality of Care Surveys" developed by CMS, Constellation Quality Health conducted a validation to ensure that the survey results were

reliable and valid. The results of the validation found the generalizability of the survey results was difficult to discern due to low response rates. Recommendations were offered for the CCOs to work with their survey vendors on strategies to increase the response rates. *Table 21: Member Satisfaction Survey Validation Results* provides information about the areas that need improvement.

Table 21. Member Satisfaction Survey Validation Results

Plan	CAHPS Survey Version	Section	Reason
United CAN	Adult	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 16.1% (299 out of 1857) which is an improvement from last year's response rate but below the target rate of 40%.
United CAN	Child with Chronic Conditions	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 10.8% (212 out of 1972) which is an improvement over the previous year's response rate but below the target rate of 40%.
United CHIP	Child with Chronic Conditions	Do the survey findings have any limitations or problems with generalization of the results?	Child CCC response rate was 14.4% for MY2022 (283 out of 1972) which is an improvement over the previous year's response rate but below the target rate of 40%.
Magnolia CAN	Adult	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 19.4% which is an improvement from last year's response rate but below the target rate of 40%.
Magnolia CAN	Child with Chronic Conditions	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 13.4% for MY2022 (212 out of 1972) which is an improvement over the previous year's response rate but below the target rate of 40%.
Magnolia	Child	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 16.7% for MY2022 which is an improvement over the previous year's response rate but below the target rate of 40%.
Molina CAN	Adult	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 10.8% (216 out of 2025 which is an improvement from last year's response rate but below the target rate of 40%.
Molina CAN	Child	Do the survey findings have any limitations or problems	The response rate was 7.7% for 2022 (570 out of 7425) which is an improvement over

Plan	CAHPS Survey Version	Section	Reason
		with generalization of the results?	the previous year's response rate but below the target rate of 40%.
Molina CHIP	Child	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 11.9% which is a slight decline from the previous year's rate but below the target rate of 40%.

Strengths, weaknesses, and recommendations for the Member Services section of the review are found in *Table 22* and *Table 23*.

Table 22: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
The health plans educate members about their rights and responsibilities. The rights and responsibilities are documented consistently across policies, Member Handbooks, Provider Manuals, and the CCOs websites.	✓		✓
Overall, the Member Handbooks are comprehensive resources for members to understand their benefits, applicable copays, health plan processes, etc.			✓
Call center performance for each CCO is monitored to identify opportunities for improvement, and action is taken to address any identified opportunities.	✓		✓
Review of a sample of grievance files revealed all health plans acknowledged and resolved grievances timely.		✓	
All the health plans use certified survey vendors for member satisfaction survey administration.	✓		
In general, member satisfaction survey response rates improved from the previous year's EQR.	✓		
The three health plans showed assessment of barriers and interventions to address member satisfaction concerns.	✓		✓

Table 23: Member Services Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina's policy did not include all contractually required member responsibilities.	Ensure policies address all contractually required responsibilities.	✓		
Issues were found with Molina's documentation of member benefits, including home health visit limitations,	Ensure member benefits are correctly documented.			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
emergency ambulance services, and eye care/vision services.				
Molina's policies did not address processes for making members aware of benefit/service changes.	Ensure policies appropriately address processes for notifying members of changes in benefits and services.			✓
Molina incorrectly documented the Member Services Call Center hours of operation in policy.	Ensure policies correctly document the hours of operation for the Member Services Call Center.	✓		✓
For Molina, multiple CAN and CHIP grievance resolution letters indicated steps had been taken to resolve the grievance but did not include the actions taken in the resolution letters. Instead, members were asked to contact the Member Services Department after the grievance was closed.	Ensure processes defined in health plan policy for handling grievances are followed.	✓		✓
Member Satisfaction Survey response rates are below the NCQA target of 40% for all health plans.	Continue to determine ways to advertise member satisfaction surveys and increase response rates. Utilize expertise from survey vendors about strategies to increase response rates.	✓		

An overview of the scores for the Member Services section is illustrated in *Table 24: Member Services Comparative Data*.

Table 24: Member Services Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*					
The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met	Met
All member rights included	Met	Met	Met	Met	Met
All member responsibilities included	Met	Met	Met	Partially Met ↓	Partially Met ↓
Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*					
Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the	Met ↑	Met ↑	Met	Partially Met	Partially Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled					
Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Met	Met	Partially Met ↓	Partially Met ↓
Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract	Met	Met	Met	Met	Met
The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages	Met	Met	Met	Met	Met
Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed	Met	Met	Met	Met	Met
CAN: Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members	Met	N/A	Met	Met	N/A
Call Center					
The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Met	Met	Met	Partially Met ↓	Partially Met ↓
Call Center scripts are in-place and staff receive training as required by the contract	Met	Met	Met	Met	Met
Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee	Met	Met	Met	Met	Met
Member Enrollment and Disenrollment *42 CFR § 438.56*					
The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met	Met	Met
Member disenrollment is conducted in a manner consistent with contract requirements	Met	Met	Met	Met	Met
Preventive Health and Chronic Disease Management Education					
The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program	Met	Met	Met	Met	Met
CAN: The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits CHIP: The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met
The CCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met
Member Satisfaction Survey					
The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Met	Met	Met	Met
The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Met	Met
The CCO reports results of the member satisfaction survey to providers	Met	Met	Met	Met	Met
The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee	Met	Met	Met	Met	Met
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*					
The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	Met	Met	Met	Met	Met
Definition of a grievance and who may file a grievance	Met	Met	Met	Met	Met
The procedure for filing and handling a grievance	Met ↑	Met ↑	Met	Met	Met
Timeliness guidelines for resolution of grievances as specified in the contract	Met ↑	Met ↑	Met ↑	Met	Met
Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met	Met	Met	Met	Met
Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO applies the grievance policy and procedure as formulated	Met	Met	Met	Partially Met ↓	Partially Met ↓
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee	Met	Met	Met	Met	Met
Grievances are managed in accordance with CCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Practitioner Changes					
The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction	Met	Met	Met	Met	Met
Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee	Met	Met	Met	Met	Met

D. Quality Improvement

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

The Quality Improvement (QI) Programs developed by the CCOs focus on the health care and services their members receive and include all aspects of health care quality. The health plans provided copies of their QI program descriptions. The program descriptions included specific goals, objectives, and priorities to help achieve their overall goals. Molina's QI Program Description had six appendices that were not included in the document received. Also, the section titled "Implementing a Credentialing Program" was outdated. This section indicates Molina maintains a comprehensive and detailed credentialing program. However, DOM has instituted a centralized credentialing process for all Medicaid providers and is no longer requiring the CCOs to conduct credentialing activities.

Information about the QI Program is shared with providers and members through each health plan's website, Provider Manuals, and Member Handbooks. However, the QI Program Description found on Magnolia's website was the 2022 QI Program Description and not the 2023 QI Program Description.

The reduction of health disparities is addressed through the health plans' Health Equity Programs. The goals of these programs are to reduce health disparity and improve culturally and linguistically appropriate services. Specific measures have been chosen to improve the health disparities for the CAN and CHIP populations. Magnolia achieved full Health Equity Accreditation in 2022.

Annually, the health plans develop a QI work plan to identify and track the planned QI activities. Constellation Quality Health received the 2022 and 2023 QI work plans for each health plan. Both work plans included the yearly quality improvement activities, the individual responsible for each task, target dates, quarterly updates, and any previously identified issues.

For CAN and CHIP, United had five specific goals outlined in the 2023 QI work plan. Those goals included improving specific HEDIS measures, CAHPS measures, provider satisfaction, EPSDT rates, and HEDIS measures associated with the Performance Improvement Projects.

Molina's 2023 QI Work Plan includes the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one. Also, there were several errors and/or missing information in the 2023 QI Work Plan.

The CCO's have established QI committees charged with oversight of their QI programs. The QI committees act as oversight committees and receive regular reports from other departments and/or subcommittees that are accountable to the committee. Members of these committees include the health plans' Chief Medial Officers, quality leads, senior managers, and other staff responsible for key functions within the organization. Participating network providers specializing in a wide variety of specialties serve as voting members.

The CCOs require their network providers to actively participate in QI activities, and each CCO provides feedback on provider performance via gaps in care reports, dashboards, and monitoring provider compliance with the CCO's practice guidelines. United monitors provider compliance with clinical and preventive health as outlined in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines. On an annual basis the health plan measures at least two clinical guidelines that address a high-volume or high-risk condition.

Magnolia's 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. The guidelines monitored are Diabetes Care, Prenatal Care, Attention Deficit and Hyperactivity Disorder, and Depression.

Molina's Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, indicates Molina annually measures performance against at least two important aspects of the clinical practice guidelines. During the onsite, Constellation Quality Health questioned Molina regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided.

The CCOs provide coverage for all early and periodic screenings, diagnosis, and treatment (EPSDT) services (Well Baby/Well Child screenings for CHIP). The DOM contract requires the CCOs to have a tracking system that provides information on member compliance with EPSDT and Well Baby/Well Child services including the diagnosis, treatment, and/or referrals needed. United, Magnolia, and Molina have developed a tracking system. Molina's tracking process indicated staff utilized the Claims Lookup tool to identify all claims members received after the original EPSDT/Well Child exam to determine potential diagnosis and referral/follow-up. If no claims could be associated as a referral, the list is passed to designated staff to call the member. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. This was an issue for Molina that was previously identified during the 2020, 2021, and 2023 EQRs and that has not been corrected.

An annual review of the overall effectiveness of the QI Programs is conducted by each CCO. The results of the annual review are used to develop and prioritize the next year's activities. United, Magnolia, and Molina submitted their 2022 QI Program Evaluations. United and Magnolia's evaluations were complete and included the analysis for each activity as well as identified barriers and opportunities. Molina's was incomplete and did not include all the results of the QI activities conducted in 2022. The results of the Geo Access reports referenced in Section Five and the Provider Directory analysis referenced in Section 11 of the 2022 QI Work Plan were not included. This continues to be an issue for Molina and was previously identified in the 2020, 2021, and 2022 EQRs. The *CAN Contract, Section 10 (D)* and *Exhibit G*, and the *CHIP Contract, Section 9 (D)* and *Exhibit F*, require the QI Program Annual Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Health plans are required to have an ongoing improvement program and report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. DOM has selected a set of performance measures (PMs) to evaluate the quality of care and services delivered by the plans to its members. To evaluate the accuracy of the PMs reported, Constellation Quality Health contracted with Aqurate Health Data Management, Inc. (Aqurate), an NCQA Licensed Organization (LO) certified to conduct HEDIS Compliance audits, to conduct a validation review. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS® measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation following the CMS-developed

protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2022, through December 31, 2022.

HEDIS® Measure Overview for CAN Programs

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure HEDIS rates were accurate and reliable, DOM also required each CCO to undergo an NCQA HEDIS Compliance Audit. The three CCOs contracted with an NCQA-licensed organization to conduct the HEDIS audits. Aqurate reviewed each CCO's final audit reports, Information Systems Capabilities Assessments, and the Interactive Data Submission System files approved by the CCOs' NCQA licensed organizations. Aqurate found that the CCOs' information systems and processes were compliant with the applicable information system standards and the HEDIS reporting requirements.

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. Several aspects crucial to the calculation of PM data reviewed included: data integration, data control, and documentation of PM calculations. The following are some of the main steps conducted during the 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 CCOs, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined the data integration processes were acceptable.
- **Data Control**—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 CCOs' data control processes and determined that the 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 each CCO. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmaps, 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 was acceptable.

The CCOs rates based on audit reports for the most recent review year are reported in *Table 25: HEDIS® Performance Measure Data for CAN Programs*. The statewide average is calculated as the average of the health plan rates and shown in the last column of the table.

Rates highlighted in green showed a substantial improvement of more than 10 percentage points year over year. The rates highlighted in red indicate a substantial decrease in the rate of more than 10 percentage points.

Table 25: HEDIS® Performance Measure Data for CAN Programs

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
Effectiveness of Care: Prevention and Screening				
Adult BMI Assessment (aba)	51.38%	44.79%	41.31%	45.31%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)				
BMI Percentile	69.10%	58.39%	54.50%	60.67%
Counseling for Nutrition	51.09%	51.09%	42.09%	48.09%
Counseling for Physical Activity	47.69%	48.66%	40.63%	45.66%
Childhood Immunization Status (cis)				
DTaP	77.13%	72.51%	73.24%	74.29%
IPV	92.94%	89.05%	89.05%	90.35%
MMR	90.75%	87.35%	87.83%	88.65%
HiB	89.54%	84.91%	84.43%	86.29%
Hepatitis B	93.43%	89.78%	90.27%	91.16%
VZV	90.27%	87.35%	87.35%	88.32%
Pneumococcal Conjugate	77.62%	74.45%	72.99%	75.02%
Hepatitis A	80.29%	78.83%	80.05%	79.72%
Rotavirus	74.70%	74.45%	73.72%	74.29%
Influenza	24.82%	28.47%	25.30%	26.20%
Combination #3	70.07%	67.15%	67.40%	68.21%
Combination #7	57.91%	55.23%	56.69%	56.61%
Combination #10	19.22%	20.68%	20.19%	20.03%
Immunizations for Adolescents (ima)				
Meningococcal	51.58%	57.66%	50.12%	53.12%
Tdap/Td	76.16%	79.32%	76.40%	77.29%
HPV	23.36%	25.30%	15.09%	21.25%
Combination #1	51.34%	57.42%	49.64%	52.80%
Combination #2	22.63%	24.33%	13.63%	20.19%
Lead Screening in Children (lsc)	67.15%	65.80%	63.99%	65.77%
Breast Cancer Screening (bcs)	47.26%	52.23%	42.56%	49.71%
Cervical Cancer Screening (ccs)	54.99%	54.26%	53.04%	54.10%
Chlamydia Screening in Women (chl)				
16-20 Years	20.05%	21.78%	15.96%	20.50%
21-24 Years	42.60%	47.56%	26.56%	43.68%
Total	38.76%	43.33%	24.61%	39.78%
Effectiveness of Care: Respiratory Conditions				

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
Appropriate Testing for Children with Pharyngitis (cwp)				
Appropriate Testing for Pharyngitis (3-17)	74.59%	74.96%	75.14%	74.84%
Appropriate Testing for Pharyngitis (18-64)	65.03%	63.76%	62.86%	64.06%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	73.31%	73.59%	72.92%	73.37%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	19.95%	22.27%	21.43%	21.29%
Pharmacotherapy Management of COPD Exacerbation (pce)				
Systemic Corticosteroid	50.76%	47.92%	48.65%	49.12%
Bronchodilator	78.40%	77.34%	74.32%	77.38%
Asthma Medication Ratio (amr)				
5-11 Years	82.22%	83.00%	80.77%	82.43%
12-18 Years	78.52%	71.14%	66.67%	73.95%
19-50 Years	61.42%	60.70%	57.83%	60.61%
51-64 Years	56.25%	56.20%	50.00%	55.34%
Total	75.79%	73.21%	69.53%	73.86%
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (cbp)	60.34%	53.77%	47.45%	53.85%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	52.94%	80.43%	NA	67.39%*
Statin Therapy for Patients with Cardiovascular Disease (spc)				
Received Statin Therapy - 21-75 years (Male)	79.83%	74.90%	78.23%	77.11%
Statin Adherence 80% - 21-75 years (Male)	58.48%	56.54%	39.18%	55.08%
Received Statin Therapy - 40-75 years (Female)	71.66%	72.98%	77.22%	72.82%
Statin Adherence 80% - 40-75 years (Female)	47.53%	51.89%	44.26%	49.57%
Received Statin Therapy - Total	75.72%	73.94%	77.83%	75.01%
Statin Adherence 80% - Total	53.26%	54.26%	41.14%	52.46%
Cardiac Rehabilitation (cre)				
Cardiac Rehabilitation - Initiation (18-64)	NQ	3.59%	1.75%	3.17% **
Cardiac Rehabilitation - Engagement1 (18-64)	NQ	5.13%	1.75%	4.37% **
Cardiac Rehabilitation - Engagement2 (18-64)	NQ	1.54%	1.75%	1.59% **
Cardiac Rehabilitation - Achievement (18-64)	NQ	0.00%	0.00%	0.00% **
Cardiac Rehabilitation - Initiation (65+)	NQ	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (65+)	NQ	NA	NA	NA
Cardiac Rehabilitation - Engagement2 (65+)	NQ	NA	NA	NA
Cardiac Rehabilitation - Achievement (65+)	NQ	NA	NA	NA
Cardiac Rehabilitation - Initiation (Total)	NQ	3.55%	1.75%	3.15% **
Cardiac Rehabilitation - Engagement1 (Total)	NQ	5.08%	1.75%	4.33% **
Cardiac Rehabilitation - Engagement2 (Total)	NQ	1.52%	1.75%	1.57% **
Cardiac Rehabilitation - Achievement (Total)	NQ	0.00%	0.00%	0.00% **

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
Effectiveness of Care: Diabetes				
Hemoglobin A1c Control for Patients With Diabetes (hbd)				
Hemoglobin A1c (HbA1c) Testing	NA	NA	NA	NA
PoorHbA1cControl	45.01%	49.15%	58.15%	50.77%
AdequateHbA1cControl	45.01%	42.34%	34.06%	40.47%
Eye Exam for Patients with Diabetes (eed)	59.61%	63.99%	52.31%	58.64%
Blood Pressure Control for Patients With Diabetes (bpd)	64.48%	57.42%	47.45%	56.45%
Kidney Health Evaluation for Patients With Diabetes (ked)				
Kidney Health Evaluation for Patients With Diabetes (18-64)	21.99%	17.01%	16.92%	18.90%
Kidney Health Evaluation for Patients With Diabetes (65-74)	NA	32.26%	NA	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	21.92%	17.10%	16.89%	18.92%
Statin Therapy for Patients with Diabetes (spd)				
Received Statin Therapy	61.09%	62.46%	53.23%	61.19%
Statin Adherence 80%	52.05%	49.77%	38.46%	49.86%
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (amm)				
Effective Acute Phase Treatment	49.07%	49.53%	59.77%	50.89%
Effective Continuation Phase Treatment	30.90%	30.85%	37.78%	31.91%
Follow-Up Care for Children Prescribed ADHD Medication (add)				
Initiation Phase	49.82%	55.14%	36.56%	50.36%
Continuation and Maintenance (C&M) Phase	66.57%	71.08%	59.35%	67.68%
Follow-Up After Hospitalization for Mental Illness (fuh)				
6-17 years - 30-Day Follow-Up	66.96%	65.34%	61.71%	65.42%
6-17 years - 7-Day Follow-Up	39.86%	36.49%	39.29%	38.20%
18-64 years - 30-Day Follow-Up	50.80%	55.51%	47.61%	52.01%
18-64 years - 7-Day Follow-Up	28.31%	31.79%	24.43%	28.90%
65+ years - 30-Day Follow-Up	NA	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	NA
30-Day Follow-Up	59.84%	61.59%	54.66%	59.72%
7-Day Follow-Up	34.77%	34.72%	31.86%	34.26%
Follow-Up After Emergency Department Visit for Mental Illness (fum)				
6-17 years - 30-Day Follow-Up	55.73%	54.49%	50.67%	54.14%
6-17 years - 7-Day Follow-Up	39.69%	37.82%	30.67%	37.02%
18-64 years - 30-Day Follow-Up	40.15%	48.06%	32.59%	41.92%

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
18-64 years - 7-Day Follow-Up	24.91%	28.62%	19.26%	25.33%
65+ years - 30-Day Follow-Up	NA	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	NA
Total - 30-Day Follow-Up	45.25%	50.34%	39.05%	46.14%
Total- 7-Day Follow-Up	29.75%	31.89%	23.33%	29.36%
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	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	41.63%	41.46%	41.28%	41.49%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	30.14%	34.76%	28.44%	31.33%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NA	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days (Total)	41.04%	40.83%	40.71%	40.89%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	29.72%	33.73%	27.43%	30.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)				
30-Day Follow-Up: 13-17 Years	28.30%	28.26%	NA	25.86%*
7-Day Follow-Up: 13-17 Years	24.53%	15.22%	NA	18.97%*
30-Day Follow-Up: 18+ Years	26.52%	27.72%	24.17%	26.60%
7-Day Follow-Up: 18+ Years	15.65%	15.79%	12.50%	15.18%
30-Day Follow-Up: Total	26.78%	27.79%	22.63%	26.50%
7-Day Follow-Up: Total	16.94%	15.71%	12.41%	15.71%
Pharmacotherapy for Opioid Use Disorder (POD)				
Pharmacotherapy for Opioid Use Disorder (16-64)	31.64%	28.66%	30.43%	30.28%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	31.28%	28.93%	30.43%	30.23%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	69.40%	69.64%	69.94%	69.58%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	74.16%	74.58%	58.67%	72.96%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	77.08%	74.47%	NA	75.25%*
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	56.37%	58.23%	53.16%	56.91%

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)				
Blood Glucose Testing (1-11)	35.45%	37.39%	35.20%	36.40%
Cholesterol Testing (1-11)	24.64%	26.99%	23.98%	25.75%
Blood Glucose and Cholesterol Testing (1-11)	21.90%	24.56%	21.43%	23.19%
Blood Glucose Testing (12-17)	47.12%	49.32%	49.72%	48.48%
Cholesterol Testing (12-17)	31.64%	33.83%	29.78%	32.44%
Blood Glucose and Cholesterol Testing (12-17)	28.85%	30.75%	26.97%	29.51%
Blood Glucose Testing (Total)	42.71%	44.49%	44.57%	43.79%
Cholesterol Testing (Total)	29.00%	31.07%	27.72%	29.84%
Blood Glucose and Cholesterol Testing (Total)	26.22%	28.25%	25.00%	27.05%
Effectiveness of Care: Overuse/Appropriateness				
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.22%	NQ	1.35%	1.25% **
Appropriate Treatment for Upper Respiratory Infection (uri)				
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	73.42%	73.20%	75.07%	73.68%
Appropriate Treatment for Upper Respiratory Infection (18-64)	56.30%	58.47%	56.38%	57.29%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	71.70%	71.61%	73.46%	72.04%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	50.85%	50.27%	59.23%	47.32%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	40.10%	41.85%	32.37%	60.22%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	49.35%	49.01%	56.98%	49.01%
Use of Imaging Studies for Low Back Pain (lbp)	71.34%	71.42%	69.80%	28.90%
Use of Opioids at High Dosage (hdo)	0.78%	1.37%	0.44%	1.00%
Use of Opioids from Multiple Providers (uop)				
Multiple Prescribers	17.99%	13.42%	24.18%	16.59%
Multiple Pharmacies	1.39%	1.03%	1.73%	1.27%
Multiple Prescribers and Multiple Pharmacies	0.76%	0.55%	0.86%	0.68%
Risk of Continued Opioid Use (cou)				
18-64 years - >=15 Days covered	5.67%	3.93%	2.17%	4.26%
18-64 years - >=31 Days covered	3.65%	2.62%	1.21%	2.75%
65+ years - >=15 Days covered	NA	NA	NA	NA

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
65+ years – >=31 Days covered	NA	NA	NA	NA
Total – >=15 Days covered	5.66%	3.92%	2.17%	4.26%
Total – >=31 Days covered	3.65%	2.62%	1.21%	2.75%
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (aap)				
20–44 Years	82.95%	83.73%	80.71%	82.84%
45–64 Years	88.95%	90.28%	84.15%	89.04%
65+ Years	78.38%	78.69%	NA	78.33%
Total	85.54%	86.62%	81.72%	85.41%
Annual Dental Visit (adv)				
2–3 Years	49.04%	51.32%	53.82%	51.34%
4–6 Years	69.63%	69.60%	61.19%	68.14%
7–10 Years	72.18%	71.19%	62.97%	70.13%
11–14 Years	67.51%	67.12%	57.85%	65.86%
15–18 Years	60.10%	59.38%	50.49%	58.43%
19–20 Years	40.11%	43.60%	33.24%	40.72%
Total	64.97%	64.83%	57.13%	63.54%
Initiation and Engagement of AOD Dependence Treatment (iet)				
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	72.34%	81.25%	NA	73.87% *
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	4.26%	6.25%	NA	4.50% *
Opioid abuse or dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13–7 Years	59.51%	63.14%	56.00%	60.66%
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	5.85%	5.51%	0.00%	4.84%
Total: Initiation of AOD Treatment: 13–17 Years	61.54%	66.55%	55.43%	62.95%
Total: Engagement of AOD Treatment: 13–17 Years	6.54%	5.46%	0.00%	5.12%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	44.14%	44.83%	41.09%	43.86%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	5.37%	7.00%	8.91%	6.76%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	45.31%	45.50%	63.83%	48.48%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	20.00%	16.22%	27.66%	19.79%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	46.02%	41.30%	45.02%	43.84%
Other drug abuse or dependence:	8.19%	8.11%	8.66%	8.25%

Measure/Data Element	United HEDIS MY 2022 CAN Rates	Magnolia HEDIS MY 2022 CAN Rates	Molina HEDIS MY 2022 CAN Rates	Statewide Average
Engagement of AOD Treatment: 18+ Years				
Total: Initiation of AOD Treatment: 18+ Years	45.31%	43.05%	45.95%	44.48%
Total: Engagement of AOD Treatment: 18+ Years	9.13%	8.76%	10.93%	9.33%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	46.56%	47.47%	41.97%	46.11%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	5.25%	7.07%	8.39%	6.64%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	45.45%	46.75%	63.16%	48.88%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	20.55%	15.58%	27.37%	19.69%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	48.65%	45.66%	46.55%	46.97%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	7.72%	7.57%	7.45%	7.60%
Total: Initiation of AOD Treatment: Total	47.58%	46.36%	46.91%	46.93%
Total: Engagement of AOD Treatment: Total	8.75%	8.31%	9.82%	8.76%
Prenatal and Postpartum Care (ppc)				
Timeliness of Prenatal Care	96.84%	95.86%	95.38%	96.03%
Postpartum Care	79.56%	70.32%	68.13%	72.67%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)				
1–11 years	57.10%	57.11%	55.46%	56.87%
12–17 years	61.27%	65.46%	61.54%	63.25%
Total	59.73%	62.11%	59.14%	60.78%
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
First 15 Months	60.02%	57.39%	57.28%	58.27%
15 Months–30 Months	66.10%	65.35%	66.75%	66.05%
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	43.95%	45.44%	43.60%	44.54%
12–17 Years	36.88%	38.53%	35.86%	37.49%
18–21 Years	21.90%	20.77%	18.96%	20.96%
Total	39.46%	40.82%	39.51%	40.08%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate; NQ: Not Required
NR indicates that the rate was not reported.
*: This statewide average includes CCO rates with small denominators.
**: This statewide average was calculated with data from only two CCOs.

HEDIS® Measure Overview for CHIP Programs

The statewide average is calculated as the average of the health plan rates and shown in the last column of the table. Rates highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease in the rate of more than 10 percent.

Table 26: HEDIS® Performance Measure Data for CHIP Programs

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates	Statewide Average
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	72.26%	49.88%	61.07%
Counseling for Nutrition	47.93%	35.28%	41.61%
Counseling for Physical Activity	48.66%	36.01%	42.34%
Childhood Immunization Status (cis)			
DTaP	83.70%	81.90%	82.92%
IPV	91.24%	89.84%	90.63%
MMR	91.97%	89.21%	90.77%
HiB	89.54%	86.98%	88.43%
Hepatitis B	88.08%	89.21%	88.57%
VZV	92.21%	88.89%	90.77%
Pneumococcal Conjugate	82.48%	84.13%	83.20%
Hepatitis A	86.13%	84.13%	85.26%
Rotavirus	83.21%	82.54%	82.92%
Influenza	29.44%	27.62%	28.65%
Combination #3	76.40%	78.10%	77.13%
Combination #7	68.13%	69.84%	68.87%
Combination #10	26.28%	25.08%	25.76%
Immunizations for Adolescents (ima)			
Meningococcal	51.82%	46.47%	49.15%
Tdap/Td	87.83%	71.53%	79.68%
HPV	21.17%	15.09%	18.13%
Combination #1	51.82%	46.23%	49.03%
Combination #2	19.95%	14.60%	17.27%
Lead Screening in Children (lsc)	64.72%	63.81%	64.33%
Chlamydia Screening in Women (chl)			
16–20 Years	39.96%	43.17%	41.00%
21–24 Years	NA	NA	NA
Total	39.96%	43.17%	41.00%
Effectiveness of Care: Respiratory Conditions			

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates	Statewide Average
Appropriate Testing for Children with Pharyngitis (cwp)			
3–17 years	76.20%	77.89%	76.78%
18–64 years	74.05%	72.97%	73.75%
65+ years	NA	NA	NA
Total	76.11%	77.73%	76.66%
Asthma Medication Ratio (amr)			
5–11 Years	83.77%	89.29%	85.71%
12–18 Years	80.21%	77.14%	79.39%
19–50 Years	NA	NA	NA
51–64 Years	NA	NA	NA
Total	81.90%	83.97%	82.54%
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	54.05%	NA	NA
Effective Continuation Phase Treatment	24.32%	NA	NA
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	49.83%	43.87%	47.80%
Continuation and Maintenance (C&M) Phase	69.44%	60.00%	67.13%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6–17 years – 30-Day Follow-Up	68.00%	68.42%	68.16%
6–17 years – 7-Day Follow-Up	42.00%	36.84%	40.00%
18–64 years – 30-Day Follow-Up	NA	NA	NA
18–64 years – 7-Day Follow-Up	NA	NA	NA
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	67.48%	68.69%	67.94%
Total-7-day Follow-Up	41.10%	35.35%	38.93%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6–17 years – 30-Day Follow-Up	72.97%	NA	NA
6–17 years – 7-Day Follow-Up	45.95%	NA	NA
18–64 years – 30-Day Follow-Up	NA	NA	NA
18–64 years – 7-Day Follow-Up	NA	NA	NA
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	70.00%	NA	NA
Total-7-day Follow-Up	42.50%	NA	NA
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

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates	Statewide Average
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)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	NA	NA	NA
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
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (Total)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
Pharmacotherapy for Opioid Use Disorder (16-64)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	NA	NA	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (ssd)	NA	NA	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NA	NA	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA	NA	NA

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates	Statewide Average
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	44.30%	40.00%	42.86%
Cholesterol Testing (1-11)	29.11%	27.50%	28.57%
Blood Glucose and Cholesterol Testing (1-11)	29.11%	27.50%	28.57%
Blood Glucose Testing (12-17)	54.27%	57.14%	55.07%
Cholesterol Testing (12-17)	32.32%	31.75%	32.16%
Blood Glucose and Cholesterol Testing (12-17)	28.66%	31.75%	29.52%
Blood Glucose Testing (Total)	51.03%	50.49%	50.87%
Cholesterol Testing (Total)	31.28%	30.10%	30.92%
Blood Glucose and Cholesterol Testing (Total)	28.81%	30.10%	29.19%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.21%	0.99%	1.14%
Appropriate Treatment or Children with URI (uri)			
3 months-17 Years	69.16%	68.85%	69.05%
18-64 Years	52.04%	50.52%	51.54%
65+ Years	NA	NA	NA
Total	68.66%	68.35%	68.55%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	35.13%	36.92%	35.71%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	35.09%	37.01%	35.71%
Use of Imaging Studies for Low Back Pain (lbp)	NA	NA	NA
Use of Opioids at High Dosage (hdo)	NA	NA	NA
Use of Opioids From Multiple Providers (uop)			
Use of Opioids From Multiple Providers – Multiple Prescribers	NA	NA	NA
Use of Opioids From Multiple Providers – Multiple Pharmacies	NA	NA	NA
Use of Opioids From Multiple Providers – Multiple Prescribers and Multiple Pharmacies	NA	NA	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	0.00%	NA	0.00%*
18-64 years - >=31 Days covered	0.00%	NA	0.00%*

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates	Statewide Average
65+ – >=15 Days covered	NA	NA	NA
65+ – >=31 Days covered	NA	NA	NA
Total – >=15 Days covered	0.00%	NA	0.00%*
Total – >=31 Days covered	0.00%	NA	0.00%*
Access/Availability of Care			
Annual Dental Visit (adv)			
2–3 Years	52.71%	59.90%	55.71%
4–6 Years	72.72%	68.83%	71.40%
7–10 Years	77.92%	73.82%	76.55%
11–14 Years	73.41%	68.36%	71.79%
15–18 Years	63.52%	58.18%	61.82%
19–20 Years	52.08%	44.26%	49.04%
Total	70.19%	66.08%	68.83%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA
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	50.00%	NA	59.02% *
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	12.50%	NA	11.48% *
Total Initiation of AOD Treatment: 13–17 years	48.89%	NA	57.35% *
Total Engagement of AOD Treatment: 13–17 years	11.11%	NA	10.29% *
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA
Total Initiation of AOD Treatment: 18+ years	NA	NA	NA

Measure/Data Element	United HEDIS MY 2022 CHIP Rates	Molina HEDIS MY 2022 CHIP Rates	Statewide Average
Total Engagement of AOD Treatment: 18+ years	NA	NA	NA
Alcohol Abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA
Alcohol Abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA
Opioid Abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA
Opioid Abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	46.15%	NA	51.90%*
Other drug abuse or dependence: Engagement of AOD Treatment: Total	9.62%	NA	8.86%*
Initiation of AOD Treatment: Total	43.33%	61.29%	49.45%*
Engagement of AOD Treatment: Total	8.33%	6.45%	7.69%*
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	NA	NA	NA
Postpartum Care	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1–11 Years	41.03%	NA	NA
12–17 Years	74.16%	63.89%	71.20%
Total	64.06%	58.93%	62.50%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	71.83%	72.83%	72.24%
15 Months–30 Months	74.38%	83.51%	78.40%
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	44.81%	45.55%	45.06%
12–17 Years	39.96%	39.90%	39.94%
18–21 Years	24.93%	25.41%	25.09%
Total	41.18%	41.72%	41.36%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR indicates that the rate was not reported.
*: This statewide average includes CCO rates with small denominators.

Non-HEDIS Performance Measure Validation – CAN Program

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by the CCOs for MY 2022 are listed in *Table 27: CAN Adult and Child Core Set Measure Rates*. The statewide averages have been included where applicable.

Table 27: CAN Non-HEDIS Performance Measure Rates

Measure	United MY 2022 Rates	Magnolia MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
Adult Core Set Measures				
Primary Care Access and Preventative Care				
Colorectal Cancer Screening (COL-AD)				
Ages 46 - 49	20.05%	21.78%	15.92%	21.01%
Ages 50 - 64	42.69%	48.57%	26.50%	45.95%
Ages 65 - 75	32.84%	39.64%	NA	37.08%*
Total	38.76%	43.92%	24.54%	41.63%
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)				
Ages 18 - 64	0.67%	0.61%	0.69%	0.65%
Ages 65+	0.00%	3.86%	NA	2.76%*
Total	0.66%	0.64%	0.69%	0.66%
Maternal and Perinatal Health				
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)				
Most or moderately effective contraception– 3 days	13.44%	11.17%	12.46%	11.79%
Most or moderately effective contraception– 90 days	54.35%	40.70%	54.09%	44.46%
LARC - 3 Days	0.92%	0.46%	0.44%	0.59%
LARC - 90 Days Reported	11.37%	7.37%	9.25%	8.47%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)				
Most or moderately effective contraception rate	23.63%	23.21%	23.46%	23.41%
LARC rate	2.43%	2.29%	2.57%	2.36%
Care of Acute and Chronic Conditions				
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)				
Ages 18 - 64	24.43%	25.52%	24.19%	24.86%
Ages 65+	NA	0.00%	0.00%	0.00*
Total	24.38%	25.46%	24.19%	24.81%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)				
Ages 40 - 64	54.12%	59.71%	55.68%	57.14%
Ages 65+	230.41%	225.56%	0.00%	227.48%
Total	54.94%	60.72%	55.61%	58.07%
HEART FAILURE ADMISSION RATE (PQI-08)				
Ages 18 - 64	54.46%	51.24%	48.85%	52.01%
Ages 65+	0.00%	75.19%	0.00%	43.88%
Total	54.35%	51.30%	48.83%	52.00%
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)				
Ages 18 - 39	3.06%	1.03%	1.30%	1.84%
HIV VIRAL LOAD SUPPRESSION (HVL - AD)				

Measure	United MY 2022 Rates	Magnolia MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
Ages 18 - 64	19.61%	29.12%	20.25%	26.45%
Ages 65+	NA	NA	NA	NA
Total	20.75%	29.02%	20.25%	26.49%
Behavioral Health Care				
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)				
Ages 18 - 64	0.83%	1.33%	0.71%	1.06%
Ages 65+	NA	NA	NA	NA
Total	0.83%	1.33%	0.71%	1.06%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)				
Ages 18 - 64	4.36%	3.20%	4.16%	3.82%
Ages 65+	NA	NA	NA	NA
Total	4.35%	3.20%	4.16%	3.81%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)				
Overall	37.32%	40.16%	44.40%	38.67%
Prescription for Buprenorphine	34.60%	36.77%	43.60%	35.63%
Prescription for Oral Naltrexone	2.01%	0.91%	2.00%	1.49%
Prescription for Long-acting, injectable naltrexone	0.24%	0.13%	0.00%	0.19%
Prescription for Methadone	1.54%	2.74%	0.40%	2.11%
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	1.24%	1.21%	3.09%	1.53%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)				
Age 1 Screening	40.15%	5.19%	33.06%	19.97%
Age 2 Screening	48.91%	5.72%	46.93%	25.21%
Age 3 Screening	50.36%	5.46%	45.07%	24.71%
Total Screening	46.47%	5.41%	39.48%	22.59%
Maternal and Perinatal Health				
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)				
Most or moderately effective contraception–3 days	1.68%	1.42%	0.00%	1.29%
Most or moderately effective contraception–90 days	61.76%	44.50%	7.94%	43.97%
LARC - 3 Days	1.26%	0.53%	3.17%	1.08%
LARC - 90 Days Reported	15.97%	10.11%	47.62%	16.70%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)				
Most or moderately effective contraception rate	29.03%	28.32%	26.01%	28.28%
LARC Rate	2.68%	2.29%	2.10%	2.42%
Dental and Oral Health Services				

Measure	United MY 2022 Rates	Magnolia MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)				
Numerator 1 At Least One Sealant	50.73%	54.40%	34.38%	49.87%
Numerator 2 All Four Molars Sealed	35.24%	37.76%	21.91%	34.33%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)				
Age <1	0.63%	0.79%	0.99%	0.80%
Ages 1-2	22.28%	22.74%	19.74%	21.63%
Ages 3-5	59.05%	58.72%	48.41%	56.43%
Ages 6-7	64.66%	64.64%	54.93%	62.69%
Ages 8-9	65.46%	64.49%	55.01%	63.06%
Ages 10-11	63.66%	61.41%	52.41%	60.64%
Ages 12-14	58.42%	55.92%	45.72%	55.22%
Ages 15-18	48.36%	46.60%	37.24%	45.89%
Ages 19-20	28.58%	27.74%	20.99%	26.99%
Total Ages <1-20	50.98%	50.85%	39.25%	48.54%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)				
Ages 1-2	9.59%	11.81%	9.37%	10.25%
Ages 3-5	27.03%	27.51%	21.21%	25.94%
Ages 6-7	31.47%	31.44%	24.22%	30.11%
Ages 8-9	31.62%	31.31%	25.88%	30.48%
Ages 10-11	30.71%	29.16%	21.75%	28.54%
Ages 12-14	26.51%	25.65%	18.78%	24.96%
Ages 15-18	19.01%	17.83%	13.26%	17.67%
Ages 19-20	8.14%	9.27%	5.93%	8.35%
Total Ages 1-20	24.11%	24.15%	17.76%	22.95%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)				
Ages 1-2	5.52%	6.31%	4.88%	5.58%
Ages 3-5	25.44%	25.24%	18.91%	23.92%
Ages 6-7	30.94%	30.75%	23.30%	29.44%
Ages 8-9	31.27%	30.92%	25.07%	30.03%
Ages 10-11	30.41%	28.98%	21.35%	28.28%
Ages 12-14	26.32%	25.44%	18.25%	24.71%
Ages 15-18	18.85%	18%	12.79%	17.46%
Ages 19-20	8.14%	9.07%	5.71%	8.22%
Total Ages 1-20	23.21%	23.08%	16.04%	21.82%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)				
Ages 1-2	2.95%	4.01%	3.05%	3.33%
Ages 3-5	0.38%	0.43%	0.54%	0.44%
Ages 6-7	0.00%	0.00%	0.02%	0.00%
Ages 8-9	0.00%	0.00%	0.08%	0.01%
Ages 10-11	0.00%	0.00%	0.00%	0.00%

Measure	United MY 2022 Rates	Magnolia MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
Ages 12-14	0.00%	0.00%	0.05%	0.01%
Ages 15-18	0.00%	0.00%	0.06%	0.01%
Ages 19-20	0.00%	0.00%	0.00%	0.00%
Total Ages 1-20	0.40%	0.44%	0.76%	0.48%

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.
*: This statewide average includes CCO rates with small denominators.
**: Since only one health plan reported this rate, a statewide average cannot be calculated

Non-HEDIS Performance Measure Validation – CHIP Program

Table 28: CHIP Adult and Child Core Set Measure Rates provides an overview of rates reported by United and Molina for the CHIP population.

Table 28: CHIP Non-HEDIS Performance Measure Rates

Measure	United MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
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	0.29%	0.97%	0.51%
Total	0.29%	0.97%	0.51%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	0.00%	10.36%	3.49%
Ages 65+	NA	NA	NA
Total	0.00%	10.36%	3.49%
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	0.00%	0.00%	0.00%
Ages 65+	NA	NA	NA
Total	0.00%	0.00%	0.00%
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	0.00%	0.00%	0.00%
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NA	NA	NA

Measure	United MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
Ages 65+	NA	NA	NA
Total	NA	NA	NA
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	NA	NA	NA
Prescription for Buprenorphine	NA	NA	NA
Prescription for Oral Naltrexone	NA	NA	NA
Prescription for Long-acting, injectable naltrexone	NA	NA	NA
Prescription for Methadone	NA	NA	NA
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	1.34%	1.10%	1.26%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	51.61%	NA	NA
Age 2 Screening	54.01%	56.47%	55.73%
Age 3 Screening	48.18%	53.24%	51.99%
Total Screening	51.15%	54.33%	53.41%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	NA	NA	NA
Most or moderately effective contraception – 90 days	NA	NA	NA
LARC - 3 Days	NA	NA	NA
LARC - 90 Days	NA	NA	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	27.51%	26.36%	27.14%
LARC Rate	1.72%	2.01%	1.81%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	47.09%	26.20%	40.49%
Numerator 2 All Four Molars Sealed	32.89%	18.36%	28.30%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	NA	NA	NA
Ages 1-2	32.91%	31.95%	32.53%
Ages 3-5	61.65%	56.14%	59.58%
Ages 6-7	69.39%	65.24%	67.88%

Measure	United MY 2022 Rates	Molina MY 2022 Rates	Statewide Average
Ages 8–9	72.30%	65.75%	70.01%
Ages 10–11	69.90%	62.55%	67.31%
Ages 12–14	64.70%	57.65%	62.29%
Ages 15–18	54.04%	45.66%	51.25%
Ages 19–20	43.51%	33.99%	40.47%
Total Ages <1–20	61.17%	54.62%	58.87%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1–2	16.42%	18.91%	17.41%
Ages 3–5	32.20%	28.45%	30.83%
Ages 6–7	38.29%	36.15%	37.56%
Ages 8–9	39.33%	36.77%	38.48%
Ages 10–11	37.08%	33.75%	36.00%
Ages 12–14	31.39%	27.65%	30.20%
Ages 15–18	21.68%	19.55%	21.00%
Ages 19–20	14.22%	10.00%	12.83%
Total Ages 1–20	30.27%	27.65%	29.40%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1–2	11.27%	11.42%	11.33%
Ages 3–5	30.51%	25.45%	28.65%
Ages 6–7	37.75%	34.44%	36.61%
Ages 8–9	39.15%	35.47%	37.94%
Ages 10–11	36.92%	32.67%	35.54%
Ages 12–14	31.32%	26.56%	29.81%
Ages 15–18	21.63%	18.61%	20.67%
Ages 19–20	14.22%	10.00%	12.83%
Total Ages 1–20	29.74%	25.92%	28.47%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	3.31%	4.87%	3.93%
Ages 3–5	0.43%	0.38%	0.41%
Ages 6–7	0.00%	0.19%	0.07%
Ages 8–9	0.00%	0.09%	0.03%
Ages 10–11	0.00%	0.17%	0.05%
Ages 12–14	0.00%	0.05%	0.02%
Ages 15–18	0.00%	0.26%	0.08%
Ages 19–20	0.00%	0.00%	0.00%
Total Ages 1–20	0.19%	0.44%	0.27%

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

Conclusions

All three CAN CCOs showed more than a 10 percentage-point improvement in more measures for MY 2022 than they did for MY 2021. All three CCOs showed improvement in the oral health measures.

United CAN improved by 10 percentage points or more for the following MY 2022 HEDIS and CMS Core Set measure rates for the CAN population:

- Follow-up After High -Intensity Care for Substance Use Disorder (FUI), 7 days (18-64) and 7 days total.
- Chronic Obstructive Pulmonary Disease (COPD) or Asthma in older adults' admission rate (PQI-05) Age 65+ and Total indicators.
- Developmental Screening in the first 3 years of life (DEV-CH), Age 1 screening and Total screening indicator.
- Sealant Receipt on Permanent First Molars (SFM-CH) for both indicators.
- Topical Fluoride for Children (TLF-CH) all indicators besides the Ages 1-2 and Ages 19-20 indictors for Rate 2.
- Oral Evaluation, and Dental Services (OEV_CH), all indicators besides the Age <1 indicator.

Magnolia CAN improved by 10 percentage points or more for the following MY 2022 HEDIS and CMS Core Set measure rates for the CAN population:

- Asthma Medication Ratio (AMR) Age 51-64 indicator.
- Kidney Health Evaluation for Patients With Diabetes (KED) Age 65-74 indicator.
- Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) 7 days, Age 18-64 indicator, 30 days, Age 18-64 indicator, Total 7 days and 30 days indicators.
- Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate (PQI-05): Age 65+ indicator.
- Heart failure admission rate (PQI-08) Age 65+ indicator.
- Topical fluoride for children (TLF-CH) Rate 1 and Rate 2 indicators improved for all but two (Age 1-2 and ages 19-20) indicators.

Molina CAN improved by 10 percentage points or more for the following MY 2022 HEDIS and CMS Core Set measure rates for the CAN population:

- Immunizations for Adolescents (IMA), the Tdap indicator.
- Asthma Medication Ratio (AMR), the 19-50 Years indicator.

- Follow-Up Care for Children Prescribed ADHD Medication (ADD), the Continuation and Maintenance (C&M) Phase indicator.
- Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) rate improved for the following indicators: Age 18-64 (7 days and 30 days), 7 days and 30 days total.
- Heart Failure Admission Rate (PQI-08), age 18-64, and total indicators.
- Sealant Receipt on Permanent First Molars (SFM-CH), both indicators.
- Oral Evaluation, Dental Services (OEV-CH) improved for all but three (Age<1, Ages 1-2, and Ages 19-20) indicators.
- Topical Fluoride for Children (TLF-CH), the Rate 1 indicator improved for Ages 3-5, Ages 6-7, Ages 8-9, Ages 10-11, and Ages 12-14 and the Rate 2 indicator improved for all but three indicators (Ages 1-2, Ages 15-18, and Ages 19-20).

United CAN rates fell by 10 percentage points or more for the Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) and the Heart Failure Admission Rate (PQI-08), the Age 65+ indicator.

Molina CAN rates fell by 10 percentage points or more for the following:

- Pharmacotherapy Management of COPD Exacerbation (PCE).
- The Systemic Corticosteroid indicator, Statin Therapy for Patients with Cardiovascular Disease (SPC) the Statin Adherence 80% - 21-75 years (Male), Statin Adherence 80% - 40-75 years (Female), Statin Adherence 80% - Total indicators.
- Statin Therapy for Patients with Diabetes (SPD) the Statin Adherence 80% indicator.
- Antidepressant Medication Management (AMM) rate decreased for both indicators.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM) the 7 days (18-64) indicator.
- Pharmacotherapy for Opioid Use Disorder (POD) the Age 16-64 and Total indicators.
- Use of Opioids from Multiple Providers (UOP) the Multiple Prescribers indicator increased by over 10 percentage points. The rate increase indicates lower performance for this measure.

There were no MY 2022 HEDIS measure rates or non-HEDIS Adult Core Set and Child Core Set measure rates that decreased more than 10 percentage points for Magnolia CAN.

United CHIP improved by 10 percentage points or more for the following MY 2022 HEDIS and CMS Core Set measure rates for the CHIP population:

- Follow-up care for children prescribed ADHD Medication (ADD), both Initiation Phase and Continuation and Maintenance (C&M) Phase indicators.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM), the 6-17 years 30-day and 7-day follow-up indicators.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), the Blood Glucose testing for 1-11 years indicator.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), the 12-17 age group indicator.
- Developmental Screening in the first 3 years of life (DEV-CH), Age 1 screening indicator.
- Sealant Receipt on Permanent First Molars (SFM-CH) all indicators.
- Topical Fluoride for Children (TLF-CH), all indicators besides the Ages 1-2 indictor for Rate 2.
- Oral Evaluation, Dental Services (OEV_CH), all indicators besides the Age <1 indicators.

Molina CHIP improved by 10 percentage points or more for the following HEDIS MY 2022 HEDIS and CMS Core Set measure rates for the CHIP population:

- Childhood Immunization Status (CIS) improved for the Combination #7 indicator.
- Follow-up care for children prescribed ADHD Medication (ADD) rate improved for both indicators.
- Follow-Up After Hospitalization for Mental Illness (FUH) rate improved for the Age 6-17 years 30 days Follow-Up and Total 30 days Follow-Up indicators.
- Developmental Screening in the first 3 years of life (DEV-CH) the Age 3 Screening indicator improved.
- Sealant receipt on permanent first molars (SFM-CH) both indicators improved.
- Oral evaluation, dental services (OEV-CH) improved for all but one indicator (Age<1).
- Topical fluoride for children (TLF-CH) the Rate 1 and Rate 2 indicators improved for all but two indicators (Ages 1-2 and Ages 19-20).

United's CHIP rates fell by 10 percentage points or more for the:

- Antidepressant Medication Management (AMM), the Effective Continuation Phase Treatment indicator.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), 1-11 Years indicator.
- Diabetes Short-Term Complications Admission Rate (PQI01-AD), all indicators.

Molina CHIP rates fell by 10 percentage points or more for the:

- Lead Screening in Children (LSC) measure.
- Appropriate Treatment for Upper Respiratory Infection (URI) rate for the 18-64 Years indicator.
- First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) rate for Age 12-17 years indicator.

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: Validation of 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 each health plan to conduct PIPs for the following topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Each health plan is required to submit PIPs to Constellation Quality Health for validation annually. Constellation Quality Health validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Twenty-three projects were validated for the three health plans. Results of the validation, project status, and interventions for each project are displayed in the tables that follow.

Table 29: United CAN PIPs

Behavioral Health Readmissions (Reducing 30-day Psychiatric Inpatient Readmission Rates)	
The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest rate from 21.4% in 2021 to 18.7% with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2021 to 19% in 2022. Individual facility rates were reported as well for each of the five facilities.	
Previous Validation Score	Current Validation Score
74/75=99% HIGH CONFIDENCE IN REPORTED RESULTS	74/75=99% HIGH CONFIDENCE IN REPORTED RESULTS
Interventions	
• Collaboration with high volume Hinds County outpatient and inpatient providers to schedule and facilitate meetings to discuss ways to improve readmissions rates by increasing the seven day-follow-up appointment. • Meds to Beds Program to provide transition solutions to coordinate care and discharge medications for members discharged from inpatient facilities. • Enhanced Case Management. • Direct referrals to Genoa Pharmacy. • Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from Inpatient level of care.	
Improving Pregnancy Outcomes	
The Improved Pregnancy Outcomes PIP goal is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment. This PIP has a DOM goal rate of 94.92% for the HEDIS Timeliness of Prenatal care rate. The baseline rate was 92.21% and the remeasurement number three rate was 96.84%. This rate reflects an improvement in the visit rate and exceeds the goal rate.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Home visit care management services in seven underserved communities in MS. • Care management for high-risk pregnant members and their babies less than a year old. • The Optum Whole Person Care Program provides telephonic and/or face-to-face outreach to high-risk members to educate the member and help with establishing an obstetric practice. • Dedicated maternity Member Services Team for telephonic outreach to low-risk members or to members whose risk is unknown to identify any barriers such as transportation childcare and connect the member to support resources. • Member and provider education with the First Steps packets and the OB toolkits. • National Healthy Starts program to address social needs. • Provider education with OB Toolkits.	

- Weekly data analysis with risk stratification.
- Healthy Starts Program to address social needs.

Respiratory Illness Management

Respiratory Illness examines the appropriate medications (bronchodilators or systemic corticosteroids) for members with COPD exacerbations based on HEDIS measures, as well as the asthma medication ratio HEDIS measures. For bronchodilators, the baseline was 74.96%, 76.36% in 2021, and the 2022 rate was 78.40%, which demonstrates improvement. Corticosteroids improved from 42.24% at baseline, to 49.89% in 2021, and improving again in 2022 to 50.76%. The AMR baseline was 70.7% and increased to 75.79% for 2022.

Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results

Interventions

- Clinical practice consultants visit high volume practices to discuss Clinical Practice Guidelines and evidence-based Quality Performance Guidelines and assist with interpreting patient care opportunity reports.
- Pharmacy outreach to ensure members have educational materials, prescriptions are filled, and assist with overrides or claims issues related to prescribed inhalers.
- Communication with clinics regarding non-compliant members, patient care opportunity reports, and provider education.

Sickle Cell Disease Management Decreasing ER Utilization

The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28%, decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%. Thus, the most recent rate did not show improvement in year over year trending.

Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Interventions

- Outreach to providers encouraging the use of hydroxyurea for patients who do not have a pharmacy claim for hydroxyurea.
- Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients.
- Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments.
- Telehealth campaigns and after-hour care newsletters.
- Weekly interdisciplinary rounds for Case Management.
- Provider education with the After Hour Care newsletter.

Constellation Quality Health provided recommendations for United's Behavioral Health Readmission and Sickle Cell PIPs. They are displayed in *Table 30: United CAN Performance Improvement Project Recommendations*.

Table 30: United CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The inpatient readmissions PIP showed improvement in the latest rate from 21.4% in 2021 to 18.7% with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2021 to 19% in 2022	Continue to monitor BH readmission rates and determine barriers to case management enrollment for re-admitters.
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate was 36.28% a baseline, decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%.	Continue ongoing interventions such as the Sickle Cell Disease Program and daily dashboard reviews to assess patient tracking of ER utilization and medication non-adherence.

Magnolia submitted four PIPs. Topics for those PIPs included Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness. 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 is also included.

Table 31: Magnolia CAN PIPs

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. This PIP showed improvement in the latest rate from 26.88% in 2021 to 25.9% in 2022, with a goal of 6%. Many interventions have been implemented over the five-year PIP period.	
Previous Validation Score	Current Validation Score
80/80 = 100% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Member Outreach • Facility collaboration • Staff Additions for Transition of Care Assessments • Clinical Provider Training	

- Discharge Bags
- Medicine Planners for Patients
- Member Education

Reducing Preterm Births

The Reducing Preterm Births PIP is focused on reducing the preterm birth rate for pregnant mothers with HTN/pre-eclampsia who give birth prior to 37 weeks gestation. The baseline rate was 14.47%, and the third remeasurement rate was 15.05%. This rate increased which reflects a lack of improvement, as the goal is to reduce the preterm birth rate.

Previous Validation Score	Current Validation Score
72/73= 99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Interventions

- Completing Notification of Pregnancy as applicable.
- Enrolling member in the Start Smart for Baby program.
- Refer to Care Management for continuous follow-up.
- Medical record review for monitoring and tracking.

Sickle Cell Disease Outcomes

The Sickle Cell Disease PIP focuses on increasing compliance with Hydroxyurea for eligible members throughout the treatment period. This PIP measures the rate of members with sickle cell disease that remain compliant with the medication during their treatment period. The baseline rate was 37.5%, decreasing to 25.87% in 2023. The goal is to increase the rate to 47%. Thus, the most recent rate did not show improvement year over year trending.

Previous Validation Score	Current Validation Score
80/80 = 100% Hight Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Interventions

- The 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.
- Letters are mailed to the Providers of those members identified, encouraging the Provider to discuss medication adherence at the member's next scheduled appointment.
- Outreach is conducted to all members who received letters to provide education and to address any barriers/concerns.
- Texting campaigns to encourage medication refill reminders.

Asthma/COPD

The Asthma/COPD PIP focuses on the percentage of members 12-18 years of age with persistent asthma and the spirometry test for members 40 and older with COPD. This indicator uses the HEDIS measure, AMR. The AMR rate was 71.15% at baseline, which has essentially not changed in 2022 at 71.15%, with a goal of 76.86%. The spirometry testing rate was 28.38% at baseline which has declined to 22.27% for 2022. The goal is 36.82%.

Previous Validation Score	Current Validation Score

73/74=99% High Confidence in reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Direct outreach by the Population Health Management Team to non-compliant members identified in both the AMR and Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) populations. • Distribution of the updated HEDIS Quick Reference Guides for MY2023 to Providers. • The Pharmacy Team mailed letters encouraging the addition of a long-term controller medication to both members and providers in the AMR population. • Interactive texting campaigns for medication refill and missed refill reminders.	

Constellation Quality Health provided Magnolia with recommendations for the Reducing Preterm Births, Sickle Cell Disease Outcomes, and the Asthma/COPD PIPs. They are displayed in *Table 32: Magnolia Performance Improvement Project Recommendations*.

Table 32: Magnolia 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% and the remeasurement number 3 rate was 15.05%. This rate reflects an increase in the rate that reflects a lack of improvement, as the goal is to reduce the preterm birth rate to 11.04%.	Continue to monitor interventions and efforts toward member education and member tracking, as well as member self-monitoring to work toward reducing the preterm birth rate.
Sickle Cell Disease Outcomes	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent rate did not show improvement in year-over-year trending for medication compliance.	Continue ongoing interventions of texting campaigns and multi-team outreach to ensure members have the information needed to remain compliant.
Asthma/COPD	Was there any documented, quantitative improvement in processes or outcomes of care?	The AMR rate showed no change from the baseline rate of 71.15%. The Spirometry testing rate was 28.38% at baseline which has declined to 22.27% for 2022.	Continue member and provider education, texting campaign, and the health equity dashboard to identify members that need additional resources.

For this EQR, Molina submitted seven CAN PIPs for validation. Topics included, Behavioral Health Readmissions, Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. All the CAN 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 is also included.

Table 33: Molina CAN PIPs

Behavioral Health Readmissions	
The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. The latest report had Q1 2023 data with a readmission rate of 54.2% and increased from the Q4 2022 rate of 10.8%. Case management enrollment for the 13 readmitted members was 100%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Community connectors • Primary care initiative • Scheduling process changed • Onsite discharge planning • Transition of Care letters sent to members • Patient Outreach	
Asthma Medication Ratio	
The aim for the Asthma PIP is to increase the compliance rate or member who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The Asthma PIP focused on the AMR HEDIS rate for ages 5 to 64. Quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements, with a goal of 72.89%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Asthma education video on proper use of the inhaler • Monitoring of the non-compliant members and encourage providers to contact members to close the gap in care • Telephone call campaign to encourage members to get their annual wellness exams • Provider toolkits and educational materials • Member education materials	
Pharmacotherapy Management of COPD Exacerbation	
The COPD PIP utilizes the systemic corticosteroid HEDIS measure and the bronchodilator HEDIS measure. For Q1 to Q2 2023, there was an increase from 48.65% to 60.94% for steroid measure, with a goal of 53.43%, and an improvement from 59.46% to 79.69% for the bronchodilators, with a goal of 81.8%.	

Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Smoking Cessation Program to provide access to over-the-counter tobacco cessation products. • Provider Education Tools	
Follow-up After Hospitalization for Mental Illness	
This PIP assesses 7- and 30-day follow up for members hospitalized for treatment of mental illness. For the 30-day follow up, the rate improved from 34.34% to 44.73%, with a goal of 56.13%. The 7-day rate improved from 21.72% to 27.23%, with a goal of 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• TOC Coaches: Once notified of assigned admitted members, the TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan. • Discharge planning checklist • Processes to improve efficiency of scheduling follow-up appointments • Provider Education	
Obesity	
This PIP utilizes the BMI percentile documentation, counseling for nutrition, and counseling for physical activity HEDIS measures. For BMI percentile, there was improvement from Q1 to Q2 with rates of 14.44% increasing to 18.69%, a goal of 61.31%. Counseling for nutrition improved 7.41% to 9.86%, with a goal of 52.31%. Counseling for physical activity improved 7.1% to 9.92%, with a goal of 57.42%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member Incentives • Member outreach and member events for awareness and education	
Prenatal and Postpartum Care	
This PIP examines the rate of deliveries that received prenatal care within the first trimester and post-partum care visits within 84 days of delivery. For prenatal visits, the rate declined from 86.19% to 84.72%, with the goal of 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%.	
Previous Validation Score	Current Validation Score

80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Provider Education • Member incentives-Gift cards and car seats • Member outreach events • Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize electric breast pump for the first six months of their child's life.	
Sickle Cell Disease	
This focuses on the percentage of members with Sickle Cell Disease who are enrolled in case management. The rate declined from 6.25% to 4.9%, with a goal of 15.9%.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Internal monitoring and tracking for inpatient care and ED visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration with the MS Sickle Cell Foundation (MSCF). • Member education materials	

Constellation Quality Health provided recommendations for four PIPs wherein a decline in at least one indicator was identified. These are displayed in *Table 34: Molina CAN Performance Improvement Project Recommendation*.

Table 34: Molina CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The latest report had Q1 2023 data with a readmission rate of 54.2%, which increased from the Q4 2022 rate of 10.8%. Case management enrollment for the 13 readmitted members was 100%.	Continue to monitor BH readmission rates. Complete lessons learned report to assess key take-aways from the PIP.
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate declined from 6.25% to 4.9%, with a goal of 15.9%.	Continue ongoing interventions for tracking and monitoring of members that need to be enrolled in case management.

Project	Section	Reason	Recommendation
Asthma	Was there any documented, quantitative improvement in processes or outcomes of care?	Quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements, with a goal of 72.89%.	Continue ongoing interventions to educate provider and members toward efforts to improve medication compliance.
Prenatal and Postpartum Care	Was there any documented, quantitative improvement in processes or outcomes of care?	For prenatal visits, the rate declined from 86.19% to 84.72%, with the goal of 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%.	Continue community events and utilization of Spectra Medix value-based purchasing platform for improving patient monitoring and PPC rates.

CHIP PIP VALIDATION RESULTS

United submitted the same four CHIP PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction, Follow Up After Hospitalization, and Obesity. All the CHIP PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each project's status and the interventions are also included.

Table 35: United CHIP PIPs

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
The Adolescent Well Child Visits (AWC)/Child and Adolescent Well Care Visits (WCV) PIP goal is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year. The AWC measure was retired and replaced with the WCV measures. This measure looks at the percentage of members completing at least one comprehensive wellness visit during the calendar year. The rate for the 12 – 17-year-olds declined from 40.16% to 39.96%. This is below the goal rate of 41.36%. The rate for 18 - 21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%.	
Previous Validation Score	Current Validation Score
80/80 = 100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Phone calls to noncompliance members and after hour and weekend clinic days. Staff collaborated with participating clinics to close care gaps. • Clinical practice consultants and clinical transformation consultants conduct educational sessions with providers on HEDIS requirements. • Resumption of the Farm to Fork activities for members to receive educational materials regarding wellness visits and immunizations.	

Follow Up After Hospitalization for Mental Illness	
The goal for the Follow-Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7-day and 30-day follow-up visits. The Pip report showed that the 30-day follow up rate improved from 65.8% in 2021 to 67.48% in 2022, exceeding the goal rate of 59.42%. The 7-day follow up rate improved from 35.11% in 2021 to 41.1% in 2022. The goal rate for United is 38.95%.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay. • Continue demographic workflow to improve capture of current contact numbers for enrollees. • Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCP to communicate relevant treatment information involving member care. • Network notes and Optum news and updates for UBH clinicians and facilities. • Case management initiates calls to schedule follow-up appointments.	
Reducing Adolescent and Childhood Obesity	
The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity. The BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93% with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66% with a goal rate of 68.61%.	
Previous Validation Score	Current Validation Score
100/100=100% High Confidence in Reported Results	94/95=100% Hight Confidence in Reported Results
Interventions	
• Member and provider education. • Phone calls to noncompliant members. • After-hours and weekend clinic days. • Clinical Practice Consultants conduct routine visits to PCPs to provide education on HEDIS measures and appropriate coding and billing. • Community outreach activities such as the Farm to Fork program and health fairs.	
Getting Needed Care CAHPS	
For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%.	
Previous Validation Score	Current Validation Score
100/100=100% High Confidence in Reported Results	94/95=100% High Confidence in Reported Results

Interventions
• Member education regarding the provider network and how to access care. • Clinical Practice Consultants make face-to-face visits with high volume clinics to discuss the CAHPS survey. • Provide member education during phone calls and town hall meetings regarding United's provider network. • Offer case management to providers to support or expedite referrals.

Constellation Quality Health provided recommendations for United's Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV), Reducing Adolescent and Childhood Obesity, and Getting Needed Care CAHPS as displayed in *Table 36: United CHIP Performance Improvement Project Recommendations*.

Table 36: United CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Adolescent Well Child Visits (AWC)/ new measure Child and Adolescent Well Care Visits (WCV)	Was there any documented, quantitative improvement in processes or outcomes of care?	The WCV (adolescence well care visits) PIP showed the rate for the 12 – 17-year-olds declined from 40.16% to 39.96%. This is below the goal rate of 41.36%. The rate for 18 - 21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%.	Continue to assess interventions and consider sub-analysis of patient care reports to determine if specific subsets of the population are impacting the reduction in rates.
Reducing Adolescent and Childhood Obesity	Was there any documented, quantitative improvement in processes or outcomes of care?	The BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93% with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66% with a goal rate of 68.61%.	Continue to assess interventions and consider sub-analysis of patient care reports to determine if specific subsets of the population are impacting the reduction in rates.
Getting Needed Care CAHPS	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%.	Continued analysis by Task Force and provider education should continue in efforts to improve satisfaction rates.

Molina submitted the same four PIPs this year for validation that were submitted last year. The topics included Well Care/Well Child, Asthma Medication Ratio, Obesity, and Follow-up After

Hospitalization for Mental Illness. All the CHIP PIPs scored in the "High Confidence in Reported Results" range as noted in the tables that follow. A summary of each project's status and the interventions is also included.

Table 37: Molina CHIP PIPs

Asthma Medication Ratio	
The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. Quarterly rates show a decline from 93.02% in Q1 2023 to 76.92% in Q2 2023. The rates are above the goal rate of 71.28% (benchmark should be adjusted now that several remeasurements are above it).	
Previous Validation Score	Current Validation Score
85/85=100% High Confidence in Reported Results	79/80= 99% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of the inhaler • Telephone campaigns to encourage members to get their annual wellness exams • Provider education with toolkits and assistance with member outreach	
Follow-up After Hospitalization for Mental Illness	
The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate for 6–17-year-olds improved from 46.43% in Q1 2023 to 59.18% in Q2 2023. The goal is 56.13%. For the 7-day rate, the rate increased from 28.6% in Q1 to 34.7% in Q2. The goal is 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care collaborative on-site discharge planning • Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation • Implementation of a Discharge Planning Checklist • Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge	
Obesity	
The Obesity PIP aims to increase the percentage of CHIP members who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. The BMI documentation rate improved from 11.29% in Q1 to 15.23% in Q2, with a goal of 61.31%. The nutrition counseling rate also improved from 5.68% to 8.96%, with a goal of 52.31%. Counseling for physical activity improved from 4.73% to 8.73%, with a goal of 57.42%.	
Previous Validation Score	Current Validation Score

80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider toolkits to help facilitate tracking reports and address areas needed • Member education, community outreach, and incentives	
Well Care/Well Child	
The aim for the Well Care/Well Child PIP is to increase the number of CHIP members who receive at least six or more well care/well child visits during the first 0-15 months of life. The most recent rates were 59.52% in Q1 and 63.16% in Q2. The goal is 56.13%.	
Previous Validation Score	Current Validation Score
85/85=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Provider education with periodic face-to-face visits offering HEDIS toolkits, non-compliant member list, provider portal training and HEDIS Tip Sheets for well visits. • Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale. • Member incentives provided on the day of the screening.	

The following recommendation was provided for Molina's Asthma CHIP PIP.

Table 38: Molina CHIP Performance Improvement Project Recommendation

Project	Section	Reasoning	Recommendation
Asthma AMR	Was there any documented, quantitative improvement in processes or outcomes of care?	Quarterly rates show a decline from 93.02% in Q1 2023 to 76.92% in Q2 2023. The rates are above the goal rate of 71.28%	Continue efforts to sustain case management, member education, and provider education. Consider increasing benchmark as rate declined but was still above goal rate.

Tables 39 and *40* display the strengths, weaknesses, and recommendations for the Quality Improvement section.

Table 39: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The Quality Improvement Programs developed by the CCO's, focuses on the health care and services their members receive and include all aspects of health care quality.	✓		

Strengths	Quality	Timeliness	Access to Care
The reduction of health care disparities is addressed by each CCO through their Health Equity Programs.	✓		✓
THE CCOs were fully compliant with the HEDIS validation determination standards for the CAN and CHIP HEDIS performance measures.	✓		
Based on the validation of PM rates, there were no concerns with data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported.	✓		
The CCOs showed improvement of more than 10 percentage points in MY 2022 for more measures than they did in MY 2021.	✓		
PIP reports included the CMS elements and integrated Corrective Actions from the previous review.	✓		
PIPs were based on analysis of comprehensive aspects of enrollee needs and services and priority topics designated by the Division.	✓		

Table 40: Quality Improvement Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina's QI work plan used to track annual QI activities contained several errors. Those errors included: • In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1. • The Availability of Practitioners section (PDF pages 16 – 28) and the Accessibility of Services section (PDF pages 29 – 30) lacked benchmark goals for each activity. • The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications which measure those scores apply. • The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists.	Ensure the QI work plans contain accurate goals and are clear regarding what is being measured and reported.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
• The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care practitioners instead of behavioral health practitioners. • The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. However, Policy MHMS-QI-006, Access to Care lists this timeframe as seven calendar days. • The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care. • In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days.				
Molina's Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, indicates Molina annually measures performance against at least two important aspects of the clinical practice guidelines. During the onsite, Constellation Quality Health questioned Molina regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided.	Measure provider compliance with the clinical and preventive guidelines as required the *CAN Contract, Section 10 (M)* and the *CHIP Contract, Section 9 (M)* and report the results to the applicable providers.	✓		✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina is not tracking member follow-up treatment and referrals needed for abnormal findings on an EPSDT and Well-Baby/Well-Child exam, as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)*. This was an issue previously identified during the 2020, 2021, and 2023 EQRs that has not been corrected.	To ensure compliance with the contractual requirements, Molina must follow their process for tracking members identified with an abnormal finding on an EPSDT and Well-Baby/Well-Child exam that includes the diagnosis, treatment, and referrals needed to address the abnormal findings, as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)*.	✓		✓
Molina's 2022 QI Program Evaluation was incomplete and did not include all of the results of the QI activities conducted in 2022. This continues to be an issue and was previously identified in the 2020, 2021, and 2022 EQRs.	To assess the effectiveness of the QI Program, the results of all activities must be analyzed, barriers identified, and recommendations included in the annual QI program evaluation as required by the *CAN Contract, Section 10*, and *Exhibit G* and the *CHIP Contract, Section 9 (D)* and *Exhibit F*.	✓		
During source code review for United, it was identified that the age of the member was calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and United's vendor corrected the source code. United confirmed that the corrected source code was used to calculate the final rates.	It is recommended that the CCOs improve processes around oversight of their software vendors and ensure they are following specifications when calculating the DOM required performance measures.	✓		
There were several HEDIS and non-HEDIS rates that fell by 10 percentage points or more.	The CCOs should monitor and investigate reasons for measure rates that decreased by 10 percentage points or more. The CCOs should continue working toward improvement of non-HEDIS measure rates and ensure that all available data sources are explored to calculate non-HEDIS rates.	✓		
Based on the review of some of Magnolia's HEDIS Compliance Audit Final Audit Reports, and onsite discussion, it was identified that there were opportunities for improvement in communication and oversight between	Improve communication and oversight with the corporate HEDIS team and centralized operations to ensure accuracy, monitoring and tracking for the DOM required PMs.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
the corporate HEDIS team, centralized operations, and the CCO.				
All three CAN health plans showed a decline in rates for the sickle cell PIPs. Thirteen of the 23 PIPs across the health plans showed a decline in PIP rates.	Continue interventions to determine if rates can improve wherein most recent trends show a decline. Monitor interim rates to assess for improvement as new interventions are initiated. Modify benchmark if initial benchmark has been exceeded.	✓		

Table 41: Quality Improvement Comparative Data provides an overview of each health plan's scores for the Quality Improvement standards.

Table 41: Quality Improvement Comparative Data

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*					
The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met	Met
The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities	Met	Met	Met	Met	Met
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Partially Met ↓	Partially Met ↓
Quality Improvement Committee					
The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met	Met
The QI Committee meets at regular intervals	Met	Met	Met	Met	Met
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met	Met
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*					
Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures"	Met	Met	Met	Met	Met
Quality Improvement Projects					
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met	Met	Met	Met
The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Met	Met	Met	Met	Met
Provider Participation in Quality Improvement Activities					
The CCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met
The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines	Met	Met	Met	Partially Met ↓	Partially Met ↓
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Initial visits for newborns CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Initial visits for newborns	Met	Met	Met	Met	Met
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: EPSDT screenings and results CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Well-Baby and Well-Child screenings and results	Met	Met	Met	Partially Met ↓	Partially Met ↓

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Diagnosis and/or treatment for children CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Diagnosis and/or treatment for children	Met	Met	Met	Met ↑	Met ↑
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*					
A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Met	Met	Not Met	Not Met
The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met	Met

E. Utilization Management

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

The Utilization Management (UM) section of the review includes UM Program structure, design, and evaluation, medical necessity determinations, appeals, care management, and transitional care management.

Utilization Management (UM) Program

United's CAN and CHIP Utilization Management (UM) Program is integrated within the UnitedHealthcare Clinical Services area, and the Chief Medical Officer provides clinical oversight of the UM Program. Magnolia's UM Program is structured within the Population Health Management and Clinical Operations Department, and the Chief Medical Director provides overall oversight of the UM activities. Molina's Health Care Services program is integrated within the CAN and CHIP UM Program, wherein the Chief Medical Officer has authority and responsibility.

Each plan has a UM Program Description and policies and procedures that define and describe UM activities and provide guidance to staff. For Molina, incorrect information and/or omitted information was identified in the CAN and CHIP Health Care Services Program Description and Service Authorization policy related to extensions of service authorization requests. Also, Magnolia referenced Turning Point as a vendor; however, Turning Point is not referenced as a vendor in the health plan's UM policies and Program Description.

Coverage and Authorization of Services

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

Appropriate clinical staff conduct reviews of service authorization requests using McKesson's InterQual guidelines, Milliman Care Guidelines (MCG) guidelines, State criteria, and/or internal clinical coverage policies. It was noted that Magnolia referenced use of an external review vendor's clinical criteria in some determination notices; but the UM Program Description and UM policies did not mention use of the vendor for some clinical determinations. Each health plan assesses the consistency of criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers. Each reviewer and Medical Director received passing scores. For each health plan, nonclinical staff perform administrative tasks and provide support to the clinical staff.

Review of the health plans' approval files reflected timely completion with reviews conducted by appropriately licensed practitioners. For United and Magnolia, the review of a sample of denial files showed that the reviews were conducted according to contractual requirements. Molina's CAN and CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request.

Each health plan has a pharmacy benefit manager that manages all pharmaceutical services for members. The Preferred Drug List links provided in Molina's CHIP Member Handbook and CHIP Provider Manual were not functional.

Appeals

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

Processes for filing and managing member appeals are outlined in health plan Member Handbooks, UM Program Descriptions, Provider Manuals, policies, and websites. Appeals may be filed verbally or in writing at any time by the member, legal guardian, authorized representative, or service provider. Timeframes for appeal acknowledgment, resolution, and extension are described by each health plan.

The health plans log and categorize appeals and analyze appeals data for trends and opportunities for quality improvement. Results are reported internally to appropriate committees. The sample appeals files reviewed for the health plans showed timely resolution. For United, the Written Consent for Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf for CAN and CHIP. Molina's CAN and CHIP files were extended based on the lack of the receipt of a signed Authorized Representative Form, and subsequently closed with no indication of notification to the Division found in the files.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

Each health plan has developed and implemented Care Management (CM), Disease Management, and Population Health Management Programs according to requirements in the *CAN* and *CHIP Contracts*. The health plans use various resources to identify potential candidates for the CM services.

Once a member is referred for CM services, each health plan conducts a Health Risk Assessment to assess the member's needs and risk level. The health plans provide care management techniques to ensure comprehensive, coordinated care for all members based upon the member's identified need and risk level. Each health plan also provides transition of care services for new and existing members that are transitioning across various care settings. The interdisciplinary transitional care team ensures continuity of care and a successful transition for members within their home or community settings through various methods and resources.

Care management sample files indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members, and care management activities were conducted appropriately according to the members' assigned risk level. For UHC, there were identified issues with the transitional care management activities provided to CHIP members regarding documentation of notes that entail a follow-up schedule of the member's progress and case closure.

Strengths, weaknesses, and recommendations for the Utilization Management section of the review are found in *Table 42* and *Table 43*.

Table 42: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
The sample of approval files reflected reviews were completed in a timely manner according to contractual standards for all health plans.		✓	✓
Each health plan conducted inter rater reliability testing. Clinicians and Medical Directors received passing scores.	✓		
The sample of appeal files reflected appeals were processed in a timely manner for all health plans.	✓	✓	

Table 43: Utilization Management Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
For United, some CHIP transitional care management files did not have ongoing documentation of notes that entail a follow up schedule of the members' progress and process for case closure.	Obtain and accurately document a follow up schedule of the members' process while receiving transitional care management services.	✓		✓
Molina's CAN and CHIP Adverse Benefit Determination letters and UHC's policy incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. Also, an additional UHC policy and UHC's website included incorrect information stating that a written request is required when a verbal request is submitted. This is no longer a contractual requirement.	Update the CAN and CHIP Adverse Benefit Determination letters, website, and policies to remove the requirement that a member must follow a verbal appeal request with a written request.			✓
For Molina, some CAN and CHIP appeal files were extended based on the lack of the receipt of a signed Authorized Representative Form, and subsequently closed with no indication of notification to DOM that an extension was needed.	Ensure processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals, including notification to the DOM when appeal extensions are needed.			✓
Magnolia referenced Turning Point (a vendor) in appeal determination notices. However, use of a vendor for appeal determinations was not referenced in Magnolia's UM policies and Program Description.	Update UM policies and procedures and the Magnolia Health Utilization Management Program Description 2023 to include information about use of vendors for UM and/or appeal determinations.	✓		
Some of United's appeal acknowledgement and resolution letters were addressed to the provider or Appeals Department but appeared to be communicating with the member.	Ensure processes are in place to review the language within the appeal acknowledgement and resolution letters so they accurately address the appellant.			✓

An overview of all scores for the Utilization Management section is illustrated in *Table 44: Utilization Management Services Comparative Data for the 2023 EQR*.

Table 44: Utilization Management Services Comparative Data for the 2023 EQR

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Utilization Management (UM) Program					
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Met	Met	Met	Met	Met
Structure of the program	Met	Met	Met	Met	Met
Lines of responsibility and accountability	Met	Met	Met	Met	Met
Guidelines/standards to be used in making utilization management decisions	Met	Met	Partially Met ↓	Met	Met
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met ↑	Met ↑	Met	Met	Met
Consideration of new technology	Met	Met	Met	Met	Met
The appeal process, including a mechanism for expedited appeal	Met	Met	Met	Met	Met
The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met
Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*					
Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met	Met
The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Met ↑	Met	Met	Met	Met
The CCO has established policies and procedures for prior authorization of medications	Met	Met	Met	Met	Met
Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Met
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met
A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Met	Met ↑	Partially Met ↓	Partially Met ↓
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*					
The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including	Met	Met	Met	Met	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met	Met	Met
The procedure for filing an appeal	Partially Met	Partially Met	Met ↑	Met ↑	Met ↑

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met ↑	Met ↑	Met ↑	Met	Met
Written notice of the appeal resolution as required by the contract	Met	Met ↑	Met	Met	Met
Other requirements as specified in the contract	Met	Met	Met	Met	Met
The CCO applies the appeal policies and procedures as formulated	Partially Met	Partially Met	Met ↑	Partially Met ↓	Partially Met ↓
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met
Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*					
The CCO has developed and implemented a Care Management and a Population Health Program	Met	Met	Met	Met	Met
The CCO uses varying sources to identify members who may benefit from Care Management	Met	Met	Met	Met	Met
A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level	Met	Met	Met	Met	Met
The detailed health risk assessment includes: Identification of the severity of the member's conditions/disease state	Met	Met	Met	Met	Met

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Evaluation of co-morbidities or multiple complex health care conditions	Met	Met	Met	Met	Met
Demographic information	Met	Met	Met	Met	Met
Member's current treatment provider and treatment plan, if available	Met	Met	Met	Met	Met
The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment	Met	Met	Met	Met	Met
The risk level assignment is periodically updated as the member's health status or needs change	Met	Met	Met	Met	Met
The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met ↑	Met	Met
The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract	Met	Met	Met	Met	Met
The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met	Met	Met	Met
The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	Met	Met	Met	Met	Met
CAN: The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants CHIP: The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants	Met	Met	Met	Met	Met
Transitional Care Management					

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
The CCO monitors continuity and coordination of care between PCPs and other service providers	Met	Met	Met	Met	Met
The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Met	Partially Met ↓	Met	Met	Met
The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process	Met	Met	Met	Met	Met
The CCO meets other Transition of Care contract requirements	Met	Met	Met	Met	Met
Annual Evaluation of the Utilization Management Program					
A written summary and assessment of the effectiveness of the UM program is prepared annually	Met	Met	Met	Met	Met
The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met	Met

F. Delegation

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

Constellation Quality Health's review of delegation functions included the delegate lists provided by the CCOs, sample delegation contracts, delegation monitoring materials, and documentation of delegation oversight.

United has delegation agreements with the entities identified in *Table 45: United Delegated Entities and Services*.

Table 45: United Delegated Entities and Services

United Delegated Entities	United Delegated Services
Optum Behavioral Health	Case management, utilization management, quality management, network contract management
Dental Benefit Providers	Call center services, claims processing timeliness, network adequacy
Medical Transportation Management (MTM)	Claims processing, quality management, call center operations, network adequacy
eviCore National	Radiology and Cardiology utilization management

	services, prior authorization handling, call center services
MARCH Vision Care	Network contract management, call center operations, claims processing
OptumRX	Network adequacy, call center services, claims processing timeliness, prior authorization handling

Magnolia has delegation agreements with the entities identified in *Table 46: Magnolia Delegated Entities and Services*.

Table 46: Magnolia Delegated Entities and Services

Magnolia Delegated Entities	Magnolia Delegated Services
Envolve Dental	Dental Administrator, Claims, Network, Utilization Management, Credentialing and Quality Management
Envolve Vision	Vision Services, Claims, Network, Utilization Management, Credentialing and Quality Management
Centene Pharmacy Solutions	Pharmacy Benefit Manager, Claims, Network, Utilization Management, Credentialing and Quality Management
Medical Transportation Management, Inc. (MTM)	Non-Emergency Transportation Claims, Network, Utilization Management, Credentialing and Quality Management
National Imaging Associates, Inc. (NIA)	Radiology Utilization Management
Turning Point	Musculoskeletal Surgical Quality and Safety and Utilization Management

Molina has delegation agreements with the entities listed in *Table 47: Molina Delegated Entities and Services*.

Table 47: Molina Delegated Entities and Services

Molina Delegated Entities	Molina Delegated Services
March Vision	Vision Administration
Medical Transportation Management (MTM)	Non-Emergent Transportation
Progeny	Care management, utilization management
Skygen	Dental Administration
CVS/Caremark	Pharmacy Benefit Manager
Healthmap	Case Management

Each of the health plans has policies that define delegation requirements as well as processes for evaluating potential delegates, approval of delegation, implementing written delegation agreements, and conducting ongoing monitoring and annual evaluations for existing delegates.

Prior to executing a delegation agreement, the health plans conduct pre-delegation assessments to evaluate potential delegates' abilities to conduct delegated activities in compliance with health plan standards and requirements of the *CAN* and *CHIP Contracts*.

Upon completion of pre-delegation assessments and approval of delegation, the health plans execute written delegation agreements that specify the delegated activities as well as health plan and delegate responsibilities, performance expectations, reporting requirements, and consequences for substandard performance and failure to fulfill obligations.

Constellation Quality Health reviewed the CCO's documentation of oversight activities conducted for their delegates.

United and Magnolia provided the annual evaluation for all entities. Both CCOs measured compliance and performance of all delegated vendors. No issues were identified.

Molina provided a pre-delegation audit and the annual audits for all their delegates except CVS/Caremark. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation audit report was not provided. This was an issue identified during the 2022 EQR.

Tables 48 and *49* display the strengths, weaknesses, and recommendations for the Administration section.

Table 48: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
The health plans have policies that define delegation requirements as well as processes for evaluating potential delegates, approval of delegation, implementing written delegation agreements, and conducting ongoing monitoring and annual evaluations for existing delegates.	✓		
Prior to executing a delegation agreement, the health plans conduct pre-delegation assessments to evaluate potential delegates' abilities to conduct delegated activities in compliance with health plan standards and contractual requirements.	✓		

Table 49: Delegation Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina - The annual delegation oversight audit of CVS/Caremark was not conducted as required by the *CAN*	In addition to the monthly and/or quarterly monitoring reports, the CCOs must complete the annual delegation oversight audit of for all delegated entities as required	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Contract, Section 15 (B) and the *CHIP Contract, Section 14 (B).*	by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B).*			

Table 50: Delegation Services Comparative Data for the 2023 EQR illustrates the scoring for each standard reviewed during the 2023 EQR.

Table 50: Delegation Services Comparative Data for the 2023 EQR

Standard	United CAN	United CHIP	Magnolia CAN	Molina CAN	Molina CHIP
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*					
The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Met	Met
The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions	Met ↑	Met ↑	Met ↑	Not Met	Not Met

FINDINGS SUMMARY

Overall, United CAN, United CHIP, and Magnolia CAN sustained or showed the most improvement. *Table 51: Scoring Overview* provides an overview of the scoring for each section of the EQR. The percentages highlighted in green indicate the health plan sustained or showed an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings.

Table 51: Overall Scoring

	Met	Partially Met	Not Met	Not Evaluated/ Not Applicable	Total Standards	*Percentage Met Scores
Administration						
United CAN	31	0	0	0	31	100%
United CHIP	31	0	0	0	31	100%
Magnolia CAN	29	2	0	0	31	93.5% ↓
Molina CAN	30	1	0	0	31	96.8% ↓

	Met	Partially Met	Not Met	Not Evaluated/ Not Applicable	Total Standards	*Percentage Met Scores
Molina CHIP	30	1	0	0	31	96.8% ↓
Provider Services						
United CAN	47	2	0	0	49	95.9% ↓
United CHIP	47	1	0	0	48	97.9% ↑
Magnolia CAN	47	2	0	0	49	95.9% ↑
Molina CAN	46	0	3	0	49	93.9% ↓
Molina CHIP	44	1	2	0	47	93.6% ↓
Member Services						
United CAN	33	0	0	0	33	100% ↑
United CHIP	32	0	0	0	32	100% ↑
Magnolia CAN	33	0	0	0	33	100% ↑
Molina CAN	28	5	0	0	33	84.8% ↓
Molina CHIP	27	5	0	0	32	84.4% ↓
Quality Improvement						
United CAN	19	0	0	0	19	100%
United CHIP	19	0	0	0	19	100%
Magnolia CAN	19	0	0	0	19	100%
Molina CAN	15	3	1	0	19	78.9% ↓
Molina CHIP	15	3	1	0	19	78.9% ↓
Utilization						
United CAN	52	2	0	0	54	96.3% ↑
United CHIP	51	3	0	0	54	94.4% ↑
Magnolia CAN	53	1	0	0	54	98.1% ↑
Molina CAN	52	2	0	0	54	96.3% ↓
Molina CHIP	52	2	0	0	54	96.3% ↓
Delegation						
United CAN	2	0	0	0	2	100% ↑
United CHIP	2	0	0	0	2	100% ↑
Magnolia CAN	2	0	0	0	2	100% ↑
Molina CAN	1	0	1	0	2	50%
Molina CHIP	1	0	1	0	2	50%
Totals						
United CAN	**184**	**4**	**0**	**0**	**188**	**97.9% ↑**
United CHIP	**182**	**4**	**0**	**0**	**186**	**97.8% ↑**
Magnolia CAN	**183**	**5**	**0**	**0**	**188**	**97% ↑**
Molina CAN	**172**	**11**	**5**	**0**	**188**	**91.5% ↓**
Molina CHIP	**169**	**12**	**4**	**0**	**185**	**91.4% ↓**

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

Table 52: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons displays and allows a comparison of the total percentage of standards scored as "Met" for the Part 438 Subpart D and QAPI Standards for the 2023—2024 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings for the CCO. Those highlighted in yellow represent a reduction from the CCO's prior review. Up (↑) and down (↓) arrows are included to further illustrate the change from the previous reviews.

Table 52: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons

Federal Standards	United CAN			United CHIP			Magnolia CAN			Molina CAN			Molina CHIP		
	2023	2022	2021	2023	2022	2021	2023	2022	2021	2023	2022	2021	2023	2022	2021
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	100%	100%	100%	100%	100%	100%	87% ↓	89%	100%	87% ↑	78%	100%	87% ↑	78%	100%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	100%	100%	100%	94% ↓	100%	100%	100% ↑	94%	100%	100%	100%	94%	100%	100%	89%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	100% ↑	92%	100%	100%	100%	100%	100% ↑	92%	100%	92% ↓	100%	100%	92% ↓	100%	100%
Confidentiality *(§ 438.224)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	90% ↑	75%	91%	90% ↑	70%	82%	100% ↑	80%	100%	90% ↓	95%	100%	90% ↓	95%	95%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	100% ↑	50%	100%	100% ↑	50%	100%	100% ↑	50%	100%	50%	50%	50%	50%	50%	50%

Federal Standards	United CAN			United CHIP			Magnolia CAN			Molina CAN			Molina CHIP		
	2023	2022	2021	2023	2022	2021	2023	2022	2021	2023	2022	2021	2023	2022	2021
Practice Guidelines *(§ 438.236, § 457.1233)*	100%	100%	100%	100%	100%	100%	100% ↑	82%	100%	100%	100%	100%	100%	100%	100%
Health Information Systems *(§ 438.242, § 457.1233)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	79% ↓	89%	89%	79% ↓	89%	89%
Disenrollment Requirements and Limitations *(§ 438.56)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enrollee Rights Requirements *(§ 438.100)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	67% ↓	100%	100%	67% ↓	100%	100%
Emergency and Post-Stabilization Services *(§ 438.114)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

Attachments

- Attachment 1: Assessment of Corrective Actions from Previous EQR
- Attachment 2: MississippiCAN CAHPS®ECHO 3.0 Report Summary

Attachment 1: Assessment of Corrective Actions from Previous EQR

CONSTELLATION QUALITY HEALTH EXTERNAL QUALITY REVIEW
ASSESSMENT OF CORRECTIVE ACTIONS FROM PREVIOUS EQR

UnitedHealthcare Community Plan of Mississippi – MSCAN

Standards	UnitedHealthcare Community Plan of MS – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	A listing of covered and excluded benefits is found in the CAN Provider Manual. Issues noted with documentation of benefits included: •The benefits grid in the CAN Provider Manual, page 11, indicates well child care is not covered. However, information about well child care is found elsewhere in CAN Provider Manual. This is an issue identified during the previous 2021 EQR. •The behavioral health benefits grid in the CAN Provider Manual, page 12, lists peer support services but does not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. This is an issue that was identified during the previous 2021 EQR. *Corrective Action: Revise the CAN Care Provider Manual to correct the issues identified with documentation of benefits for well child care and peer support services.*	✓	
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	The CAN Contract, Section 6 (E) states, "The Contractor must also utilize a web-based provider directory, which must be updated within 5 business days upon changes to the provider network." However, Policy NQM-052, Web-Based Directory Usability Testing, page 2, item D, states, "The Web-based practitioner and hospital directory information is updated within 30 calendar days of when new information is received." Onsite discussion confirmed updates are made to the online Provider Directory within 24 hours. *Corrective Action: Revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.*	✓	
MEMBER SERVICES			
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the	A listing of covered and excluded benefits is found in the CAN Member Handbook. Issues noted with documentation of benefits included:	✓	

Standards	UnitedHealthcare Community Plan of MS – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in coverage;	•The benefits information on page 38 of the CAN Member Handbook indicates well child care is not covered. This is an issue identified during the previous EQR. •The behavioral health benefits grid on page 39 of the Member Handbook lists peer support services but does not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. This is an issue identified during the previous EQR. *Corrective Action: Revise the CAN Member Handbook to correct the issues identified with documentation of benefits for well child care and peer support services.*		
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: 1.2 The procedure for filing and handling a grievance;	Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, captures the process for filing a grievance, which is reflected in the Member Handbook. However, the CAN Member Handbook, page 62, offers the member the option of filing an Expedited Grievance. This option is not mentioned in the grievance policy or on United's website. *Corrective Action: Update Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, and United's website to include the process followed for an expedited grievance.*	✓	
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, includes the steps United follows if an extension is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension. *Corrective Action: Update the notice sent to members regarding the need for an extension and include the member's right to file a grievance if they disagree with the extension.*	✓	
UTILIZATION MANAGEMENT			
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	The notice sent to members when United requests an extension for completing a UM decision is missing the information about the member's right to file a grievance regarding the extension, as required by 42 CFR 438.408 (c). This requirement is also not specifically mentioned in the CAN UM Program Descriptions, the policy, the Provider Manual, or in the CAN Member Handbook.	✓	

Standards	UnitedHealthcare Community Plan of MS – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	*Corrective Action: Update the notice sent to members regarding a request for an extension to include the member's right to file a grievance as required by 42 CFR 438.408 (c). Also, update the CAN UM Program Description, the policy, the Provider Manual, and the CAN Member Handbook regarding the member's right to file a grievance.*		
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	Links provided in the Member Handbook to access the listing of OTC medicines and the PDL result in an error message indicating "Page Not Found." This issue was identified during a previous EQR and CCME recommended the link be corrected. *Corrective Action: Ensure the embedded links for the PDL and OTC medications list in the CAN Member Handbook are functional.*	✓	
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: 1.2 The procedure for filing an appeal;	The process and timeframe for filing appeals are documented in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. The process and timeframe are also found in the CAN Member Handbook, Provider Manual, and on United's website. However, the website, CAN Member Handbook (page 63), and the Provider Manual incorrectly require the member to follow a verbal appeal with a written appeal. *Corrective Action: Correct the appeal information found on United's website, CAN Member Handbook, and Provider Manual to remove the requirement that a verbal appeal must be followed with a written appeal.*	✓	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	Appeal resolution timeframes are documented in policy, the CAN Member Handbook, Provider Manual, and on United's website. The information indicates United may extend the timeframe for appeal resolution and will provide written notice to the member of the delay. United provided a copy of the notice sent to members if an extension is needed. This notice, the CAN Member Handbook, Provider Manual, and United's website do not inform members of their right to file a grievance if they disagree with the extension, as required by the CAN Contract, Section 6, and 42 CFR § 438.408 (c). *Corrective Action: Include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal in the member notice, the CAN Member Handbook, Provider Manual, and United's website.*	✓	

Standards	UnitedHealthcare Community Plan of MS – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
2. The CCO applies the appeal policies and procedures as formulated.	A sample of CAN appeal files was reviewed. The following issues were identified: •The rationale in the resolution notices in five files was not written in language clear and understandable to members. The rationale was confusing regarding the physician who made the appeal decision. For example, the verbiage in one of the notices mentions the reviewing physician specializes in Plastic Surgery. The next paragraph indicates the decision was made by a physician board certified in Internal Medicine. •The acknowledgement letter for one file was not sent within the 10-calendar day requirement. United acknowledged during the onsite that the resolution letters were confusing, and that they are working on a solution to improve the notifications. *Corrective Action: Continue working on a solution to improve the appeal resolution notifications. Develop a plan to monitor and edit the notifications before sending the notices to members.*	✓	
DELEGATION			
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.	Delegate oversight documentation submitted for review confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated are subjected to an annual evaluation process. Issues noted with documentation of delegation oversight include: •Optum Behavioral Health — routine monitoring was provided in a file labeled "35_MSCAN_DVOC_Scorecard_OBH_MS 2021-2022," but there was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities. Annual evaluation documentation was provided for credentialing and recredentialing activities. •Medical Transportation Management (MTM) —routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents. However, there was no documentation of a formal annual evaluation of delegated services. •epicoria National — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for delegated services.	✓	

Standards	UnitedHealthcare Community Plan of MS – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	•MARCH Vision Care — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing. •Optum RX — routine monitoring was provided as noted on the DVOC Scorecard document, but there was no documentation of a formal annual evaluation of delegated services. *Corrective Action: Ensure each entity delegated to conduct any service or activity that is ultimately a health plan responsibility is subjected to a formal evaluation at least once a year, and that the formal annual evaluation includes all activities delegated to the entity. Refer to the CAN Contract, Section 15 (B).*		

UnitedHealthcare Community Plan of Mississippi – MS CHIP

Standards	UnitedHealthcare Community Plan of MS – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
2. Initial provider education includes: 2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	A listing of covered and excluded benefits is found in the CHIP Provider Manual. The behavioral health benefits grid in the CHIP Provider Manual, page 10, lists peer support services but does not indicate whether these are covered or not. This is also the case in the CHIP Member Handbook, page 32. Onsite discussion confirmed these services are covered. This is an issue that was identified during the previous 2021 EQR. *Corrective Action: Revise the CHIP Care Provider Manual and CHIP Member Handbook to correct the issues identified with documentation of benefits for peer support services.*	✓	

Standards	UnitedHealthcare Community Plan of MS – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	The CHIP Care Provider Manual correctly documents most appointment access standards; however, page 56 does not include the 7-day timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge. This is a repeated finding from the 2021 EQR. *Corrective Action: Revise the CHIP Care Provider Manual to include complete information about the timeframe for appointments post-discharge from an acute psychiatric hospital.*	✓	
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	The *CHIP Contract, Section 6 (E)* states, "The Contractor must also utilize a web-based provider directory, which must be updated within 5 business days upon changes to the provider network." However, Policy NQM-052, Web-Based Directory Usability Testing, page 2, item D, states, "The Web-based practitioner and hospital directory information is updated within 30 calendar days of when new information is received." Onsite discussion confirmed updates are made to the online Provider Directory within 24 hours. *Corrective Action: Revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.*	✓	
MEMBER SERVICES			
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 their enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in their coverage;	A listing of covered and excluded benefits is found in the CHIP Member Handbook. Issues noted with documentation of benefits included: •The behavioral health benefits information in the grid in the CHIP Member Handbook, page 32, lists peer support services but does not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. This is an issue that was identified during the previous 2021 EQR. *Corrective Action: Revise the CHIP Member Handbook to correct the issues identified with documentation of benefits for peer support services.*	✓	
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:	The CAN Member Handbook, page 62, offers the member the option of filing an Expedited Grievance. This option is not mentioned in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, or on United's website. *Corrective Action: Update the CHIP Member Handbook, Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance and United's website to include the process followed for an expedited grievance.*	✓	

Standards	UnitedHealthcare Community Plan of MS – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
1.2 The procedure for filing and handling a grievance;			
1.3 Timeliness guidelines for resolution of the grievance;	Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, includes the steps United follows if an extension or additional time is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension. *Corrective Action: Update the notice sent to members regarding the need for an extension and include the member's right to file a grievance if they disagree with the extension.*	✓	
UTILIZATION MANAGEMENT			
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	The notice sent to members when United requests an extension for completing a UM determination is missing information regarding the member's right to file a grievance regarding the extension, as required by 42 CFR §438.408 (c). This requirement is also not specifically mentioned in UM Program Descriptions, policy, the Provider Manual, or the Member Handbook. *Corrective Action: Update the notice sent to members regarding a request for an extension to include the member's right to file a grievance as required by 42 CFR §438.408 (c). Also, update the CHIP UM Program Description, the policy, the Provider Manual, and the CHIP Member Handbook regarding the member's right to file a grievance.*	✓	
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: 1.2 The procedure for filing an appeal;	United's website, the CHIP Member Handbook (page 49), and the Provider Manual incorrectly require the member to follow a verbal appeal with a written appeal. *Corrective Action: Correct the appeal information found on United's website, CHIP Member Handbook, and the Provider Manual to remove the requirement that a verbal appeal must be followed with a written appeal.*	✓	
1.5 Timeliness guidelines for resolution of the appeal;	Appeal resolution timeframes are documented in policy, the CHIP Member Handbook, Provider Manual, and on United's website. The information indicates United may extend the timeframe for appeal resolution and will provide written notice to the member of the delay. United provided a copy of the notice sent to members if an extension is needed. This notice,	✓	

Standards	UnitedHealthcare Community Plan of MS – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	the CHIP Member Handbook, Provider Manual, and United's website do not inform members of their right to file a grievance if they disagree with this extension, as required by the CHIP Contract, Section 6, and 42 CFR § 438.408 (c). *Corrective Action: Include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal in the member notice, the CHIP Member Handbook, Provider Manual, and United's website.*		
1.6 Written notice of the appeal resolution;	The CHIP Uphold and Overturned letter templates provided with the desk materials contain the required information. Additionally, the "Your Additional Rights" enclosure provides information and instructions for requesting an Independent External Review. However, it does not include the requirement that members have the right to request and receive benefits while the Independent External Review is pending, and that the member can be held liable for the cost. This was an issue identified during the 2021 EQR and not corrected. *Corrective Action: Edit the "Your Additional Rights" enclosure for CHIP appeal letters to include the requirement that members have the right to request and receive benefits and can be held liable for the cost, according to the CHIP Contract, Section E (14)(d).*	✓	
2. The CCO applies the appeal policies and procedures as formulated.	A sample of CHIP appeal files wase reviewed. The following issues were identified: •The rationale in the resolution notices for four CHIP files was not written in language clear and understandable to members. The rationale was confusing regarding the physician who made the appeal decision. For example, the notice indicated the decision was made by a physician specializing in Plastic Surgery. However, further verbiage states the decision was made by a medical director who specializes in Pediatrics and Neonatology. United acknowledged during the onsite that the resolution letters were confusing, and that they are working on a solution to improve the notifications. •Also, none of the resolution letters sent when the denial was upheld contained the requirement that members have a right to request and receive benefits while the Independent External Review is pending. *Corrective Action: Continue working on a solution to improve the appeal resolution notifications. Develop a plan to monitor and edit the notifications before sending the notices to members. Include information regarding the member's right to request and receive benefits while the Independent External Review is pending, and that the member can be held liable for the cost.*	✓	

Standards	UnitedHealthcare Community Plan of MS – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
DELEGATION			
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.	Oversight documentation submitted confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated are subjected to an annual evaluation process. Issues noted with documentation of delegation oversight include: •Optum Behavioral Health — routine monitoring was provided in a file labeled "35_MSCAN_DVOC_Scorecard_OBH_MS 2021-2022," but there was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities. Annual evaluation documentation was provided for credentialing and recredentialing activities. •eviCore National — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for delegated services. •MARCH Vision Care — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing. •Optum RX — routine monitoring was provided as noted on the DVOC Scorecard document, but there was no documentation of a formal annual evaluation of delegated services. *Corrective Action: Ensure each entity delegated to conduct any service or activity that is ultimately a health plan responsibility is subjected to a formal evaluation at least once a year, and that the formal annual evaluation includes all activities delegated to the entity. Refer to the CAN Contract, Section 15 (B).*	✓	

Magnolia Health Plan – MSCAN

Standards	Magnolia Health Plan – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	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 revealed that one voting member only attended 50% of the meetings. *Corrective Action Plan: Reinforce attendance expectations with members of the Compliance Committee.*	✓	
PROVIDER SERVICES			
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.	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 psychiatric hospital (when the*	✓	

Standards	Magnolia Health Plan – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	CCO is aware of the discharge). Add the timeframes for routine and urgent care dental appointments, general urgent care providers, and emergency care providers.		
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	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.*	✓	
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	The Provider Manual directs the reader to the website to view the full list of Preventive Health Guidelines. However, the hyperlink provided is non-functional, returning an error message. This is a finding originally noted during the previous EQR. *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.*	✓	
MEMBER SERVICES			
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: 1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	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 processing a grievance in Policy MS.MBRS.07, Member Grievance and Complaints Process and in the member notice.*	✓	
UTILIZATION MANAGEMENT			

Standards	Magnolia Health Plan – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
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.	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. 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.*	✓	
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: 1.2 The procedure for filing an appeal;	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 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.*	✓	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	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 sent to the member regarding the extension does not mention the member's right	✓	

Standards	Magnolia Health Plan – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	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.*		
2. The CCO applies the appeal policies and procedures as formulated.	A sample of appeal files was 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.*	✓	
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions: 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. *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.*	✓	
DELEGATION			
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO	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 deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.	✓	

Standards	Magnolia Health Plan – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
if the CCO were directly performing the delegated functions.	•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.*		

Molina Healthcare of Mississippi – MSCAN

Standards	Molina Healthcare of Mississippi – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
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. 1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	During onsite discussion, Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients. *Corrective Action Plan: Develop and implement a process to monitor provider panel limitations to ensure members have appropriate choice among providers.*	✓	
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.	Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Appointment access standards are defined in Policy MHMS-QI-006, Access to Care. Most appointment access standards listed in the policy are consistent with the		✓

Standards	Molina Healthcare of Mississippi – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	contractual requirements. However, the timeframe for specialist appointments is specified as 20–30 calendar days. The *CAN Contract, Section 7 (B) 2* lists the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents: •For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CAN Member Handbook, page 36, lists the requirement as 21 days for adults and 14 days for children. •For PCP routine sick appointments, the policy correctly lists the timeframe as seven calendar days, but the CAN Member Handbook, page 35, lists the requirement as 14 days. •For specialist appointments, the *CAN Contract, Section 7 (B) (2)* states the timeframe is 45 calendar days, but the CAN Member Handbook, page 36, lists the timeframe as 21 days. •For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CAN Provider Manual, page 60, states the timeframe is 14 days. •The CAN Provider Manual does not include the appointment access requirements for routine and urgent dental appointments. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits. Correct the timeframe for specialty appointments in Policy MHMS-QI-006, Access to Care. Revise the applicable CAN Member Handbook and/or CAN Provider Manual to reflect the correct appointment access standards for PCP well care appointments, PCP routine sick appointments, specialist appointments, and Behavioral Health/Substance Use routine appointments. Add the appointment access standards for routine and urgent dental appointments to the CAN Provider Manual.*		
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and	A link in the CAN Provider Manual takes the reader to a listing of covered benefits on Molina's website.		✓

Standards	Molina Healthcare of Mississippi – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
services provided under fee-for-service payment by DOM;	For Home Health Services, the list of covered benefits on the website link indicates a limit of 25 visits per year. However, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year. *Corrective Action Plan: Revise the CAN benefit information on the website to provide complete and correct information about the number of visits allowed for home health services.*		
MEMBER SERVICES			
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in coverage;	The CAN Member Handbook, page 38, indicates Home Health Services have no limit on the number of visits. Benefit information on Molina's CAN website does list a limit of 25 visits. Of note, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year. *Corrective Action Plan: Correct the number of visits allowed for Home Health Services in the CAN Member Handbook.*		✓
QUALITY IMPROVEMENT			
4. The CCO tracks provider compliance with EPSDT service provision requirements for: 4.3 Diagnosis and/or treatment for children.	Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment addresses EPSDT services, how Molina tracks services, and follow-up with members who have not received or are behind in getting services. This policy also includes the process followed for tracking follow-up treatment and referrals. Per Policy QI- 003, follow-up activities are to be documented on the EPSDT tracker. Molina provided the EPSDT tracking report. However, this report did not include documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The CAN Contract, Section 5 (D) requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's EPSDT tracking system does not meet this contractual requirement.		✓

Standards	Molina Healthcare of Mississippi – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	Corrective Action Plan: Implement a system for tracking members identified with an abnormal finding on an EPSDT exam that includes the diagnosis, treatments, and referrals needed to address the abnormal findings as required by the CAN Contract, Section 5 (D).		
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	CCME received the 2021 QI Program Evaluation two days before the onsite. This Evaluation had been approved by the QIC in April 2022 and the Board in May 2022. There was a note on each page that indicates the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The QI Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the evaluation: •In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions a root cause analysis was completed. However, it was not included in the QI Program Evaluation. •The Geographic Access Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing activities (reference Section 19.0, 2021 work plan) were not included in the QI Program Evaluation. •The Delegation Oversight activities were incomplete. After the Onsite, Molina submitted another copy of the 2021 QI Program Evaluation. Additional information was added related to the delegation oversight. However, this QI Program Evaluation is also incomplete. This continues to be an issue and was identified in the 2020 and 2021 EQRs. The *CAN Contract, Section 10 (D) (8)* requires the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Exhibit G (7)* further defines the requirements for the QI Program Evaluation. *Corrective Action Plan: Correct the 2021 Quality Improvement Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the CAN Contract, Section 10, and Exhibit G.*		✓

Standards	Molina Healthcare of Mississippi – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
UTILIZATION MANAGEMENT			
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: 1.2 The procedure for filing an appeal;	Procedures for filing an appeal are described in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Information regarding the process for filing an appeal was also found in the CAN Member Handbook, the CAN Provider Manual, and on Molina's website. These documents incorrectly indicate that a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification template. Also, Policy MHMS-MRT-02, Standard Member Appeals, documents information that must be included in appeal acknowledgement letters. However, the CAN standard appeal acknowledgement letter template does not include the statement offering a State Fair Hearing or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy. *Corrective Action: Remove the requirement that a member must follow a verbal appeal request with a written request from Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, CAN Provider Manual, the appeal request forms, and on Molina's website. Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.*	✓	
DELEGATION			
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.	CCME reviewed the delegate oversight documents provided by Molina. The following issues were identified: •For CVS/Caremark, documentation included reports of routine monitoring and delegate reporting, but no documentation of a pre-delegation assessment was provided. The date of initial delegation was noted by the CCO as 10/1/21. •For March Vision Care, the credentialing file review worksheet did not include evidence of monitoring the delegate for conducting initial site visits. The documentation indicated site visits are delegated to March Vision Care. The addendum to Policy CR 01, Credentialing Program Policy, states initial credentialing site visits are required for all providers. This is a repeat finding from the previous EQR.		✓

Standards	Molina Healthcare of Mississippi – MSCAN 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	Corrective Action: Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained. When site visits are delegated to a credentialing delegate, ensure they are monitored for conducting the site visits according to health plan policy.		

Molina Healthcare of Mississippi – MS CHIP

Standards	Molina Healthcare of Mississippi – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	During onsite discussion, Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients. *Corrective Action Plan: Develop and implement a process to monitor provider panel limitations to ensure members have appropriate choice among providers.*	✓	
2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Appointment access standards are defined in Policy MHMS-QI-006, Access to Care. Most appointment access standards listed in the policy are consistent with the contractual requirements. However, the timeframe for specialist appointments is specified as 20-30 calendar days. The *CHIP Contract, Section 7 (B) (2)* lists the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents: •For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CHIP Member Handbook, page 37, lists the requirement as 21 days for adults and 14 days for children. •For specialist appointments, the *CHIP Contract, Section 7 (B) (2)* states the timeframe is 45 calendar days, but the CHIP Member Handbook, page 37, lists the timeframe as 21 days. •For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CHIP Provider Manual, page 76, states the timeframe is 14 days. •The CHIP Provider Manual does not include the appointment access requirements for routine and urgent dental appointments. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits. Correct the timeframe for specialty*		✓

Standards	Molina Healthcare of Mississippi – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	appointments in Policy MHMS-QI-006, Access to Care. Revise the applicable CHIP Member Handbook and/or CHIP Provider Manual to reflect the correct appointment access standards for PCP well care appointments, specialist appointments, and Behavioral Health/Substance Use routine appointments. Add the appointment access standards for routine and urgent dental appointments to the CHIP Provider Manual.		
2. Initial provider education includes: 2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	A link in the CHIP Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Radiology/X-rays, the list of covered benefits on the website link indicates these services must be conducted in a physician's office or hospital outpatient department. However, the CHIP Member Handbook, page 40, does not include the restriction on location. *Corrective Action Plan: Revise the CHIP benefit information on the website to provide complete and correct information about restrictions on location requirements for Radiology/X-ray services.*	✓	
MEMBER SERVICES			
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 their enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in their coverage;	For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to location (as noted in benefit information on Molina's CHIP website) and states that a prior authorization is required for these services. The onsite discussion with Molina staff indicated prior authorization is required only for advanced imaging services and not for routine X-rays. *Corrective Action Plan: Revise the benefit information in the CHIP Member Handbook to provide complete and correct information about restrictions on location and prior authorization requirements for Radiology/X-ray services.*	✓	
QUALITY IMPROVEMENT			
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: 4.3 Diagnosis and/or treatment for children.	For CHIP, Molina follows Policy MHMS-QI-005, Well-Baby and Well-Child Services, regarding tracking Well-Baby and Well-Child Services. This policy did not include Molina's process for tracking treatments or referrals needed for abnormal findings during the Well-Child and Well-Baby service. This was an issue identified during the previous EQR and not corrected. During the onsite, Molina indicated the wrong policy had been uploaded. The correct draft policy was provided after the onsite. The process added to		✓

Standards	Molina Healthcare of Mississippi – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	Policy MHMS-QI-005 indicates follow-up activities will be included in the Well-Baby and Well-Child tracking report. Molina provided the Well-Baby Well-Child tracking report. However, this report did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The *MS CHIP Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's Well-Baby Well-Child tracking system does not meet this contractual requirement. *Corrective Action Plan: Implement a system for tracking members identified with an abnormal finding on a Well-Baby Well-Child exam that includes the diagnosis, treatments, and referrals needed to address the abnormal findings as required by the CHIP Contract, Section 5 (D).*		
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	CCME received the 2021 QI Program Evaluation two days before the onsite. This QI Program Evaluation had been approved by the QIC in April 2022 and the Board in May 2022. There was a note on each page that indicates the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the Evaluation: •In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions that a root cause analysis was completed; however, not included in the QI Program Evaluation. •The Geographic Access Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing activities (reference Section 19.0, 2021 work plan) were not included in the Program Evaluation. •The Delegation Oversight activities were incomplete. After the onsite, Molina submitted another copy of the 2021 QI Program Evaluation. Additional information had been added related to delegation oversight. However, this Evaluation is also incomplete. This continues to be an issue and was identified in the		✓

Standards	Molina Healthcare of Mississippi – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	2020 and 2021 EQRs. The *CHIP Contract, Section 9 (D) (8)* requires the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Exhibit F (C) (6)* further defines the requirements for the QI Program Evaluation. *Corrective Action Plan: Correct the 2021 Quality Improvement Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the CHIP Contract, Section 9, and Exhibit F.*		
UTILIZATION MANAGEMENT			
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: 1.2 The procedure for filing an appeal;	Procedures for filing an appeal are described in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Information regarding the process for filing an appeal was also found in the CHIP Member Handbook, the CHIP Provider Manual, and on Molina's website. These documents incorrectly indicate a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification letter. Also, Policy MHMS-MRT-02, Standard Member Appeals, includes information that must be included in appeal acknowledgement letters. However, the CHIP standard appeal acknowledgement letter template does not include the statement of offering the one-page "Grievance/Appeal Form" as mentioned in the policy. Also, this policy mentions the offering of a State Fair Hearing as being included in the acknowledgement letter. However, a State Fair Hearing is not applicable for CHIP. *Corrective Action: Remove the requirement that a member must follow-up a verbal request for an appeal with a written request from Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, CHIP Provider Manual, the appeal request forms, and on Molina's website. Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.*	✓	

Standards	Molina Healthcare of Mississippi – MS CHIP 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
DELEGATION			
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.	CCME reviewed the delegate oversight documents provided by Molina. The following issues were identified: •For CVS/Caremark, documentation included reports of routine monitoring and delegate reporting, but no documentation of a pre-delegation assessment was provided. The date of initial delegation was noted by the CCO as 10/1/21. •For March Vision Care, the credentialing file review worksheet did not include evidence of monitoring the delegate for conducting initial site visits. The documentation indicated site visits are delegated to March Vision Care. The addendum to Policy CR 01, Credentialing Program Policy, states initial credentialing site visits are required for all providers. This is a repeated finding from the previous EQR. *Corrective Action: Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained. When site visits are delegated to a credentialing delegate, ensure they are monitored for conducting the site visits according to health plan policy.*		✓

Attachment 2: 2023 CAHPS®ECHO 3.0 Summary

2023 CAHPS®ECHO 3.0 Report Summary

Constellation Quality Health contracted with DataStat, Inc. an NCQA Certified CAHPS Survey Vendor, to conduct Experience of Care and Behavioral Health Outcomes (ECHO) Surveys, developed by the Agency for Healthcare Research and Quality (AHRQ), to learn about the experiences of adult and child members who have received counseling or treatment from network providers. The surveys address key topics such as access to counseling and treatment, provider communication, plan information, and overall rating of counseling and treatment received. For MississippiCAN, attempts were made to survey 2,250 adult enrollee households and 2,250 child enrollee households. For Mississippi CHIP, attempts were made to survey 1,500 enrollee households. The surveys for both MississippiCAN and Mississippi CHIP were conducted by mail from October 27, 2023, through February 23, 2024, using a standardized survey procedure and questionnaire.

The results of these surveys can be used by the State and by the health plans to assess CAN and CHIP enrollees' experiences regarding their behavioral healthcare; identify strengths and weaknesses in quality of care and services; make determinations about resource allocation to improve weaknesses; and identify the effects of health plan efforts to improve over time.

Summary of Overall Rating Question

Survey recipients were asked to rate their experience with counseling or treatment from 0 (worst) to 10 (best). The figures below display the proportion of members who provided ratings of 8, 9, or 10, along with the overall MississippiCAN Adult and Child and overall Mississippi CHIP ratings.

Figure 1: Summary of Overall Rating Question – MississippiCAN Adult

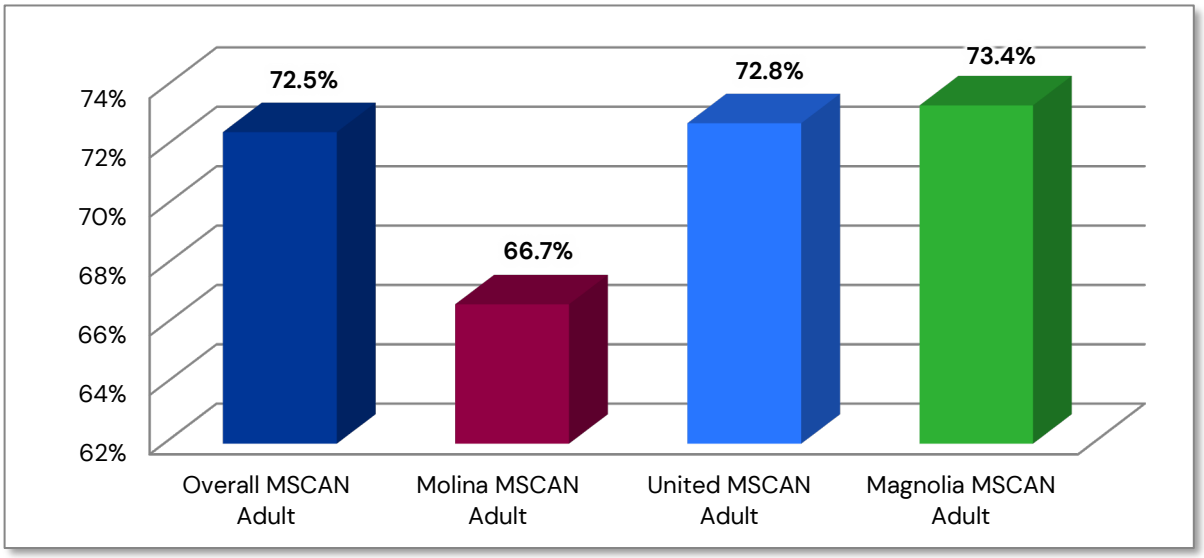


Figure 2: Summary of Overall Rating Question – MississippiCAN Child

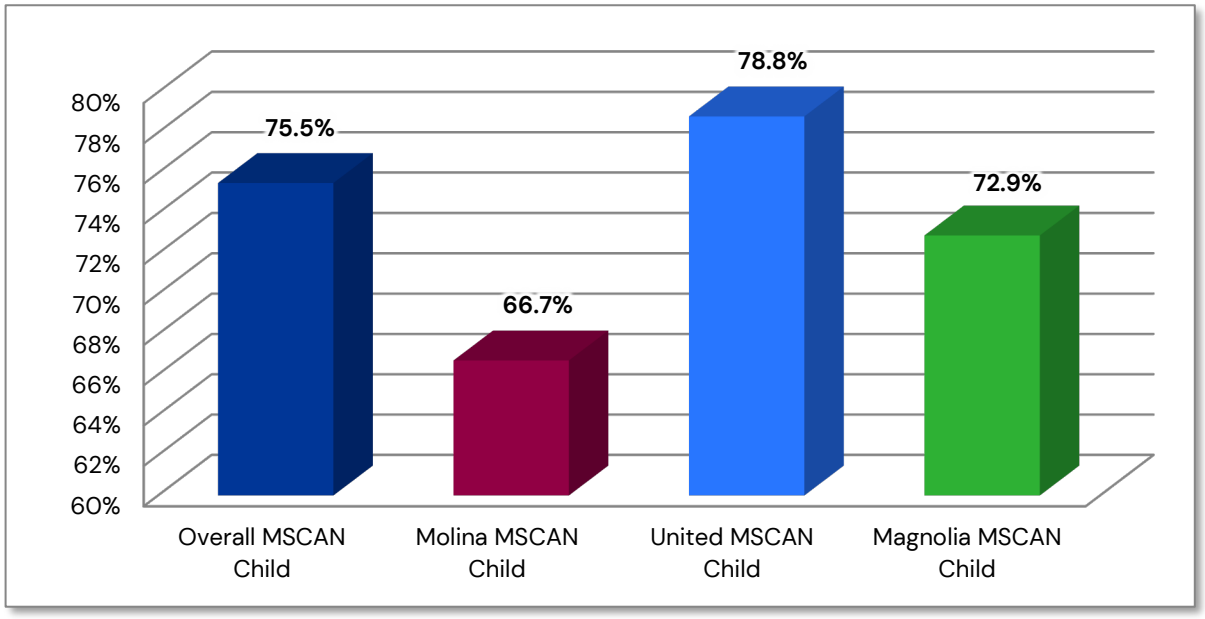
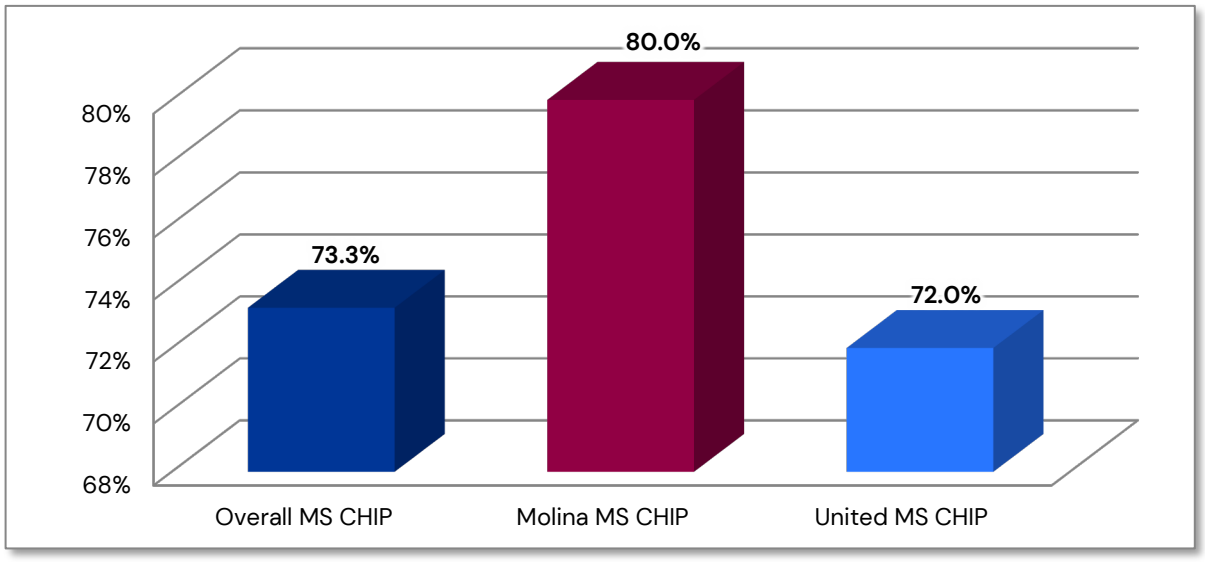


Figure 3: Summary of Overall Rating Question – Mississippi CHIP



Summary of Key Strengths and Opportunities for Improvement

Reponses to survey questions that indicate a positive experience are labeled as achievements and are summarized as achievement scores. Achievement scores for survey questions are computed as the proportion of enrollees who indicate a positive experience; therefore, the lower the achievement score, the greater the need for the health plan to improve.

The following tables display the ten survey questions most highly correlated with member satisfaction with counseling and treatment (Q29) and their corresponding achievement scores. Among the ten items, the five questions with the highest achievement scores are presented first as Key Strengths. These are areas that appear to matter the most to members, and where the health plan is doing well. The five questions with the lowest achievement scores are presented second, as Opportunities for Improvement. These are areas that appear to matter the most to members, but where the health plan is not doing as well and could focus quality improvement efforts.

Table 1: Key Strengths and Opportunities for Improvement MSCAN – Adult

Key Strengths – MSCAN Adult	Achievement Score
Q13. Clinicians usually or always showed respect	94.0
Q11. Clinicians usually or always listened carefully	90.0
Q14. Clinicians usually or always spent enough time	89.5
Q15. Usually or always felt safe with clinicians	89.0
Q27. Care responsive to cultural needs	88.2
Opportunities for Improvement – MSCAN Adult	**Achievement Score**
Q39. Delays in treatment while waiting for plan approval were not a problem	35.4
Q5. Usually or always got urgent treatment as soon as needed	75.4
Q29. A lot or somewhat helped by treatment	81.8
Q18. Usually or always involved as much as you wanted in treatment	85.8
Q12. Clinicians usually or always explained things	88.0

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

Key Strengths – MSCAN Child	Achievement Score
Q14. Clinicians usually or always showed respect	96.9
Q13. Clinicians usually or always explained things	94.4
Q12. Clinicians usually or always listened carefully	90.7
Q15. Clinicians usually or always spent enough time	87.0
Q20. Usually or always got professional help wanted for child	84.4
Opportunities for Improvement – MSCAN Child	**Achievement Score**
Q28. Care responsive to cultural needs	71.4
Q30. A lot or somewhat helped by treatment	80.4
Q7. Usually or always got appointment as soon as wanted	82.0
Q23. Given as much information as wanted to manage condition	82.6
Q21. Child usually or always had someone to talk to when troubled	84.3

Table 3: Key Strengths and Opportunities for Improvement MS CHIP

Key Strengths – MS CHIP	Achievement Score
Q14. Clinicians usually or always showed respect	96.7
Q13. Clinicians usually or always explained things	96.6
Q12. Clinicians usually or always listened carefully	93.3
Q15. Clinicians usually or always spent enough time	92.2
Q20. Usually or always got professional help wanted for child	86.7
Opportunities for Improvement – MS CHIP	**Achievement Score**
Q38. Told about other ways to get treatment after benefits were used up	40.0
Q3. Usually or always got help by telephone	41.9
Q28. Care responsive to cultural needs	66.7
Q23. Given as much information as wanted to manage condition	76.4
Q30. A lot or somewhat helped by treatment	79.4