# 2021 External Quality Review

## MOLINA HEALTHCARE OF MISSISSIPPI

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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 contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. This review determines the level of performance demonstrated by Molina Healthcare of Mississippi (Molina). This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The goals and objectives of the review were to:

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

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

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

## I. Summary and Overall Findings

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

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

- Confidentiality (§ 438.224)
- Grievance and Appeal Systems (§ 438.228, § 457.1260)
- Sub contractual Relationships and Delegation (§ 438.230, § 457.1233)
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems (§ 438.242, § 457.1233)
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess Molina's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

### *Administration*

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

The review of the Administration section focuses on Molina's policy management, staffing, information systems, compliance, and confidentiality practices. Molina has policies and procedures in place to ensure the provision of quality services. Onsite discussion revealed that Molina has formed a Policy Committee responsible for policy development, review, and revisions as needed.

Molina has outlined all key positions in their Organizational Chart. Onsite discussion indicated that recruitment is underway to fill Marketing/Public Relations position vacated in May 2021.

The 2021 Molina Healthcare of Mississippi Compliance Plan and the Code of Business Conduct and Ethics govern the way Molina's employees, officers, and directors conduct business activities. The Compliance Committee works with the Compliance Officer with respect to implementing the Compliance Plan. The Compliance Committee meets quarterly and as needed.

Molina's ISCA documentation indicates the organization's personnel and systems have the capabilities to perform the Medicaid processing required by Mississippi. Molina's 30-day claims processing rate exceeds the State's 90-day requirement. Additionally, Molina has incorporated resilience into its systems to minimize downtime and protect data in the event of a disaster. Finally, the organization has an extensive Disaster Recovery plan that is tested and updated yearly.

It is the policy of Molina to preserve the confidentiality of information related to members, employees, providers, contractors, business partners, proprietary businesses, and all other types of confidential information. Examples and procedural information are included in HIPAA specific policies and training materials for members and providers.

## *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*

Molina's processes and requirements for provider credentialing and recredentialing are documented in various policies and state-specific addenda. Although Addendum B (Molina Healthcare of Mississippi State Specific Credentialing Requirements) of Policy CR 01, Credentialing Program Policy, states Molina conducts initial site assessments prior to completing the initial credentialing process for private practitioner offices and other patient care settings, Molina reported that the process for conducting site visits has not yet been established and Molina plans to contract with a vendor to conduct site visits. This is a repeat finding from the previous EQR. None of Molina's policies or addenda address the requirement for obtaining fingerprints for CHIP providers designated as high risk by DOM. Molina reported they are trying to establish a contract with a vendor to conduct this activity, but it is unknown when this will be finalized. This is also a repeat finding from the previous EQR.

The Professional Review Committee (PRC) is chaired by Molina's Medical Director and uses a peer review process to review Level 2 credentialing files. Network provider representation on the PRC includes providers with specialties of Family Medicine, Sports Medicine, OB/GYN, and Internal Medicine; however, processes are in place to invite ad hoc attendees when practitioners of additional specialties are needed. Review of PRC minutes confirmed the committee met at appropriate intervals, the quorum was established for each meeting, and member attendance is satisfactory.

No issues were identified in initial credentialing and recredentialing files for CAN and CHIP practitioners. However, one file for a CHIP mental health clinic did not include evidence of fingerprinting as required by the *CHIP Contract, Section 7 (E) (6)*. This is a repeat finding from the 2020 EQR.

Appropriate processes are established for monitoring the adequacy of the provider network using contractually-required geographic access and appointment availability standards. Quarterly Geographic Access assessments are conducted, and results are reported to the Executive Quality Improvement Committee. Molina also conducts appointment and after-hour accessibility audits quarterly. Activities are in place to ensure network providers can serve members with special needs, including foreign language and cultural requirements.

Molina's Provider Services staff develop, conduct, and evaluate provider education and training programs. Initial provider orientation is conducted within 30 days of a provider becoming active in the network, and ongoing training is conducted routinely. Molina reported that although most education continues to be provided virtually, some face to face provider interactions are being conducted with provider approval.

Provider Directories include information for PCPs, hospitals, specialists, ancillary services, behavioral health/substance use disorder facilities, and pharmacies. The print version of the CAN and CHIP Provider Directories did not include an indication of provider abilities to accommodate people with physical disabilities.

Molina adopts preventive health and clinical practice guidelines that are specific to the demographics and needs of Molina's member population and are selected based on scientific evidence and recommendations made by national clinically based organizations. The guidelines are reviewed and updated at least every 2 years. Providers are informed of the PHGs and CPGs, in various ways, such as Provider Manuals, provider orientation sessions, newsletters, and Molina's website. Printed copies of the guidelines are available upon request.

Policy MHMS-QI-124, Standards of Medical Record Documentation, defines minimum standards for maintenance of member medical records and lists elements that must be included in member medical records. The policy does not provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc. Medical record maintenance and documentation standards are included in the CAN and CHIP Provider Manuals.

Provider satisfaction was validated using the *CMS Protocol 6. Administration or Validation of Quality of Care Surveys*. Response rates for the provider satisfaction survey were low and may affect generalizability of the results.

### *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*

Member Rights and Responsibilities are outlined in the Member Handbook, the CAN website, member materials, and in Policy MHMS-ME-003, Member Rights and Responsibilities. The CAN website omits the requirement that members are financially responsible for unauthorized services obtained from out-of-network providers. The CAN website does not indicate that members are financially responsible unauthorized health care services obtained from non-participating providers, as required in the *CAN Contract, Section 6 (J) and 42 CFR § 438.100*. All other member rights and responsibilities were clearly identified in the above referenced sources.

Molina makes available a toll-free telephone number to the Molina Members Services Call Center, Provider Services Call Center, and 24-Hour Nurse Advice Line. New Member Welcome Packets are provided within 14 days of the member's enrollment. Enrollment and disenrollment process are outlined in policy, the Member Handbook, and on the website.

Call Center communication is monitored and evaluated for provider and member services staff to improve the quality of call handling. The Quality Improvement Committee (QIC) minutes reported the Service Level performance for member calls as 90.3%.All call center quality goals were met or exceeded.

Information for members on the provision of screening, preventive, and medically necessary diagnostic and treatment services is available for members.

Policies and procedures are in place outlining the definitions of grievance terminology and processes for filing grievances. Timeliness standards and information about categorizing, monitoring, and analyzing grievances are outlined in policies, the Member Handbook, Provider Manual, and on the website. Of the CAN and CHIP grievance files reviewed, no issues were identified.

Member Satisfaction Survey validation for Molina CAN was performed based on the CMS Survey Validation Protocol. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the protocol. Molina contracts with SPH Analytics Research, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, to conduct the Adult and Child Surveys. The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS. For Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (10.3%). For the Child survey, generalizability of the survey results is also difficult to discern due to low response rates (10.2%).

### *Quality Improvement*

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

Molina has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided to all CAN and CHIP members. The 2021 Quality Improvement Program Description was submitted for review. This program description covers the CAN and CHIP populations, is updated annually, and is submitted to the QIC and the Board of Directors for approval. Molina's Cultural Competency Plan described in the QI program description provides a summary of the plan to address healthcare disparities through tools and needed trainings. Providers and members are informed about QI activities through Molina's website. In the Provider Manual, a description of the QI program is provided and informs Providers they may request more information about initiatives and/or the progress toward meeting quality goals by calling Provider Services.

Molina provided the 2020 work plan and the first and second quarter work plans for 2021 for review. The work plans included the QI activities across several sections, the responsible parties, timelines, the action plans/goals, and the results or status for each activity. Results for the CAN and CHIP lines of business are clearly delineated in the work plans. Last year there were several errors noted in the work plan. Molina addressed these

errors in their corrective action plan and implemented the changes in the Q2 2021 work plan.

The QIC is responsible for the oversight, implementation, coordination, and integration of all QI activities. This committee sets the strategic direction for all QI activities. The QIC is co-chaired by the Chief Medical Officer and the Health Plan Quality Lead. Voting members include Molina's senior leaders representing all departments of the organization and four network providers. The committee co-chairs convene and preside over regularly scheduled quarterly meetings and convene special meetings as needed. A quorum of at least 51% of the committee members with no less than half of network provider participants are necessary to enact or implement decisions. It was noted for the Q2 and Q3 2020 meetings there was not a quorum because only one network provider attended the meeting. During the previous EQR, CCME recommended Molina recruit additional network providers to serve on the QIC. Molina responded and indicated they were seeking additional providers. The identification of those providers should be completed by 4th quarter 2021. In the September 2021 meeting minutes, it was noted a new provider was added; however, Molina should continue recruitment efforts due to poor provider participation.

Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby, and Well-Child Services and Immunization Services, define the requirements for the EPSDT Program. These policies did not address how Molina tracks provider or member compliance with treatments or referrals needed for abnormal conditions identified through the EPSDT, Well-Baby, and Well-Child services. Also, the tracking reports did not include the treatment and/or referrals made for any abnormal findings. This was an issue found during the previous EQR. Molina addressed the corrective action and indicated once the member is identified, follow-up will be provided via letter or phone to determine if the member received a referral, received treatment, missed any follow-up appointments, and/or need assistance with securing an appointment with an appropriate specialist. A draft template was also included that addressed the deficiencies. However, this tracking report template was not implemented.

Annually Molina completes an evaluation of the QI program to assess the overall effectiveness of the organization's QI processes for CAN and CHIP members. The Quality Improvement Program 2020 Annual Evaluation was provided as evidence of this evaluation. The evaluation included an executive summary that provided a brief overview of the evaluation and areas of focus and or recommendation for the next year (2021). The evaluation also included several appendices that covered the results of the CLAS analysis, population assessment, quality performance measures report, potential quality of care issues, and the member and provider experience report. Areas not included in the evaluation were the results and analysis of the availability of practitioners, accessibility of services, continuity and coordination of medical care, the provider directory analysis,

results of delegation oversight, and credentialing activities. The performance improvement projects were included in the executive summary; however, the information was incomplete. There was no mention of the barriers and interventions to address the barriers. Most of the target rates were listed as "TBD." These were the same or similar errors found during the previous EQR. Molina addressed these errors and indicated the 2021 QI Program Evaluation is expected to be completed by 1st or 2nd quarter of 2022 and the evaluation will include all required elements outlined in the contract.

### *Performance Measure Validation*

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

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Molina for the CAN and CHIP populations. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted the validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2020, through December 31, 2020.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Molina. Aqurate found that Molina's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2020.

All relevant HEDIS performance measures for the CAN population were compared for the current review year (MY 2020) to the previous year (MY 2019) and the changes from 2019 to 2020 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have a substantial increase or decrease in rate from 2019 to 2020. Substantial increase or decrease is a change in rate of greater than 10%. Since Molina did not have enrollment in the CHIP product line in 2019, the PM validation was conducted only on the MY 2020 rates.

**Table 1: CAN HEDIS Measures with Substantial Changes in Rates**

| Measure/Data Element | Measure Year 2019 | Measure Year 2020 | Change from 2019 to 2020 |
|---|---|---|---|
| **Substantial Increase in Rate (>10% improvement)** | | | |

| Measure/Data Element | Measure Year 2019 | Measure Year 2020 | Change from 2019 to 2020 |
|---|---|---|---|
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) | 44.87% | 55.84% | 10.97% |
| **Substantial Decrease in Rate (>10% decrease)** | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | | | |
| *Counseling for Nutrition* | 50.85% | 40.63% | -10.22% |
| *Counseling for Physical Activity* | 46.72% | 35.52% | -11.20% |
| Immunizations for Adolescents (ima) | | | |
| *Tdap* | 69.18% | 58.64% | -10.54% |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | | | |
| *Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)* | 47.06% | 36.59% | -10.47% |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) | | | |
| *Blood Glucose Testing (1-11)* | 37.74% | 25.65% | -12.09% |
| *Blood Glucose and Cholesterol Testing (1-11)* | 19.81% | 8.38% | -11.43% |
| *Blood Glucose Testing (12-17)* | 49.4% | 37.59% | -11.81% |
| *Blood Glucose Testing (Total)* | 44.85% | 32.77% | -12.08% |
| Annual Dental Visit (adv) | | | |
| *2-3 Years* | 47.18% | 35.57% | -11.61% |
| *4-6 Years* | 66.11% | 50.05% | -16.06% |
| *7-10 Years* | 67.22% | 53.45% | -13.77% |
| *11-14 Years* | 60.41% | 50.16% | -10.25% |
| *Total* | 59.62% | 48.14% | -11.48% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years* | 71.43% | 60.42% | -11.01% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | 0.00% | 2.08% | 2.08% |
| *Total: Initiation of AOD Treatment: 13-17 Years* | 68.89% | 55.56% | -13.33% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) | | | |
| *6-11 years* | 71.19% | 49% | -22.19% |

In addition, Aqurate conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Aqurate found Molina was compliant with data integration, data control, and documentation of PM calculations.

For CAN, the source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission rate (PQI01-AD),

Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission rate (PQI-05), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period.

For CAN and CHIP, the source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator.

For CHIP, the source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission rate (PQI01-AD), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period.

Molina did not report two non-HEDIS measures for the CAN and CHIP populations as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.

The HEDIS and non-HEDIS measure rates for the CAN and CHIP populations reported by Molina for 2020 are listed in the Quality Improvement section of this report.

### *Performance Improvement Project Validation*

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

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

### *CAN PIP Validation Results*

DOM requires the CCOs to conduct PIPs that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). For the previous EQR (2020), Molina submitted seven PIPs for validation that addressed the DOM required topics. All of the PIPs except the Behavioral Health Readmission PIP scored within the "Not Credible" range. CCME requested that Molina submit a corrective action plan to address the deficiencies found in the PIPs. For the current EQR, Molina provided the same seven PIP documents for validation. It was noted that the corrective actions from the previous EQR were implemented and included in the PIP documents provided. 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 2: Behavioral Health Readmissions PIP**

| 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 Behavioral Health Readmissions for Hinds County PIP showed an increase in readmissions from the overall 2020 rate of 23.8% to Q1 2021 at 27.7%. Enrollment in high-risk case management for unique readmitted patients is reported to be 100%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 80/80=100%<br>High Confidence in Reported Results | 73/74=99%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Community connectors<br>• Primary care initiative<br>• Scheduling process changed<br>• Onsite d/c planning<br>• Transition of Care letters sent to members<br>• Patient Outreach | |

**Table 3: Asthma Medication Ratio PIP**

| Asthma Medication Ratio | |
|---|---|
| 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 rate reduced from 66% to 60.8% in Q2 2021, with a goal of 71%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 73/74=99%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Asthma education video on proper use of the inhaler<br>• Monitoring of the non-compliant members and encouraging providers to contact members to close the gap in care<br>• Telephone call campaign to encourage members to get their annual wellness exams<br>• Provider toolkits and educational materials<br>• Member educational materials | |

### Table 4: Pharmacotherapy Management of COPD Exacerbation PIP

| Pharmacotherapy Management of COPD Exacerbation (PCE) | |
|---|---|
| The COPD PIP focuses on improving the rate of COPD members who are dispensed a systemic corticosteroid within 14 days of an acute event. The PCE measure is used, and both rates improved to above goal rate. For systemic corticosteroid, the rate improved from 40% to 69.4% with a goal of 67%. The bronchodilator rate improved from 80% to 83.3% with a goal of 81.8%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products<br>• Provider Education: The Provider Toolkit is a quick reference guide for providers. This kit includes the 2021 revised HEDIS Tip Sheets to support the providers in meeting the goals of the NCQA HEDIS measures, MHMS resources (i.e., useful phone and fax numbers), and tips to increase member satisfaction. | |

### Table 5: Follow-up 7 and 30 Days After Hospitalization for Mental Illness PIP

| Follow-up 7 and 30 Days After Hospitalization for Mental Illness | |
|---|---|
| Measures the percentage of behavioral health discharges for which the member received follow-up within 7 days and 30 days of discharge. The 7-day rate improved from 8.1% in Q1 to 26.3% in Q2. The goal is 28%. For 30-day follow up, the rate also improved from 16.9% in Q1 to 46% in Q2 with a goal of 50%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>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.<br>• Discharge planning checklist<br>• Processes to improve efficiency of scheduling follow-up appointments<br>• Provider Education | |

### Table 6: Prenatal and Postpartum Care PIP

| Prenatal and Postpartum Care | |
|---|---|
| The aim of the Prenatal and Postpartum Care PIP is to improve the percentage of deliveries that receive a prenatal care visit as a member of Molina in the first trimester. And improve the percentage of deliveries that had a postpartum visit on or between 21-56 days of delivery. Both measures improved but are not yet at the goal rate. For prenatal care, the rate improved from 89.67% to 90.3% with a goal of 93.6%. The post-partum rate improved from 30.8% to 35% with a goal of 74.3%. | |
| **Previous Validation Score** | **Current Validation Score** |

| Prenatal and Postpartum Care | |
|---|---|
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Provider Education<br>• Member incentives-gift cards and car seats<br>• Member outreach events<br>• 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 6 months of their child's life. | |

**Table 7: Sickle Cell Disease PIP**

| Sickle Cell Disease | |
|---|---|
| The aim for the Sickle Cell Disease PIP is to increase the rate of case management services for members with Sickle Cell Disease (SCD). The rate improved from 49% to 5.7% in Q2 2021. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Internal monitoring and tracking for inpatient care and ED visits<br>• 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.<br>• Collaboration: Working in collaboration with MSCF, a non-profit 501(c)3 that has been in existence in MS since 1996. The goal of this organization is to improve the lives of individuals and families in MS, living with sickle cell disease. QI is also in collaboration with MHMS internal teams, mainly Health Care Services and Member and Community Engagement.<br>• Member educational materials | |

**Table 8: Obesity PIP**

| Obesity | |
|---|---|
| The Obesity PIP focuses on the child population. The BMI percentile, Nutrition, and Counseling HEDIS rates are utilized. The rates did not show improvement from Q1 to Q2. For BMI Percentile, the rate went from 12.6% to 12.5%, with a goal of 61.3%. The nutrition rate went from 11.5% to 7.3% with a goal of 52.3%. The counseling rate declined from 8.4% to 5.4% with a goal of 57.4%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 73/74=99%<br>High Confidence in Reported Results |
| **Interventions** | |

| Obesity |
|---|
| • Provider Education<br>• Member Incentives<br>• Member outreach and member events for awareness and education |

### *CHIP PIP Validation Results*

The four PIPs Molina submitted for validation this year are the same PIPs that were submitted last year. The topics included Adolescent Well Care, Asthma, Obesity, and Follow Up After Hospitalization. Last year, the PIPs did not meet the validation requirements and Molina was required to submit a corrective action plan to address the deficiencies. For the current EQR, Molina provided the same four PIP documents for validation. It was noted that the corrective actions from the previous EQR were implemented and included in the PIP documents uploaded. All the CHIP 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 9: Well Care/Well Child PIP**

| Adolescent Well Care/Well Child | |
|---|---|
| The aim for the Adolescent Well Care/Well Child PIP is to increase the number of CHIP members who receive at least 6 or more well care/well child visits during the first 0-15 months of life. The baseline rate for this PIP was 42.59% with a goal of 55.79%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>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<br>• Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale<br>• Member incentives provided on the day of the screening | |

**Table 10: Asthma Medication Ration PIP**

| Asthma Medication Ratio (AMR) | |
|---|---|
| The aim for the Asthma PIP is to increase the compliance rate of asthma medication for CHIP members. The baseline rates for Q1 2021 are presented in the documentation. For the AMR PIP, the baseline rate was presented at 84.5% with a goal of 71.28%, so the HEDIS measure is above goal at baseline. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |

| Asthma Medication Ratio (AMR) |
|---|
| **Interventions** |
| • Asthma education for members on the proper use of the inhaler<br>• Telephone campaigns to encourage members to get their annual wellness exams<br>• Provider education with toolkits and assistance with member outreach |

**Table 11: Obesity PIP**

| Obesity- Ages 3 to 19 | |
|---|---|
| The Obesity PIP aim is to increase the percentage of CHIP member who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. For the Obesity PIP, the rates for all three components were 0%. The BMI percentile goal is 61.31%; the Nutrition goal rate is 52.31%; and the physical activity counseling goal is 57.42%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Provider toolkits to help facilitate tracking reports and address areas needed.<br>• Member education, community outreach, and incentives. | |

**Table 12: Follow-up After Hospitalization for Mental Illness PIP**

| Follow-up After Hospitalization for Mental Illness (FUH)- Ages 6 to 19 | |
|---|---|
| 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 was 14.29% at baseline with a goal of 50%. The 7-day baseline rate was 7.14% with a goal of 28.3%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Transition of Care collaborative on-site discharge planning.<br>• Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation.<br>• Implementation of a Discharge Planning Checklist<br>• Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge. | |

## *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)*

CCME's assessment of Molina's CAN and CHIP Utilization Management (UM) Program includes reviews of the Health Care Services (HCS) Program Description, program

evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. The HCS Program Description describes collaboration between the UM Program and other programs within the HCS Department. Policies and procedures define how services are implemented and provided to members. However, CCME identified incorrect and/or omitted information related to urgent extended prior authorization requests in CAN and CHIP policies, and noted Policy MHMS-MRT-02, Standard Member Appeals, does not include processes for CHIP Independent External Reviews.

Appropriate reviewers conduct reviews of service authorization requests using InterQual criteria or other established criteria. Review of approval and denial files provided evidence that appropriate processes are followed, and no major issues were identified. Review of appeals files indicate staff consistently follow appeal processes for handling appeals of adverse benefit determinations. Care Management (CM) policies document CM processes and services provided; however, CCME could not identify documentation of Molina's processes for addressing continuity of care when a CAN or CHIP member disenrolls from the health plan. CM files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Overall, the identified weaknesses include documentation related to timeliness of UM decisions, lack of documentation of review processes, and lack of documentation of processes addressing continuity of care when a member disenrolls.

### *Delegation*

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

Processes and requirements for delegation of services and activities are found in various policies that address pre-assessment audits, delegation requirements, performance monitoring and annual oversight, and corrective action and/or termination of delegation agreements. Policy DO005, Credentialing Delegation Requirements, does not address site visits for providers credentialed by delegated credentialing entities nor does it address collection of fingerprints for CHIP providers designated as high risk by DOM. As noted in the Provider Services section of this EQR, Molina has not yet finalized processes for office site visits or collection of fingerprints at initial credentialing for applicable providers.

Molina's Healthcare Delegation Oversight team conducts annual oversight and ongoing monitoring for each of its delegates. Documentation of monitoring and oversight activities was submitted and revealed appropriate metrics are reviewed for claims, UM, and call center activities. However, file review worksheets for credentialing delegates did not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for CHIP providers designated as high-risk by DOM.

### *Quality Improvement Plans and Recommendations from Previous EQR*

During the previous EQR, there were five standards scored as "Partially Met" and six standards scored as "Not Met." Following the 2020 EQR, Molina submitted a Corrective Action Plan to address the deficiencies identified. CCME reviewed and accepted the Corrective Action Plan on June 18, 2021. The following is a high-level summary of those deficiencies:

- Credentialing files from 2018 and 2019, prior to COVID-19 restrictions, contained no evidence of a site visit being conducted, and onsite discussion confirmed Molina had not been conducting site visits as a part of initial credentialing.
- Molina had not developed or implemented process to comply with the requirement from the *CHIP Contract, Section 7 (E) (6)* to obtain fingerprints from CHIP providers identified as high-risk by DOM.
- Molina's was using an incorrect parameter for measuring appointments after discharge from an acute psychiatric hospital.
- Molina submitted no evidence that results of the member satisfaction survey were analyzed to identify potential quality problems.
- Documentation that the member satisfaction survey results were reported to network providers was not submitted for review.
- Documentation that Molina reported results of the member satisfaction surveys and the impact of measures taken to address any identified quality problems to the QIC was not submitted for review.
- There were errors or missing information noted in the Q3 2020 Quality Improvement work plan. The 2020 work plan only included a few references to CHIP.
- All performance improvement projects except Behavioral Health Readmission received a validation score within the "Not Credible" range and did not meet the validation requirements.
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) / Well-Baby and Well-Child tracking reports failed to link identified problems with the EPSDT or Well-Baby and Well-Child service and did not include or indicate members who received additional treatments or referrals.
- Molina's 2019 annual Quality Improvement Program evaluation did not include all required elements.
- Issues were identified with appeals information documented on Molina's website and in the Provider Manual.
- Delegation oversight monitoring tools did not address all requirements.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address the deficiencies and found the Corrective Action Plans regarding initial credentialing site visits, collection of fingerprints for applicable CHIP providers, the EPSDT/Well-Baby and Well-Child tracking reports, the QI Program evaluation, and delegation oversight monitoring tools were not implemented.

## II. Conclusions

Molina met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*.

*Table 13: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides a snapshot of Molina's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

**Table 13: Compliance Review Results for Part 438 Subpart D and QAPI Standards**

| Category | Number of CAN and CHIP Standards | Number of CAN and CHIP Standards Scored as "Met" | Overall Score |
|---|---|---|---|
| • Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)* | 18 | 18 | 100% |
| • Coordination and Continuity of Care *(§ 438.208, § 457.1230)* | 36 | 34 | 94.4% |
| • Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* | 28 | 28 | 100% |
| • Provider Selection *(§ 438.214, § 457.1233)* | 77 | 73 | 94.8% |
| • Confidentiality *(§ 438.224)* | 2 | 2 | 100% |
| • Grievance and Appeal Systems *(§ 438.228, § 457.1260)* | 40 | 39 | 97.5% |
| • Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)* | 4 | 2 | 50% |
| • Practice Guidelines *(§ 438.236, § 457.1233)* | 20 | 20 | 100% |
| • Health Information Systems *(§ 438.242, § 457.1233)* | 8 | 8 | 100% |
| • Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240 )* | 38 | 34 | 89.5% |

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

The 2021 Annual EQR shows that Molina achieved a "Met" score for 96% of the standards reviewed for CAN and 95% of the standards reviewed for CHIP. As the following chart indicates, 3% of the standards for CAN were scored as "Partially Met" and 4% of the CHIP standards were scored as "Partially Met." Scores of "Not Met" were given to 1% of the

standards for both CAN and CHIP. The charts that follow displays the current review results.

Figure 1: 2021 Annual EQR Review Results for CAN

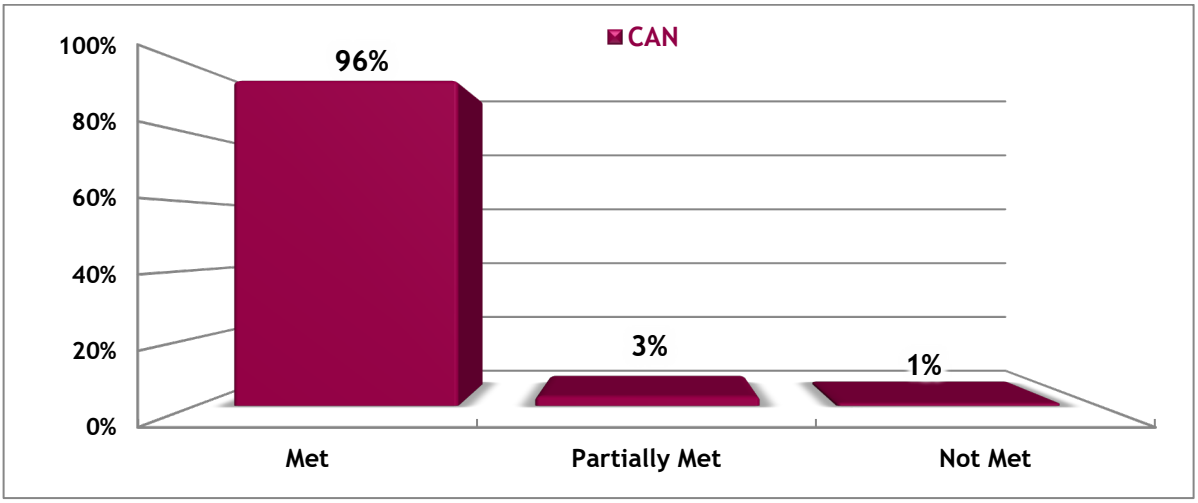



Figure 2: 2021 Annual EQR Review Results for CHIP

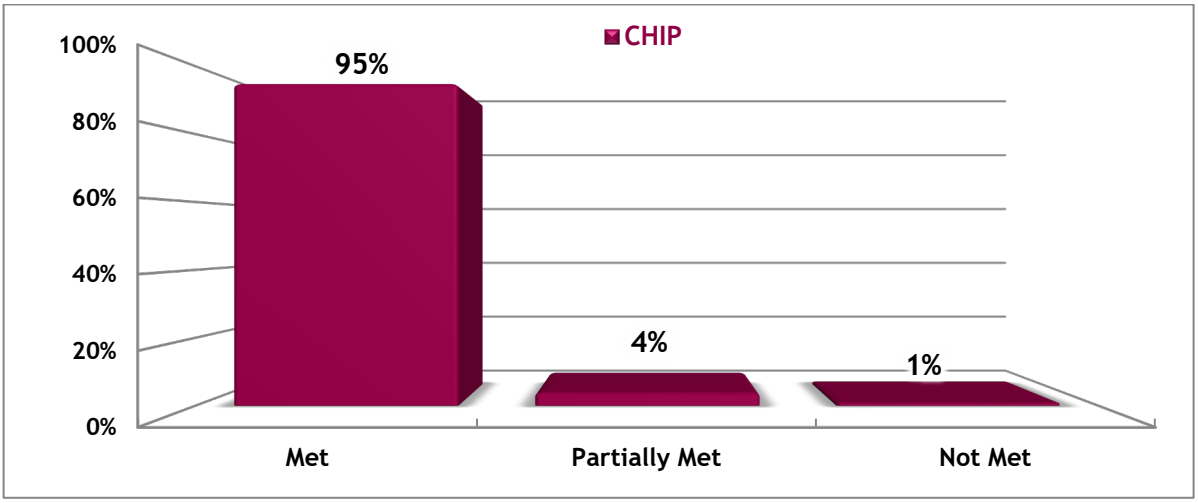



*Table 14, Scoring Overview—CAN,* provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. For 2021, 216 of 224 standards received a score of "Met." There were six standards scored as "Partially Met" and two standards that received a "Not Met" score.

Table 14: Scoring Overview—CAN

| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | Percentage "Met" |
|---|---|---|---|---|---|---|---|
| Administration | | | | | | | |

| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | Percentage "Met" |
|---|---|---|---|---|---|---|---|
| 2020 | 32 | 0 | 0 | 0 | 0 | 32 | 100% |
| 2021 | 31 | 0 | 0 | 0 | 0 | 31 | 100% |
| Provider Services | | | | | | | |
| 2020 | 67 | 1 | 1 | 17 | 0 | 86 | 97.1% |
| 2021 | 81 | 2 | 1 | 0 | 0 | 84 | 96.4% |
| Member Services | | | | | | | |
| 2020 | 33 | 0 | 3 | 0 | 0 | 36 | 90.1% |
| 2021 | 33 | 0 | 0 | 0 | 0 | 33 | 100% |
| Quality Improvement | | | | | | | |
| 2020 | 15 | 2 | 2 | 0 | 0 | 19 | 78.9% |
| 2021 | 17 | 2 | 0 | 0 | 0 | 19 | 89.5% |
| Utilization Management | | | | | | | |
| 2020 | 54 | 1 | 0 | 0 | 0 | 55 | 98.1% |
| 2021 | 53 | 2 | 0 | 0 | 0 | 55 | 96.4% |
| Delegation | | | | | | | |
| 2020 | 1 | 1 | 0 | 0 | 0 | 2 | 50% |
| 2021 | 1 | 0 | 1 | 0 | 0 | 2 | 50% |
| **Totals** | | | | | | | |
| **2020** | **197** | **5** | **6** | **17** | **0** | **225** | **97%** |
| **2021** | **216** | **6** | **2** | **0** | **0** | **224** | **96%** |

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

*Table 15, Scoring Overview—CHIP,* provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. For 2021, 208 of 218 standards received a score of "Met." There were eight standards scored as "Partially Met" and two standards that received a "Not Met" score.

**Table 15: Scoring Overview—CHIP**

| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | Percentage "Met" |
|---|---|---|---|---|---|---|---|
| Administration | | | | | | | |
| 2020 | 32 | 0 | 0 | 0 | 0 | 32 | 100% |
| 2021 | 31 | 0 | 0 | 0 | 0 | 31 | 100% |
| Provider Services | | | | | | | |

| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | Percentage "Met" |
|---|---|---|---|---|---|---|---|
| 2020 | 63 | 2 | 2 | 17 | 0 | 84 | 94.1% |
| 2021 | 78 | 3 | 1 | 0 | 0 | 82 | 95.1% |
| Member Services | | | | | | | |
| 2020 | 28 | 0 | 0 | 4 | 0 | 32 | 100% |
| 2021 | 29 | 0 | 0 | 0 | 0 | 29 | 100% |
| Quality Improvement | | | | | | | |
| 2020 | 14 | 2 | 2 | 1 | 0 | 19 | 77.8% |
| 2021 | 17 | 2 | 0 | 0 | 0 | 19 | 89.5% |
| Utilization Management | | | | | | | |
| 2020 | 53 | 1 | 0 | 0 | 0 | 54 | 98.1% |
| 2021 | 52 | 3 | 0 | 0 | 0 | 55 | 94.5% |
| Delegation | | | | | | | |
| 2020 | 1 | 1 | 0 | 0 | 0 | 2 | 50% |
| 2021 | 1 | 0 | 1 | 0 | 0 | 2 | 50% |
| **Totals** | | | | | | | |
| **2020** | **191** | **6** | **4** | **22** | **0** | **223** | **96%** |
| **2021** | **208** | **8** | **2** | **0** | **0** | **218** | **95%** |

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

## *Assessment of Strengths and Weaknesses*

The following tables provide an overview of strengths, weaknesses, and recommendations related to quality, timeliness, and access to care identified during this annual review of Molina.

**Table 16: Evaluation of Quality**

| Strengths Related to Quality |
|---|
| • Molina formed a Policy Committee to develop a departmental workflow and the annual approach to policy development, reviews, and updates.<br>• The Compliance department provides a quarterly supplemental compliance training with tips and training resources in addition to the annual, mandated education requirement.<br>• Clearly defined access management policies are in place to bolster the organization's security plans.<br>• Molina provides helpful examples of FWA and confidential information in policies and training materials for employees, members, and providers.<br>• Molina's Professional Review Committee uses a peer review process to review Level 2 credentialing files for credentialing determinations. Network provider representation on the Professional Review Committee |

| Strengths Related to Quality |
|---|
| includes practitioners with specialties of Family Medicine, Sports Medicine, OB/GYN, and Internal Medicine.<br>• Molina conducts initial provider orientation within 30 days of the date a provider is active in the network. Ongoing training is conducted annually, quarterly, or on an as-needed basis.<br>• Molina's web-based Appeals and Grievances Request Form is a good resource for members with clear information that reflects the relevant policies and procedures.<br>• PIP reports included the CMS elements and integrated corrective actions from the previous review.<br>• The performance measure validation found that Molina was fully compliant with all information system standards and submitted valid and reportable rates for all HEDIS measures in scope of the audit.<br>• There were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Molina followed measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.<br>• The following HEDIS MY 2020 measure rates were strengths for Molina since their rates had a greater than 10% improvement: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) improved by over 10 percentage points.<br>• A full-time nurse auditor was hired to enhance year-round interrater reliability activities and to ensure staff performance is consistent with policies and procedures. Education and reinforcement occur quickly and is on-going.<br>• Molina took action to terminate its delegation agreement with one delegate that continued to have issues year over year, even after placing the delegate on a bi-annual audit schedule. |

| Weaknesses Related to Quality | Corrective Actions / Recommendations Related to Quality |
|---|---|
| • Attendance is not documented on Compliance Committee minutes. | • Recommendation: For future Compliance Committee meetings, document attendance. |
| • Molina has not established a process for conducting site visits for initial credentialing. This is a repeat finding from the previous EQR. | • Corrective Action: Develop and implement a process for conducting site visits for providers to comply with requirements of the *CAN Contract, Section 7 (E) (3)* and the *CHIP Contract, Section 7 (E) (3).* |
| • None of Molina's policies or addenda address the requirement for obtaining fingerprints for CHIP providers designated as high risk by DOM. Molina reported they are trying to establish a contract with a vendor to conduct this activity, but it is unknown when this will be finalized. This is a repeat finding from the previous EQR. | • Corrective Action: Develop and implement a process for collecting fingerprints for CHIP providers designated as high-risk by DOM, as required by the *CHIP Contract, Section 7 (E) (6).* |
| • One Initial Credentialing file for a mental health clinic did not include evidence of fingerprinting for the owner, who holds 100% ownership. This is a repeat finding from the previous EQR. | • Corrective Action: Ensure credentialing files for CHIP providers designated as high risk by DOM include evidence of collection of fingerprints. |
| • Policy MHMS-QI-124, Standards of Medical Record Documentation, does not provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc. | • Corrective Action: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to include detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc. |

| Weaknesses Related to Quality | Corrective Actions / Recommendations Related to Quality |
|---|---|
| • Low response rates for the provider satisfaction survey may affect generalizability of the results. | • Recommendation: Generate new initiatives to advertise the provider satisfaction survey and gather more responses for providers. |
| • For CAN and CHIP, documentation of Molina's processes for addressing continuity of care when a member disenrolls from the health plan could not be identified. | • Corrective Action: For CAN and CHIP, include in a policy or other document Molina's processes for addressing continuity of care when a member disenrolls from a health plan according to requirements in *CAN Contract, Section 9 (A) (4)* and *CHIP Contract, Section 8 (A) (3).* |
| • The header in Policy MHMS-MRT-02, Standard Member Appeals indicates that it applies to the CAN and CHIP lines of business; however, the following issues were noted:<br>○ No documentation on the process for CHIP members to request an Independent External Review.<br>○ CHIP Policy MHMS-MRT-05, Member Independent External Review, is not included on the list of references. | • Corrective Action: For CHIP, edit Policy MHMS-MRT-02, Standard Member Appeals, to include information on the Independent External Review process for CHIP members and include Policy MHMS-MRT-05, Member Independent External Review to the list of references. |
| • The Member Satisfaction Survey sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult, Child, and Child CCC CAHPS surveys. | • Recommendation: Initiate new interventions to attempt an increase in response rates. |
| • Poor participation by network providers serving on the Quality Improvement Committee continues to be an issue. | • Recommendation: Continue to recruit additional network providers to serve on the QIC. |
| • The EPSDT and Well Child, and Well Baby policies did not address Molina's processes for tracking treatments or referrals needed for abnormal findings during the EPSDT or Well-Child, or Well Baby service. Also, the tracking reports did not include the treatment and/or referrals made for any abnormal findings. | • Corrective Action: Include the process Molina uses for tracking treatments or referrals needed for abnormal findings during the EPSDT or Well Child or Well Baby service. Also, include the follow-up on the EPSDT tracking report. |
| • The 2020 QI Program Evaluation did not include an evaluation of the results of all QI activities completed or ongoing in 2020. This was an issue identified during the previous EQR. | • Corrective Action: Correct the 2020 QI Program Evaluation and included a description and results of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program. |
| • For CAN, the source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission Rate (PQI01-AD), Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission rate (PQI-05), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission Rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period. | • Recommendation: Improve processes around calculation, reporting, and verification of the rates reported for the DOM required Adult and Child Core set measures. |

| Weaknesses Related to Quality | Corrective Actions / Recommendations Related to Quality |
|---|---|
| • For CAN and CHIP, the source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator.<br>• For CHIP, the source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission Rate (PQI01-AD), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission Rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period. | |
| • Molina did not report two non-HEDIS measures as required by DOM for the CAN and CHIP populations. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). | • Recommendation: Work proactively with DOM for clarification on measures that are required to be reported. |
| • Three of the CAN PIPs did not show any quantitative improvements. Those PIPs include the Asthma, Behavioral Health Readmission, and Obesity PIPS. | • Recommendation: Review the current interventions for the Asthma, Behavioral Health Readmission, and the Obesity PIPs to determine if there are additional barriers needing to be addressed and interventions added to improve the rates. |
| • Policy DO005, Credentialing Delegation Requirements, does not address site visits for providers credentialing by delegated credentialing entities nor does it address collection of fingerprints for CHIP providers designated as high risk by DOM. As noted in the Provider Services section of this EQR, Molina has not yet finalized processes for office site visits or collection of fingerprints at initial credentialing for applicable providers. | • Corrective Action: When the processes for conducting initial credentialing site visits for both CAN and CHIP providers and collecting fingerprints at initial credentialing for CHIP providers designated as high risk by DOM are finalized, ensure that Policy DO005, Credentialing Delegation Requirements, is updated to include whether the delegates or Molina itself will be responsible for these activities for providers who are credentialed by delegated credentialing entities. |
| • Documentation of monitoring and oversight activities revealed file review worksheets for credentialing delegates did not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for CHIP providers designated as high-risk by DOM. | • Corrective Action: If credentialing delegates are responsible for conducting site visits and collecting provider fingerprints, ensure delegated credentialing file review worksheets include evidence that the delegate is monitored for these activities and that credentialing files include evidence. |

### Table 17: Evaluation of Timeliness

| Strengths Related to Timeliness | |
|---|---|
| • The QIC 2020 Q4 Committee Minutes reported that Service Level performance for member calls: 90.3%. (Previous goal 80%). All call center quality goals were met or exceeded. | |
| **Weaknesses Related to Timeliness** | **Corrective Actions / Recommendations Related to Timeliness** |
| • Incorrect or omitted information in CAN Policy MHMS-HCS-UM-383 and CHIP Policy MHMS-HCS-UM-383.1 Timeliness of UM Decision Making and Notification, related to urgent extended prior authorization requests:<br>○ Incorrect documentation indicating that requests can be extended up to 48 hours and a decision must be made no later than 72 hours.<br>○ No documentation that Molina has to request an extension from DOM. | • Corrective Action: For CAN and CHIP, edit CAN Policy MHMS-HCS-UM-383 and CHIP Policy MHMS-HCS-UM-383.1, Timeliness of UM Decision Making and Notification, to reflect the correct timeframe requirements for urgent extended prior authorization requests and to indicate that Molina has to request the extension from DOM, according to requirements in *CAN Contract, Section 5 (J) (6) and CHIP Contract, Section 5 (I)(4).* |
| • For CAN Policy MHMS-HCS-UM-383, the header indicates Medicare line of business instead of CAN. | • Recommendation: Edit the header in Policy MHMS-HCS-UM-383 Timeliness of UM Decision Making and Notification, to reflect the line of business is MSCAN and not Medicare. |

### Table 18: Evaluation of Access to Care

| Strengths Related to Access to Care |
|---|
| • Appropriate processes are in place to monitor the adequacy of Molina's provider network and ensure adequate choice for members.<br>• The CAN and CHIP websites include a copy of the appeal request form that is fillable and can be downloaded and printed. |

| Weaknesses Related to Access to Care | Corrective Actions / Recommendations Related to Access to Care |
|---|---|
| • Documentation in Policy MHMS-QI-006, Access to Care, indicates Molina conducts appointment and after-hour accessibility audits for PCPs, high-volume specialists, high-impact specialists, and behavioral health providers. However, the policy does not define the frequency of conducting appointment access and after hours audits or the department or entity that conducts the audits. Also, the policy does not include the appointment access timeframe for urgent care providers. | • Recommendation: Revise Policy MHMS-QI-006, Access to Care, to include the frequency of conducting appointment access and after hours audits, which department or entity that conducts the audits, and the appointment access timeframe for urgent care providers. |
| • A review of the print version of the CAN and CHIP Provider Directories revealed the directories did not include an indication regarding providers' abilities to accommodate people with physical disabilities. | • Corrective Action: Develop and implement a process to include providers' abilities to accommodate people with physical disabilities in the print version of the Provider Directory, as required by the *CAN Contract Section 6 (E)* and *42 CFR § 438.10(h) (1) (iv) (viii).* |
| • The CAN member website does not clearly specify that members are financially | • Recommendation: Edit the CAN member website to clearly specify that members are financially |

| Weaknesses Related to Access to Care | Corrective Actions / Recommendations Related to Access to Care |
|---|---|
| responsible for unauthorized health care services obtained from non-participating providers. | responsible unauthorized health care services obtained from non-participating providers, as required in the CAN Contract, Section 6 (J) and 42 CFR § 438.100. |

## METHODOLOGY

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

On July 6, 2021, CCME sent notification of the initiation of the annual EQR to Molina (see Attachment 1). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN Program.

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

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on August 4, 2021, for review at the CCME offices (see Attachment 1).

The second segment was a virtual onsite review conducted on November 1, 2021, and November 2, 2021. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Molina administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

## FINDINGS

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

## I. Administration

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

Molina has policies and procedures in place to ensure the provision of quality services. Onsite discussion revealed that Molina has formed a Policy Committee responsible for policy development, review, and updates as needed. The Quality Improvement Committee references updates from the Policy Committee in their quarterly agenda.

Molina has outlined all key positions in their Organizational Chart. Onsite discussion indicated that recruitment is underway to fill a Marketing/Public Relations position vacated in May 2021.

The 2021 Molina Healthcare of Mississippi Compliance Plan and the Code of Business Conduct and Ethics governs the way Molina's employees, officers, and directors conduct business activities. Every employee, officer, and director must be familiar with it and adhere to it at all times. The Compliance Committee works with the Compliance Officer with respect to implementing the Compliance Plan. The Compliance Committee meets quarterly and as needed. Onsite discussion indicated that the Compliance Committee presently meets virtually.

Compliance education and training sessions are mandatory for all employees and new hires and is part of employees' annual performance evaluations. The Compliance Department provides quarterly supplemental trainings and resources in addition to the mandated, annual education requirement. Instances of non-compliance are subject to discipline, up to and including termination. The Compliance Officer, in conjunction with the Compliance Committee, ensures meaningful, effective, and consistent disciplinary action in all instances of noncompliance. Auditing and monitoring are used to identify areas of compliance deficiencies, respond to reports of suspected noncompliance, and to assess continuing compliance and the effectiveness of corrective measures implemented to ameliorate previously identified compliance deficiencies. Where appropriate, individuals with specific investigative expertise in the management of fraud investigations are utilized to investigate instances of suspected healthcare fraud.

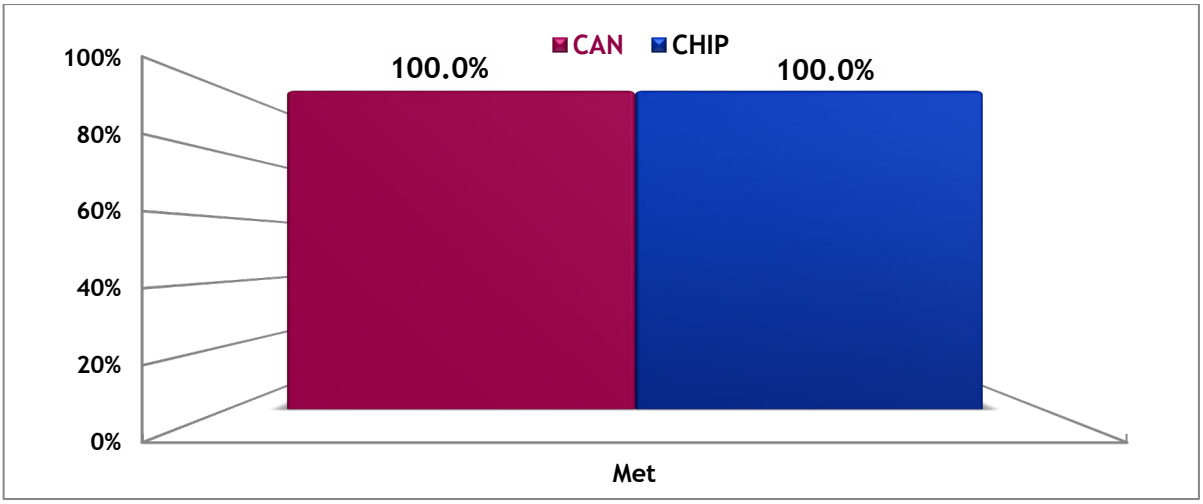
Molina's ISCA documentation indicates the organization's personnel and systems have the capabilities to perform the Medicaid processing required by Mississippi. One notable area where the organization demonstrates this is its clean claims processing rates. Molina's 30-day claims processing rate exceeds the State's 90-day requirement. Additionally, Molina has incorporated resilience into its systems to minimize downtime and protect data in the event of a disaster. Finally, the organization has an extensive Disaster Recovery plan that is tested and updated yearly.

It is Molina's policy to preserve the confidentiality of information related to members, employees, providers, contractors, business partners, proprietary businesses, and all

other types of confidential information. Examples and procedural information are included in HIPAA specific policies and training materials for members and providers.

In the Administration section of the review, Molina received "Met" scores for 100% of the standards reviewed, as illustrated in *Figure 3: Administration Findings*.

**Figure 3: Administration Findings**




### *Strengths*

- Molina has formed a Policy Committee for the purpose of developing departmental workflow and the annual approach to policy development, reviews, and updates.
- The Compliance department provides a quarterly supplemental compliance training with tips and training resources in addition to the annual mandated education requirement.
- Clearly defined access management policies are in place to bolster the organization's security plans.
- Molina provides helpful examples of FWA and confidential information in policies, training materials to employees, members, and providers.

### *Weaknesses*

- The Compliance Committee minutes did not document attendance on the committee minutes.

### *Recommendations*

- For future Compliance Committee minutes, document attendance.

## II. Provider Services

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

The review of Provider Services encompasses credentialing and recredentialing functions, network adequacy, provider education, preventive health and clinical practice guidelines, practitioner medical record documentation standards and monitoring, and provider satisfaction surveys.

### *Provider Credentialing and Selection*

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

Molina's processes and requirements for credentialing and recredentialing providers are documented in various policies and state-specific addenda. Addendum B (Molina Healthcare of Mississippi State Specific Credentialing Requirements) of Policy CR 01, Credentialing Program Policy, states Molina conducts initial site assessments prior to completing the initial credentialing process for private practitioner offices and other patient care settings. The addendum indicates the site visit requirements apply to all practitioners. During onsite discussion, Molina reported the process for conducting site visits has not yet been established, and there are plans to contract with a vendor to conduct site visits. This is a repeat finding from the previous EQR. Staff indicated that site visits for providers who have already completed credentialing will be conducted when the process is finalized.

None of Molina's policies or supporting documentation address the requirement for obtaining fingerprints for CHIP providers designated as high risk by DOM. Molina reported they are trying to establish a contract with a vendor to conduct this activity, but it is unknown when this will be finalized. This is a repeat finding from the previous EQR.

In Molina's response to the corrective action plans for these issues from the 2020 EQR, Molina indicated the health plan was focusing on identifying and contracting with a vendor to conduct site visits and collect fingerprints; that the target date for having a vendor in place and an established process was August 1, 2021; and that the plan would continue to develop processes for how and where information related to site visits and fingerprints will be maintained. Based on the findings of the current EQR, these corrective action plans were not implemented. See *Table 19: Previous Site Visits and Fingerprint Collection CAP Items.*

**Table 19: Previous Site Visits and Fingerprint Collection CAP Items**

| Standard | EQR Comments |
|---|---|
| **II. A. Credentialing and Recredentialing (CAN and CHIP)** | |

| Standard | EQR Comments |
|---|---|
| 3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.<br><br>3.2 Site assessment. | CCME understands that due to Covid-19, restrictions are in place that prevent provider office site visits from being conducted as part of initial credentialing. However, of 14 initial credentialing files reviewed, 10 were from 2018 and 2019, prior to Covid-19. These 10 files contained no evidence of a site visit being conducted, and onsite discussion confirmed Molina has not been conducting site visits as a part of initial credentialing. However, Policy CR 01, Credentialing Program Policy, Addendum B states, "Molina will conduct an initial site assessment prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the provider office visit." Requirements for site visits are specified in the *CAN Contract, Section 7 (E). Requirements for site visits are specified in the CHIP Contract, Section 7 (E).*<br><br>*Corrective Action: Develop and implement a process to conduct site visits for initial credentialing to begin when Covid-19 restrictions are lifted.* |
| **Molina's Response:** Molina has updated our credentialing policies and procedures to include information for site visits CR-01-Addendum B (document uploaded to portal.) It includes detailed information that addresses how site visits will be conducted. These visits will begin once the public health emergency is over. Molina is in the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. Our ETA around this process is July 1, 2021. | |
| **II. A. Credentialing and Recredentialing (CHIP)** | |
| 1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements. | Processes and requirements for credentialing and recredentialing health care providers are found in the Credentialing Program Policy (Policy CR 01), the Assessment of Organizational Providers Policy (Policy CR 02), and in Mississippi-specific addenda to the policies. None of the documents address the requirement from the *CHIP Contract, Section 7 (E) (6)*, which states, "Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk Provider and any person with a 5 percent or more direct or indirect ownership interest in the Provider, as those terms are defined in 455.101." Onsite discussion confirmed that Molina is not obtaining fingerprints from CHIP providers identified as high-risk by DOM.<br><br>*Corrective Action Plan: Develop and implement a process to obtain fingerprints from identified high-risk CHIP providers. The process must be documented in the appropriate credentialing policies.* |
| **Molina's Response:** Molina has updated our credentialing policies and procedures to include information for site fingerprinting (CR-02- Addendum B uploaded to portal.) It includes detailed information that addresses how site visits will be conducted. These visits will begin once the public health emergency is over. Molina is in the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. Our ETA around this process is July 1, 2021.<br><br>Update (5-25-2021): The process for collecting fingerprints or the location for maintaining such information has not been developed or determined yet, but Molina can provide an update once the process is finalized. After several internal meetings where the complexities of this requirement were discussed, Molina has | |

| Standard | EQR Comments |
|---|---|
| | decided to focus on identifying and contracting with a vendor to meet this requirement. Molina reached out to DOM about Molina engaging Gainwell to perform related credentialing functions to meet this requirement, and DOM was supportive of this idea. Molina has reached out to Gainwell and is working to set up a meeting between the parties to further discuss.<br><br>Molina Comments – June 16th, 2021: Molina met with Gainwell Technologies on June 8, 2021, to discuss performing of this function as a delegated service. Molina will have a follow up meeting with Gainwell to inform them that the site visit and fingerprinting requirement is retroactive for all applicable Molina providers. Molina will continue to work on and develop a site visit and fingerprinting process that will address how and where related information will be maintained. We are targeting having a vendor in place and an established process for how fingerprints will be collected and where the information will be stored by no later than August 1, 2021. |

Molina's Medical Director has overall responsibility for credentialing processes and activities. The Medical Director chairs, and is a voting member of, the Professional Review Committee (PRC). Level 1 (clean) credentialing files can be approved by the Medical Director with a report of approved practitioners presented at each PRC meeting. Using a peer review process, the PRC reviews Level 2 credentialing files. Network provider representation on the PRC currently includes providers with specialties of Family Medicine, Sports Medicine, OB/GYN, and Internal Medicine. Practitioners with other specialties are invited to participate when representation of their discipline is needed, and ad hoc committees representing a specific specialty may be appointed to screen applicants from their respective specialty and make credentialing recommendations to the PRC. The PRC meets at least quarterly, and the quorum is established as the presence of four voting practitioners at any meeting. The Medical Director may remove or replace a PRC member if the member is absent from more than two meetings per year. Review of PRC minutes confirmed the committee meets at appropriate intervals and member attendance is satisfactory. The minutes reflected thorough review and discussion of Level 2 providers prior to making credentialing determinations.

No issues were identified in initial credentialing and recredentialing files for CAN and CHIP practitioners. However, for organizational provider files, one initial credentialing file for a mental health clinic did not include evidence of fingerprinting for the owner, who holds 100% ownership. Refer to the *CHIP Contract, Section 7 (E) (6)*. This is a repeat finding from the 2020 EQR. In Molina's response to the 2020 EQR corrective action plan for this issue, Molina reported the health plan had updated the credentialing policies and procedures to include information for site fingerprinting and detailed information that addresses how site visits will be conducted. The plan indicated these activities would begin once the public health emergency is over, and that Molina was in the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. The estimated completion date was reported to be July 1, 2021. See *Table 20: Previous Credentialing File Review CAP Items*.

**Table 20: Previous Credentialing File Review CAP Items**

| Standard | EQR Comments |
|---|---|
| **II. A. Credentialing and Recredentialing (CAN and CHIP)** | |
| 6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities. | Of 11 initial organizational provider credentialing files reviewed, six are considered high-risk by DOM for the purposes of fingerprinting requirements. None of the files included fingerprints.<br>*Corrective Action: Ensure credentialing files for CHIP providers considered by DOM to be high risk include submitted fingerprints.* |
| **Molina Response:** Molina has updated our credentialing policies and procedures (CR-02- Addendum B uploaded to portal) to include information for site fingerprinting. It includes detailed information that addresses how site visits will be conducted. These visits will begin once the public health emergency is over. Molina is in the process of identifying a vendor or developing an internal process with hiring staff to conduct site visits. Our ETA around this process is July 1, 2021. | |

## *Availability of Services*

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

Standards for access to various provider types are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. The standards documented in the policies are compliant with contractual requirements. Quarterly Geographic Access Assessment Reports are run using the correct parameters to assess compliance with requirements for geographic accessibility. Results are reviewed and are reported to the Quality Improvement Committee (QIC). Member complaints about network access may also be used to identify inadequacies in the provider network.

Documentation in Policy MHMS-QI-006, Access to Care, indicates Molina conducts appointment and after-hour accessibility audits on a sample of PCPs, high-volume and high-impact specialists, and behavioral health providers. Ongoing monitoring includes member complaints related to accessibility, scheduling processes, wait times, and delays. The policy does not define the frequency of conducting appointment access and after hours audits. Onsite discussion confirmed the audits are conducted quarterly. The policy also does not define the department or entity that conducts the audits. Onsite discussion revealed the audits are conducted by the Quality HEDIS Call Center.

The appointment access standards listed in the policy are compliant with Contractual requirements; however, the policy does not include the appointment access timeframe for urgent care providers. Onsite discussion confirmed the appointment access requirement for urgent care providers is within 24 hours. Recommendations were offered to address the identified issues with the policy.

During the 2020 EQR, CCME identified issues related to incorrect timeframes in the Appointment Availability Report Behavioral Health (First Quarter 2020 MSCAN and First Quarter 2020 CHIP) for follow-up appointments after discharge from an acute psychiatric hospital. Findings of the current EQR confirmed Molina addressed and corrected this issue. See *Table 21: Previous Network Adequacy CAP Items*.

**Table 21: Previous Network Adequacy CAP Items**

| Standard | EQR Comments |
|---|---|
| **II B. Adequacy of the Provider Network (CAN)** | |
| 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. | The *CAN Contract, Section 7 (B) (2)* stipulates that follow-up appointments should be scheduled within 7 days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavior Health 1st Quarter 2020 MSCAN indicates that the standard was measured using a 14-calendar day parameter.<br>*Corrective Action: Review and revise the process for measuring follow-up appointments after discharge from an acute psychiatric hospital to reflect the required 7-day appointment timeframe as required by the CAN Contract, Section 7 (B) (2).* |
| **Molina's Response:** Per the email sent from Jeremy Ketchum to Wendy Johnson on April 15, 2020, Molina Healthcare disagrees with the finding. The data for the Q1 Behavioral Health Availability Report is reported on a DOM issued template. The fields were pre-populated by DOM. Molina agrees the 14-calendar day language is non-compliant with the contract language. However, we are not at liberty to alter DOM templates for reporting. DOM issued a new reporting manual and updated this report in July of 2020. However, in the new template this is still being measured at 14 calendar days. Molina has since reported this discrepancy to DOM, and they have updated the template to correct the reporting template deficiency going forward. | |
| **II B. Adequacy of the Provider Network (CHIP)** | |
| 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. | Evidence was found that accessibility standards are being measured and, except for the requirement for appointments after discharge from an acute psychiatric hospital, appear to be met. The *CHIP Contract, Section 7 (B) (2)* stipulates that follow-up appointments should be scheduled within 7 days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavior Health 1st Quarter 2020 CHIP indicates that the standard was measured using a 14-calendar day parameter.<br>*Corrective Action: Review and revise the process for measuring follow-up appointments after discharge from an acute psychiatric hospital to reflect the required seven-day appointment timeframe, as required by the CHIP Contract, Section 7 (B) (2).* |
| **Molina's Response:** This is the same response as number two for the MSCAN finding. However, the email sent from Jeremy Ketchum only addressed the finding for MSCAN and not CHIP. We will work with the Division of Medicaid to have the CHIP template updated as well.<br><br>Molina agrees the 14-calendar day language is non-compliant with the contract language. However, we are not at liberty to alter DOM templates for reporting. For this reason, Molina disagrees with this finding. | |

Processes for ensuring network providers can serve members with special needs, including foreign language and cultural requirements, are addressed in Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness. Molina uses various data sources to assess the language needs and cultural backgrounds of its membership. Activities conducted to assess the membership and network include extracting member race, ethnicity, and language information from internal and external data sources, collecting practitioner race/ethnicity and language information, collecting and analyzing complaints related to the cultural and linguistic needs of the membership, comparing member and practitioner data to identify gaps in the network, and developing action plans as needed to address identified gaps. Molina's website includes resources about culturally and linguistically-appropriate services. The information addresses interpreter services and includes downloadable/printable resources, trainings about culturally competent healthcare, and links to additional external resources.

### *Provider Education*

*42 CFR § 438.414, 42 CFR § 457.1260*

Molina's Provider Services staff develop, conduct, and evaluate provider education and training programs. Input is received from all applicable internal departments and external organizations, including DOM, as needed to determine specific training topics. Initial provider orientation is conducted within 30 days following the date the provider is active in the network. Ongoing training is conducted annually, quarterly, or on an as-needed basis. Policy MHMS-NM-008, Provider Education and Training lists, some of the topics covered in provider training sessions. Molina staff reported that most education provided virtually, but some face to face provider interactions are being conducted. Provider preference is considered along with positive COVID-19 cases in the area prior to conducting face-to-face interactions with providers.

As stated in Policy MHMS-PC-01, MHMS Provider Directory Requirements, Molina maintains Provider Directories that include information for PCPs, hospitals, specialists, ancillary services, behavioral health/substance use disorder facilities, and pharmacies. Copies of the Provider Directories are available in State Medicaid Regional Offices and WIC offices, and members may access the Provider Directories on Molina's website. Included in the policy are elements that must be included in the Provider Directories. The paper Provider Directory is updated at least every six months and the online directory is updated nightly. A review of the online CAN and CHIP Provider Directories confirmed all required elements are included. A review of the print version of the CAN and CHIP Provider Directories revealed they did not include an indication regarding providers' abilities to accommodate people with physical disabilities, as required by the *CAN Contract Section 6 (E)* and *42 CFR § 438.10(h) (1) (iv) (viii)*.

Molina adopts preventive health guidelines (PHGs) to provide up-to-date information about important preventive health topics to providers and to reduce inter-provider variation. Clinical Practice Guidelines (CPGs) are adopted to provide up-to-date

treatment and diagnostic information about important clinical topics. The PHGs and CPGs are specific to the demographics and needs of Molina's membership and are based on scientific evidence and recommendations made by national clinically based organizations. The National Quality Improvement Committee (NQIC), with participation from physicians and other health professionals, is responsible for the selection, review, and approval of PHGs and CPGs. The PHGs and CPGs are reviewed for approval and adoption through the local health plan Quality Improvement Committee and are reviewed and updated at least every two years. Providers are informed of the PHGs and CPGs, in various ways, such as Provider Manuals, provider orientation sessions, newsletters, and Molina's website. Printed copies of the guidelines are available upon request.

Policy MHMS-QI-124, Standards of Medical Record Documentation, defines minimum standards for maintenance of member medical records and lists elements that must be included in member medical records. The policy states Molina has an established medical record review process, and that "results of medical record reviews (as applicable through HEDIS or Potential Quality of Care processes) are evaluated to identify specific practitioner deficiencies and opportunities for improvement throughout the network." However, the policy does not provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments and which department or staff conduct the audits. Onsite discussion also did not provide clear information about the medical record review process. Additional information was requested to be submitted after the completion of the onsite but no additional information was provided.

Medical record maintenance and documentation standards are included in the CAN and CHIP Provider Manuals. Molina's website refers the reader to the Provider Manuals for the list of medical record documentation elements.

### *Provider Satisfaction Survey Validation*

Provider satisfaction was validated using the *CMS Protocol 6. Administration or Validation of Quality of Care Surveys*. The sample size was 1,500. SPH Analytics collected 129 surveys (44 mail, 45 internet, 40 phone) from the eligible provider population from September to October 2020. The mail/internet survey response rate was 6.6%, and the phone survey response rate was 6.8%. The rate in the previous survey was 15.6%.

Response rates for the provider satisfaction survey are low and may affect generalizability of the results. CCME recommends that Molina generate new initiatives to advertise the provider satisfaction survey and gather more responses for providers. Results were presented to the Member and Provider Satisfaction Committee (MPSC) June 2021 meeting. Root cause analysis was conducted and presented in the MPSC minutes.

The table below offers the section of the provider satisfaction survey validation worksheet that needs improvement, the reason, and the recommendation.

**Table 22: Provider Satisfaction Survey Validation Results**

| Section | Reason | Recommendation |
|---|---|---|
| Do the survey findings have any limitations or problems with generalization of the results? | Provider satisfaction was validated using the CMS Protocol 6. Administration or Validation of Quality of Care Surveys.<br>The sample size was 1,500. SPH Analytics collected 129 surveys (44 mail, 45 internet, and 40 phone) from the eligible provider population from September to October 2020. The mail/internet survey response rate is 6.6%, and your phone survey response rate is 6.8%. The rate in the previous survey was 15.6%. | Generate new initiatives to advertise survey and gather more responses for providers. |

As noted in *Figure 4, Provider Services Findings*, Molina received "Met" scores for 96.4% of the Provider Services standards for CAN and 94% of the Provider Services standards for CHIP.

**Figure 4: Provider Services Findings**

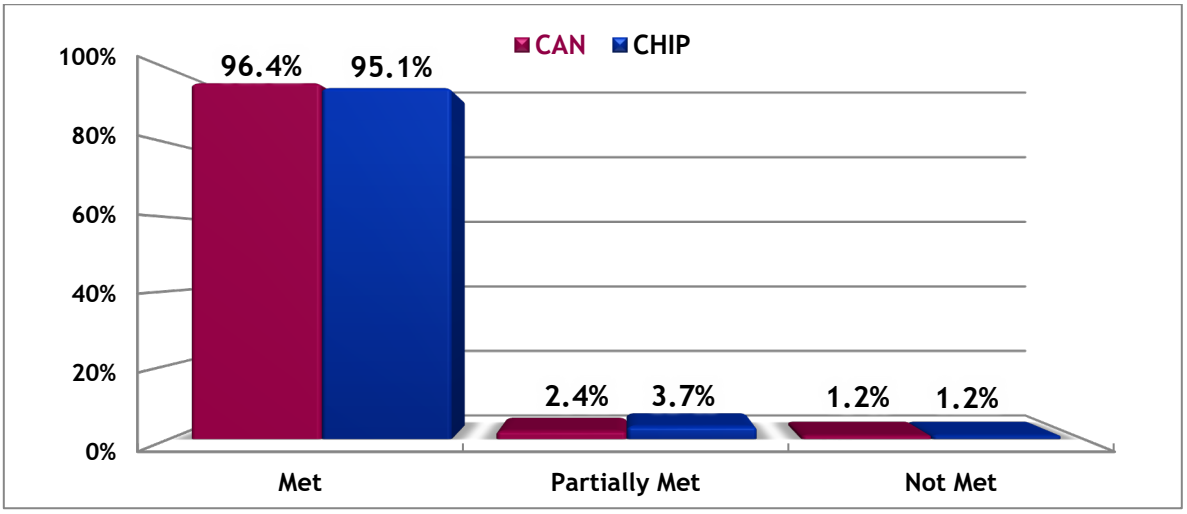


Table 23: Provider Services

| Section | Standard | CAN Review | CHIP Review |
|---|---|---|---|
| Credentialing and Recredentialing | The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements | Not Met | Not Met |
| | Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities | Met | Partially Met |
| Provider Education | The CCO regularly maintains and makes available a Provider Directory that includes all required elements | Partially Met | Partially Met |
| Practitioner Medical Records | The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers | Partially Met | Partially Met |

### *Strengths*

- Molina's Professional Review Committee uses a peer review process to review Level 2 credentialing files for credentialing determinations. Network provider representation on the Professional Review Committee includes practitioners with specialties of Family Medicine, Sports Medicine, OB/GYN, and Internal Medicine. Review of PRC minutes confirmed the committee met at appropriate intervals and member attendance was satisfactory.
- Appropriate processes are in place to monitor the adequacy of Molina's provider network and ensure adequate choice for members.
- Molina conducts initial provider orientation within 30 days of the date a provider is active in the network. Ongoing training is conducted annually, quarterly, or on an as-needed basis. Provider training includes topics essential for providers to understand Molina's programs, processes, and requirements. Molina staff reported that most education provided virtually, but some face to face provider interactions are being conducted.

### *Weaknesses*

- Molina has not established a process for conducting credentialing site visits. This is a repeat finding from the previous EQR.
- None of Molina's policies or supporting documentation address the requirement for obtaining fingerprints for CHIP providers designated as high risk by DOM. Molina reported they are trying to establish a contract with a vendor to conduct this activity,

but it is unknown when this will be finalized. This is a repeat finding from the previous EQR.

- One Initial Credentialing file for a mental health clinic did not include evidence of fingerprinting for the owner, who holds 100% ownership. Refer to the *CHIP Contract, Section 7 (E) (6)*. This is a repeat finding from the previous EQR.
- Policy MHMS-QI-006, Access to Care, indicates Molina conducts appointment and after-hour accessibility audits for PCPs, high-volume specialists, high-impact specialists, and behavioral health providers. The policy does not define the frequency of conducting appointment access and after hours audits or the department or entity that conducts the audits.
- Policy MHMS-QI-006, Access to Care, does not include the appointment access timeframe for urgent care providers.
- The print versions of the CAN and CHIP Provider Directories did not include an indication regarding providers' abilities to accommodate people with physical disabilities.
- Policy MHMS-QI-124, Standards of Medical Record Documentation, does not provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc.
- Low response rates for the provider satisfaction survey may affect generalizability of the results.

### *Corrective Actions*

- Develop and implement a process for conducting provider site visits to comply with requirements of the *CAN Contract, Section 7 (E) (3)* and the *CHIP Contract, Section 7 (E) (3)*.
- Develop and implement a process for collecting fingerprints for CHIP providers designated as high-risk by DOM, as required by the *CHIP Contract, Section 7 (E) (6)*.
- Ensure credentialing files for CHIP providers designated as high risk by DOM include evidence of collection of fingerprints.
- Develop and implement a process to include providers' abilities to accommodate people with physical disabilities in the print version of the Provider Directory, as required by the *CAN Contract Section 6 (E)* and *42 CFR § 438.10(h) (1) (iv) (viii)*.
- Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to include detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc.

### *Recommendations*

- Revise Policy MHMS-QI-006, Access to Care, to include the frequency of conducting appointment access and after-hours audits, which department or entity that conducts the audits, etc.
- Revise Policy MHMS-QI-006, Access to Care, to include the appointment access timeframe for urgent care providers.
- Generate new initiatives to advertise the provider satisfaction survey and gather more responses for providers.

## III. Member Services

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

Member Rights and Responsibilities are outlined in the Member Handbook, on the CAN website, in member materials, and in Policy MHMS-ME-003, Member Rights and Responsibilities. The CAN website omits the requirement that members are financially responsible for unauthorized services obtained from out-of-network providers. The CAN website does not indicate that members are financially responsible unauthorized health care services obtained from non-participating providers, as required in the *CAN Contract, Section 6 (J)* and *42 CFR § 438.100*. All other member rights and responsibilities were clearly identified in the above referenced sources.

Molina makes available a toll-free telephone number for the Members Services Call Center, Provider Services Call Center, and a 24-Hour Nurse Advice Line. New Member Welcome Packets are provided within 14 days of the member's enrollment and include all contractually-required information, such as an introduction letter, ID card, Member Handbook, and instructions to access the Provider Directory. Enrollment and disenrollment processes are outlined in policy, the Member Handbook, and on the website.

Call Center communication is monitored and evaluated for provider and member services staff to improve the quality of call handling. The QIC minutes reported that Service Level performance for member calls increased to 90.3% (previous annual goal of 80%). All call center quality goals were met or exceeded.

### *Grievances*

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

Policies and procedures are in place outlining the definitions of grievance terminology and processes for filing grievances. Timeliness standards and information about categorizing, monitoring, and analyzing grievances are outlined in policies, the Member Handbook, Provider Manual, and on the website. Of the CAN and CHIP grievance files reviewed, no issues were identified.

## *Member Satisfaction Survey*

Member Satisfaction Survey validation for Molina CAN was performed based on the CMS Survey Validation Protocol. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the protocol. Molina contracts with SPH Analytics Research, a certified CAHPS survey vendor, to conduct the Adult and Child Surveys. The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS.

For Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (10.3%) which included 136 completed surveys out of a sample of 1,318. For the Child survey, generalizability of the survey results is also difficult to discern due to low response rates (10.2%) which included 166 completed surveys out of 1630 sampled.

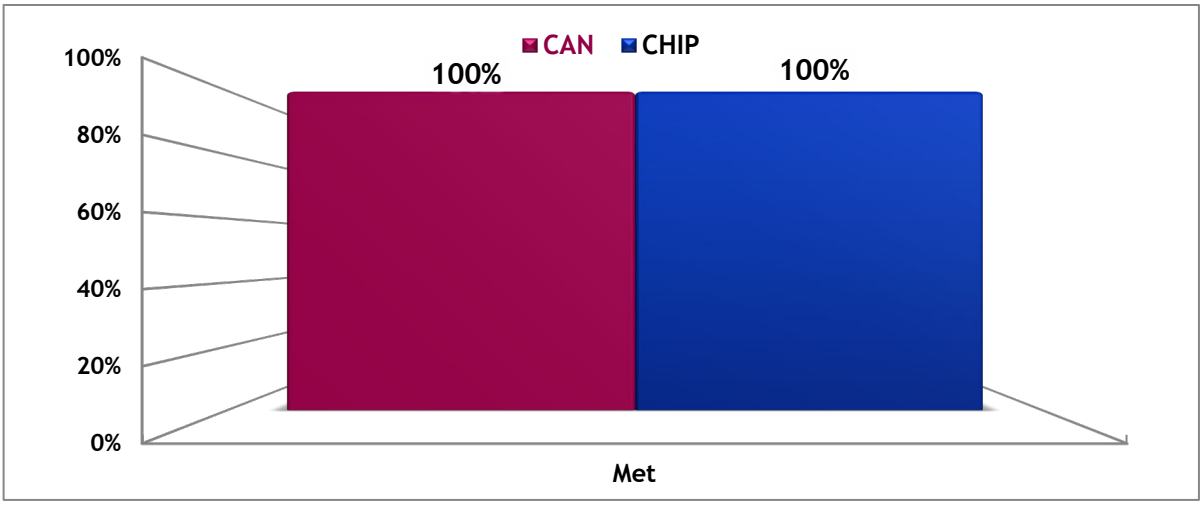
**Table 24: Previous Member Satisfaction Survey CAP Items**

| Standard | EQR Comments |
|---|---|
| **III F. Member Satisfaction Survey (CAN)** | |
| 2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems. | Molina submitted no evidence that results of the member satisfaction survey were analyzed to identify potential quality problems.<br>*Corrective Action: Ensure member satisfaction survey results are reviewed/analyzed by the appropriate committee to identify potential quality problems.* |
| **Molina's Response:** Upon receipt of the member satisfaction survey, Quality Improvement conducts a root cause analysis w/key driver diagram on the survey results to identify internal/external barriers, potential quality issues, and opportunities for improvement, specifically on survey questions that were below the recommended benchmarks. (CAHPS Key Driver Diagram uploaded to portal.) Also, results of the analysis were shared with applicable departments for collaboration and implementation of interventions focused to increase future survey ratings. However, we agree that the results were not reviewed by the Molina QIC or other committees.<br><br>Beginning Quarter 3, the 2021 Members Satisfaction Survey and successive surveys will be analyzed using the root cause analysis w/key driver diagram. Quality Improvement will ensure that results of the analysis will be presented to the QIC and the newly established Molina Member and Provider Satisfaction Committee (this committed kicked off in Q1 2021) for feedback and collaboration on identified interventions that will be implemented. | |
| 3. The CCO reports results of the member satisfaction survey to providers. | Documentation of survey results reported to network providers was not submitted for review.<br>*Corrective Action: Report the results of the member satisfaction surveys to network providers.* |
| **Molina's Response:** The Member Satisfaction/CAHPS survey was distributed to all Molina internal departments during 3rd Quarter 2020. | |

| Standard | EQR Comments |
|---|---|
| During 1st Quarter 2021, Molina has developed a new Member and Provider Satisfaction Committee that will review and make recommendations regarding the Member Satisfaction Survey ongoing. The committee is led by Network Management, Provider Services, and Member Services. The committee has representatives from various Molina departments, including Quality Improvement. The committee's charter has been approved and will be sent to the QIC for approval. Outlined in the committee's responsibilities is to ensure that member satisfaction survey results be disseminated to Molina internal departments and network providers. The committee will also collaborate with Molina Communications Department on appropriate, DOM approved dissemination efforts. Beginning in Quarter 3- 2021, the Member and Provider Satisfaction Committee will ensure survey results are reported to all Molina departments and network providers.<br>Additionally, survey results will be provided to our network providers during monthly meetings for discussion with specific areas of concern and focus. Information about the survey results will be listed in the News section of our website for providers to view and receive as education. Additional details regarding specific questions from the survey will be provided upon request. | |
| 4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee. | Documentation that Molina reported results of the member satisfaction surveys and the impact of measures taken to address any quality problems identified to the QIC, was not submitted for review.<br>*Corrective Action: Report the results of the member satisfaction surveys to the QIC.* |
| **Molina's Response:** Going forward, the Members Satisfaction Surveys will be analyzed using the root cause analysis w/key driver diagram. Quality Improvement will ensure that results of the surveys will be presented to the QIC and the newly established Molina Member and Provider Satisfaction Committee for feedback and collaboration of identified interventions that will need to be implemented.<br><br>Subsequently, the Member Satisfaction survey results will be presented to the Molina Board of Directors. | |

As noted in *Figure 5: Member Services Findings*, Molina achieved "Met" scores for 100% of the Member Services Standards for both CAN and CHIP.

**Figure 5: Member Services Findings**



### *Strengths*

- The QIC 2020 Q4 Committee Minutes reported that Service Level performance for member calls increased to 90.3% (previous goal 80%). All call center quality goals were met or exceeded.
- Molina's web-based Appeals and Grievances Request Form is a good resource for members with clear information that reflects the relevant policies and procedures.

### *Weaknesses*

- The CAN member website does not clearly specify that members are financially responsible for unauthorized health care services obtained from non-participating providers.
- The Member Satisfaction Survey sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult and Child surveys.

### *Recommendations*

- Edit the CAN member website to clearly specify that members are financially responsible for unauthorized health care services obtained from non-participating providers, as required in the *CAN Contract, Section 6 (J) and 42 CFR § 438.100*.
- Initiate new interventions to increase response rates.

## IV. Quality Improvement

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

Molina has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided to all CAN and CHIP members. The 2021 Quality Improvement Program Description covers the CAN and CHIP populations, is updated annually, and submitted to the Quality Improvement Committee and the Board of Directors for approval. The program description includes the program's goals, objectives, structure, and scope of activities. Part of QI activities is to reduce healthcare disparities. Molina's Cultural Competency Plan described in the QI program description provides a summary of the plan to address healthcare disparities through tools and needed trainings. Molina reviews and modifies the QI program objectives as needed on an ongoing basis and formally at least yearly. Providers and members are informed about QI activities through Molina's website. In the Provider Manual, a description of the QI program is provided and informs providers they may request more information about initiatives and/or the progress toward meeting quality goals by calling Provider Services.

Value Based Reimbursement (VBR) opportunities are available for network providers. The VBR program has been active since Q4 2020. Molina expects this program will continue to evolve and is on-going. The first VBR payment was finalized in Q1 2021 for performance results in Q4 2020. Subsequent VBR payments were finalized in second quarter 2021 for

performance results in first quarter 2021. Molina's goal is to finalize additional VBR agreements in 2021 with all FQHCs and other selected provider groups to strengthen and enhance the program.

Molina provided the 2020 work plan and the first and second quarter work plans for 2021 for review. The work plans included the QI activities across several sections, responsible parties, timelines, action plans/goals, and results or status for each activity. Results for the CAN and CHIP lines of business are clearly delineated in the work plans.

Last year, there were several errors noted in the work plan. Molina addressed these errors in their corrective action plan and implemented the changes in the 2nd Quarter 2021 work plan. *Table 25: Previous Quality Improvement Program CAP* provides details of the deficiencies identified in the work plan and Molina's response or resolution for those deficiencies.

**Table 25: Previous Quality Improvement Program CAP**

| Standard | EQR Comments |
|---|---|
| **IV A. Quality Improvement (QI) Program CAN and CHIP** | |
| 4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). | There were errors or missing information noted in the 3rd quarter 2020 work plan. These included:<br>•Section 2.0, Patient Safety Initiatives—the objective states "Identify a process to receive, track, investigate, validate, and manage Potential Quality of Care Issues." This was an activity completed in 2019 even though listed as ongoing for 2020.<br>•Section 5, Availability of Practitioners—the goals are not documented for the ratio of PCPs to members and the Ratio of High-Volume Specialist and High-Volume Behavioral Health Providers to members. Also, the goal for the percentage of members with one open Behavioral Health provider is missing.<br>•Section 5, Availability of Practitioners—the standards for measuring the percentage of adults and children that have access to a PCP is incorrect. The *CAN Contract, Section 7 (B), Provider Network Requirements* lists the standard for adult and pediatric members as two PCPs within 15 miles for urban and two PCPs within 30 miles for rural.<br>•Section 5, Availability of Practitioners—the standards for measuring the percentage of members with one open specialist and the percentage of members with one open Behavioral Health specialist does not include the time requirements (30 minutes) for urban providers and does not include the requirements for rural providers. The *CAN Contract, Section 7 (B)* lists the requirements as one specialist and one Behavioral Health specialist within 30 minutes or 30 miles for urban and within 60 minutes or 60 miles for rural providers. |

| Standard | EQR Comments |
|---|---|
| | •Section 6.0, Accessibility of Services—the standard for measuring a regular and routine PCP appointment is listed as 90% within six weeks. The *CAN Contract, Section 7 (B), Provider Network Requirements* lists the standard as not to exceed 30 calendar days for a PCP Well Visit and not to exceed seven calendar days for a PCP Routine Sick Visit.<br>•Section 7.0 Accessibility of Services: Behavioral Health—the standard used to measure urgent care for Behavioral Health is listed as within 48 hours. However, the *CAN Contract, Section 7 (B)* lists this requirement as not to exceed 24 hours. Also, the post discharge follow-up (not to exceed seven calendar days) is not included.<br>•Section 9.0, Continuity and Coordination of Medical Care—the timeframe for notifying members of the termination of a PCP is listed as within 30 days of termination date or within 30 days of notification. However, the *CAN Contract, Section 7 (D), Provider Termination, Number 4, Member Notification*, states the Contractor shall send a written notice within 15 calendar days of notice or issuance of termination of a Provider to Members who received primary care from the Provider.<br>*Corrective Action: Correct the errors identified in the 2020 QI Work Plan.* |
| **Molina's Response:** Section 2.0, Patient Safety Initiatives-The identification of a process to receive, track, investigate, validate, and manage Potential Quality of Care issues was completed in 2019. This process was documented in our QI-008 Potential Quality of Care Serious Reportable Adverse Events Policy and Procedure that was submitted during the audit. The QI Work Plan has been updated to reflect the changes to the wording of the objective for Section 2.0.<br>Section 5: Network Management and Operations is collaborating internally to develop provider to member ratio goals for PCPs, High Volume Specialists and Behavioral Health providers. Applicable goals, compliance percentages and summaries will be documented in written format in future quarterly QI workplan updates rather than attaching visual geographic analysis reports. Applicable slides have been updated to reflect the following goals: Goal (Met = 100%; Partially Met = equal to or greater than 90%; Not Met = less than 90%). The QI workplan has been updated to remove the reference to the incorrect standard.<br>Section 5: The QI workplan has been updated to remove the reference to the incorrect standard. Access standard compliance percentages and other summaries will be documented in written format in future quarterly QI workplan updates rather than attaching visual geographic analysis reports.<br>Section 6.0, Accessibility of Services-The QI Work Plan has been updated to reflect the CAN Contract guidelines for regular and routine PCP appointment not to exceed 30 calendar days for a PCP Well Visit and not to exceed 7 calendar days for a PCP Routine Sick Visit. The QI Work Plan has been updated to reflect the goal of 90% for all PCP appointment scheduling timeframes.<br>Section 7.0, Accessibility of Services: Behavioral Health-The QI Work Plan has been updated to reflect the CAN Contract guidelines for urgent care for behavioral health not to exceed 24 hours and BH post discharge follow-up not to exceed 7 calendar days.<br>Section 7.0, Accessibility of Services-Behavioral Health-The QI Work Plan has been updated to reflect the goal of 90% for all BH appointment scheduling timeframes.<br>Section 9.0, Continuity and Coordination of Medical Care<br>Molina Comments-June 16, 2021 | |

| Standard | EQR Comments |
|---|---|
| | Applicable slides have been updated to include the correct standard from Molina's contract with DOM. Related slides from the QI workplan have been updated and are being provided with Molina's response. Due to the updates, the QI Work Plan will be presented for review and approval during the 2nd Quarter 2021 QIC meeting. Upon approval, the revised QI Work Plan will be used for submission of quarterly and annual DOM reports. |

The Quality Improvement Committee is responsible for the oversight, implementation, coordination, and integration of all QI activities. This committee sets the strategic direction for all QI activities. The QIC receives reports from all QI subcommittees and advises and directs the committees on the focus and implementation of the program and work plan. These subcommittees include the Professional Review Committee, Healthcare Services Committee, and the Delegation Oversight Committee. The QIC is co-chaired by the Chief Medical Officer and the Health Plan Quality Lead. Voting members include Molina's senior leaders representing all departments of the organization and four network providers. The committee co-chairs convene and preside over regularly scheduled quarterly meetings and convene special meetings as needed. A quorum of at least 51% of the committee members with no less than half of network provider participants is necessary to enact or implement decisions. It was noted for the Q2 and Q3 2020 meetings, there was not a quorum because only one network provider was in attendance. During the previous EQR, CCME recommended Molina recruit additional network providers to serve on the QIC. Molina responded and indicated they were seeking additional providers. The identification of those providers should be completed by Q4 2021. In the September 2021 meeting minutes, it was noted a new provider was added, however, Molina should continue the recruitment efforts due to poor provider participation.

Molina's Provider Manual includes details about the Quality Management Program. Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by providers. Such participation includes but is not limited to: Access to Care Standards, Site and Medical Record-Keeping Practice Reviews, and Delivery of Patient Care Information. Provider HEDIS profile reports are generated to provide feedback on performance. Providers received performance reports during monthly meetings and through Molinas's provider portal. Molina monitors compliance with the established performance standards at least annually. Performance below Molina's standards may result in corrective action.

Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby, and Well-Child Services and Immunization Services, define EPSDT Program requirements. The policies did not address how Molina tracks provider or member compliance with treatments or referrals needed for abnormal conditions identified through the EPSDT and Well-Baby and Well-Child services. Also, the tracking reports did not include the treatment and/or referrals made for any abnormal

findings. This was an issue found during the previous EQR. Molina addressed the corrective action and indicated once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments, and/or needed assistance with securing an appointment with an appropriate specialist. A draft template was included that addressed the deficiencies. However, this tracking report template was not implemented. *Table 26: Previous Provider Participation in Quality Improvement Activities CAP Items* provides an overview of the deficiency and corrective actions.

**Table 26: Previous Provider Participation in Quality Improvement Activities CAP Items**

| Standard | EQR Comments |
|---|---|
| **IV E. Provider Participation in Quality Improvement Activities (CAN)** | |
| 4. The CCO tracks provider compliance with EPSDT service provision requirements for:<br>4.3 Diagnosis and/or treatment for children. | Per Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, Molina has a tracking system that tracks at a minimum, initial visits for newborns, EPSDT screenings and reporting of all screening results, and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the EPSDT service and did not include or indicate members who received additional treatments or referrals as required by the *CAN Contract, Section 5 (D)*.<br>*Corrective Action Plan: The EPSDT tracking report should include the date the EPSDT service was provided, ICD 10 or CPT codes for the diagnosis, treatment and/or referrals for any suspected problem identified during the EPSDT screening as required by the CAN Contract, Section 5 (D).* |
| **Molina's Response:** Quality Improvement is currently collaborating with Provider Services, Network Management, and Claims to establish a monthly EPSDT tracking report that includes dates of service, newborn visits and EPSDT screenings, and screening results and treatment and referrals.<br>Members who receive an abnormal finding during their EPSDT screening will be identified via claims data and ICD 10/z codes. Once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments and/or need assistance with securing an appointment with the appropriate specialist. (please see draft template-EPSDT-Well Baby Well Child Tracking Report uploaded to portal). | |
| **IV E. Provider Participation in Quality Improvement Activities (CHIP)** | |
| 4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:<br>4.3 Diagnosis and/or treatment for children. | Per Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, Molina has a tracking system that tracks at a minimum, initial visits for newborns, Well-Baby and Well-Child screenings and reporting of all screening results and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the Well-Baby and Well-Child service and did not include or indicate members who received additional treatments or referrals as required by the *CHIP Contract, Section 5 (D)*. |

| Standard | EQR Comments |
|---|---|
| | *Corrective Action Plan: The Well Baby and Well Child Services tracking report should include the date the service was provided, ICD 10 or CPT codes for the diagnosis, treatment and/or referrals for any suspected problem identified during the Well Baby and/or Well Child Services screening as required by the CHIP Contract, Section 5 (D).* |
| **Molina's Response:** Quality Improvement is currently collaborating with Provider Services, Network Management, and Claims to establish a monthly Well-Baby Well-Child tracking report that includes dates of service, newborn visits and Well-Baby/Well-Child screenings, and screening results and treatment and referrals.<br>Members who receive an abnormal finding during their Well-Baby/Well-Child screening will be identified via claims data and ICD 10/z codes. Once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments and/or need assistance with securing an appointment with the appropriate specialist. (See Example Template_EPSDT_Well Baby Well Child Tracking Report uploaded to portal). | |

Annually Molina completes an evaluation of the QI program to assess the overall effectiveness of the organization's QI processes for CAN and CHIP members. The Quality Improvement Program 2020 Annual Evaluation was provided as evidence of this evaluation. The evaluation included an executive summary that provided a brief overview of the evaluation and areas of focus and/or recommendations for the next year (2021). It also included several appendices that covered the results of the CLAS analysis, population assessment, quality performance measures report, potential quality of care issues, and the member and provider experience report. Areas not included in the evaluation were the results and analysis of the availability of practitioners, accessibility of services, continuity and coordination of medical care, provider directory analysis, results of delegation oversight, and credentialing activities.

The performance improvement projects were included in the executive summary, however; the information was incomplete. There was no mention of the barriers and interventions to address the barriers. Most of the target rates were listed as "TBD." These were the same or similar errors found during the previous EQR. Molina addressed these errors and indicated the 2021 QI Program Evaluation is expected to be completed by Q1 or Q2 2022 and the evaluation will include all required elements outlined in the contract (see *Table 27: Previous Annual Evaluation of the Quality Improvement Program CAP Items*).

**Table 27: Previous Annual Evaluation of the Quality Improvement Program CAP Items**

| Standard | EQR Comments |
|---|---|
| **IV F. Annual Evaluation of the Quality Improvement Program (CAN)** | |
| 1. A written summary and assessment of the effectiveness of the QI program is prepared annually. | Per the *CAN Contract, Section 10 (D) and Exhibit G*, the annual performance evaluation of the QI program includes: a |

| Standard | EQR Comments |
|---|---|
| | description of completed and ongoing QI activities including Case Management effectiveness evaluation, identified issues, including tracking of issues over time, trending of measures to assess performance in quality of clinical care and quality of service to Members, and an analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care and quality of service to members, and overall effectiveness of the QI program. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight.<br>*Corrective Action: The Quality Improvement Evaluation must meet all the requirements contained in the CAN Contract, Section 10 (D) and Exhibit G. Specifically, a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.* |
| Molina's Response: To comply with requirements of Section 10 (D) and Exhibit G, per the CAN Contract, Molina will ensure the 2021 QI Program Evaluation (reported in 1st Quarter 2022) and subsequent annual evaluations include the following components: a description of completed and ongoing Molina QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program. Molina is currently collecting data sets from multiple sources to obtain information for the QI Evaluation program. Moreover, we are collaborating with our corporate counter parts to discuss data set collection for compliance requirements. | |
| **IV F. Annual Evaluation of the Quality Improvement Program (CAN)** | |
| 1. A written summary and assessment of the effectiveness of the QI program is prepared annually | The Quality Improvement Program 2019 Annual Evaluation, Executive Summary and three Appendices (Appendix A – Member and Provider Experience Report, Appendix B – CLAS Analysis Report and Appendix C – Population Health Assessment) was provided for review. Per Molina staff this program evaluation included CHIP.<br>The *CHIP Contract, Section 10 (D) and Exhibit G*, requires the annual performance evaluation of the QI program to include a description of completed and ongoing QI activities including Case Management effectiveness evaluation, identified issues, including tracking of issues over time, trending of measures to assess performance in quality of clinical care and quality of service to Members, and an analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care and quality of service to members, and overall effectiveness of the QI program. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight. |

| Standard | EQR Comments |
|---|---|
| | *Corrective Action: The Quality Improvement Evaluation must meet all the requirements contained in the CHIP Contract, Section 10 (D) and Exhibit G. Specifically, a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.* |
| **Molina's Response:** To comply with requirements of Section 10 (D) and Exhibit G, per the CHIP Contract, Molina will ensure the 2021 QI Program Evaluation (reported in 1st Quarter 2022) and subsequent annual evaluations include the following components: a description of completed and ongoing Molina QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program. Molina is currently collecting data sets from multiple sources to obtain information for the QI Evaluation program. Moreover, we are collaborating with our corporate counter parts to discuss data set collection for compliance requirements. | |

## *Performance Measure Validation*

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

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Molina for the CAN and CHIP populations. DOM has selected a set of PMs to evaluate the quality of care and services delivered by Molina to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as well as the Adult and Child Core Set measures, when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2020, through December 31, 2020.

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, DOM required each CCO to undergo an NCQA HEDIS Compliance Audit. Molina contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Aqurate reviewed the CCOs' final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Molina. Aqurate found that Molina's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2020.

All relevant CAN HEDIS performance measures were compared for the current review year (MY 2020) to the previous year (MY 2019), and the changes from 2019 to 2020 are reported in *Table 28: CAN HEDIS Performance Measure Results*. The rate changes shown

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

**Table 28: CAN HEDIS Performance Measure Results**

| Measure/Data Element | HEDIS 2020 (MY 2019) CAN Rates | HEDIS MY 2020 CAN Rates | Change |
|---|---|---|---|
| Effectiveness of Care: Prevention and Screening | | | |
| Adult BMI Assessment (aba) | 0.00% | 49.56% | NA |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | | | |
| *BMI Percentile* | 57.91% | 49.15% | -8.76% |
| *Counseling for Nutrition* | 50.85% | 40.63% | -10.22% |
| *Counseling for Physical Activity* | 46.72% | 35.52% | -11.20% |
| Childhood Immunization Status (cis) | | | |
| *DTaP* | NA | 59.12% | NA |
| *IPV* | NA | 79.81% | NA |
| *MMR* | NA | 77.37% | NA |
| *HiB* | NA | 73.48% | NA |
| *Hepatitis B* | NA | 79.32% | NA |
| *VZV* | NA | 76.89% | NA |
| *Pneumococcal Conjugate* | NA | 57.18% | NA |
| *Hepatitis A* | NA | 69.83% | NA |
| *Rotavirus* | NA | 60.58% | NA |
| *Influenza* | NA | 26.76% | NA |
| *Combination #2* | NA | 55.72% | NA |
| *Combination #3* | NA | 51.58% | NA |
| *Combination #4* | NA | 48.66% | NA |
| *Combination #5* | NA | 42.58% | NA |
| *Combination #6* | NA | 21.17% | NA |
| *Combination #7* | NA | 40.15% | NA |
| *Combination #8* | NA | 20.68% | NA |
| *Combination #9* | NA | 17.76% | NA |
| *Combination #10* | NA | 17.27% | NA |
| Immunizations for Adolescents (ima) | | | |
| *Meningococcal* | 48.63% | 45.74% | -2.89% |
| *Tdap* | 69.18% | 58.64% | -10.54% |
| *HPV* | 15.75% | 11.92% | -3.83% |
| *Combination #1* | 46.58% | 43.55% | -3.03% |
| *Combination #2* | 14.38% | 10.22% | -4.16% |
| Lead Screening in Children (lsc) | NA | 66.67% | NA |
| Breast Cancer Screening (bcs) | NA | 36.36% | NA |
| Cervical Cancer Screening (ccs) | 45.26% | 47.93% | 2.67% |

| Measure/Data Element | HEDIS 2020 (MY 2019) CAN Rates | HEDIS MY 2020 CAN Rates | Change |
|---|---|---|---|
| Chlamydia Screening in Women (chl) | | | |
| *16-20 Years* | 47.65% | 48.26% | 0.61% |
| *21-24 Years* | 69.15% | 63.2% | -5.95% |
| *Total* | 53.91% | 53.13% | -0.78% |
| Effectiveness of Care: Respiratory Conditions | | | |
| Appropriate Testing for Children with Pharyngitis (cwp) | 72.75% | 75.29% | 2.54% |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr) | NA | NA | NA |
| Pharmacotherapy Management of COPD Exacerbation (pce) | | | |
| *Systemic Corticosteroid* | 60.00% | 54.39% | -5.61% |
| *Bronchodilator* | 77.65% | 80.7% | 3.05% |
| Asthma Medication Ratio (amr) | | | |
| *5-11 Years* | NA | 75.53% | NA |
| *12-18 Years* | NA | 54.55% | NA |
| *19-50 Years* | NA | NA | NA |
| *51-64 Years* | NA | NA | NA |
| *Total* | NA | 62.89% | NA |
| Effectiveness of Care: Cardiovascular Conditions | | | |
| Controlling High Blood Pressure (cbp) | 46.72% | 47.2% | 0.48% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | NA | NA | NA |
| Statin Therapy for Patients with Cardiovascular Disease (spc) | | | |
| *Received Statin Therapy - 21-75 years (Male)* | NA | NA | NA |
| *Statin Adherence 80% - 21-75 years (Male)* | NA | NA | NA |
| *Received Statin Therapy - 40-75 years (Female)* | NA | NA | NA |
| *Statin Adherence 80% - 40-75 years (Female)* | NA | NA | NA |
| *Received Statin Therapy - Total* | NA | 78.95% | NA |
| *Statin Adherence 80% - Total* | NA | 86.67% | NA |
| Effectiveness of Care: Diabetes | | | |
| Comprehensive Diabetes Care (cdc) | | | |
| *Hemoglobin A1c (HbA1c) Testing* | 88.37% | 82% | -6.37% |
| *HbA1c Poor Control (>9.0%)* | 57.36% | 55.96% | -1.40% |
| *HbA1c Control (<8.0%)* | 36.05% | 36.25% | 0.20% |
| *Eye Exam (Retinal) Performed* | 53.88% | 49.15% | -4.73% |
| *Blood Pressure Control (<140/90 mm Hg)* | 55.43% | 51.82% | -3.61% |
| Statin Therapy for Patients with Diabetes (spd) | | | |
| *Received Statin Therapy* | NA | 52.14% | NA |
| *Statin Adherence 80%* | NA | 77.05% | NA |
| Effectiveness of Care: Behavioral Health | | | |

| Measure/Data Element | HEDIS 2020 (MY 2019) CAN Rates | HEDIS MY 2020 CAN Rates | Change |
|---|---|---|---|
| Antidepressant Medication Management (amm) | | | |
| *Effective Acute Phase Treatment* | 73.49% | 74.76% | 1.27% |
| *Effective Continuation Phase Treatment* | 66.27% | 58.89% | -7.38% |
| Follow-Up Care for Children Prescribed ADHD Medication (add) | | | |
| *Initiation Phase* | NA | 52.05% | NA |
| *Continuation and Maintenance (C&M) Phase* | NA | 60.66% | NA |
| Follow-Up After Hospitalization for Mental Illness (fuh) | | | |
| *6-17 years - 30-Day Follow-Up* | 53.91% | 62.5% | 8.59% |
| *6-17 years - 7-Day Follow-Up* | 30.45% | 35.12% | 4.67% |
| *18-64 years - 30-Day Follow-Up* | 37.23% | 45.52% | 8.29% |
| *18-64 years - 7-Day Follow-Up* | 20.07% | 24.55% | 4.48% |
| *65+ years - 30-Day Follow-Up* | NA | NA | NA |
| *65+ years - 7-Day Follow-Up* | NA | NA | NA |
| *30-Day Follow-Up* | 46.68% | 53.37% | 6.69% |
| *7-Day Follow-Up* | 25.95% | 29.44% | 3.49% |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | | | |
| *Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)* | 47.06% | 36.59% | -10.47% |
| *Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)* | 25.49% | 24.39% | -1.1% |
| *Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)* | 23.93% | 25.24% | 1.31% |
| *Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)* | 13.68% | 16.5% | 2.82% |
| *Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)* | NA | NA | NA |
| *Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)* | NA | NA | NA |
| *Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)* | 30.95% | 28.47% | -2.48% |
| *Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)* | 17.26% | 18.75% | 1.49% |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua) | | | |
| *30-Day Follow-Up: 13-17 Years* | NA | NA | NA |
| *7-Day Follow-Up: 13-17 Years* | NA | NA | NA |
| *30-Day Follow-Up: 18+ Years* | 4.11% | 6% | 1.89% |
| *7-Day Follow-Up: 18+ Years* | 2.74% | % | 0.26% |
| *30-Day Follow-Up: Total* | 3.85% | 5.45% | 1.60% |
| *7-Day Follow-Up: Total* | 2.56% | 2.73% | 0.17% |

| Measure/Data Element | HEDIS 2020 (MY 2019) CAN Rates | HEDIS MY 2020 CAN Rates | Change |
|---|---|---|---|
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd) | 77.90% | 71.19% | -6.71% |
| Diabetes Monitoring for People with Diabetes and Schizophrenia (smd) | NA | 49.12% | NA |
| Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc) | NA | NA | NA |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa) | 53.21% | 59.25% | 6.04% |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) | | | |
| *Blood Glucose Testing (1-11)* | 37.74% | 25.65% | -12.09% |
| *Cholesterol Testing (1-11)* | 21.7% | 13.09% | -8.61% |
| *Blood Glucose and Cholesterol Testing (1-11)* | 19.81% | 8.38% | -11.43% |
| *Blood Glucose Testing (12-17)* | 49.4% | 37.59% | -11.81% |
| *Cholesterol Testing (12-17)* | 30.12% | 25.53% | -4.59% |
| *Blood Glucose and Cholesterol Testing (12-17)* | 28.31% | 21.99% | -6.32% |
| *Blood Glucose Testing (Total)* | 44.85% | 32.77% | -12.08% |
| *Cholesterol Testing (Total)* | 26.84% | 20.51% | -6.33% |
| *Blood Glucose and Cholesterol Testing (Total)* | 25% | 16.49% | -8.51% |
| Effectiveness of Care: Overuse/Appropriateness | | | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs) | 0.60% | 1.21% | 0.61% |
| Appropriate Treatment for Children with URI (uri) | 71.40% | 74.74% | 3.34% |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) | 44.87% | 55.84% | 10.97% |
| Use of Imaging Studies for Low Back Pain (lbp) | 81.02% | 71.96% | -9.06% |
| Use of Opioids at High Dosage (hdo) | BR | 4.76% | NA |
| Use of Opioids from Multiple Providers (uop) | | | |
| *Multiple Prescribers* | BR | 18.1% | NA |
| *Multiple Pharmacies* | BR | 3.82% | NA |
| *Multiple Prescribers and Multiple Pharmacies* | BR | 2.80% | NA |
| Risk of Continued Opioid Use (cou) | | | |
| *18-64 years - >=15 Days covered* | 11.37% | 11.52% | 0.15% |
| *18-64 years - >=31 Days covered* | 2.98% | 4.43% | 1.45% |
| *65+ years - >=15 Days covered* | NA | NA | NA |
| *65+ years - >=31 Days covered* | NA | NA | NA |
| *Total - >=15 Days covered* | 11.37% | 11.52% | 0.15% |
| *Total - >=31 Days covered* | 2.98% | 4.43% | 1.45% |
| Access/Availability of Care | | | |
| Adults' Access to Preventive/Ambulatory Health Services (aap) | | | |
| *20-44 Years* | 87.66% | 83.06% | -4.60% |

| Measure/Data Element | HEDIS 2020 (MY 2019) CAN Rates | HEDIS MY 2020 CAN Rates | Change |
|---|---|---|---|
| *45-64 Years* | 87.40% | 85.38% | -2.02% |
| *65+ Years* | NA | NA | NA |
| *Total* | 87.56% | 83.59% | -3.97% |
| Annual Dental Visit (adv) | | | |
| *2-3 Years* | 47.18% | 35.57% | -11.61% |
| *4-6 Years* | 66.11% | 50.05% | -16.06% |
| *7-10 Years* | 67.22% | 53.45% | -13.77% |
| *11-14 Years* | 60.41% | 50.16% | -10.25% |
| *15-18 Years* | 50.29% | 44.37% | -5.92% |
| *19-20 Years* | 39.47% | 31.3% | -8.17% |
| *Total* | 59.62% | 48.14% | -11.48% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years* | NA | 66.67% | 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* | 71.43% | 60.42% | -11.01% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | 0.00% | 2.08% | 2.08% |
| *Total: Initiation of AOD Treatment: 13-17 Years* | 68.89% | 55.56% | -13.33% |
| *Total: Engagement of AOD Treatment: 13-17 Years* | 2.22% | 1.85% | -0.37% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years* | 45.04% | 51.16% | 6.12% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years* | 3.82% | 2.79% | -1.03% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years* | 53.73% | 47.15% | -6.58% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years* | 28.36% | 22.76% | -5.60% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years* | 48.82% | 43.79% | -5.03% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 4.04% | 4.97% | 0.93% |
| *Total: Initiation of AOD Treatment: 18+ Years* | 45.80% | 44.66% | -1.14% |
| *Total: Engagement of AOD Treatment: 18+ Years* | 7.52% | 7.44% | -0.08% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: Total* | 46.38% | 51.98% | 5.60% |

| Measure/Data Element | HEDIS 2020 (MY 2019) CAN Rates | HEDIS MY 2020 CAN Rates | Change |
|---|---|---|---|
| *Alcohol abuse or dependence: Engagement of AOD Treatment: Total* | 3.62% | 2.64% | -0.98% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: Total* | 54.41% | 46.4% | -8.01% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 29.41% | 22.4% | -7.01% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: Total* | 51.62% | 45.42% | -6.20% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: Total* | 3.54% | 4.68% | 1.14% |
| *Total: Initiation of AOD Treatment: Total* | 47.89% | 45.43% | -2.46% |
| *Total: Engagement of AOD Treatment: Total* | 7.04% | 7.05% | 0.01% |
| Prenatal and Postpartum Care (ppc) | | | |
| *Timeliness of Prenatal Care* | 99.03% | 95.38% | -3.65% |
| *Postpartum Care* | 69.34% | 66.42% | -2.92% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) | | | |
| *6-11 years* | 71.19% | 49% | -22.19% |
| *12-17 years* | 56.10% | 63.28% | 7.18% |
| *Total* | 62.41% | 57.02% | -5.39% |
| Utilization | | | |
| Well-Child Visits in the First 30 Months of Life (W30) | | | |
| *First 15 Months* | 42.50% | 50.09% | 7.59% |
| *15 Months-30 Months* | | 51.23% | NA |
| Child and Adolescent Well-Care Visits (WCV) | | | |
| *3-11 Years* | | 33.71% | NA |
| *12-17 Years* | | 28.33% | NA |
| *18-21 Years* | | 14.73% | NA |
| *Total* | | 30.78% | NA |

*NA: Indicates denominator was too small or data were not available; NR: Not reported. *Indicates rate was calculated*

As shown, the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) measures improved by over 10 percentage points. The HEDIS measure rates that had a substantial decline (greater than 10%) from the previous HEDIS rate (2019) included:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc), the Counseling for Nutrition and Counseling for Physical Activity indicators fell by greater than 10 and 11 percentage points respectively.
- Immunizations for Adolescents (ima), the Tdap indicator fell over 10 percentage points.

- Follow-Up After Emergency Department Visit for Mental Illness (FUM), the Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17) fell more than 10 percentage points.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm), the Blood Glucose Testing (1-11), Blood Glucose and Cholesterol Testing (1-11), Blood Glucose Testing (12-17), Blood Glucose Testing (Total) indicators all fell by nearly 12 percentage points or more.
- Annual Dental Visit (adv), nearly all indicators fell more than 11 percentage points.
- Initiation and Engagement of AOD Dependence Treatment (iet), the Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years and Total: Initiation of AOD Treatment: 13-17 Years indicators fell by more than 11 percentage points.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) the 6-11 years indicator fell by more than 22 percentage points.

Since Molina did not have enrollment in the CHIP product line in 2019, the PM validation was conducted only on the MY 2020 rates. The rates reported by Molina are listed in *Table 29: Chip HEDIS Performance Measure Results*.

**Table 29: CHIP HEDIS Performance Measure Results**

| Measure/Data Element | HEDIS MY 2020 CHIP Rates |
|---|---|
| **Effectiveness of Care: Prevention and Screening** | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | |
| *BMI Percentile* | 49.64% |
| *Counseling for Nutrition* | 40.88% |
| *Counseling for Physical Activity* | 37.71% |
| Childhood Immunization Status (cis) | |
| *DTaP* | 68.35% |
| *IPV* | 82.28% |
| *MMR* | 85.44% |
| *HiB* | 81.01% |
| *Hepatitis B* | 76.58% |
| *VZV* | 81.01% |
| *Pneumococcal Conjugate* | 72.15% |
| *Hepatitis A* | 81.65% |
| *Rotavirus* | 70.89% |
| *Influenza* | 29.11% |
| *Combination #2* | 59.49% |

| Measure/Data Element | HEDIS MY 2020 CHIP Rates |
|---|---|
| *Combination #3* | 58.86% |
| *Combination #4* | 53.16% |
| *Combination #5* | 53.16% |
| *Combination #6* | 20.89% |
| *Combination #7* | 49.37% |
| *Combination #8* | 19.62% |
| *Combination #9* | 18.99% |
| *Combination #10* | 18.35% |
| Immunizations for Adolescents (ima) | |
| *Meningococcal* | 42.54% |
| *Tdap/Td* | 61.57% |
| *HPV* | 14.18% |
| *Combination #1* | 41.04% |
| *Combination #2* | 13.81% |
| Lead Screening in Children (lsc) | 77.85% |
| Breast Cancer Screening in Children (bcs) | NA |
| Chlamydia Screening in Women (chl) | |
| *16-20 Years* | 37.99% |
| *21-24 Years* | NA |
| *Total* | 37.99% |
| **Effectiveness of Care: Respiratory Conditions** | |
| Appropriate Testing for Children with Pharyngitis (cwp) | 79.1% |
| Asthma Medication Ratio (amr) | |
| *5-11 Years* | NA |
| *12-18 Years* | NA |
| *19-50 Years* | NA |
| *51-64 Years* | NA |
| *Total* | NA |
| **Effectiveness of Care: Cardiovascular conditions** | |
| Controlling High Blood Pressure (cbp) | NA |
| **Effectiveness of Care: Behavioral** | |
| Antidepressant Medication Management (amm) | |
| *Effective Acute Phase Treatment* | NA |
| *Effective Continuation Phase Treatment* | NA |
| Follow-up care for children prescribed ADHD Medication (add) | |
| Initiation Phase | NA |
| Continuation and Maintenance (C&M) Phase | NA |

| Measure/Data Element | HEDIS MY 2020 CHIP Rates |
|---|---|
| Follow-Up After Hospitalization for Mental Illness (fuh) | |
| *6-17 years - 30-Day Follow-Up* | 51.11% |
| *6-17 years - 7-Day Follow-Up* | 28.89% |
| *18-64 years - 30-Day Follow-Up* | NA |
| *18-64 years - 7-Day Follow-Up* | NA |
| *65+ years - 30-Day Follow-Up* | NA |
| *65+ years - 7-Day Follow-Up* | NA |
| *Total-30-day Follow-Up* | 52.13% |
| *Total-7-day Follow-Up* | 29.79% |
| Follow-Up After Emergency Department Visit for Mental Illness (fum) | |
| *6-17 years - 30-Day Follow-Up* | NA |
| *6-17 years - 7-Day Follow-Up* | NA |
| *18-64 years - 30-Day Follow-Up* | NA |
| *18-64 years - 7-Day Follow-Up* | NA |
| *65+ years - 30-Day Follow-Up* | NA |
| *65+ years - 7-Day Follow-Up* | NA |
| *Total-30-day Follow-Up* | NA |
| *Total-7-day Follow-Up* | NA |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) | |
| *Blood Glucose Testing (1-11)* | 26.92% |
| *Cholesterol Testing (1-11)* | 23.08% |
| *Blood Glucose and Cholesterol Testing (1-11)* | 17.31% |
| *Blood Glucose Testing (12-17)* | 48.65% |
| *Cholesterol Testing (12-17)* | 22.97% |
| *Blood Glucose and Cholesterol Testing (12-17)* | 21.62% |
| *Blood Glucose Testing (Total)* | 39.68% |
| *Cholesterol Testing (Total)* | 23.02% |
| *Blood Glucose and Cholesterol Testing (Total)* | 19.84% |
| **Effectiveness of Care: Overuse/Appropriateness** | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs) | 0.83% |
| Appropriate Treatment or Children with URI (uri) | |
| *3 months-17 Years* | 71.87% |
| *18-64 Years* | 72% |
| *65+ Years* | NA |
| *Total* | 71.87% |
| Use of Imaging Studies for Low Back Pain (lbp) | NA |
| Risk of Continued Opioid Use (cou) | |

| Measure/Data Element | HEDIS MY 2020 CHIP Rates |
|---|---|
| *18-64 years - >=15 Days covered* | NA |
| *18-64 years - >=31 Days covered* | NA |
| *65+ - >=15 Days covered* | NA |
| *65+ - >=31 Days covered* | NA |
| *Total - >=15 Days covered* | NA |
| *Total - >=31 Days covered* | NA |
| **Access/Availability of Care** | |
| Annual Dental Visit (adv) | |
| *2-3 Years* | 41.74% |
| *4-6 Years* | 60.08% |
| *7-10 Years* | 65.22% |
| *11-14 Years* | 61.25% |
| *15-18 Years* | 51.96% |
| *19-20 Years* | 38.60% |
| *Total* | 58% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)* | NA |

| Measure/Data Element | HEDIS MY 2020 CHIP Rates |
|---|---|
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)* | NA |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)* | 51.43% |
| *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)* | 2.86% |
| Prenatal and Postpartum Care (ppc) | |
| *Timeliness of Prenatal Care* | NA |
| *Postpartum Care* | NA |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) | |
| *1-11 Years* | NA |
| *12-17 Years* | 59.46% |
| *Total* | 50.82% |
| **Utilization** | |
| Well-Child Visits in the First 30 Months of Life (w30) | |
| First 15 Months | 64.05% |
| 15 Months-30 Months | 58.82% |
| Child and Adolescent Well-Care Visits (WCV) | |
| *3-11 Years* | 38.81% |
| *12-17 Years* | 31.56% |
| *18-21 Years* | 18.84% |
| *Total* | 34.6% |

*NA: Indicates denominator was too small or data were not available; NR: Not reported. * indicates rate was calculated with small denominator.*

DOM requires the CCOs to report all Adult and Child Core Set measures annually. 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 included data integration, data control, and documentation of PM calculations. The following are some of the main steps included in Aqurate's validation process:

**Data Integration**—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by Molina, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined that the data integration processes for Molina were acceptable.

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

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

The measure rates for the CAN population reported by Molina for 2020 are listed in *Table 30*: *CAN Non-HEDIS Performance Measure Rates*.

**Table 30: CAN Non-HEDIS Performance Measure Rates**

| Measure | MY 2020 Rate |
|---|---|
| **Adult Core Set Measures** | |
| **Primary Care Access and Preventative Care** | |
| SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD) | |
| *Ages 18-65* | 0.79% |
| *Ages 65+* | NA |
| *Total* | 0.79% |

| Measure | MY 2020 Rate |
|---|---|
| **Maternal and Perinatal Health** | |
| PC-01: ELECTIVE DELIVERY (PC-01) | |
| *Women with elective vaginal deliveries or elective cesarean sections* | NR |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD) | |
| *Most or moderately effective contraception - 3 days* | 13.02% |
| *Most or moderately effective contraception - 60 days* | 53.28% |
| *LARC - 3 Days* | 0.68% |
| *LARC - 60 Days Reported* | 10.13% |
| CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD) | |
| *Most or moderately effective contraception Rate* | 27.90% |
| *LARC Rate* | 3.70% |
| **Maternal and Perinatal Health** | |
| DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) | |
| *Ages 18 - 64* | 23.74 |
| *Ages 65+* | NA |
| *Total* | 23.74 |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) | |
| *Ages 40 - 64* | 58.16 |
| *Ages 65+* | NA |
| *Total* | 58.14 |
| HEART FAILURE ADMISSION RATE (PQI-08) | |
| *Ages 18 - 64* | 54.93 |
| *Ages 65+* | NA |
| *Total* | 54.92 |
| ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) | |
| *Ages 18 - 39* | 4.24 |
| HIV VIRAL LOAD SUPPRESSION (HVL - AD) | |
| *Ages 18 - 64* | 17.12% |
| *Ages 65+* | NA |
| *Total* | 16.81% |
| **Behavioral Health Care** | |
| USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) | |
| *Ages 18 - 64* | 4.66% |
| *Ages 65+* | NA |
| *Total* | 4.66% |

| Measure | MY 2020 Rate |
|---|---|
| CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) | |
| *Ages 18 - 64* | 5.18% |
| *Ages 65+* | NA |
| *Total* | 5.18% |
| USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD) | |
| *Overall* | 51.03% |
| *Prescription for Buprenorphine* | 49.48% |
| *Prescription for Oral Naltrexone* | 1.55% |
| *Prescription for Long-acting, injectable naltrexone* | 0.52% |
| *Prescription for Methadone* | 0.00% |
| **Child Core Set Measures** | |
| Primary Care Access and Preventative Care | |
| SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH) | |
| *Ages 12 - 17* | 0.65% |
| DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH) | |
| *Age 1 Screening* | 26.53% |
| *Age 2 Screening* | 40.39% |
| *Age 3 Screening* | 35.75% |
| *Total Screening* | 28.43% |
| AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH) | |
| *Total (Newborn < 91 Days at Dx)* | NA |
| **Maternal and Perinatal Health** | |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH) | |
| *Most or moderately effective contraception - 3 days* | 2.22% |
| *Most or moderately effective contraception - 60 days* | 53.02% |
| *LARC - 3 Days* | 0.81% |
| *LARC - 60 Days Reported* | 11.90% |
| CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH) | |
| *Most or moderately effective contraception Rate* | 29.30% |
| *LARC Rate* | 2.51% |
| SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH) | |
| *Numerator 1 At Least One Sealant* | NR |
| *Numerator 2 All Four Molars Sealed* | NR |
| PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH) | |
| *Ages 1 - 20* | 45.90% |

*NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate*

Source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short-Term Complications Admission rate (PQI01-AD), Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission rate (PQI-05), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period. Also, source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator. Processes should be improved around the calculation, reporting, and verification of the rates reported for the Adult and Child Core set measures.

Molina did not report two non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.

The table for the CHIP population follows *(Table 31: CHIP Non-HEDIS Performance Measure Rates.*

**Table 31: CHIP Non-HEDIS Performance Measure Rates**

| Measure | MY 2020 Rate |
|---|---|
| **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* | 0.23% |
| *Ages 65+* | NA |
| *Total* | 0.23% |
| Maternal and Perinatal Health | |
| PC-01: ELECTIVE DELIVERY (PC-01) | |
| *Women with elective vaginal deliveries or elective cesarean sections* | NR |
| **Care of Acute and Chronic Conditions** | |
| DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) | |
| *Ages 18 - 64* | 9.49 |
| *Ages 65+* | NA |
| *Total* | 9.49 |
| HEART FAILURE ADMISSION RATE (PQI-08) | |

| Measure | MY 2020 Rate |
|---|---|
| *Ages 18 - 64* | 0.00 |
| *Ages 65+* | NA |
| *Total* | 0.00 |
| ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) | |
| *Ages 18 - 39* | 0.00 |
| **Care of Acute and Chronic Conditions** | |
| USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) | |
| *Ages 18 - 64* | NA |
| *Ages 65+* | NA |
| *Total* | NA |
| CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) | |
| *Ages 18 - 64* | NA |
| *Ages 65+* | NA |
| *Total* | 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* | 0.56% |
| DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH) | |
| *Age 1 Screening* | NA |
| *Age 2 Screening* | 51.27% |
| *Age 3 Screening* | 46.19% |
| *Total Screening* | 48.33% |
| AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH) | |
| *Total (Newborn < 91 Days at Dx)* | NA |
| Maternal and Perinatal Health | |
| CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH) | |
| *Most or moderately effective contraception - 3 days* | NA |
| *Most or moderately effective contraception - 60 days* | NA |
| *LARC - 3 Days* | NA |
| *LARC - 60 Days Reported* | NA |
| CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH) | |
| *Most or moderately effective contraception rate* | 24.54% |
| *LARC Rate* | 1.71% |
| Dental and Oral Health Services | |
| SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH) | |

| Measure | MY 2020 Rate |
|---|---|
| *Numerator 1 At Least One Sealant* | NR |
| *Numerator 2 All Four Molars Sealed* | NR |
| PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH) | |
| *Ages 1 - 20* | 45.90% |

*NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate*

Source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission rate (PQI01-AD), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period. Also, the source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator. Improved processes around calculation, reporting, and verification of the rates reported for the Adult and Child Core set measures are needed.

Molina did not report two non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.

## *Performance Improvement Project Validation*

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

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

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

### *CAN PIP Validation Results*

DOM requires the CCOs to conduct PIPs that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). For the previous EQR (2020), Molina submitted seven PIPs for validation that addressed the DOM required topics. All of the PIPs except the Behavioral Health Readmission PIP scored within the "Not Credible" range. CCME requested that Molina submit a corrective action plan to address the deficiencies found in the PIPs. *Table 32: Previous Quality Improvement Projects CAP Items* provides a summary of the deficiencies and Molina's response.

**Table 32: Previous Quality Improvement Projects CAP Items**

| Standard | EQR Comments |
|---|---|
| **IV D. Quality Improvement Projects (CAN)** | |
| 2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects." | All projects except Behavioral Health Readmission received a validation score within the "Not Credible" range and did not meet the validation requirements. The following items were not documented:<br>•Data analysis and rationale for choosing the topic<br>•Sampling information<br>•Data analysis plan<br>•Goal and benchmark rates<br>•Analysis of findings<br>•Barriers and interventions linked to each barrier<br>Details of the validation activities and recommendations for the PIPs are found in Attachment 3, CCME EQR Validation Worksheets.<br>*Corrective Action: The performance improvement projects should be documented on the CCME provided template and include all required elements.*<br>*Correct the issues identified below regarding the PIPs.* |
| **Molina's Response**: To ensure compliance, starting 2nd Quarter 2021, Quality Improvement will use the template provided by CCME for MSCAN quarterly and annual reporting of Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal/Postpartum Care and Sickle Cell Disease Performance Improvement Projects. All elements in the template will be addressed for each PIP (please see example Asthma PIP uploaded to portal).<br><br>Molina Comments-June 16, 2021<br>Applicable slides have been updated to include the correct standard from Molina's contract with DOM. Related slides from the QI workplan have been updated and are being provided with Molina's response. Due to the updates, the QI Work Plan will be presented for review and approval during the 2nd Quarter 2021 QIC meeting. Upon approval, the revised QI Work Plan will be used for submission of quarterly and annual DOM reports. | |
| **CAN Performance Improvement Projects:**<br>Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal and Post-partum Care, Sickle Cell Disease | |

| Standard | EQR Comments |
|---|---|
| Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | Data analysis is not offered in PIP report proposal for rationale to initiate study.<br>*Include a summary of the rationale and data analysis that led to initiation of this PIP.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include narrative summary of the rationale and data supporting the need of the PIP. | |
| Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? | Sampling information not provided in the report.<br>*Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include information on the sampling plan, if applicable. | |
| Did the plan employ valid sampling techniques that protected against bias? | Information is not documented in the PIP report.<br>*Include information on sampling technique(s); if not applicable, indicate in the report using a PIP report template.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include information on sampling techniques, if applicable. | |
| Did the study design clearly specify the sources of data? | Data sources are not indicated in proposal.<br>*Include information on sources of data.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include data source information. | |
| Did the study design prospectively specify a data analysis plan? (1) | Data analysis plan is not documented.<br>*Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include a quarterly and annual data analysis plans, per DOM reporting frequency. beginning 2nd Quarter 2021, all MSCAN PIP reports will include data source information. | |
| Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? | No findings presented.<br>*Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include quarterly and annual numerical results and findings, per DOM reporting frequency. | |
| Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? | Analysis of baseline is not offered in report and follow-up activities are not documented.<br>*Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will include a quarterly and annual analysis of the baseline, per DOM reporting frequency. | |
| Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? | Interventions not documented in the report.<br>*Add the barriers and interventions linked to each barrier to the report.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all MSCAN PIP reports will document interventions implemented for the PIP. | |

For the current EQR, Molina provided the same seven PIP documents for validation that were submitted for the previous EQR. It was noted that the corrective actions from the previous EQR were implemented and included in the PIP documents uploaded. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in the tables that follow. A summary of each PIP's status and the interventions are also included.

**Table 33: Behavioral Health Readmissions PIP**

| 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 Behavioral Health Readmissions for Hinds County showed an increase in readmissions from the overall 2020 rate of 23.8% to Q1 2021 at 27.7%. Enrollment in high-risk case management for unique readmitted patients is reported to be 100%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 80/80=100%<br>High Confidence in Reported Results | 73/74=99%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Community connectors<br>• Primary care initiative<br>• Scheduling process changed<br>• Onsite d/c planning<br>• Transition of Care letters sent to members<br>• Patient Outreach | |

**Table 34: Asthma Medication Ratio PIP**

| 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 rate reduced from 66% to 60.8% in Q2 2021, with a goal of 71%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 73/74=99%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Asthma education video on proper use of the inhaler<br>• Monitoring of the non-compliant members and encourage providers to contact members to close the gap in care<br>• Telephone call campaign to encourage members to get their annual wellness exams<br>• Provider toolkits and educational materials<br>• Member educational materials | |

### Table 35: Pharmacotherapy Management of COPD Exacerbation PIP

| Pharmacotherapy Management of COPD Exacerbation (PCE) | |
|---|---|
| The COPD PIP focuses on improving the rate of COPD members who are dispensed a systemic corticosteroid within 14 days of an acute event. The PCE measure is used and both rates improved to above goal rate. For systemic corticosteroid, the rate improved from 40% to 69.4% with a goal of 67%. The bronchodilator rate improved from 80% to 83.3% with a goal of 81.8%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products.<br>• Provider Education: The Provider Toolkit is a quick reference guide for providers. This kit includes the 2021 revised HEDIS Tip Sheets to support the providers in meeting the goals of the NCQA HEDIS measures, MHMS resources (i.e., useful phone and fax numbers), and tips to increase member satisfaction. | |

### Table 36: Follow-up 7 and 30 Days after Hospitalization for Mental Illness PIP

| Follow-up 7 and 30 Days after Hospitalization for Mental Illness | |
|---|---|
| Measures the percentage of behavioral health discharges for which the member received follow-up within 7 days and 30 days of discharge. The 7-day rate improved from 8.1% in Q1 to 26.3% in Q2. The goal is 28%. For 30-day follow up, the rate also improved from 16.9% in Q1 to 46% in Q2 with a goal of 50%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>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.<br>• Discharge planning checklist<br>• Processes to improve efficiency of scheduling follow-up appointments<br>• Provider Education | |

### Table 37: Prenatal and Postpartum Care PIP

| Prenatal and Postpartum Care |
|---|
| The aim of the Prenatal and Postpartum Care PIP is to improve the percentage of deliveries that receive a prenatal care visit as a member of Molina in the first trimester. And improve the percentage |

| Prenatal and Postpartum Care | |
|---|---|
| of deliveries that had a postpartum visit on or between 21-56 days of delivery. Both measures improved but are not yet at the goal rate. For prenatal care, the rate improved from 89.67% to 90.3% with a goal of 93.6%. The post-partum rate improved from 30.8% to 35% with a goal of 74.3%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Provider Education<br>• Member incentives-Gift cards and car seats<br>• Member outreach events<br>• 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 6 months of their child's life. | |

**Table 38: Sickle Cell Disease PIP**

| Sickle Cell Disease | |
|---|---|
| The aim for the Sickle Cell Disease PIP is to increase the rate of case management services for members with Sickle Cell Disease (SCD). The rate improved from 49% to 5.7% in Q2 2021. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Internal monitoring and tracking for inpatient care and ED visits<br>• 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.<br>• Collaboration: Working in collaboration with MS Sickle Cell Foundation (MSCF). MSCF is a non-profit 501(c)3 that has been in existence in MS since 1996. The goal of this organization is to improve the lives of individuals and families in MS, living with sickle cell disease. QI is also in collaboration with MHMS internal teams, mainly Health Care Services and Member and Community Engagement.<br>• Member educational materials | |

**Table 39: Obesity PIP**

| Obesity | |
|---|---|
| The Obesity PIP focuses on the child population. The BMI percentile, Nutrition, and Counseling HEDIS rates are utilized. The rates did not show improvement from Q1 to Q2. For BMI Percentile, the rate went from 12.6% to 12.5%, with a goal of 61.3%. The nutrition rate went from 11.5% to 7.3% with a goal of 52.3%. The counseling rate declined from 8.4% to 5.4% with a goal of 57.4%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62= 45.2%<br>Not Credible | 73/74=99%<br>High Confidence in Reported Results |

| Obesity |
| --- |
| **Interventions** |
| • Provider Education<br>• Member Incentives<br>• Member outreach and member events for awareness and education |

CCME provided recommendations for the Asthma, Behavioral Health Readmission, and Obesity PIPS. They are displayed in *Table 40: CAN Performance Improvement Project Recommendations*.

**Table 40: CAN Performance Improvement Project Recommendations**

| Project | Section | Reason | Recommendation |
| --- | --- | --- | --- |
| Asthma | Was there any documented, quantitative improvement in processes or outcomes of care? | AMR rate declined from 66% to 60.8%. The goal is 71%. | Continue current and in-progress interventions to determine if they can improve the rate toward goal rate. |
| Behavioral Health Readmissions | Was there any documented, quantitative improvement in processes or outcomes of care? | Rate of readmissions increased from 23.8% overall 2020 to 27.7% in Q1 2021. The goal is a 5% decline from the previous year's rate. The case management enrollment rate is 100%. | Continue current interventions of discharge planning, patient outreach, and community connectors to establish appropriate care management of members. |
| Obesity | Was there any documented, quantitative improvement in processes or outcomes of care? | All rates showed a lack of improvement. The BMI percentile rate declined from 12.6% to 12.5%; the nutrition rate declined from 11.5% to 7.3%; and the counseling rate declined from 8.4% to 5.4%. | Determine if there are additional barriers to improving rates that are relevant for providers and/or members. |

## *CHIP PIP Validation Results*

For the current EQR, Molina provided the same four PIPs for validation that were submitted for the previous EQR. The topics included Adolescent Well Care, Asthma, Obesity, and Follow Up After Hospitalization. Last year the PIPs did not meet the validation requirements and Molina was required to submit a corrective action plan to address the deficiencies. See *Table 41: Previous CHIP Quality Improvement Projects CAP Items*.

### Table 41: Previous CHIP Quality Improvement Projects CAP Items

| Standard | EQR Comments |
|---|---|
| **IV D. Quality Improvement Projects (CHIP)** | |
| 2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects." | All projects received a validation score within the "Not Credible" rage and failed to meet the validation requirements.<br>The following items were not documented:<br>•Data analysis and rationale for choosing the topic<br>•Sampling information<br>•Data analysis plan<br>•The goal and benchmark rates<br>•Analysis of findings<br>•Barriers and interventions linked to each barrier<br>Details of the validation activities and recommendations for the PIPs may be found in *Attachment 3, CCME EQR Validation Worksheets.*<br>*Corrective Action: The performance improvement projects should be documented on the CCME provided template and include all required elements.*<br>*Correct the issues identified below regarding the PIPs.* |
| **Molina's Response:** To ensure compliance, starting 2nd Quarter 2021, Quality Improvement will use the template provided by CCME for MSCAN quarterly and annual reporting of Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal/Postpartum Care and Sickle Cell Disease Performance Improvement Projects. All elements in the template will be addressed for each PIP (please see example Asthma PIP uploaded to portal). | |
| **CHIP Performance Improvement Projects:**<br>Medication Management for People with Asthma, Follow Up After Hospitalization for Mental Illness, Obesity, Well Care | |
| Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | Data analysis is not offered in PIP report proposal for rationale to initiate study.<br>*Include a summary of the rationale and data analysis that led to initiation of this PIP.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include narrative summary of the rationale and data supporting the need of the PIP. | |
| Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? | Sampling information not provided in the report.<br>*Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include information on the sampling plan, if applicable. | |
| Did the plan employ valid sampling techniques that protected against bias? | Information is not documented in the PIP report.<br>*Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include information on sampling techniques, if applicable. | |

| Standard | EQR Comments |
|---|---|
| Did the study design clearly specify the sources of data? | Data sources are not indicated in proposal.<br>*Include information on sources of data.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include data source information. | |
| Did the study design prospectively specify a data analysis plan? **(1)** | Data analysis plan is not documented.<br>*Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include a quarterly and annual data analysis plans, per DOM reporting frequency. | |
| Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? | No findings presented.<br>*Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include quarterly and annual numerical results and findings, per DOM reporting frequency. | |
| Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? | Analysis of baseline is not offered in report and follow-up activities are not documented.<br>*Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include quarterly and annual numerical results and findings, per DOM reporting frequency. | |
| Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? | Interventions not documented in the report.<br>*Add the barriers and interventions linked to each barrier to the report.* |
| **Molina's Response:** Beginning 2nd Quarter 2021, all CHIP PIP reports will include a quarterly and annual analysis of the baseline, per DOM reporting frequency. | |

For the current EQR, Molina provided the same four PIP documents for validation as those provided for the previous EQR. It was noted that the corrective actions from the previous EQR were implemented and included in the PIP documents provided. All the CHIP 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 42: Well Care/Well Child PIP**

| Adolescent 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 6 or more well care/well child visits during the first 0-15 months of life. The baseline rate for this PIP was 42.59% with a goal of 55.79%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |

| Adolescent Well Care/Well Child |
|---|
| **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.<br>• Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale.<br>• Member incentives provided on the day of the screening. |

**Table 43: Asthma Medication Ration PIP**

| Asthma Medication Ratio (AMR) | |
|---|---|
| The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. The baseline rates for Q1 2021 are presented in the documentation. For the AMR PIP, the baseline rate was presented at 84.5% with a goal of 71.28%, so the HEDIS measure is above goal at baseline. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Asthma education for members on the proper use of the inhaler.<br>• Telephone campaigns to encourage members to get their annual wellness exams.<br>• Provider education with toolkits and assistance with member outreach. | |

**Table 44: Obesity PIP**

| Obesity- Ages 3 to 19 | |
|---|---|
| The Obesity PIP's aim is to increase the percentage of CHIP member who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. For the Obesity PIP, the rates for all three components were 0%. The BMI percentile goal is 61.31%; the Nutrition goal rate is 52.31%; and the physical activity counseling goal is 57.42%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Provider toolkits to help facilitate tracking reports and address areas needed.<br>• Member education, community outreach, and incentives. | |

Table 45: Follow-up After Hospitalization for Mental Illness PIP

| Follow-up After Hospitalization for Mental Illness (FUH)- Ages 6 to 19 | |
|---|---|
| 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 was 14.29% at baseline with a goal of 50%. The 7-day baseline rate was 7.14% with a goal of 28.3%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 28/62=45.2%<br>Not Credible | 72/72=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Transition of Care collaborative on-site discharge planning.<br>• Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation.<br>• Implementation of a Discharge Planning Checklist.<br>• Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge. | |

There were no recommendations or corrective actions needed for the CHIP PIPs. Details of the validation activities for the performance measures and PIPs, and specific outcomes related to each activity, may be found in *Attachment 3, CCME EQR Validation Worksheets*.

For this review period, Molina met 90% of all the requirements in the Quality Improvement section for the CAN and CHIP populations as noted in *Figure 6: Quality Improvement Findings*.

Figure 6: Quality Improvement Findings

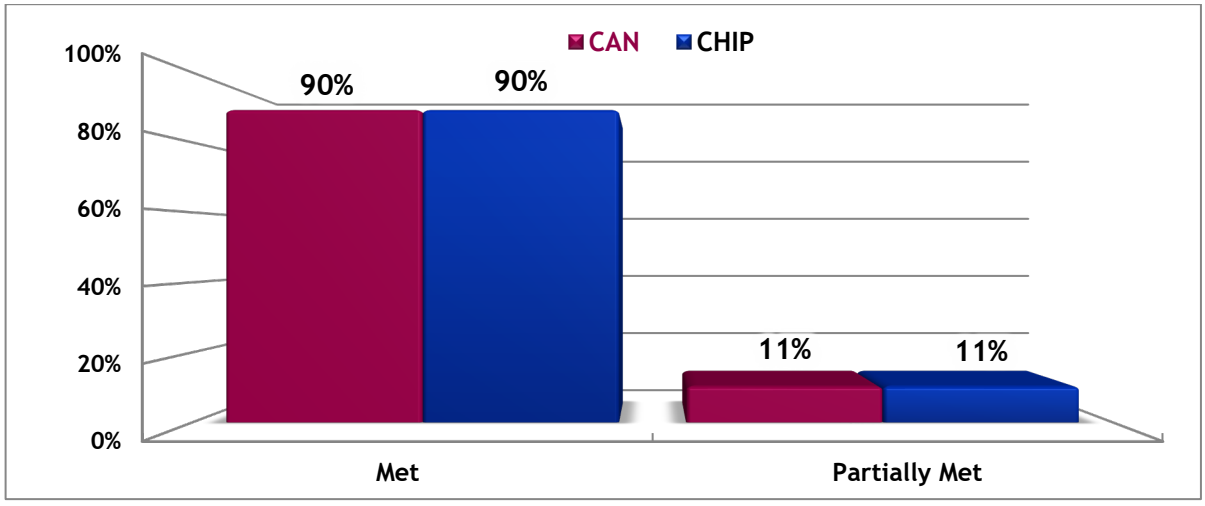


Table 46: Quality Improvement

| Section | Standard | CAN 2021 Review | CHIP 2021 Review |
|---|---|---|---|
| Provider Participation in Quality Improvement Activities | The CCO tracks provider compliance with EPSDT service provision requirements for:<br>Diagnosis and/or treatment for children. | Partially Met | Partially Met |
| Annual Evaluation of the Quality Improvement Program | A written summary and assessment of the effectiveness of the QI program is prepared annually | Partially Met | Partially Met |

### *Strengths*

- PIP reports included the CMS elements and integrated corrective actions from the previous review.
- The performance measure validation found that Molina was fully compliant with all information system standards and submitted valid and reportable rates for all HEDIS measures in scope of the audit.
- There were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Molina followed measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.
- The following HEDIS MY 2020 measure rates were strengths for Molina since their rates had a greater than 10% improvement:
    - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) improved by over 10 percentage points.

### *Weaknesses*

- Poor participation by network providers serving on the Quality Improvement Committee continues to be an issue.
- The EPSDT and Well Child and Well Baby policies did not address Molina's processes for tracking treatments or referrals needed for abnormal findings during the EPSDT or Well-Child and Well Baby services. Also, the tracking reports did not include the treatment and/or referrals made for any abnormal findings.
- The 2020 Program Evaluation did not include an evaluation of the results of all QI activities completed or ongoing in 2020. This was an issue identified during the previous EQR.

- The following HEDIS MY 2020 measure rates were determined to be areas of opportunities for Molina since their rates had a greater than 10% decline:
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc), the Counseling for Nutrition and Counseling for Physical Activity indicators fell by greater than 10 and 11 percentage points respectively.
    - Immunizations for Adolescents (ima), the Tdap indicator fell over 10 percentage points.
    - Follow-Up After Emergency Department Visit for Mental Illness (FUM), the Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17) fell more than 10 percentage points.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm), the Blood Glucose Testing (1-11), Blood Glucose and Cholesterol Testing (1-11), Blood Glucose Testing (12-17), Blood Glucose Testing (Total) indicators all fell by nearly 12 percentage points and more.
    - Annual Dental Visit (adv), nearly all indicators fell more than 11 percentage points.
    - Initiation and Engagement of AOD Dependence Treatment (iet), the Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years and Total: Initiation of AOD Treatment: 13-17 Years indicators fell by more than 11 percentage points.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) the 6-11 years indicator fell by more than 22 percentage points.
- For CAN, the source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission Rate (PQI01-AD), Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission rate (PQI-05), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults Admission Rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period.
- For CAN and CHIP, the source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator.
- For CHIP, the source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission Rate (PQI01-AD), Heart Failure Admission rate (PQI-08), and the Asthma in Younger Adults

Admission Rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period.

- Molina did not report two non-HEDIS measures as required by DOM for the CAN and CHIP populations. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH).
- Three of the CAN PIPs did not show any quantitative improvements. Those PIPs include Asthma, Behavioral Health Readmission, and Obesity.

### *Corrective Actions*

- Include the process Molina uses for tracking treatments or referrals needed for abnormal findings during the EPSDT or Well-Child and Well-Baby services. Also, include the follow-up on the EPSDT tracking report.
- Correct the 2020 QI Program Evaluation and include a description and results of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.

### *Recommendations*

- Continue to recruit additional network providers to serve on the QIC.
- Work proactively with DOM for clarification on measures that are required to be reported.
- Improve processes around calculation, reporting, and verification of the rates reported for the DOM required Adult and Child Core set measures.
- Review the current interventions for the Asthma, Behavioral Health Readmissions, and the Obesity PIPs to determine if there are additional barriers needing to be addressed and interventions added to improve the rates.

## V. Utilization Management

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

CCME's review of CAN and CHIP UM Programs included various UM documents, medical necessity determination processes, pharmacy requirements, the Care Management Program, and review of approval, denial, appeal, and care management files, and the respective websites.

Molina's Utilization Management (UM) Program is structured within the Health Care Services (HCS) Program, where the key functions are eligibility and oversight, resource management, and quality management. The Associate Vice President of Health Care

Services HCS, in consultation with the Chief Medical Officer, has authority and responsibility for HCS program development and implementation.

The Health Care Services Program Description and UM policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in Mississippi. Onsite discussion confirmed Molina ensures network practitioners can provide input in UM activities, such as appeals and grievances, UM guidelines, and criteria during quarterly Health Care Services Committee (HCSC) meetings.

CCME identified issues with information related to extensions of urgent prior authorization requests in Molina's Timeliness of UM Decision Making and Notification (CAN Policy MHMS-HCS-UM-383 and CHIP Policy MHMS-HCS-UM-383.1). Molina attempted to correct the identified issues in CAN Policy MHMS-HCS-UM-383 and submit it with other materials requested during the onsite. This change could not be considered because the current EQR focuses on previous plan activities and updated documents will be addressed in the next EQR.

Reviews of service authorization requests for CAN and CHIP members are conducted utilizing McKesson's InterQual or MCG, internal clinical review criteria such as medical policies, or other established criteria. Behavioral health services are reviewed using American Society of Addiction Medicine criteria in addition to InterQual to make determinations. Molina assesses consistency in criteria application and decision-making through annual inter-rater reliability testing for physician reviewers and clinical reviewers for medical and behavioral health services. All reviewers received passing scores at or above the benchmark. Onsite discussion confirmed Molina discontinued using InterQual in 2021 and hired a full-time nurse auditor to ensure consistent and appropriate reviewer performance.

Review of approval and denial files reflected consistent decision-making using approved criteria according to an established hierarchy. Utilization decisions are made by appropriate professionals within required timeframes. Approval notices containing all required information were faxed to providers and Adverse Benefit Determination notices were written in clear language with instructions for requesting an appeal.

CVS Caremark is the pharmacy benefit manager and is responsible for implementing pharmaceutical services for CAN and CHIP members. Molina uses the most current version of the MS Medicaid Program Preferred Drug List, accessible on Molina's website, to fulfill pharmacy requirements.

Molina has developed and implemented a Care Management Program outlined in the HCS Program Description and a Population Health Management Program outlined in the Population Health Strategy. The HCS Program Description defines and outlines Molina's

approach to providing medical and behavioral health care management (CM) services, and CM policies provide direction and guidance to staff. Additionally, Molina has policies describing disease management services, and Transitional Care Management activities are provided to identified members.

For CAN and CHIP, CCME could not identify documentation of Molina's processes for addressing continuity of care when the member disenrolls from the health plan, as required by the *CAN Contract, Section 9 (A) (4) and CHIP Contract, Section 8 (A) (3)*. Even though the plan later included the requirement into Policy MHMS-HCS-CM-406 Transition to Other Care When Benefits End and resubmitted it with other onsite follow-up requests, this change could not be considered because this current EQR focuses on previous plan activities and updated documents will be addressed in the next EQR.

CM files reflect staff are providing the appropriate level of case management services according to the member's risk level and needs. Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriate for the member's health condition.

### *Appeals*

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

Molina has established policies describing processes for handling appeals of adverse benefit determinations that are consistent with requirements in the *CAN* and *CHIP Contract* and Federal Regulations. The appeal resolution timeframe begins upon receiving a verbal or written appeal request. Definitions of appeal terminology and information about who may file an appeal are correctly documented. Procedures for filing an appeal are clearly provided and consistently documented in policies, the Member Handbook, the Provider Manual, and on the website. Additionally, the appeal request form is posted on the respective CAN and CHIP websites, is fillable, and can be downloaded and printed. Molina ensures members can contact Member Services to receive information and assistance with appeals in languages other than English.

Review of CAN and CHIP appeal files reflected timely acknowledgement, resolution, and notification of determinations by professionals with appropriate clinical experience. Resolution letters are written clearly and provide instructions for requesting a State Fair Hearing or an Independent External Review.

The header on Policy MHMS-MRT-02, Standard Member Appeals indicates that it applies to both CAN and CHIP lines of business. The policy outlines processes by which CAN members can request a State Fair Hearing and it cross-references the Member State Fair Hearing Policy & Procedure. However, processes for CHIP members to request an Independent External Review and reference to the Member Independent External Review Policy and Procedure were not included. CCME offered recommendations to address this issue.

As noted in Table 47, during the 2020 EQR period Molina had deficiencies related to procedures for filing appeals. Issues identified included incorrect or omitted instructions on the CAN and CHIP websites, and in the CHIP Member Handbook and Provider Manual. Molina has revised the websites and documents to address these deficiencies.

**Table 47: Previous Appeals CAP Items**

| Standard | EQR Comments |
|---|---|
| **V C. Appeals (CAN)** | |
| 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:<br>1.2 The procedure for filing an appeal; | Appeals procedures and instructions are documented in Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, the Provider Manual, and on the website. CCME identified the following documentation issues on the website:<br>•The address provided to submit written appeals includes has a P.O. Box in North Charleston, SC instead of Capitol St. in Jackson, MS.<br>•The website incorrectly states appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the notice of Adverse Benefit Determination.<br>•The website does not indicate that an authorized representative can file on the member's behalf.<br>•The website does not address that members can present evidence or examine their case file at any time during the appeals process.<br><br>*Corrective Action: Edit the CAN website to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal to meet requirements of the CAN Contract, Section (K).* |
| We have updated our website to include the correct address to file an appeal.<br>How to Appeal a Denial \| Medicaid \| Molina Healthcare of Mississippi<br><br>We have updated our website to read "All appeals must be filed within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (denial letter)." This language is consistent with the Provider Manual and Member Handbook.<br>How to Appeal a Denial \| Medicaid \| Molina Healthcare of Mississippi<br><br>We have updated our website to read "We can accept your appeal from someone else with your permission. For Example:<br>• A friend<br>• A family member<br>• A provider part of Molina<br>• A provider that is not part of Molina<br>• A lawyer"<br>This language is consistent with our provider manual and member handbook.<br>How to Appeal a Denial \| Medicaid \| Molina Healthcare of Mississippi<br><br>We have updated our website to read "You have the opportunity to present Molina with evidence of the facts or law about your case, in person or in writing." And "You, or someone legally authorized to do so, can ask us for a complete copy of your case file at any time, including medical records (subject to Health Insurance Portability and Accountability Act (HIPAA) requirements), a copy of the guidelines (criteria), benefits, other | |

| Standard | EQR Comments |
|---|---|
| documents and records, and any other information related to your appeal. These can be provided free of charge."<br>How to Appeal a Denial \| Medicaid \| Molina Healthcare of Mississippi<br>All include instructions and procedures for filing an appeal to meet requirements of the CAN Contract, Section (K) have been added to the website. | |
| **V C. Appeals (CHIP)** | |
| 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:<br>1.2 The procedure for filing an appeal; | Appeals procedures and instructions are documented in Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, Provider Manual, and on the website. CCME identified the following documentation issues on the website:<br>•The website incorrectly states that appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the notice of Adverse Benefit Determination letter.<br>•The website does not address or describe that someone else, an authorized representative, can file on the member's behalf.<br>•The website does not address that members can present evidence or examine their case file at any time during the appeals process.<br>Additionally, the CHIP Member Handbook, Provider Manual, and website do not specify that a written appeal request must follow a verbal appeal request within 30 days after the call, unless expedited, as required by the *CHIP Contract, Section 6 (K)*.<br>*Corrective Action: Edit the CHIP website to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal. Revise the CHIP Member Handbook, Provider Manual and website to indicate written appeal request must follow a verbal appeal request within 30 days after the call, unless expedited to meet requirements in the CHIP Contract, Section (K).* |
| We have updated our website to include the correct address to file an appeal.<br>How to Appeal a Denial \| CHIP \| Molina Healthcare of Mississippi<br>We have updated our website to read "All appeals must be filed within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (denial letter)." This language is consistent with the Provider Manual and Member Handbook.<br>How to Appeal a Denial \| CHIP \| Molina Healthcare of Mississippi<br>We have updated our website to read "We can accept your appeal from someone else with your permission. For Example:<br>• A friend<br>• A family member<br>• A provider part of Molina<br>• A provider that is not part of Molina<br>• A lawyer"<br>This language is consistent with our provider manual and member handbook.<br>How to Appeal a Denial \| CHIP \| Molina Healthcare of Mississippi | |

| Standard | EQR Comments |
|---|---|
| We have updated our Provider Manual, Member Handbook, and Website to read "If you call to file your appeal, you must send Molina a signed, written appeal request within 30 calendar days after you first called us, unless you ask for an expedited (fast) plan appeal."<br><br>Provider Manual (***Please see MHMSC065 Provider Manual - CHIP- Revised - 04092021 attached, page 144, first paragraph.)***<br><br>Website<br><br>How to Appeal a Denial \| CHIP \| Molina Healthcare of Mississippi<br><br>Member Handbook<br><br>Page 54 of the CHIP member handbook - "If you call to file your appeal, you must send Molina a signed, written appeal within 30 calendar days after you first called us to file your appeal, unless you ask for an expedited (fast) plan appeal." | |

As noted in Figure 7: Utilization Management Findings, Molina received scores of "Met" for 94.5% of the standards and 5.5% were scored as "Partially Met."

**Figure 7: Utilization Management Findings**

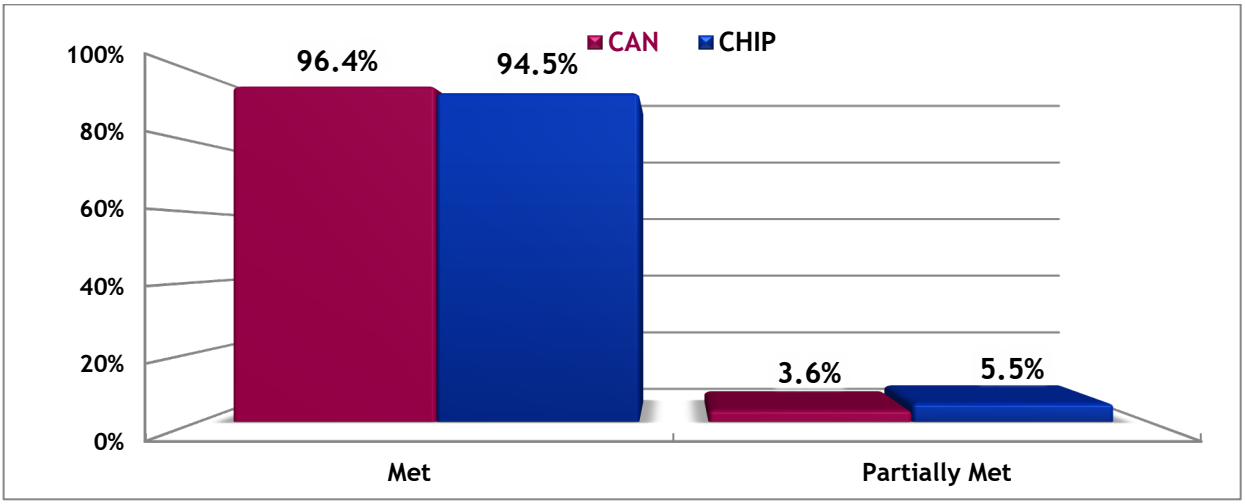



**Table 48: Utilization Management**

| Section | Standard | CAN 2021 Review | CHIP 2021 Review |
|---|---|---|---|
| Utilization Management Program | The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:<br>Timeliness of UM decisions, initial notification, and written (or electronic) verification | Partially Met | Partially Met |
| Appeals | The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit | Met | Partially Met |

| Section | Standard | CAN 2021 Review | CHIP 2021 Review |
|---|---|---|---|
| | determination by the CCO in a manner consistent with contract requirements, including:<br>Written notice of the appeal resolution as required by the contract | | |
| Care Management | The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan | Partially Met | Partially Met |

### *Strengths*

- A full-time nurse auditor was hired to enhance year-round interrater reliability activities and to ensure staff performance is consistent with policies and procedures by reviewing UM documentation, engaging with UM staff, and presenting audit findings during weekly UM huddles. Education and reinforcement occur quickly and is ongoing.
- The CAN & CHIP websites include a copy of the appeal request form that is fillable and can be downloaded and printed.

### *Weaknesses*

- Incorrect or omitted information in CAN Policy MHMS-HCS-UM-383 and CHIP Policy MHMS-HCS-UM-383.1 Timeliness of UM Decision Making and Notification, related to urgent extended prior authorization requests:
    - Incorrect documentation indicating that requests can be extended up to 48 hours and a decision must be made no later than 72 hours.
    - No documentation that Molina has to request an extension from DOM.
    - For CAN Policy MHMS-HCS-UM-383, the header indicates Medicare line of business instead of CAN.
- For CAN and CHIP, documentation of Molina's processes for addressing continuity of care when a member disenrolls from the health plan could not be identified.
- The header of Policy MHMS-MRT-02, Standard Member Appeals indicates that it applies to the CAN and CHIP lines of business, however, the following issues were noted:
    - No documentation on the process for CHIP members to request an Independent External Review.
    - CHIP Policy MHMS-MRT-05, Member Independent External Review, is not included on the list of references.

### *Corrective Actions*

- For CAN and CHIP, edit CAN Policy MHMS-HCS-UM-383 and CHIP Policy MHMS-HCS-UM-383.1, Timeliness of UM Decision Making and Notification, to reflect the correct

timeframe requirements for extensions of urgent prior authorization requests and to indicate that Molina must request approval of the extension from DOM, according to requirements in *CAN Contract, Section 5 (J) (6)* and *CHIP Contract, Section 5 (I) (4)*.

- For CAN and CHIP, include in a policy or other document Molina's processes for addressing continuity of care when a member disenrolls from a health plan according to requirements in the *CAN Contract, Section 9 (A) (4)* and *CHIP Contract, Section 8 (A) (3)*.
- For CHIP, edit Policy MHMS-MRT-02, Standard Member Appeals, to include information on the Independent External Review process for CHIP members and include Policy MHMS-MRT-05, Member Independent External Review to the list of references.

### *Recommendations*

- For CAN, edit the header in Policy MHMS-HCS-UM-383 Timeliness of UM Decision Making and Notification, to reflect the line of business is MSCAN and not Medicare.

## VI. Delegation

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

CCME's External Quality Review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials. Molina reported 14 current delegation agreements, as shown in *Table 49: Delegated Entities and Services.*

**Table 49: Delegated Entities and Services**

| Delegated Entities | Delegated Services |
|---|---|
| SKYGEN | Dental benefit administration |
| CareMark | Pharmacy benefit administration |
| March Vision | Vision network, claims administration, and call center services |
| MTM | Non-emergent medical transportation and customer service |
| •Baptist Memorial Medical Group (BMMG)<br>•George Regional Health System (GRHS)<br>•Hattiesburg Clinic, PA (HBC)<br>•Memorial Hospital at Gulfport (MGP)<br>•Mississippi Physicians Care Network (MPCN)<br>•Magnolia Regional Health Center (MRHC)<br>•North Mississippi Health Services (NMHS)<br>•Oschner Health System (OCH)<br>•Premier Health (SRMC)<br>•University of Mississippi Medical Center (UMMC) | Credentialing and recredentialing |

Processes and requirements for delegation of services and activities are found in various policies that address topics such as pre-assessment audits, delegation requirements, performance monitoring and annual oversight, and corrective action and/or termination of delegation agreements. Policy DO005, Credentialing Delegation Requirements, does not address site visits for providers credentialing by delegated credentialing entities nor does it address collection of fingerprints for CHIP providers designated as high risk by DOM. As noted in the Provider Services section of this EQR, Molina has not yet finalized processes for office site visits or collection of fingerprints at initial credentialing for applicable providers.

As confirmed during onsite discussion, Molina's Healthcare Delegation Oversight team conducts annual oversight and ongoing monitoring for each of its delegates. Documentation of monitoring and oversight activities was submitted. The documentation revealed appropriate metrics are reviewed for claims, UM, call centers, etc. File review worksheets (audit tools)for credentialing delegates include most of the required credentialing elements; however, the tools do not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for CHIP providers designated as high-risk by DOM. Based on the findings of the current EQR, it is evident that Molina did not address or correct the findings from the 2020 EQR, as shown in *Table 50: Previous Delegation CAP Items*.

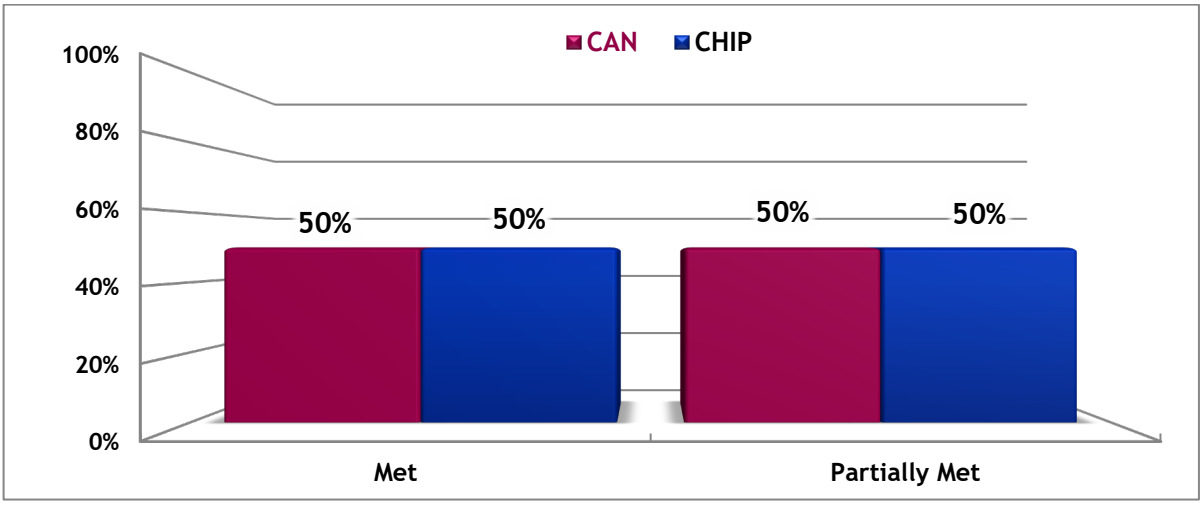
**Table 50: Previous Delegation CAP Items**

| Standard | EQR Comments |
|---|---|
| **VI. Delegation (CAN)** | |
| 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. | The site assessments and reassessments specified in the *CAN Contract, Section 7 (E)* were not included in the monitoring tools.<br>*Corrective Acton: Update the credentialing and recredentialing monitoring tools to include the site assessments and reassessments as specified in the CAN Contract, Section 7 (E).* |
| **Molina's Response:** Molina's intention is to sub-delegate site visit responsibilities to our existing Credentialing delegates who demonstrate ability to perform the function. (See draft of updated Delegation Agreement should we decide to move forward with using our delegates for this process.) In the event the Credentialing delegate is unwilling or unable to take on site visit responsibilities, Molina Healthcare will be responsible for completion of the visit. | |
| **VI. Delegation (CHIP)** | |
| 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. | The site assessments and reassessments specified in the *CHIP Contract, Section 7 (E)* and the fingerprinting requirements for high-risk providers, as required by the *CHIP Contract, Section 7 (E) (6),* were not included on the monitoring tools.<br>*Corrective Action: Update the credentialing and recredentialing monitoring tools to include the site assessments, reassessments, and the fingerprinting requirements noted in the CHIP Contract Section 7 (E).* |

| Standard | EQR Comments |
|---|---|
| **Molina's Response:** Molina's intention is to sub-delegate site visit responsibilities to our existing Credentialing delegates who demonstrate ability to perform the function. (See draft of updated Delegation Agreement should we decide to move forward with using our delegates for this process.) In the event the Credentialing delegate is unwilling or unable to take on site visit responsibilities, Molina Healthcare will be responsible for completion of the visit. | |

As indicated in *Figure 8, Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met" for both CAN and CHIP.

**Figure 8: Delegation Findings**




## *Strengths*

- Molina took action to terminate its delegation agreement with one delegate that continued to have issues year over year, even after placing the delegate on a bi-annual audit schedule.

## *Weaknesses*

- Policy DO005, Credentialing Delegation Requirements, does not address site visits for providers credentialed by delegated credentialing entities nor does it address collection of fingerprints for CHIP providers designated as high risk by DOM. As noted in the Provider Services section of this EQR, Molina has not finalized processes for office site visits or collection of fingerprints at initial credentialing for applicable providers.
- Documentation of monitoring and oversight activities revealed file review worksheets for credentialing delegates did not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for CHIP providers designated as high-risk by DOM.

### *Corrective Actions*

- When processes for conducting initial credentialing site visits for both CAN and CHIP providers and collecting fingerprints at initial credentialing for CHIP providers designated as high risk by DOM are finalized, ensure that Policy DO005, Credentialing Delegation Requirements, is updated to include whether the delegates or Molina itself will be responsible for these activities for providers who are credentialed by delegated credentialing entities.
- When credentialing delegates are responsible for conducting site visits and collecting provider fingerprints, ensure delegated credentialing file review worksheets include evidence the delegate is monitored for these activities and that credentialing files include evidence.

## ATTACHMENTS

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

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

July 6, 2021

Bridget Galatas
Chief Executive Officer
Molina Healthcare of Mississippi
188 E Capitol St Ste 700
Jackson, MS 39201

Dear Ms. Galatas:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2021 External Quality Review (EQR) of Molina Healthcare of Mississippi is being initiated. The review will include the MississippiCAN Program (MSCAN) and MississippiCHIP Program (MSCHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

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

The onsite visit will be conducted on November 1, 2021, through November 2, 2021, for the MississippiCAN and MississippiCHIP Programs.

In preparation for the desk review, the items on the enclosed Mississippi CAN Materials Request for Desk Review and Mississippi CHIP Materials Request for Desk Review lists should be provided to CCME no later than August 5, 2021.

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

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

We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site. We will also send written desk instructions on how to use the file transfer site. Ensuring successful upload of desk materials is our priority and we value the opportunity to

provide support. Of course, additional information and technical assistance will be provided as needed.

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

## External Quality Review 2021 for MississippiCAN
### MATERIALS REQUESTED FOR DESK REVIEW

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

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

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

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

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

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

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

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

9. The Quality Improvement work plans for MSCAN for 2020 and 2021.

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

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

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

b. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction, and
    - 15 sample records from those abstracted charts.
c. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP, and
    - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

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

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

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

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

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

17. Provide reports for measuring provider adherence to medical record standards for 2020 and 2021.

18. A complete list of all MSCAN members enrolled in the Care Management program from July 2020 through July 2021. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

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

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

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

24. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of July 2020 through July 2021.

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

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

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

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

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

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

31. A sample provider contract for the MSCAN program.

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

h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of July 2020 through July 2021.

33. For the MSCAN program, a listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

34. Contracts for all delegated entities.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

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

| Folder | Requested Document | Description |
|---|---|---|
| a. | HEDIS MY 2020 (Measurement Year 2020) Record of Administration, Data Management and Processes (Roadmap) | • Please submit the same Roadmap your CCO completed for the HUDIS MY 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section.<br>• Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this. |
| b. | IDSS (CSV and Excel workbooks) for MSCAN | Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN. |
| c. | HEDIS MY 2020 Final Audit Report (from Licensed Organization) for MSCAN | Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization. |
| d. | Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any | • If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure.<br>• If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code. |
| e. | Source code used to generate each of the non-HEDIS performance measures | • Please submit source code for each measure.<br>• If non-HEDIS performance measures were calculated by a vendor, please provide the vendor's name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production. |

| Folder | Requested Document | Description |
|---|---|---|
| f. | Numerator positive case listings for the HEDIS and non-HEDIS measures | *Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 f) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite review.* |
| g. | List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS and non-HEDIS measures | *Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.* |
| h. | Rate reporting template populated with data for non-HEDIS measure rates | CCME will provide the rate reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure. |

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

37. Provide a complete list of all services that require prior authorization.

38. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (including provider office site visits as appropriate) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the MSCAN program made in the months of July 2020 through July 2021. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
    d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of July 2020 through July 2021, including any medical information and approval criteria used in the decision.

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

**These materials:**

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

## External Quality Review 2021 for Mississippi CHIP

### MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the CHIP program, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

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

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

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

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

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

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

9. The Quality Improvement work plans for CHIP for 2020 and 2021.

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

11. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with non-HEDIS measures:

- any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.

b. For projects with measures derived from medical record abstraction:
   - full documentation of the abstraction process and tool used during abstraction, and
   - 15 sample records from those abstracted charts.

c. For projects with measures derived from administrative electronic systems:
   - full source code documentation of how the measure was processed and calculated for the PIP, and
   - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

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

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

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

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

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

17. Provide reports for measuring provider adherence to medical record standards for 2020 and 2021.

18. A complete list of all CHIP members enrolled in the Care Management program from July 2020 through July 2021. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

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

22. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the CHIP program.

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

24. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of July 2020 through July 2021.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the CHIP program. Please also include the letter template used to notify CHIP members that their annual out-of-pocket maximum has been met.

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

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

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

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30. A copy of the provider handbook or manual for the CHIP program.

31. A sample provider contract for the CHIP program.

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

f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of July 2020 through July 2021.

33. For the CHIP program, a listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

34. Contracts for all delegated entities.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

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

| Folder | Requested Document | Description |
|---|---|---|
| a. | HEDIS MY 2020 (Measurement Year 2020) Record of Administration, Data Management and Processes (Roadmap) | • Please submit the same Roadmap your CCO completed for the HEDIS MY 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section.<br>• Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this. |
| b. | IDSS (CSV and Excel workbooks) for MSCHIP | Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCHIP. |
| c. | HEDIS MY 2020 Final Audit Report (from Licensed Organization) for MSCHIP | Please submit the CHIP Final Audit Report that was issued by the NCQA HEDIS Licensed Organization. |
| d. | Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any | • If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure.<br>• If your CCO used [2]HEDIS Certified Measures [SM,] to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code. |

| Folder | Requested Document | Description |
|---|---|---|
| e. | Source code used to generate each of the non-HEDIS performance measures | • Please submit source code for each measure.<br>• If non-HEDIS performance measures were calculated by a vendor, please provide the vendor's name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production. |
| f. | Numerator positive case listings for the HEDIS and non-HEDIS measures | *Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 f) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite review.* |
| g. | List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS and non-HEDIS measures | *Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.* |
| h. | Rate reporting template populated with data for non-HEDIS measure rates | CCME will provide the rate reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure. |

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37. Provide a complete list of all services that require prior authorization.

38. Provide electronic copies of the following files for the CHIP program:
    a. Credentialing files (including provider office site visits as appropriate) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the CHIP program made in the months of July 2020 through July 2021. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP program made in the months of July 2020 through July 2021, including any medical information and approval criteria used in the decision.

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

**These materials:**

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

## II. Attachment 2: Materials Requested for Onsite Review

## External Quality Review 2021

### MATERIALS REQUESTED FOR ONSITE REVIEW

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

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

## III. Attachment 3: EQR Validation Worksheets

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

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **Molina CAN/CHIP** |
| **Survey Validated** | **PROVIDER SATISFACTION** |
| **Validation Period** | 2019-2020 |
| **Review Performed** | 2021 |

***Review Instructions***

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

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

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **1.1** | Review whether there is a clear written statement of the survey's purpose(s). | **MET** | Survey purpose documented in the report. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

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

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **2.1** | Assess whether the survey was tested for face validity and content validity and found to be valid | **MET** | Survey was tested for validity. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey was tested for reliability. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

## ACTIVITY 3: REVIEW THE SAMPLING PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **3.1** | Review that the definition of the study population was clearly identified. | **MET** | Study population was identified.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **3.2** | Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives. | **MET** | Sampling frame was clearly defined and appropriate.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **3.4** | Review whether the sample size is sufficient for the intended use of the survey. | **MET** | Sample size was sufficient according to CAHPS survey guidelines.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **3.5** | Review that the procedures used to select the sample were appropriate and protected against bias. | **MET** | Procedures to select the sample were appropriate.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

## ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **4.1** | Review the specifications for calculating response rates to make sure they are in accordance with industry standards | **MET** | The specifications for response rates were in accordance with standards.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **4.2** | Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings. | **MET** | Response rate was reported and bias in generalizability was documented.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

## ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.1** | Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits | **MET** | The quality plan was documented.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.3** | Were procedures developed to handle treatment of missing data or data determined to be unusable? | **MET** | Procedures for missing data were developed and applied.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

## ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **6.1** | Was the survey data analyzed? | **MET** | Survey data were analyzed.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

## ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

| Results Elements | | Validation Comments and Conclusions |
|---|---|---|
| **7.1** | Were procedures implemented to address responses that failed edit checks? | Procedures were in place to address response issues.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | Only 129 providers out of 1500 (6.6%% mail/internet and 6.8% phone survey response rate) completed the survey. This is a low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020<br><br>***Recommendation**: Generate new initiatives to advertise survey and gather more responses for providers* |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data was analyzed according to work plan.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |
| **7.5** | Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings? | The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.<br>*Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2020 |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **MOLINA CAN** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION - ADULT** |
| **Validation Period** | 2019-2020 |
| **Review Performed** | 2021 |

***Review Instructions***

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

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

| | Survey Element | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **1.1** | Review whether there is a clear written statement of the survey's purpose(s). | **MET** | Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

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

| | Survey Element | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **2.1** | Assess whether the survey was tested for face validity and content validity and found to be valid | **MET** | Survey was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 3: REVIEW THE SAMPLING PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **3.1** | Review that the definition of the study population was clearly identified. | **MET** | Study population was identified.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.2** | Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives. | **MET** | Sampling frame was clearly defined and appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.4** | Review whether the sample size is sufficient for the intended use of the survey. | **MET** | Sample size was sufficient according to CAHPS survey guidelines.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.5** | Review that the procedures used to select the sample were appropriate and protected against bias. | **MET** | Procedures to select the sample were appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **4.1** | Review the specifications for calculating response rates to make sure they are in accordance with industry standards | **MET** | The specifications for response rates were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **4.2** | Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings. | **MET** | Response rate was reported and bias in generalizability was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.1** | Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits | **MET** | The quality plan was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.3** | Were procedures developed to handle treatment of missing data or data determined to be unusable? | **MET** | Procedures for missing data were developed and applied.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |

## ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **6.1** | Was the survey data analyzed? | **MET** | Survey data were analyzed.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |

## ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

| Results Elements | | Validation Comments and Conclusions |
|---|---|---|
| **7.1** | Were procedures implemented to address responses that failed edit checks? | Procedures were in place to address response issues.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 1,318. The total completed surveys was 136 for a 10.3% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020<br><br>***Recommendation:*** *Initiate new interventions to attempt an increase in response rates.* |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data were analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **7.5** | Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings? | The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **MOLINA CAN** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION - CHILD** |
| **Validation Period** | 2019-2020 |
| **Review Performed** | 2021 |

***Review Instructions***

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

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

| | Survey Element | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **1.1** | Review whether there is a clear written statement of the survey's purpose(s). | **MET** | Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

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

| | Survey Element | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **2.1** | Assess whether the survey was tested for face validity and content validity and found to be valid | **MET** | Survey was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 3: REVIEW THE SAMPLING PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **3.1** | Review that the definition of the study population was clearly identified. | **MET** | Study population was identified.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.2** | Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives. | **MET** | Sampling frame was clearly defined and appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.4** | Review whether the sample size is sufficient for the intended use of the survey. | **MET** | Sample size was sufficient according to CAHPS survey guidelines.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.5** | Review that the procedures used to select the sample were appropriate and protected against bias. | **MET** | Procedures to select the sample were appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **4.1** | Review the specifications for calculating response rates to make sure they are in accordance with industry standards | **MET** | The specifications for response rates were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **4.2** | Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings. | **MET** | Response rate was reported and bias in generalizability was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.1** | Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits | **MET** | The quality plan was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.3** | Were procedures developed to handle treatment of missing data or data determined to be unusable? | **MET** | Procedures for missing data were developed and applied.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |

## ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **6.1** | Was the survey data analyzed? | **MET** | Survey data were analyzed.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |

## ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

| Results Elements | | Validation Comments and Conclusions |
|---|---|---|
| **7.1** | Were procedures implemented to address responses that failed edit checks? | Procedures were in place to address response issues.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 1,630. The total completed surveys was 166 for a 10.2% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020<br><br>***Recommendation:*** *Initiate new interventions to attempt an increase in response rates.* |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data was analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **7.5** | Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings? | The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **ALL HEDIS MEASURES** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| **HEDIS** |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **NOT APPLICABLE** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

| SAMPLING ELEMENTS (if Administrative Measure then N/A for section) | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| S1 Sampling | Sample treated all measures independently. | **N/A** | This hybrid measure was reported using only administrative data. |
| S2 Sampling | Sample size and replacement methodologies met specifications. | **N/A** | This hybrid measure was reported using only administrative data. |

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **HIV VIRAL LOAD SUPPRESSION (HVL - AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **PC-01: ELECTIVE DELIVERY (PC-01)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

| GENERAL MEASURE ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| G1 Documentation | Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes. | **Not Applicable** | This measure was not reported. |

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Not Applicable** | This measure was not reported. |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N1 Numerator | Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate. | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **Not Applicable** | This measure was not reported. |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **Not Applicable** | This measure was not reported. |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **Not Applicable** | This measure was not reported. |

| SAMPLING ELEMENTS (if Administrative Measure then N/A for section) | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| S1 Sampling | Sample treated all measures independently. | **Not Applicable** | This measure was not reported. |
| S2 Sampling | Sample size and replacement methodologies met specifications. | **Not Applicable** | This measure was not reported. |

| REPORTING ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| R1 Reporting | Were the state specifications for reporting performance measures followed? | **Not Applicable** | This measure was not reported. |
| Overall assessment | | | This measure was not reported. |

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| G1 | 10 | Not Applicable | |
| D1 | 10 | Not Applicable | |
| D2 | 5 | Not Applicable | |
| N1 | 10 | Not Applicable | |
| N2 | 5 | Not Applicable | |
| N3 | 5 | Not Applicable | |
| N4 | 5 | Not Applicable | |
| N5 | 5 | Not Applicable | |
| S1 | 5 | Not Applicable | |
| S2 | 5 | Not Applicable | |
| R1 | 10 | Not Applicable | |

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

| | |
|---|---|
| **Plan's Measure Score** | **N/A** |
| **Measure Weight Score** | **N/A** |
| **Validation Findings** | **N/A** |

| AUDIT DESIGNATION |
|---|
| **NOT VALID/NOT REPORTED** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Met** | |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | The measure programming did not include an appropriate mechanism to confirm exclusions. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N1 Numerator | Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate. | **Met** | |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

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

**VALIDATION SUMMARY**

| Element | Standard Weight | Validation Result | Score |
|---|---|---|---|
| **G1** | **10** | **Met** | 10 |
| **D1** | **10** | **Met** | 10 |
| **D2** | **5** | **Met** | 4 |
| **N1** | **10** | **Met** | 10 |
| **N2** | **5** | **Met** | 5 |
| **N3** | **5** | **Met** | 5 |
| **N4** | **5** | **Met** | 5 |
| **N5** | **5** | **Met** | 5 |
| **S1** | **5** | **Met** | 5 |
| **S2** | **5** | **Met** | 5 |
| **R1** | **10** | **Met** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **74** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **98.7%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | The source code picked up discharges that occurred after the measurement year. This was incorrect and will need to be corrected in the future. Since this impacted very few records the rate is reportable. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

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

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| **G1** | **10** | **Met** | 10 |
| **D1** | **10** | **Met** | 10 |
| **D2** | **5** | **Met** | 5 |
| **N1** | **10** | **Met** | 10 |
| **N2** | **5** | **Met** | 4 |
| **N3** | **5** | **Met** | 5 |
| **N4** | **5** | **Met** | 5 |
| **N5** | **5** | **Met** | 5 |
| **S1** | **5** | **Met** | 5 |
| **S2** | **5** | **Met** | 5 |
| **R1** | **10** | **Met** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **74** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **98.7%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | The source code picked up discharges that occurred after the measurement year. This was incorrect and will need to be corrected in the future. Since this impacted very few records the rate is reportable. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

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

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| **G1** | **10** | **Met** | 10 |
| **D1** | **10** | **Met** | 10 |
| **D2** | **5** | **Met** | 5 |
| **N1** | **10** | **Met** | 10 |
| **N2** | **5** | **Met** | 4 |
| **N3** | **5** | **Met** | 5 |
| **N4** | **5** | **Met** | 5 |
| **N5** | **5** | **Met** | 5 |
| **S1** | **5** | **Met** | 5 |
| **S2** | **5** | **Met** | 5 |
| **R1** | **10** | **Met** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **74** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **98.7%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | The source code picked up discharges that occurred after the measurement year. This was incorrect and will need to be corrected in the future. Since this impacted very few records the rate is reportable. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

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

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| **G1** | **10** | **Met** | 10 |
| **D1** | **10** | **Met** | 10 |
| **D2** | **5** | **Met** | 5 |
| **N1** | **10** | **Met** | 10 |
| **N2** | **5** | **Met** | 4 |
| **N3** | **5** | **Met** | 5 |
| **N4** | **5** | **Met** | 5 |
| **N5** | **5** | **Met** | 5 |
| **S1** | **5** | **Met** | 5 |
| **S2** | **5** | **Met** | 5 |
| **R1** | **10** | **Met** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **74** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **98.7%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **HEART FAILURE ADMISSION RATE (PQI-08)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | The source code picked up discharges that occurred after the measurement year. This was incorrect and will need to be corrected in the future. Since this impacted very few records the rate is reportable. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

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

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| **G1** | **10** | **Met** | 10 |
| **D1** | **10** | **Met** | 10 |
| **D2** | **5** | **Met** | 5 |
| **N1** | **10** | **Met** | 10 |
| **N2** | **5** | **Met** | 4 |
| **N3** | **5** | **Met** | 5 |
| **N4** | **5** | **Met** | 5 |
| **N5** | **5** | **Met** | 5 |
| **S1** | **5** | **Met** | 5 |
| **S2** | **5** | **Met** | 5 |
| **R1** | **10** | **Met** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **74** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **98.7%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCAN** |
| **Name of PM:** | **SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

| GENERAL MEASURE ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| G1 Documentation | Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes. | **Not Applicable** | This measure was not reported. |

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Not Applicable** | This measure was not reported. |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N1 Numerator | Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate. | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

| REPORTING ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| R1 Reporting | Were the state specifications for reporting performance measures followed? | **Not Applicable** | This measure was not reported. |
| Overall assessment | | | Not Applicable |

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| **G1** | **10** | **Not Applicable** | 10 |
| **D1** | **10** | **Not Applicable** | 10 |
| **D2** | **5** | **Not Applicable** | 5 |
| **N1** | **10** | **Not Applicable** | 10 |
| **N2** | **5** | **Not Applicable** | 5 |
| **N3** | **5** | **Not Applicable** | 5 |
| **N4** | **5** | **Not Applicable** | 5 |
| **N5** | **5** | **Not Applicable** | 5 |
| **S1** | **5** | **Not Applicable** | 5 |
| **S2** | **5** | **Not Applicable** | 5 |
| **R1** | **10** | **Not Applicable** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **N/A** |
| **Measure Weight Score** | **N/A** |
| **Validation Findings** | **N/A** |

| AUDIT DESIGNATION |
|---|
| **NOT VALID/NOT REPORTED** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **ALL HEDIS MEASURES** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| **HEDIS** |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **NOT APPLICABLE** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **NOT APPLICABLE** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **NOT APPLICABLE** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

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

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

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

| SAMPLING ELEMENTS (if Administrative Measure then N/A for section) | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| S1 Sampling | Sample treated all measures independently. | **N/A** | This hybrid measure was reported using only administrative data. |
| S2 Sampling | Sample size and replacement methodologies met specifications. | **N/A** | This hybrid measure was reported using only administrative data. |

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **NOT APPLICABLE** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **PC-01: ELECTIVE DELIVERY (PC-01)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

| GENERAL MEASURE ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| G1 Documentation | Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes. | **Not Applicable** | This measure was not reported. |

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Not Applicable** | This measure was not reported. |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N1 Numerator | Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate. | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **Not Applicable** | This measure was not reported. |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **Not Applicable** | This measure was not reported. |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **Not Applicable** | This measure was not reported. |

| SAMPLING ELEMENTS (if Administrative Measure then N/A for section) | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| S1 Sampling | Sample treated all measures independently. | **Not Applicable** | This measure was not reported. |
| S2 Sampling | Sample size and replacement methodologies met specifications. | **Not Applicable** | This measure was not reported. |

| REPORTING ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| R1 Reporting | Were the state specifications for reporting performance measures followed? | **Not Applicable** | This measure was not reported. |
| Overall assessment | | | This measure was not reported. |

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| G1 | 10 | Not Applicable | |
| D1 | 10 | Not Applicable | |
| D2 | 5 | Not Applicable | |
| N1 | 10 | Not Applicable | |
| N2 | 5 | Not Applicable | |
| N3 | 5 | Not Applicable | |
| N4 | 5 | Not Applicable | |
| N5 | 5 | Not Applicable | |
| S1 | 5 | Not Applicable | |
| S2 | 5 | Not Applicable | |
| R1 | 10 | Not Applicable | |

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

| | |
|---|---|
| **Plan's Measure Score** | **N/A** |
| **Measure Weight Score** | **N/A** |
| **Validation Findings** | **N/A** |

| AUDIT DESIGNATION |
|---|
| **NOT VALID/NOT REPORTED** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

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

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Met** | |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | The measure programming did not include an appropriate mechanism to confirm exclusions. |

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

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

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

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

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| **G1** | **10** | **Met** | 10 |
| **D1** | **10** | **Met** | 10 |
| **D2** | **5** | **Met** | 4 |
| **N1** | **10** | **Met** | 10 |
| **N2** | **5** | **Met** | 5 |
| **N3** | **5** | **Met** | 5 |
| **N4** | **5** | **Met** | 5 |
| **N5** | **5** | **Met** | 5 |
| **S1** | **5** | **Met** | 5 |
| **S2** | **5** | **Met** | 5 |
| **R1** | **10** | **Met** | 10 |

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

| | |
|---|---|
| **Plan's Measure Score** | **74** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **98.7%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **HEART FAILURE ADMISSION RATE (PQI-08)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Adult Core Set Measures |

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

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

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

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

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

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

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

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

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

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

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

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MSCHIP** |
| **Name of PM:** | **SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **11/1/2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| Child Core Set Measures |

| GENERAL MEASURE ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| G1 Documentation | Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes. | **Not Applicable** | This measure was not reported. |

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Not Applicable** | This measure was not reported. |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N1 Numerator | Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate. | **Not Applicable** | This measure was not reported. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Not Applicable** | This measure was not reported. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **N/A** | |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **N/A** | |
| N5 Numerator Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **N/A** | |

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

| REPORTING ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| R1 Reporting | Were the state specifications for reporting performance measures followed? | **Not Applicable** | This measure was not reported. |
| Overall assessment | | | Not Applicable |

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| G1 | 10 | Not Applicable | |
| D1 | 10 | Not Applicable | |
| D2 | 5 | Not Applicable | |
| N1 | 10 | Not Applicable | |
| N2 | 5 | Not Applicable | |
| N3 | 5 | Not Applicable | |
| N4 | 5 | Not Applicable | |
| N5 | 5 | Not Applicable | |
| S1 | 5 | Not Applicable | |
| S2 | 5 | Not Applicable | |
| R1 | 10 | Not Applicable | |

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

| | |
|---|---|
| **Plan's Measure Score** | **N/A** |
| **Measure Weight Score** | **N/A** |
| **Validation Findings** | **N/A** |

| AUDIT DESIGNATION |
|---|
| **NOT VALID/NOT REPORTED** |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA (MMA)** |
| **Reporting Year:** | **2021/2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method was reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan as documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates was provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NOT MET** | Rate declined from 66% to 60.8%. The goal is 71%.<br><br>Recommendation: Continue current and in-progress interventions to determine if they can improve the rate toward goal rate. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **N/A** | No improvement to assess. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **N/A** | No improvement to assess using statistical analyses. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 73 |
| Project Possible Score | 74 |
| Validation Findings | 99% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **BEHAVIORAL HEALTH READMISSIONS FOR HINDS COUNTY** |
| **Reporting Year:** | 2021/2021 |
| **Review Performed:** | 2021 |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method was reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates was provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NOT MET** | Rate of readmissions increased from 23.8% overall in 2020 to 27.7% in Q1 2021. The goal is a 5% decline from the previous year's rate. The case management enrollment rate was 100%.<br><br>*Recommendation: Continue current interventions of discharge planning, patient outreach, and community connectors to establish appropriate care management of members.* |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **N/A** | No improvement to assess. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **N/A** | No improvement to assess using statistical analyses. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

| AUDIT DESIGNATION |
|---|
| **High Confidence in Reported Results** |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **COPD** |
| **Reporting Year:** | 2021/2021 |
| **Review Performed:** | 2021 |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method was reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates was provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **MET** | Systemic corticosteroid rate improved from40% to 69.4%; bronchodilator rate improved from 80% to 83.3%. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **MET** | Improvement was related to interventions focused on member education, TOC connections, and member compliance data analysis. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical tests were reported. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 80 |
| Project Possible Score | 80 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS** |
| **Reporting Year:** | **2021/2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method was reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates was provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **MET** | 7-day follow-up rate improved from 8.1% to 26.3%. 30-day follow-up rate improved from 16.9% to 46%. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **MET** | Improvement was related to interventions focused on member education, post d/c follow-up, and TOC packets. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical tests were reported. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 80 |
| Project Possible Score | 80 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **OBESITY** |
| **Reporting Year:** | **2021/2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method was reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates is provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NOT MET** | All rates showed a lack of improvement. The BMI percentile rate declined from 12.6% to 12.5%; the nutrition rate declined from 11.5% to 7.3%; and the counseling rate declined from 8.4% to 5.4%.<br><br>Recommendation: Determine if there are additional barriers to improving rates that are relevant for providers and/or members. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **NA** | No improvement to assess. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **NA** | No testing required due to lack of improvement. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

| AUDIT DESIGNATION |
|---|
| **High Confidence in Reported Results** |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **PRENATAL AND POSTPARTUM CARE - PPC** |
| **Reporting Year:** | 2021/2021 |
| **Review Performed:** | 2021 |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method was reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates was provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **MET** | The prenatal care rate improved from 8.7% to 90.3%; the postpartum care rate improved from 30.8% to 35%. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **MET** | Improvement was related to interventions focused on provider education, member incentives, member outreach, and care management for high-risk OB members. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical tests were reported. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 80 |
| Project Possible Score | 80 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CAN** |
| **Name of PIP:** | **SICKLE CELL DISEASE** |
| **Reporting Year:** | **2021/2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection method as reported and considered a reliable and valid source of data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Data collection tools were reported. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis performed according to plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were presented clearly in Table format. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were noted. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of quantitative rates was provided in PIP report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were reported and linked to barriers to achieving the target rate. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **MET** | The case management rate improved from 4.85% to 5.74% with a goal of 15.9%. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **MET** | Improvement was related to interventions focused on internal member tracking for inpatient care and ED visits, well-care incentives, and collaboration with MSCF. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical tests were reported. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge with current data. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 80 |
| Project Possible Score | 80 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CHIP** |
| **Name of PIP:** | **ASTHMA (AMR)** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data were collected using valid and reliable data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Instruments for data collection were specified in report. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan is not documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel are in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Data analysis for available data was conducted. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Baseline rate was reported. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **NA** | Baseline data only. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis was included in the report for the baseline rate. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were documented in the report. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NA** | Baseline data only. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **NA** | Baseline data only. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **NA** | Baseline data only. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Baseline data only. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 72 |
| Project Possible Score | 72 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CHIP** |
| **Name of PIP:** | **FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)- 6 TO 19 YEAR OLDS** |
| **Reporting Year:** | **2019-2020** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **STEP 1: Review the Selected Study Topic(s)** | | |
| **1.1** Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)** | **NOT MET** | Data analysis was not offered in PIP report proposal for rationale to initiate study.<br><br>*Corrective Action: Include a summary of the rationale and data analysis that led to initiation of this PIP.* |
| **STEP 2: Review the PIP Aim Statement** | | |
| **2.1** Was the statement of PIP Aim(s) appropriate and adequate? **(10)** | **MET** | Study questions were documented. |
| **STEP 3: Identified PIP population** | | |
| **3.1** Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)** | **MET** | Study addressed key aspect of enrollee care. |
| **3.2** Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)** | **MET** | PIP did not exclude enrollees that are eligible. |
| **STEP 4: Review Sampling Methods** | | |
| **4.1** Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)** | **NOT MET** | Sampling information was not provided in the report.<br><br>*Corrective Action: Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.* |
| **4.2** Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:* | **NOT MET** | Information is not documented in the PIP report.<br><br>*Corrective Action: Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.* |
| **4.3** Did the sample contain a sufficient number of enrollees? **(5)** | **N/A** | Sample not provided as rate was not provided in report for baseline. |

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **STEP 5: Review Selected PIP Variables and Performance Measures** | | |
| **5.1** Did the study use objective, clearly defined, measurable indicators? **(10)** | **MET** | Indicators were clearly defined for FUH 7-day and FUH 30-day. |
| **5.2** Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)** | **MET** | Indicators measured changes in health status and processes of care. |
| **STEP 6: Review Data Collection Procedures** | | |
| **6.1** Did the study design clearly specify the data to be collected? **(5)** | **MET** | Data to be collected were specified in report as part of study indicator. |
| **6.2** Did the study design clearly specify the sources of data? **(1)** | **NOT MET** | Data sources are not indicated in proposal<br><br>*Corrective Action: Include information on sources of data.* |
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **N/A** | Unable to judge as data sources were not reported. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **N/A** | Instruments for data collection were not specified in report. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **NOT MET** | Data analysis plan was not documented.<br><br>*Corrective Action: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.* |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **N/A** | Unable to judge. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **N/A** | No data analysis performed. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **NOT MET** | No findings presented although report says HEDIS 2018 will be used as baseline.<br><br>*Corrective Action: Include the results for baseline rate in PIP report with comparison to benchmark rate.* |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **N/A** | No repeat measurements yet. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **NOT MET** | Analysis of baseline was not offered in report and follow-up activities were not documented.<br><br>*Corrective Action: Include the results for baseline rate in PIP report. Common analysis plans* |

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| | | *are annual, quarterly, or monthly.* |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **NOT MET** | Interventions not documented in the report.<br><br>*Corrective Action: Add the barriers and interventions linked to each barrier to the report.* |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **N/A** | No findings presented. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **N/A** | No improvement to assess. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **N/A** | No improvement to assess. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **N/A** | Unable to judge. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 28 |
| Project Possible Score | 62 |
| Validation Findings | 45.2% |

| AUDIT DESIGNATION |
|---|
| NOT CREDIBLE |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CHIP** |
| **Name of PIP:** | **FOLLOW UP AFTER HOSPITALIZATION - 7 AND 30 DAY** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data were collected using valid and reliable data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Instruments for data collection were specified in report. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Data analysis for available data was conducted. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Baseline rate was reported. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **NA** | N/A used as measurement for second rate. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis was included in the report for the baseline rate. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were documented in the report. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NA** | Baseline data only. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **NA** | Baseline data only. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **NA** | Baseline data only. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Baseline data only. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 72 |
| Project Possible Score | 72 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CHIP** |
| **Name of PIP:** | **OBESITY** |
| **Reporting Year:** | **2021** |
| **Review Performed:** | **2021** |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data were collected using valid and reliable data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Instruments for data collection were specified in report. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan was not documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel were listed in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Data analysis for available data was conducted. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Baseline rate was reported. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **NA** | Baseline data only. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis as included in the report for the baseline rate. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were documented in the report. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NA** | Baseline data only. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **NA** | Baseline data only. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **NA** | Baseline data only. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Baseline data only. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 72 |
| Project Possible Score | 72 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Molina CHIP** |
| **Name of PIP:** | **WELL CHILD AND WELL CARE PIP** |
| **Reporting Year:** | 2021 |
| **Review Performed:** | 2021 |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.2** Did the study design clearly specify the sources of data? **(1)** | **MET** | Data sources are indicated in proposal. |
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data are collected using valid and reliable data. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Instruments for data collection are specified in report. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Data analysis plan is documented. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Personnel are in report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Data analysis for available data was conducted. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Baseline rate is reported. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **NA** | Baseline data only (NA for repeated measurement) |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis is included in the report for the baseline rate. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions are documented in the report. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NA** | Baseline data only. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **NA** | Baseline data only. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **NA** | Baseline data only. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Baseline data only. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

| | |
|---|---|
| Project Score | 72 |
| Project Possible Score | 72 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| High Confidence in Reported Results |

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

## IV. Attachment 4: Tabular Spreadsheet

# CCME CAN Data Collection Tool

| | |
|---|---|
| **Plan Name:** | **Molina Healthcare MS CAN** |
| **Review Performed:** | 2021 |

## I. ADMINISTRATION

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **I. ADMINISTRATION** | | | | | | |
| **I A. General Approach to Policies and Procedures** | | | | | | |
| 1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly. | X | | | | | Molina has policies and procedures in place to ensure the provision of quality services. The Quality Improvement Committee references updates from the new Policy Committee in their quarterly agenda. |
| **I B. Organizational Chart / Staffing** | | | | | | |
| 1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: | | | | | | |
| 1.1 *Chief Executive Officer; | X | | | | | Molina's Plan President and Chief Executive Officer (CEO) is Bridget Galatas. |
| 1.2 *Chief Operating Officer; | X | | | | | The Chief Operating Officer is Kyle Godfrey. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.3 Chief Financial Officer; | X | | | | | Edward Mohr Is the Chief Financial Officer. |
| 1.4 Chief Information Officer; | X | | | | | The Chief Information Officer for Centene is Jeffrey Cangialosi. |
| 1.4.1 *Information Systems personnel; | X | | | | | |
| 1.5 Claims Administrator; | X | | | | | Sandy Dunbar is the Claims Administrator. |
| 1.6 *Provider Services Manager; | X | | | | | Earl Robinson is Provider Service Manager and Chinwe Nichols is the Provider Services Director. |
| 1.6.1 *Provider credentialing and education; | X | | | | | |
| 1.7 *Member Services Manager; | X | | | | | The Member Services Director is Juan (Emilio) Bellizzia Arriaga. |
| 1.7.1 Member services and education; | X | | | | | |
| 1.8 Complaint/Grievance Coordinator; | X | | | | | Bert Emrick is the Appeals and Grievances Manager. |
| 1.9 Utilization Management Coordinator; | X | | | | | Chris Cauthen is the Director or Utilization Management. |
| 1.9.1 *Medical/Care Management Staff; | X | | | | | |
| 1.10 Quality Management Director; | X | | | | | Loleta Kellum is AVP Quality Improvement. |
| 1.11 *Marketing, member communication, and/or public relations staff; | X | | | | | Juvante Johnson is the Government Contracts Manager. |
| 1.12 *Medical Director; | X | | | | | Thomas Joiner is the Chief Medical Officer. |
| 1.13 *Compliance Officer. | X | | | | | Latasha McGill is AVP of Compliance. |
| 2. Operational relationships of CCO staff are clearly delineated. | X | | | | | |
| **I C. Management Information Systems** *42 CFR § 438.242, 42 CFR § 457.1233 (d)* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. The CCO processes provider claims in an accurate and timely fashion. | X | | | | | Mississippi requires 90% of clean claims to be processed within 30 days, and 99% of clean claims to be processed within 90 days. Molina exceeds the contract requirements with an average of more than 99% of clean claims processed within 30 days, and a 90-day average of 100%. |
| 2. The CCO tracks enrollment and demographic data and links it to the provider base. | X | | | | | Molina ensures member demographic and enrollment information is up-to-date based on updates received from the State. If there are manual updates needed to meet eligibility information, an authorized member service staff person is allowed to update the information. |
| 3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities. | X | | | | | Molina's HEDIS performance data is generated using NCQA-Certified HEDIS Software. ISCA documentation states Molina upgrades its HEDIS software monthly or as needed. Finally, part of Molina's HEDIS reporting validation involves comparing the current data to prior years. |
| 4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented. | X | | | | | Molina's IT infrastructure incorporates technology (clustering, SAN storage, data replication) to provide resilience and minimize outages. In the event there are issues with Molina's primary data center, there is a data copy at a disaster recovery site. |
| **I D. Compliance/Program Integrity** | | | | | | |
| 1. The CCO has a Compliance Plan to guard against fraud, waste and abuse. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2. The Compliance Plan and/or policies and procedures address requirements, including: | X | | | | | |
| 2.1 Standards of conduct; | | | | | | The Code of Business Conduct and Ethics governs the way Molina's employees, officers, and directors conduct business activities. Every employee, officer, and director must be familiar with it and always adhere to it. |
| 2.2 Identification of the Compliance Officer; | | | | | | |
| 2.3 Information about the Compliance Committee; | | | | | | |
| 2.4 Compliance training and education; | | | | | | Education and training sessions are mandatory for all employees. |
| 2.5 Lines of communication; | | | | | | |
| 2.6 Enforcement and accessibility; | | | | | | |
| 2.7 Internal monitoring and auditing; | | | | | | Auditing and monitoring are used to identify areas of noncompliance, respond to suspected noncompliance, to assess continuing compliance, and to assess the effectiveness of corrective measures implemented to address previously identified deficiencies. Where appropriate, individuals with specific investigative expertise in the management of fraud investigations shall be used to investigate instances of suspected healthcare fraud. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2.8 Response to offenses and corrective action; | | | | | | |
| 2.9 Exclusion status monitoring. | | | | | | |
| 3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities. | X | | | | | |
| 4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse. | X | | | | | |
| 5. The CCO's policies and procedures define how investigations of all reported incidents are conducted. | X | | | | | |
| 6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments. | X | | | | | |
| 7. The CCO implements and maintains a Pharmacy Lock-In Program. | X | | | | | Processes and requirements for the Pharmacy Lock-In Program are specified in Policy MHMS-PH-005, Pharmacy Lock-In Program. |
| **I E. Confidentiality**<br>*42 CFR § 438.224* | | | | | | |
| 1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy. | X | | | | | |

## II. PROVIDER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **II. A. Credentialing and Recredentialing**<br>*42 CFR § 438.214, 42 CFR § 457.1233(a)* | | | | | | |
| 1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements. | | | X | | | Credentialing processes and requirements are found in:<br>•Policy CR 01, Credentialing Program Policy and Addendum B – Molina Healthcare of Mississippi State Specific Credentialing Requirements<br>•Policy CR 02, Assessment of Organizational Providers Policy and Addendum B – Molina Healthcare of Mississippi State Specific Credentialing Requirements<br>•Policy MHMS-PC-11, MHMS Provider Network General Requirements<br><br>Addendum B of Policy CR 01 states Molina conducts initial site assessments prior to completing the initial credentialing process for private practitioner offices and other patient care settings. Reassessments are conducted if the provider's location has changed since the previous credentialing activity and when a complaint has been lodged against a specific provider. The addendum indicates the site visit requirements apply to "All practitioners." During onsite discussion, Molina reported that a process for conducting site visits has not yet been established and that Molina is planning to contract with a vendor to conduct site visits. Molina confirmed that site visits for providers who have already completed credentialing will be conducted when the processes |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | is finalized. **This is a repeat finding from the previous EQR.**<br><br>In Molina's CAP response to this finding from the previous EQR, Molina reported that:<br>•They were focusing on identifying and contracting with a vendor to conduct site visits. The target date for having a vendor in place and an established process was August 1, 2021.<br>•They would continue to work on and develop a site visit process that would address how and where related information will be maintained.<br><br>*Corrective Action Plan: Develop and implement a process for conducting site visits for providers to comply with requirements of the CAN Contract, Section 7 (E) (3).* |
| 2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO. | X | | | | | Molina's Medical Director has overall responsibility for credentialing processes and activities. The Medical Director chairs and is a voting member of the Professional Review Committee (PRC). Level 1 credentialing files are considered clean credentialing files and can be approved by the Medical Director. A report of the practitioners approved by the Medical Director is presented at each PRC meeting. Using a peer review process, Level 2 credentialing files are reviewed by the PRC for credentialing determinations.<br><br>The PRC representation includes at least four network practitioners with a range of specialties. Other practitioners may be invited to participate ad |

| STANDARD | SCORE | | | | | COMMENTS |
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| | | | | | | hoc when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Pain Management Specialist, Nurse Practitioners, and Chiropractors) may be appointed to screen applicants from their respective profession and make credentialing recommendations to the PRC. Current PRC membership includes providers with specialties of Family Medicine (x3) Sports Medicine, OB/GYN, and Internal Medicine.<br><br>The PRC meets at least quarterly. Practitioners have voting privileges and the quorum is established as the presence of four voting practitioners at any regular or special meeting. The Medical Director may remove or replace a PRC member if the member is absent from more than 2 meetings per year.<br><br>Review of PRC minutes confirmed the committee meets at appropriate intervals and member attendance is satisfactory. The minutes reflected thorough review and discussion of Level 2 providers prior to making credentialing determinations. |
| 3. The credentialing process includes all elements required by the contract and by the CCO's internal policies. | X | | | | | |
| 3.1 Verification of information on the applicant, including: | | | | | | |
| 3.1.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 3.1.2 Valid DEA certificate and/or CDS Certificate; | X | | | | | |
| 3.1.3 Professional education and training or board certification if claimed by the applicant; | X | | | | | |
| 3.1.4 Work history; | X | | | | | |
| 3.1.5 Malpractice insurance coverage / claims history; | X | | | | | |
| 3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load; | X | | | | | |
| 3.1.7 Query of the National Practitioner Data Bank (NPDB); | X | | | | | |
| 3.1.8 Query of the System for Award Management (SAM); | X | | | | | |
| 3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)); | X | | | | | |
| 3.1.11 Query of the Social Security Administration's Death Master File (SSDMF); | X | | | | | |
| 3.1.12 Query of the National Plan and Provider Enumeration System (NPPES); | X | | | | | |
| 3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility; | X | | | | | |
| 3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services; | X | | | | | |
| 3.2 Site assessment. | X | | | | | Due to restrictions from the COVID-19 pandemic, site visits are on hold but will be conducted when a vendor is under contract and when public safety restrictions are lifted. |
| 3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days. | X | | | | | |
| 4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies. | X | | | | | |
| 4.1 Recredentialing every three years; | X | | | | | |
| 4.2 Verification of information on the applicant, including: | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 4.2.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |
| 4.2.2 Valid DEA certificate and/or CDS Certificate; | X | | | | | |
| 4.2.3 Board certification if claimed by the applicant; | X | | | | | |
| 4.2.4 Malpractice claims since the previous credentialing event; | X | | | | | |
| 4.2.5 Practitioner attestation statement; | X | | | | | |
| 4.2.6 Re-query the National Practitioner Data Bank (NPDB); | X | | | | | |
| 4.2.7 Re-query the System for Award Management (SAM); | X | | | | | |
| 4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List; | X | | | | | |
| 4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)); | X | | | | | |
| 4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF); | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES); | X | | | | | |
| 4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services; | X | | | | | |
| 4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility; | X | | | | | |
| 4.3 Provider office site reassessment, when applicable. | X | | | | | |
| 4.4 Review of practitioner profiling activities. | X | | | | | |
| 5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues. | X | | | | | Procedure MHMS-PC-09, MHMS Provider Termination Process, states:<br>•When a provider chooses to leave the network, Molina will give DOM 60 days prior notice of the termination date.<br>•Molina must terminate any provider for cause for any reasons set forth in *42 CFR 455.416, 455.420, 1001.1001* and *MS Code Ann. 43-13-121(7)*. When Molina terminates a provider, Molina will give DOM 60 days prior notice of its intent to terminate a provider and will submit a provider termination work plan to DOM within 10 business days of the notification.<br>•In instances where DOM terminates a provider for cause, Molina terminates the provider upon notification from DOM and submits a copy of the |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | provider termination notification to DOM within 48 hours. |
| 6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities. | X | | | | | |
| **II B. Adequacy of the Provider Network**<br>*42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* | | | | | | |
| 1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements. | | | | | | |
| 1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned. | X | | | | | |
| 1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment. | X | | | | | Nonparticipating providers can verify member enrollment by contacting the Member and Provider Contact Center. |
| 1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients. | X | | | | | Open and closed provider panels are monitored through Geo Access reports. Staff also monitor provider panel status routinely to ensure providers aren't overloaded with assigned members and to ensure members have adequate choice of providers. |
| 1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties. | X | | | | | Standards for access to PCPs are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. The standards documented in the policies are compliant with contractual requirements. Quarterly Geographic Access |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Assessment Report are run using correct parameters to assess compliance with geographic accessibility requirements. |
| 1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. | X | | | | | Standards for access to specialists and other provider types are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. The standards documented in the policies are compliant with contractual requirements. Quarterly Geographic Access Assessment Report are run using correct parameters to assess compliance with geographic accessibility requirements. |
| 1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly. | X | | | | | Quarterly Geographic Access Assessment Reports are run to assess compliance with geographic accessibility requirements. Results are reviewed and reported to the Quality Improvement Committee. Member complaints about network access may also be used to identify network inadequacies. |
| 1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations. | X | | | | | Processes for ensuring network providers can serve members with special needs, including foreign language and cultural requirements, are addressed in Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness. Molina uses various data sources to assess the language needs and cultural backgrounds of its membership.<br>The Molina website includes resources about culturally and linguistically appropriate services. The information addresses interpreter services and includes downloadable/printable resources, trainings |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | about culturally competent healthcare, and links to additional external resources. |
| 1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand. | X | | | | | |
| 2. Practitioner Accessibility | | | | | | |
| 2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements. | X | | | | | Documentation in Policy MHMS-QI-006, Access to Care, indicates Molina conducts appointment and after-hour accessibility audits on a sample of PCPs, high-volume specialists (OBGYN), high-impact specialists (oncology), and behavioral health providers. Ongoing monitoring includes member complaints related to accessibility, scheduling processes, wait times, and delays. The following are not defined in the policy:<br>•The frequency of conducting appointment access and after hours audits. Onsite discussion confirmed the audits are conducted quarterly.<br>•The department or entity that conducts the audits. Onsite discussion revealed the audits are conducted by the Quality HEDIS Call Center.<br><br>The appointment access standards listed in the policy are compliant with Contractual requirements; however, the policy does not include the appointment access timeframe for urgent care providers. Onsite discussion confirmed the appointment access requirement for urgent care providers is within 24 hours. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | The CAN Appointment Availability Reports for Q2 2021 indicate appropriate parameters are used. The MSCAN 2nd Quarter 2021 QI Work Plans document correct appointment access standards.<br><br>*Recommendation: Revise Policy MHMS-QI-006, Access to Care, to include the frequency of conducting appointment access and after hours audits, which department or entity that conducts the audits, and the appointment access timeframe for urgent care providers.* |
| **II C. Provider Education**<br>*42 CFR § 438.414, 42 CFR § 457.1260* | | | | | | |
| 1. The CCO formulates and acts within policies and procedures related to initial education of providers. | X | | | | | Molina's Provider Services staff develop, conduct, and evaluate provider education and training programs. Input is received from all applicable internal departments and external organizations, including DOM, as needed to determine specific training topics. Initial provider orientation is conducted within 30 days following the date the provider is active (contracting and credentialing processes are complete provider is configured and loaded into the QNXT system). Ongoing training is conducted annually, quarterly, or on an as-needed basis.<br><br>Policy MHMS-NM-008, Provider Education and Training lists some of the topics that are covered in |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | provider training sessions, including but not limited to:<br>•A general overview of Molina, hours of operation, key phone numbers, the plan website, the web portal, and the online provider directory.<br>•Provider roles and collaboration with Molina to ensure members receive appropriate care and access to services.<br>•Cultural competency and resources.<br>•Provider Guidelines, including covered services, claims processes, authorizations, and referrals<br>•Member eligibility, rights, and responsibilities<br>•Confidentiality requirements and the Fraud and Abuse Prevention policy.<br><br>Molina staff reported that most education is provided virtually, but some face-to-face provider interactions are being conducted. Provider preference is considered along with positive COVID-19 cases in the area prior to conducting face-to-face interactions with providers. |
| 2. Initial provider education includes: | | | | | | |
| 2.1 A description of the Care Management system and protocols; | X | | | | | |
| 2.2 Billing and reimbursement practices; | X | | | | | |
| 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs; | X | | | | | |
| 2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments; | X | | | | | |
| 2.6 Recommended standards of care including EPSDT screening requirements and services; | X | | | | | |
| 2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services; | X | | | | | |
| 2.8 Medical record handling, availability, retention, and confidentiality; | X | | | | | |
| 2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes; | X | | | | | |
| 2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete; | X | | | | | |
| 2.11 Prior authorization requirements including the definition of medically necessary; | X | | | | | |
| 2.12 A description of the role of a PCP and the reassignment of a member to another PCP; | X | | | | | |
| 2.13 The process for communicating the provider's limitations on panel size to the CCO; | X | | | | | |
| 2.14 Medical record documentation requirements; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2.15 Information regarding available translation services and how to access those services; | X | | | | | |
| 2.16 Provider performance expectations including quality and utilization management criteria and processes; | X | | | | | |
| 2.17 A description of the provider web portal; | X | | | | | |
| 2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business. | X | | | | | |
| 3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements. | | X | | | | As stated in Policy MHMS-PC-01, MHMS Provider Directory Requirements, Molina maintains Provider Directories that include information for PCPs, hospitals, specialists, ancillary services, behavioral health/substance use disorder facilities, and pharmacies. Copies of the Provider Directories are available in State Medicaid Regional Offices and WIC offices, and members may access the Provider Directories on Molina's website. Included in the policy are elements that must be included in the Provider Directories. The paper Provider Directory is updated at least every six months and the online directory is updated nightly.<br><br>A review of the online Provider Directory confirmed all required elements are included. A review of the print version of the Provider Directory revealed the directory did not include an indication regarding providers' abilities to accommodate people with physical disabilities. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | On a quarterly basis, all contracted providers are contacted by telephone, mail, or email to determine if updates are needed to the current provider demographic data, such as changes, additions, or closures of office locations; changes in office hours, phone and fax numbers, or email addresses; addition or termination of a provider; changes in Tax ID and/or NPI; and panel changes<br><br>*Corrective Action: Develop and implement a process to include providers' abilities to accommodate people with physical disabilities in the print version of the Provider Directory, as required by the CAN Contract Section 6 (E) and 42 CFR § 438.10(h) (1) (iv) (viii).* |
| 4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures. | X | | | | | |
| **II D. Primary and Secondary Preventive Health Guidelines**<br>*42 CFR § 438.236, 42 CFR § 457.1233(c)* | | | | | | |
| 1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated. | X | | | | | Molina adopts preventive health guidelines (PHGs) to provide up-to-date information about important preventive health topics to providers and to reduce inter-provider variation. The PHGs are selected based on scientific evidence and recommendations made by national clinically based organizations and are focused on age- and condition-specific |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | recommendations that are relevant to Molina's membership population.<br>The National Quality Improvement Committee (NQIC), with participation from physicians and other health professionals, is responsible for the selection, review, and approval of PHGs.<br>These processes are documented in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines: |
| 2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members. | X | | | | | Provider Services staff inform newly contracted providers about the PHGs in the Provider Manual and/or distribute them during the orientation visit. Printed copies of the guidelines are available upon request. Information about the PHGs is included in the CAN Provider Manual and indicates that annual notification of the availability of the PHGs is published in the Molina Provider Newsletter. Information about the PHGs was noted in the Second Quarter 2021 Provider Newsletter. The guidelines are available on Molina's website. |
| 3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics: | | | | | | |
| 3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services; | X | | | | | |
| 3.2 Recommended childhood immunizations; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 3.3 Pregnancy care; | X | | | | | |
| 3.4 Adult screening recommendations at specified intervals; | X | | | | | |
| 3.5 Elderly screening recommendations at specified intervals; | X | | | | | |
| 3.6 Recommendations specific to member high-risk groups; | X | | | | | |
| 3.7 Behavioral health. | X | | | | | |
| **II E. Clinical Practice Guidelines for Disease and Chronic Illness Management**<br>*42 CFR § 438.236, 42 CFR § 457.1233(c)* | | | | | | |
| 1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists. | X | | | | | As stated in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines:<br>•Molina adopts Clinical Practice Guidelines (CPGs) that provide up-to-date treatment and diagnostic information about important clinical topics and to reduce inter-provider variation in care. The CPGs are specific to the demographics and needs of Molina's member population.<br>•The National Quality Improvement Committee (NQIC), with participation from physicians and other health professionals, is responsible for the selection, review, and approval of CPGs.<br>•The adopted CPGs are based on scientific evidence and recommendations made by national clinically-based organizations. The CPGs are reviewed for approval and adoption through Molina's Quality |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Improvement Committee and are reviewed and updated at least every 2 years. |
| 2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers. | X | | | | | Provider Services staff inform newly-contracted providers about the CPGs in the Provider Manual and/or distribute them during the orientation visit. The CPGs are also disseminated through newsletters, bulletins, and are available on Molina's website. Printed copies are available upon request. |
| **II F. Practitioner Medical Records** | | | | | | |
| 1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians. | X | | | | | Policy MHMS-QI-124, Standards of Medical Record Documentation, defines minimum standards for maintenance of member medical records and lists elements that must be included in member medical records.<br>Medical record maintenance and documentation standards are included in the CAN Provider Manual. The Molina website refers the reader to the Provider Manual for the list of medical record documentation elements. |
| 2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers. | | X | | | | Policy MHMS-QI-124, Standards of Medical Record Documentation, states Molina has an established medical record review process, and that "results of medical record reviews (as applicable through HEDIS or Potential Quality of Care processes) are evaluated to identify specific practitioner deficiencies and opportunities for improvement throughout the network." The policy indicates results of medical record reviews may be used for monitoring, recredentialing, and other quality improvement activities. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | However, the policy didn't provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc. Onsite discussion did not provide clear information about the medical record review process. Additional information was requested to be submitted after the completion of the onsite but no additional information was provided.<br><br>*Corrective Action Plan: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to include detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc.* |
| **II G. Provider Satisfaction Survey** | | | | | | |
| 1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol. | X | | | | | Provider satisfaction was validated using the CMS Protocol 6. Administration or Validation of Quality of Care Surveys. The sample size was 1,500. SPH Analytics collected 129 surveys (44 mail, 45 internet, and 40 phone) from the eligible provider population from September to October 2020. The mail/internet survey response rate is 6.6%, and your phone survey response rate is 6.8%. The rate in the previous survey was 15.6%. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Response rates for the provider satisfaction survey are low and may affect generalizability of the results.<br><br>*Recommendation: Generate new initiatives to advertise the provider satisfaction survey and gather more responses for providers.* |
| 2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems. | X | | | | | |
| 3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified. | X | | | | | Results were presented to the MPSC June 2021 meeting. Root cause analysis was conducted and presented in the MPSC minutes. |

## III. MEMBER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **III A. Member Rights and Responsibilities**<br>*42 CFR § 438.100, 42 CFR § 457.1220* | | | | | | |
| 1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities. | X | | | | | Member Rights and Responsibilities are outlined in the Member Handbook, CAN member website, Provider Manual, and policies and procedures. |
| 2. Member rights include, but are not limited to, the right: | X | | | | | Policy MHMS-ME-003, Member Rights and Responsibilities accurately outlines member rights. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2.1 To be treated with respect and dignity; | | | | | | |
| 2.2 To privacy and confidentiality, both in their person and in their medical information; | | | | | | |
| 2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; | | | | | | |
| 2.4 To participate in decisions regarding health care, including the right to refuse treatment; | | | | | | |
| 2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected; | | | | | | |
| 2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services; | | | | | | |
| 2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations; | | | | | | |
| 2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210. | | | | | | |
| 3. Member responsibilities include the responsibility: | X | | | | | |
| 3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services; | | | | | | The CAN website does not include information that members are financially responsible for unauthorized services obtained from out of network providers.<br><br>*Recommendation: Edit the CAN website to clearly specify that members are financially responsible for unauthorized health care services obtained from non-participating providers, as required in the CAN Contract, Section 6 (J) and 42 CFR § 438.100.* |
| 3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care; | | | | | | |
| 3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services; | | | | | | |
| 3.4 To show courtesy and respect to providers and staff; | | | | | | |
| 3.5 To inform the CCO of changes in family size, address changes, or other health care coverage. | | | | | | |
| **III B. Member CCO Program Education**<br>*42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: | X | | | | | Policy MHMS-ME-002, Member Information Packet, states members are provided a New Member Welcome Packet within 14 days after Molina receives the member's enrollment data from DOM. The Welcome Packet includes all contractually-required information such as an introduction letter, ID card, Member Handbook, and instructions to access the Provider Directory. |
| 1.1 Full disclosure of benefits and services included and excluded in coverage; | | | | | | |
| 1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP; | | | | | | |
| 1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary. | | | | | | |
| 1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services; | | | | | | |
| 1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations; | | | | | | Services requiring prior approval are indicated in the benefits grid. Prior approval is not required for family planning services, emergency visits, or behavioral health services. Additionally, services requiring pre-authorization are clearly listed in the Provider Manual. The process and requirements for prior approval of medical, behavioral health, and pharmaceutical services are described in the CAN Member Handbook. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.4 Procedures for and restrictions on obtaining out-of-network medical care; | | | | | | |
| 1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services; | | | | | | Information about appropriate level of care for routine, urgent, or emergent care needs is clearly outlined in the Member Handbook and on Molina's website. |
| 1.6 Policies and procedures for accessing specialty/referral care; | | | | | | Information about obtaining prescription medications and durable medical equipment is available in the Member Handbook. Members may view the Preferred Drug List and website that includes participating pharmacies or contact Member Services to obtain this information. |
| 1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions; | | | | | | |
| 1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers; | | | | | | |
| 1.9 A description of the member's identification card and how to use the card; | | | | | | |
| 1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.11 Procedure for making appointments and information regarding provider access standards; | | | | | | |
| 1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal; | | | | | | The Member Handbook includes toll-free telephone numbers, hours of operation, and descriptions of services provided by Member Services and the 24-Hour Nurse Advice Line. Information about accessing the secure Member Portal and performing various self-service functions, such as viewing a benefit summary, changing the PCP, updating contact information, and requesting a new ID Card is also included. |
| 1.13 A description of EPSDT services; | | | | | | The CAN Member Handbook includes information and instructions for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for eligible members. Additionally, Molina conducts written, telephonic, and in-person outreach to inform and remind members of necessary EPSDT services. |
| 1.14 Procedures for disenrolling from the CCO; | | | | | | The CAN Member Handbook provides information about requirements for disenrollment and instructs members to call Member Services or DOM to terminate their membership. |
| 1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM; | | | | | | |
| 1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| alternate languages spoken by the provider's office; | | | | | | |
| 1.17 Instructions for reporting suspected cases of fraud and abuse; | | | | | | |
| 1.18 Information regarding the Care Management Program and how to contact the Care Management team; | | | | | | |
| 1.19 Information about advance directives; | | | | | | Advanced Directive information is provided in the Member Handbook. |
| 1.20 Additional information as required by the contract and by federal regulation. | | | | | | |
| 2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network. | X | | | | | |
| 3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract. | X | | | | | |
| 4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages. | X | | | | | |
| 5. Member grievances, denials, and appeals are reviewed to identify potential member | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| misunderstanding of the CCO program, with reeducation occurring as needed. | | | | | | |
| 6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members. | X | | | | | |
| **III C. Call Center** | | | | | | |
| 1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals. | X | | | | | A toll-free number is available for the Molina Members Services Call Center, Provider Services Call Center, and a 24-Hour Nurse Advice Line. |
| 2. Call Center scripts are in-place and staff receive training as required by the contract. | X | | | | | |
| 3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee. | X | | | | | Call Center communication is monitored and evaluated for provider and member services staff for the quality of call handling. No less than 3% of calls are randomly selected monthly. |
| **III D. Member Enrollment and Disenrollment** *42 CFR § 438.56* | | | | | | |
| 1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed. | X | | | | | |
| 2. Member disenrollment is conducted in a manner consistent with contract requirements. | X | | | | | Policy MHMS-ME-008, Enrollment Reports, and Policy MHMS-ME-009, Enrollment Accounting, describe instances when Molina can request a member to be disenrolled. |
| **III E. Preventive Health and Chronic Disease Management Education** | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits. | X | | | | | Policy MHMS-QI-125, Member Education and Prevention (ME), describes the process Molina uses to provide health education to new and established members. Members can access the website or Member Handbook for information about recommended preventive health services, available case management programs, and instructions to obtain educational support for medical, behavioral health, and pharmaceutical services. |
| 2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program. | X | | | | | |
| 3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits. | X | | | | | Molina ensures the provision of screening, preventive, and medically-necessary diagnostic and treatment services for members under 21 years of age as noted in Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment. |
| 4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion. | X | | | | | |
| **III F. Member Satisfaction Survey** | | | | | | |
| 1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. | X | | | | | The CCO conducts a formal annual assessment of member satisfaction that meets all requirements of the CMS Survey Validation Protocol. Molina contracts with SPH Analytics, a certified Consumer Assessment |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | of Healthcare Providers and Systems Survey vendor, to conduct the Adult and Child Surveys.<br><br>The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult and Child surveys.<br><br>For Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (10.3%) which included 136 completed surveys out of a sample of 1,318. For the Child survey, generalizability of the survey results is also difficult to discern due to low response rates (10.2%) which included 166 completed surveys out of 1630 sampled.<br><br>*Recommendation: Initiate new interventions to increase response rates.* |
| 2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems. | X | | | | | Molina analyzes data obtained from the Member Satisfaction Survey to identify quality problems, as noted in the MPSC June 2021 minutes. |
| 3. The CCO reports results of the member satisfaction survey to providers. | X | | | | | The plan reports the results of the Member Satisfaction Survey to providers as seen in the Provider Newsletter Q1 2021. |
| 4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee. | X | | | | | The CCO reports results of the Member Satisfaction Survey and the impact of measures taken to address any quality problems that were identified to the correct committee as noted in the MPSC June 2021 minutes. |
| **III G. Grievances**<br>*42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: | X | | | | | |
| 1.1 Definition of a grievance and who may file a grievance; | X | | | | | |
| 1.2 The procedure for filing and handling a grievance; | X | | | | | |
| 1.3 Timeliness guidelines for resolution of grievances as specified in the contract; | X | | | | | |
| 1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process; | X | | | | | |
| 1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract. | X | | | | | |
| 2. The CCO applies the grievance policy and procedure as formulated. | X | | | | | |
| 3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee. | X | | | | | Grievance logs are maintained, categorized, and reported internally to establish areas of potential quality improvement. |
| 4. Grievances are managed in accordance with CCO confidentiality policies and procedures. | X | | | | | |
| **III H. Practitioner Changes** | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction. | X | | | | | |
| 2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee. | X | | | | | |

## IV. QUALITY IMPROVEMENT

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **IV A. Quality Improvement (QI) Program**<br>*42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)* | | | | | | |
| 1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members. | X | | | | | The 2021 Quality Improvement Program Description covers the CAN and CHIP populations, is updated annually, and is submitted to the Quality Improvement Committee and the Board of Directors for approval.<br><br>The program description includes the programs goals, objectives, structure, and scope of activities. Molina reviews and modifies the QI program objectives as needed on an ongoing basis and formally at least yearly.<br><br>Providers and members are informed about QI activities through Molina's website and in the |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Provider Manual. A description of the QI program is provided and informs Providers they may request more information about initiatives and/or the progress toward meeting quality goals by calling Provider Services. |
| 2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities. | X | | | | | A goal of QI activities is to reduce healthcare disparities. Molina's Cultural Competency Plan described in the QI Program Description provides a summary of the plan to address healthcare disparities through tools and needed trainings. |
| 3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems. | X | | | | | Molina reviews potential over- and-under-utilization statistics at least yearly using cross-functional teams and collaboration with the provider network. |
| 4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s). | X | | | | | Molina provided the 2020 and 2021 QI work plans for review. The work plans included the QI activities across several sections, responsible parties, timelines, action plans/goals, and results or status for each activity. Results for the CAN and CHIP lines of business are clearly delineated in the work plans.<br>Last year there were several errors noted in the work plan. Molina addressed these errors in their corrective action plan and implemented the changes in Q2 2021 work plan.<br>Information for measuring appointment access for behavioral health providers is listed in section seven of the 2nd Quarter 2021 QI work plan. In the "Action Plan/Benchmark Goal" column, there is one set of appointment standards and in the "Results" column there is another set. This was discussed during the onsite and Molina indicated this was an error and the |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | "Action Plan/Benchmark Goal" column should be deleted. |
| **IV B. Quality Improvement Committee** | | | | | | |
| 1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities. | X | | | | | The Quality Improvement Committee (QIC) is responsible for the oversight, implementation, coordination, and integration of all QI activities. This committee sets the strategic direction for all QI activities. The QIC receives reports from all QI sub-committees and advises and directs the committees on the focus and implementation of the program and work plan. These sub-committees include the Professional Review Committee, Healthcare Services Committee, and the Delegation Oversight Committee. |
| 2. The composition of the QI Committee reflects the membership required by the contract. | X | | | | | The Chief Medical Officer and the Quality Lead co-chair the QIC. Voting members include Molina's senior leaders representing all departments of the organization and four network providers. Their specialties include pediatrics, OB/GYN, and internal medicine. During the previous EQR CCME recommended Molina recruit additional network providers to service on the QIC. Molina responded and indicated they were seeking additional network providers to serve on the QIC. The identification of those providers should be completed by Q4 2021. In the September 2021 meeting minutes, it was noted a new network provider was added. |
| 3. The QI Committee meets at regular intervals. | X | | | | | The committee co-chairs convene and preside over regularly scheduled quarterly meetings and convene special meetings as needed. A quorum of at least 51% of the committee members with no less than |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | half of network provider participants are necessary to enact or implement decisions. It was noted for the 2nd and 3rd quarter 2020 meetings there was not a quorum because only one network provider attended the meeting.<br><br>*Recommendation: Continue to recruit additional network providers to serve on the QIC.* |
| 4. Minutes are maintained that document proceedings of the QI Committee. | X | | | | | |
| **IV C. Performance Measures**<br>*42 CFR §438.330 (c) and §457.1240 (b)* | | | | | | |
| 1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures." | X | | | | | The performance measure validation found that Molina was fully compliant with all information system standards and determined that Molina submitted valid and reportable rates for all HEDIS measures in scope of this audit.<br>There were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Molina followed the measure specifications and produced reportable rates for all measures in the scope of the validation.<br>Source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission Rate (PQI01-AD), Chronic Obstructive Pulmonary Disease (COPD) Or Asthma In Older Adults Admission Rate (PQI-05), Heart Failure Admission Rate (PQI-08), and |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | the Asthma in Younger Adults Admission Rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period. Also, source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator. Processes should be improved around the calculation, reporting, and verification of the rates reported for the Adult and Child Core set measures.<br>Molina did not report two non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.<br><br>*Recommendation: Work proactively with DOM for clarification on measures that are required to be reported. Improve processes around calculation, reporting, and verification of the rates reported for the DOM required Adult and Child Core set measures.* |
| **IV D. Quality Improvement Projects**<br>*42 CFR §438.330 (d) and §457.1240 (b)* | | | | | | |
| 1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM. | X | | | | | Molina submitted seven PIPs for validation that addressed the DOM required topics, including: Behavioral Health Readmission, Asthma, COPD, |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Follow-Up After Hospitalization For Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. |
| 2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects." | X | | | | | For the current EQR, Molina provided the same seven PIP documents for validation. It was noted that the corrective actions from the previous EQR were implemented and included in the PIP documents provided. All the CAN PIPs scored in the "High Confidence in Reported Results" range. Three of the PIPs did not show any quantitative improvements. Those include the Asthma, Behavioral Health Readmission, and Obesity PIPS.<br><br>*Recommendation: Review the current interventions for the Asthma, Behavioral Health Readmission, and the Obesity PIPs to determine if there are additional barriers needing to be addressed and interventions added to improve the rates.* |
| **IV E. Provider Participation in Quality Improvement Activities** | | | | | | |
| 1. The CCO requires its providers to actively participate in QI activities. | X | | | | | Molina's Provider Manual includes details regarding their Quality Management program. Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by providers. Such participation includes but is not limited to: Access to Care Standards, Site and Medical Record-Keeping Practice Reviews, and Delivery of Patient Care Information. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2. Providers receive interpretation of their QI performance data and feedback regarding QI activities. | X | | | | | Provider HEDIS profile reports are generated to provide feedback on performance. Providers received performance reports during monthly meetings and through Molinas's provider portal. |
| 3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines. | X | | | | | The Provider Manual includes information about provider performance monitoring. Molina monitors compliance with the established performance standards at least annually. Within 30 calendar days of the review, a copy of the review report and a letter is sent to the medical group notifying them of their results. Performance below Molina's standards may result in corrective action.<br><br>Per Policy and Procedure MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina annually measures performance against at least two important aspects of the clinical practice guidelines. Results are reported to the participating practitioners/providers no less than annually. |
| 4. The CCO tracks provider compliance with EPSDT service provision requirements for: | | | | | | Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, defines the requirements for the EPSDT Program. Molina generates member targeted lists that identify members due for EPSDT services and targets those members with written notifications, telephone reminders, assistance with transportation and collaborating with providers. |
| 4.1 Initial visits for newborns; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 4.2 EPSDT screenings and results; | X | | | | | |
| 4.3 Diagnosis and/or treatment for children. | | X | | | | Policy MHMS-QI-003 addresses EPSDT services, how Molina tracks those services, and follow-up with members who have not received or are behind in getting services. This policy did not address how Molina tracks provider or member compliance with treatments or referrals needed for abnormal conditions identified through the EPSDT services. Also, the tracking reports did not include the treatment and/or referrals made for any abnormal findings. This was an issue found during the previous EQR. Molina addressed the corrective action and indicated once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments and/or needs assistance with securing an appointment with the appropriate specialist. A draft template was also included that addressed the deficiencies. However, this tracking report template was not implemented.<br><br>*Corrective Action: Include the process Molina uses for tracking treatments or referrals needed for abnormal findings during the EPSDT service. Also, include the follow-up on the EPSDT tracking report.* |
| **IV F. Annual Evaluation of the Quality Improvement Program**<br>*42 CFR §438.330 (e)(2) and §457.1240 (b)* | | | | | | |
| 1. A written summary and assessment of the effectiveness of the QI program is prepared annually. | | X | | | | Annually, Molina completes an evaluation of the QI program to assess the overall effectiveness of the organization's QI processes for its CAN and CHIP members. The Quality Improvement Program 2020 |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Annual Evaluation was provided as evidence of this evaluation. The evaluation included an executive summary that provided a brief overview of the evaluation and areas of focus and or recommendation for next year (2021). The evaluation also included several appendices that covered the results of the CLAS analysis, population assessment, quality performance measures report, potential quality of care issues and the member and provider experience report.<br><br>Areas not included in the evaluation were the results and analysis of availability of practitioners, accessibility of services, continuity and coordination of medical care, provider directory analysis, results of delegation oversight, and credentialing activities. The performance improvement projects were included in the executive summary; however, the information was incomplete. There was no mention of the barriers and interventions to address the barriers. Most of the target rates were listed as "TBD." These were the same or similar errors found during the previous EQR. Molina addressed these errors and indicated the 2021 QI Program Evaluation is expected to be completed by 1st or 2nd quarter 2022 and the evaluation will include all required elements outlined in the contract.<br><br>*Corrective Action: Correct the 2020 QI Program Evaluation and include a description and results of completed and ongoing QI activities, identified issues or barriers, trending measures to assess* |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | *performance, and any analysis to demonstrate the overall effectiveness of the QI program.* |
| 2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM. | X | | | | | |

## V. UTILIZATION MANAGEMENT

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **V A. Utilization Management (UM) Program** | | | | | | |
| 1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: | X | | | | | The 2021 Health Care Services (HCS) Program Description outlines the objectives, scope, and staff roles for Molina's Utilization Management (UM) Program for physical and behavioral health services. The Pharmacy Program Description outlines the pharmacy benefit program administered by Molina Healthcare Pharmacy Services.<br>Several policies describe UM processes and requirements, such as Policy MHMS-HCS-UM-325, Service Authorization, and Policy MHMS-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making MSCAN. |
| 1.1 Structure of the program; | X | | | | | The UM Program is structured within the Health Care Services (HCS) Program, where the key functions are eligibility and oversight, resource management and quality management. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | The Associate Vice President (AVP) of HCS in consultation with the Chief Medical Officer (CMO) have authority and responsibility for HCS program development and implementation, as stated in the HCS Program Description. |
| 1.2 Lines of responsibility and accountability; | X | | | | | |
| 1.3 Guidelines/standards to be used in making utilization management decisions; | X | | | | | Policy MHMS-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, states, Molina "uses objective evidence based clinical criteria to determine medical necessity and appropriateness of requested services." Reviewers use clinical records and a hierarchy of decision-making guidelines that include, but are not limited to, State specific guidelines, InterQual and MCG, and Molina Clinical Policy. Reviewers also consider the member's individual circumstances when making medical necessity determinations. |
| 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification; | | X | | | | Timeliness of UM decisions is described in the HCS Program Description and Policy MHMS-HCS-UM-383, Timeliness of UM Decision Making and Notification. CCME identified the following issues on pages two, seven, and 11 of Policy MHMS-HCS-UM-383 related to extensions of urgent prior authorization requests:<br>•Incorrect documentation indicating that requests can be extended up to 48 hours and a decision must be made no later than 72 hours.<br>•No documentation that Molina has to request an extension from DOM.<br>According to requirements in the *CAN Contract, Section 5 (J) (6)* "the 24 hour period may be |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | extended up to 14 additional calendar days upon request of the Member, or the Provider, or if Contractor requests an extension from the Division."<br>Additionally, the heading of Policy MHMS-HCS-UM-383 indicates it applies to the Medicare line of business; however, Molina staff confirmed the policy pertains to CAN members.<br>It is noted that after the onsite Molina attempted to correct some of the issues identified and resubmit Policy MHMS-HCS-UM-383 with other onsite requests. However, the current EQR focuses on previous plan activities and updated documents will be addressed in the next EQR.<br><br>*Corrective Action Plan: Edit Policy MHMS-HCS-UM-383, Timeliness of UM Decision Making and Notification, to reflect the correct timeframe requirements for extensions of urgent prior authorization requests and to indicate that Molina must request an extension from DOM, according to requirements in the CAN Contract, Section 5 (J) (6).*<br>*Recommendation: Edit the policy to reflect the line of business is MSCAN and not Medicare.* |
| 1.5 Consideration of new technology; | X | | | | | |
| 1.6 The appeal process, including a mechanism for expedited appeal; | X | | | | | |
| 1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee. | X | | | | | The 2021 HCS Program Description addresses roles and responsibilities of the Chief Medical Officer (CMO) and other Medical Directors. Responsibilities include but are not limited to supervising medical necessity decisions, conducting Level II reviews, and participating in plan committees. The Behavioral Health Medical Director and the Pharmacy Director collaborate with the Medical Director and CMO and have clinical oversight of the respective programs. |
| 3. 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. | X | | | | | The HCS programs are evaluated annually and updated as needed. Molina confirmed the 2020 HCS Program Evaluation was presented to the Health Care Services Committee (HCSC) and the QIC and was approved on March 4, 2021.<br>Policy MHMS-HCS-UM-300, Healthcare Services Committee, and the HCS Program Evaluation indicate external network providers participate on the HCSC where clinical policies and UM criteria and guidelines are discussed. Onsite discussions confirmed two network providers participate on the HCSC and meeting minutes reflect their attendance. |
| **V B. Medical Necessity Determinations**<br>*42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 122* | | | | | | |
| 1. Services that require prior authorization by the CCO include only the services specified by the Mississippi Division of Medicaid. | X | | | | | |
| 2. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations. | X | | | | | The HCS Program Description and departmental policies outline processes used to make UM determinations. Molina uses health plan approved policies and utilization decision-making criteria such |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | as InterQual® or MCG to conduct physical health and behavioral health reviews. Additionally, ASAM criteria is used for behavioral health reviews. Onsite discussion confirmed Molina stopped using InterQual in Q1 2021. |
| 3. Utilization management decisions are made using predetermined standards/criteria and all available medical information. | X | | | | | Review of UM approval files reflected consistent decision-making according to an established hierarchy, utilizing standards such as InterQual and MCG, Molina's Policies, clinical guidelines, pharmacy guidelines, and relevant medical information. |
| 4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions. | X | | | | | Policy MHMS-HCS-UM-325, Service Authorization, indicates members' individual circumstances and clinical information are reviewed and compared to established criteria. Physician reviewers are encouraged to recognize members' unique needs or limitations of the local delivery system.<br>Approval files reflected that physician reviewers will use clinical criteria and their clinical professional judgement to consider the member's individual circumstances when InterQual or MCG criteria are not met. |
| 5. Utilization management standards/criteria are consistently applied to all members across all reviewers. | X | | | | | Annual inter-rater reliability testing (IRR) is conducted for physicians, nurse reviewers, and behavioral health reviewers, as described in the HCS Program Description. The minimum compliance goal is 85% for physician and pharmacy reviewers and 90% for nurses. The 2020 HCS Program Evaluation reported all reviewers achieved passing scores after remediation and refresher training.<br>During the onsite, Molina reported a full-time nurse auditor was hired to ensure staff performance is |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | consistent by reviewing UM documentation, engaging with UM staff, and presenting audit findings during weekly UM huddles. |
| 6. Pharmacy Requirements | | | | | | |
| 6.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List. | X | | | | | Molina uses the Universal Preferred Drug List specified by DOM. A link to access the most current version of PDL is available on Molina's website. The user is automatically directed to DOM's website, where the PDL is available in a searchable, electronic format. Additionally, the PDL can be downloaded and printed, or hard copies can be requested by calling Members Services. |
| 6.2 The CCO has established policies and procedures for prior authorization of medications. | X | | | | | Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures, describes that CVS Caremark is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Molina, including but not limited to prior authorizations and pharmacy network management. Molina ensures a 3-day supply of medication will be approved while a prior authorization request is pending. |
| 7. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations. | X | | | | | The HCS Program Description and Policy MS.UM.12, Emergency Services, describe emergency and post-stabilization service requirements and the member's ability to access them. Molina does not require prior authorization for physical or behavioral health emergency services. Additionally, the Member Handbook and the website provide instructions for members to freely access emergent and urgent care services. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 8. Utilization management standards/criteria are available to providers. | X | | | | | |
| 9. Utilization management decisions are made by appropriately trained reviewers. | X | | | | | The HCS Program Description and Policy MHMS-HCS-UM-364, Appropriate Professionals Making UM Decisions, describe Molina's approach for ensuring UM decisions are rendered by qualified staff who are trained in the principles, procedures, and standards of utilization and medical necessity review. Initial clinical reviews are performed by Mississippi-licensed nurses and Level II clinical reviews are performed by Mississippi-licensed physicians or other appropriate healthcare practitioners. Non-licensed staff perform intake and initial screenings that do not require clinical interpretation and are required to refer clinical cases to clinical staff members. |
| 10. Initial utilization decisions are made promptly after all necessary information is received. | X | | | | | Review of approval files reflected utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within 3 calendar days/ 2 business days.<br>The HCS Program Evaluation reflects a 95% to 99% compliance rate for processing prior authorizations. During the onsite, Molina staff reported workflow changes were made that included training reviewers on different components of UM processes. |
| 11. Denials | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 11.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services. | X | | | | | UM denial files reflected that additional clinical information is requested prior to making an adverse benefit determination. |
| 11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist. | X | | | | | |
| 11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal. | X | | | | | Review of denial files reflected adverse benefit determinations are determined within the required timeframes. Determinations were communicated verbally to the requesting providers. Adverse benefit determination letters were faxed to requesting providers, mailed to providers and members, explained the basis for the denial, and included appeal procedures.<br>CCME noted some adverse benefit determination notices used CPT codes and medical jargon to refer to services requested. This issue was discussed in January 2021 during the previous EQR, and Molina has taken steps to correct it, which was evident in adverse benefit notices occurring in the later part of the year. |
| **V C. Appeals**<br>*42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260* | | | | | | |
| 1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: | X | | | | | Processes and requirements for handling and processing member appeals are described in the Health Care Services (HCS) Program Description and policies such as Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Appeals are processed, |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | tracked, and handled according to requirements in the *CAN Contract, Section 11 (O).*<br>Additionally, appeals information is provided in the Provider Manual, Member Handbook, and the member tab of the website. |
| 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal; | X | | | | | Definitions of appeal terminology and information about who may file an appeal are included in Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals, the Provider Manual, Member Handbook, and on the website. Molina implemented recommendations from the previous EQR by including correct definitions of appeals terminology on the website. |
| 1.2 The procedure for filing an appeal; | X | | | | | Procedures for filing an appeal are described and outlined in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Molina ensures members and their representative have access to appeal information, processes, and procedures on the website. Members are informed that translators are available, and Molina offers assistance with filing an appeal. Additionally, the Adverse Benefit Determination notices include appeals information and instructions according to the *CAN Contract, Section 6 (K).*<br>Onsite discussion confirmed Molina is aware of changes to the appeals process, according to *CFR 438.402 (c) (3),* which no longer requires a member's verbal appeal to be followed by a signed written appeal. Molina will ensure appeals documents are updated upon approval from DOM. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case; | X | | | | | |
| 1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay; | X | | | | | |
| 1.5 Timeliness guidelines for resolution of the appeal as specified in the contract; | X | | | | | Policy MHMS-MRT-02 and Policy MHMS-MRT-03 correctly document the resolution timeframe for standard and expedited appeals. |
| 1.6 Written notice of the appeal resolution as required by the contract; | X | | | | | |
| 1.7 Other requirements as specified in the contract. | X | | | | | |
| 2. The CCO applies the appeal policies and procedures as formulated. | X | | | | | Appeal files reflected staff follow processes outlined in the *CAN Contract* and in Molina's policies. Review of appeal files reflected timely acknowledgement, resolution, and notification of determinations. Members receive appropriate acknowledgement of their request and are informed when an extension is required. |
| 3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Policy MHMS-MRT-02, Standard Member Appeals, explains appeals are tracked, trended, analyzed, and reported quarterly to the SQIC and QIC. Meeting meetings reflected detailed discussion and reporting of appeals results. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 4. Appeals are managed in accordance with the CCO confidentiality policies and procedures. | X | | | | | |
| **V D. Care Management**<br>*42 CFR § 208, 42 CFR § 457.1230 (c)* | | | | | | |
| 1. The CCO has developed and implemented a Care Management and a Population Health Program. | X | | | | | The Integrated Care Management Program, outlined in the HCS Program Description, and the Population Health Management Program, outlined in the Population Health Strategy, describe Molina's process for ensuring and promoting access and delivery of care management services for all members. |
| 2. The CCO uses varying sources to identify members who may benefit from Care Management. | X | | | | | The HCS Program Description indicates eligible members can be identified for CM through data sources such as claims data, results of health risk assessments, and members can be referred into case management. |
| 3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level. | X | | | | | A health risk assessment will be completed within 30 calendar days after a member is identified and an Individualized Care Plan (ICP) will be completed within 30 calendar days after the health risk assessment, as described in Policy MHMS-HCS-CM-054, Individualized Care Plan Development. |
| 4. The detailed health risk assessment includes all required elements: | | | | | | The HCS program Description indicates the detailed health risk assessment includes identifying the severity of the member's condition, evaluating co-morbidities and complex health conditions, demographic information, current providers, and a treatment plan, if available. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 4.1 Identification of the severity of the member's conditions/disease state; | X | | | | | |
| 4.2 Evaluation of co-morbidities or multiple complex health care conditions; | X | | | | | |
| 4.3 Demographic information; | X | | | | | |
| 4.4 Member's current treatment provider and treatment plan, if available. | X | | | | | The ICP is developed in conjunction with the member, the member's caregiver, PCP, and other members of the health care team. Behavioral health care needs and coordination are incorporated into the ICP. |
| 5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment. | X | | | | | Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriately trained for the member's health condition, and are completed within 30 days of the health risk assessment. |
| 6. The risk level assignment is periodically updated as the member's health status or needs change. | X | | | | | |
| 7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions: | X | | | | | Molina uses care management techniques to ensure members have access to required services and provides information on available services and how access to those services. Review of CM files reflected CM activities such as documentation of referral services, health education and support, appropriate referrals, and scheduling assistance. |
| 7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health; | | | | | | |
| 7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record; | | | | | | |
| 7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care; | | | | | | |
| 7.5 Coordination of discharge planning; | | | | | | |
| 7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups; | | | | | | |
| 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; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs; | | | | | | |
| 7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate. | | | | | | |
| 8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract. | X | | | | | |
| 9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services. | X | | | | | |
| 10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan. | | X | | | | During the onsite, CCME discussed that documentation of Molina's processes for addressing continuity of care when a member disenrolls from the health plan could not be identified. These processes include transferring the member's care management history, six months of claims history, and other pertinent information, according to requirements in the *CAN Contract, Section 9 (A) (4)*.<br>Molina's staff explained that they are following that requirement. It is noted that after the onsite, Molina revised Policy MHMS-HCS-CM-406, Transition to Other Care When Benefits End, and resubmitted it with other onsite follow-up requests. However, the current EQR focuses on previous plan activities |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | and updated documents will be addressed in the next EQR.<br>*Corrective Action Plan: Include in a policy or other document Molina's processes for addressing continuity of care when the member disenrolls from the health plan, according to requirements in the CAN Contract, Section 9 (A) (4).* |
| 11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants. | X | | | | | Molina's Level 1 CM is the Health Promotion and Disease Management program, which includes activities such as member education, coordination of medical transportation, and scheduling medical appointments. Telephonic health coaching is provided to members with low acuity conditions and focuses on disease prevention and education. |
| **V E. Transitional Care Management** | | | | | | |
| 1. The CCO monitors continuity and coordination of care between PCPs and other service providers. | X | | | | | Policy MHMS-QI-004, Monitoring Continuity of Care, states, "At least annually, Molina collects data from various sources to monitor the collaboration of care between the behavioral healthcare and medical healthcare delivery systems and the continuity and coordination of care that members receive between medical care practitioners and across the health care network." The 2020 and 2021 QI Work Plans reflect Molina monitors continuity and coordination of care between the PCPs and other service providers. |
| 2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting. | X | | | | | The HCS Program Description and Policy HCS-CM-068, Molina Transitions of Care, describe Molina's approach for ensuring transitional care management services are provided to eligible members and |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | outline processes and requirements for managing transitions of care across healthcare and community settings. |
| 3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process. | X | | | | | Molina's Multidisciplinary Team coordinates and manages required services to ensure continuity of care and prevent duplication of services as members return to their home or other community setting. Policy HCS-CM-068, Molina Transitions of Care, explains that the team includes, but is not limited to, RN Care Managers, Behavioral Health Staff, and Social Services Specialists. |
| 4. The CCO meets other Transition of Care requirements. | X | | | | | Documentation in Policy HCS-CM-068 indicates Molina meets other transition of care contract requirements from the *CAN Contract, Section 8 (B) (5)*. |
| **V F. Annual Evaluation of the Utilization Management Program** | | | | | | |
| 1. A written summary and assessment of the effectiveness of the UM program is prepared annually. | X | | | | | Molina performs an evaluation of the HCS Program annually. The 2020 HCS Program Evaluation provides a summary of UM program activities, measurement outcomes, the overall effectiveness of the UM Program, and offers recommendation for improvement for 2021. The HCS Program Evaluation consists of an Executive Summary which is accompanied by Appendices A through H reporting on such activities as provider satisfaction and the Behavioral Taskforce Summary. |
| 2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM. | X | | | | | The HCS Program Evaluation was approved by QIC on April 7, 2021. |

## VI. DELEGATION

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **VI. DELEGATION**<br>*42 CFR § 438.230 and 42 CFR § 457.1233(b)* | | | | | | |
| 1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions. | X | | | | | Molina has delegation agreements in place with the following vendors:<br>•SKYGEN—dental benefit administration<br>•CareMark—pharmacy benefit administration<br>•March Vision—vision network, claims administration, call center services<br>•MTM—non-emergent medical transportation and customer service<br><br>The following are delegated credentialing entities:<br>•Baptist Memorial Medical Group (BMMG)<br>•George Regional Health System (GRHS)<br>•Hattiesburg Clinic, PA (HBC)<br>•Memorial Hospital at Gulfport (MGP)<br>•Mississippi Physicians Care Network (MPCN)<br>•Magnolia Regional Health Center (MRHC)<br>•North Mississippi Health Services (NMHS)<br>•Oschner Health System (OCH)<br>•Premier Health (SRMC)<br>•University of Mississippi Medical Center (UMMC)<br><br>Delegation agreements were provided for each of Molina's delegates. The agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions. | | | X | | | Processes and requirements for delegation of services and activities are found in various policies that address topics such as pre-assessment audits, delegation requirements, performance monitoring and annual oversight, and corrective action and/or termination of delegation agreements. Policy DO005, Credentialing Delegation Requirements, does not address site visits for providers credentialing by delegated credentialing entities. As noted in the Provider Services section of this EQR, Molina has not finalized processes for office site visits at initial credentialing for applicable providers.<br>As confirmed during onsite discussion, Molina's Healthcare Delegation Oversight team conducts annual oversight and ongoing monitoring for each of its delegates. Documentation of monitoring and oversight activities was submitted. The documentation revealed appropriate metrics are reviewed for claims, UM, call centers, etc. File review worksheets for credentialing delegates include most of the required credentialing elements; however, the tools do not include an indication that the delegate is monitored for conducting site visits at initial credentialing. Based on the findings of the current EQR, it is evident that Molina did not address or correct the findings from the 2020 EQR.<br><br>*Corrective Action: When the processes for conducting initial credentialing site visits for providers, ensure that Policy DO005, Credentialing Delegation Requirements, is updated to include whether the delegates or Molina itself will be* |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | *responsible for conducting the initial credentialing site visits for providers who are credentialed by delegated credentialing entities. If the credentialing delegate is responsible for these activities, ensure delegated credentialing file review worksheets include evidence that the delegate is monitored for these activities and that credentialing files include evidence of this.* |

# CCME CHIP Data Collection Tool

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|---|---|
| **Plan Name:** | **Molina Healthcare of MS CHIP** |
| **Review Performed:** | **2021** |

## I. ADMINISTRATION

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **I A. General Approach to Policies and Procedures** | | | | | | |
| 1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly. | X | | | | | Molina has policies and procedures in place to ensure the provision of quality services. The Quality Improvement Committee references updates from the Policy Committee in their quarterly agenda. |
| **I B. Organizational Chart / Staffing** | | | | | | |
| 1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: | | | | | | |
| 1.1 *Chief Executive Officer; | X | | | | | Molina's Plan President and Chief Executive Officer (CEO) is Bridget Galatas. |
| 1.2 *Chief Operating Officer; | X | | | | | The Chief Operating Officer is Kyle Godfrey. |
| 1.3 Chief Financial Officer; | X | | | | | Edward Mohr Is the Chief Financial Officer. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.4 Chief Information Officer; | X | | | | | The Chief Information Officer for Centene is Jeffrey Cangialosi. |
| 1.4.1 *Information Systems personnel; | X | | | | | |
| 1.5 Claims Administrator; | X | | | | | Sandy Dunbar is the Claims Administrator. |
| 1.6 *Provider Services Manager; | X | | | | | Earl Robinson is Provider Service Manager and Chinwe Nichols is the Provider Services Director. |
| 1.6.1 *Provider credentialing and education; | X | | | | | |
| 1.7 *Member Services Manager; | X | | | | | The Member Services Director is Juan (Emilio) Bellizzia Arriaga. |
| 1.7.1 Member services and education; | X | | | | | |
| 1.8 Grievance and Appeals Coordinator; | X | | | | | Bert Emrick is the Appeals and Grievances Manager. |
| 1.9 Utilization Management Coordinator; | X | | | | | Chris Cauthen is the Director or Utilization Management. |
| 1.9.1 *Medical/Care Management Staff; | X | | | | | |
| 1.10 Quality Management Director; | X | | | | | Loleta Kellum is AVP Quality Improvement. |
| 1.11 *Marketing and/or Public Relations; | X | | | | | |
| 1.12 *Medical Director; | X | | | | | Thomas Joiner is the Chief Medical Officer. |
| 1.13 *Compliance Officer. | X | | | | | Latasha McGill is AVP of Compliance. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 2. Operational relationships of CCO staff are clearly delineated. | X | | | | | |
| **I C. Management Information Systems**<br>*42 CFR § 438.242, 42 CFR § 457.1233 (d)* | | | | | | |
| 1. The CCO processes provider claims in an accurate and timely fashion. | X | | | | | Mississippi requires 90% of clean claims to be processed within 30 days, and 99% of clean claims to be processed within 90 days. Molina exceeds the contract requirements with an average of more than 99% of clean claims processed within 30 days, and a 90-day average of 100%. |
| 2. The CCO tracks enrollment and demographic data and links it to the provider base. | X | | | | | Molina ensures member demographic and enrollment information is up-to-date based on updates received from the State. If manual updates are needed to meet eligibility information, an authorized member service staff person is allowed to update the information. |
| 3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities. | X | | | | | Molina's HEDIS performance data is generated using NCQA-Certified HEDIS Software. ISCA documentation states Molina upgrades its HEDIS software monthly or as needed. Finally, part of Molina's HEDIS reporting validation involves comparing the current data to prior years. |
| 4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented. | X | | | | | Molina's IT infrastructure incorporates technology (clustering, SAN storage, data replication) to provide resilience and minimize outages. In the event there are issues with Molina's primary data center, there is a data copy at a disaster recovery site. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **I D. Compliance/Program Integrity** | | | | | | |
| 1. The CCO has a Compliance Plan to guard against fraud, waste and abuse. | X | | | | | |
| 2. The Compliance Plan and/or policies and procedures address requirements, including: | X | | | | | |
| 2.1 Standards of conduct; | | | | | | The Code of Business Conduct and Ethics governs the way Molina's employees, officers, and directors conduct business activities. Every employee, officer, and director must be familiar with and always adhere to it. |
| 2.2 Identification of the Fraud and Abuse Compliance Officer; | | | | | | |
| 2.3 Information about the Compliance Committee; | | | | | | |
| 2.4 Compliance training and education; | | | | | | Education and training sessions are mandatory for all employees. |
| 2.5 Lines of communication; | | | | | | |
| 2.6 Enforcement and accessibility; | | | | | | |
| 2.7 Internal monitoring and auditing; | | | | | | Auditing and monitoring are used to identify areas of noncompliance, respond to suspected noncompliance, to assess continuing compliance, and to assess the effectiveness of corrective measures implemented to ameliorate previously identified deficiencies. Where appropriate, individuals with specific investigative expertise in the management of |

| STANDARD | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|
| | | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | | fraud investigations shall be used to investigate instances of suspected healthcare fraud. |
| | 2.8 Response to offenses and corrective action; | | | | | | |
| | 2.9 Exclusion status monitoring. | | | | | | |
| 3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities. | | X | | | | | |
| 4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse. | | X | | | | | |
| 5. The CCO's policies and procedures define how investigations of all reported incidents are conducted. | | X | | | | | |
| 6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments. | | X | | | | | |
| 7. The CCO implements and maintains a Pharmacy Lock-In Program. | | X | | | | | Processes and requirements for the Pharmacy Lock-In Program are specified in Policy MHMS-PH-005, Pharmacy Lock-In Program. |
| **I E. Confidentiality**<br>*42 CFR § 438.224* | | | | | | | |
| 1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy. | | X | | | | | |

## II. PROVIDER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **II. A. Credentialing and Recredentialing**<br>*42 CFR § 438.214, 42 CFR § 457.1233(a)* | | | | | | |
| 1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements. | | | X | | | Credentialing processes and requirements are found in:<br>•Policy CR 01, Credentialing Program Policy and Addendum B – Molina Healthcare of Mississippi State Specific Credentialing Requirements<br>•Policy CR 02, Assessment of Organizational Providers Policy and Addendum B – Molina Healthcare of Mississippi State Specific Credentialing Requirements<br>•Policy MHMS-PC-11, MHMS Provider Network General Requirements<br><br>Addendum B of Policy CR 01 states Molina conducts initial site assessments prior to completing the initial credentialing process for private practitioner offices and other patient care settings. Reassessments are conducted if the provider's location has changed since the previous credentialing activity and when a complaint has been lodged against a specific provider. The addendum indicates the site visit requirements apply to "All practitioners." During onsite discussion, Molina reported that a process for conducting site visits has not yet been established and that Molina is planning to contract with a vendor to conduct site visits. Molina confirmed that site visits for providers who have already completed credentialing will |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | be conducted when the processes is finalized. **This is a repeat finding from the previous EQR.**<br><br>None of the policies or addenda address the requirement for obtaining fingerprints for CHIP providers designated as high risk by DOM. Molina reported they are trying to establish a contract with a vendor to conduct this activity, but it is unknown when this will be finalized. **This is a repeat finding from the previous EQR.**<br><br>In Molina's CAP response to these findings from the previous EQR, Molina reported that:<br>•They were focusing on identifying and contracting with a vendor to conduct site visits and to collect fingerprints from applicable providers.<br>•Molina would continue to work on and develop a site visit and fingerprinting process that would address how and where related information will be maintained.<br>•The target date for having a vendor in place and an established process for how fingerprints will be collected and where the information will be stored was August 1, 2021.<br><br>*Corrective Action Plan: Develop and implement a process for conducting site visits for providers to comply with requirements of the CHIP Contract, Section 7 (E) (3). Develop* |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *and implement a process for collecting fingerprints for CHIP providers designated as high-risk by DOM, as required by the CHIP Contract, Section 7 (E) (6).* |
| 2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO. | X | | | | | Molina's Medical Director has overall responsibility for credentialing processes and activities. The Medical Director chairs and is a voting member of the Professional Review Committee (PRC). Level 1 credentialing files are considered clean credentialing files and can be approved by the Medical Director. A report of the practitioners approved by the Medical Director is presented at each PRC meeting. Using a peer review process, Level 2 credentialing files are reviewed by the PRC for credentialing determinations.<br><br>The PRC representation includes at least four network practitioners with a range of specialties. Other practitioners may be invited to participate ad hoc when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Pain Management Specialist, Nurse Practitioners, and Chiropractors) may be appointed to screen applicants from their respective profession and make credentialing recommendations to the PRC. Current PRC membership includes providers with specialties of Family Medicine (x3) Sports Medicine, OB/GYN, and Internal Medicine. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | The PRC meets at least quarterly. Practitioners have voting privileges and the quorum is established as the presence of four voting practitioners at any regular or special meeting. The Medical Director may remove or replace a PRC member if the member is absent from more than 2 meetings per year.<br><br>Review of PRC minutes confirmed the committee meets at appropriate intervals and member attendance is satisfactory. The minutes reflected thorough review and discussion of Level 2 providers prior to making credentialing determinations. |
| 3. The credentialing process includes all elements required by the contract and by the CCO's internal policies. | X | | | | | |
| 3.1 Verification of information on the applicant, including: | | | | | | |
| 3.1.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |
| 3.1.2 Valid DEA certificate and/or CDS certificate; | X | | | | | |
| 3.1.3 Professional education and training or board certification if claimed by the applicant; | X | | | | | |
| 3.1.4 Work history; | X | | | | | |
| 3.1.5 Malpractice claims history; | X | | | | | |
| 3.1.6 Formal application with attestation statement delineating any physical or | X | | | | | |

| STANDARD | | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load; | | | | | | |
| | | 3.1.7 Query of the National Practitioner Data Bank (NPDB); | X | | | | | |
| | | 3.1.8 Query of the System for Award Management (SAM); | X | | | | | |
| | | 3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List; | X | | | | | |
| | | 3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)); | X | | | | | |
| | | 3.1.11 Query of the Social Security Administration's Death Master File (SSDMF) | X | | | | | |
| | | 3.1.12 Query of the National Plan and Provider Enumeration System (NPPES) | X | | | | | |
| | | 3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility; | X | | | | | |
| | | 3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number or providers billing laboratory services; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.1.15 Fingerprints, when applicable. | | | | X | | For the initial credentialing files, none of the providers were designated as high-risk by DOM. |
| 3.2 Site assessment. | X | | | | | Due to restrictions from the COVID-19 pandemic, site visits are on hold but will be conducted when a vendor is under contract and when public safety restrictions are lifted. |
| 3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days. | X | | | | | |
| 4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies. | X | | | | | |
| 4.1 Recredentialing every three years; | X | | | | | |
| 4.2 Verification of information on the applicant, including: | | | | | | |
| 4.2.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |
| 4.2.2 Valid DEA certificate and/or CDS Certificate; | X | | | | | |
| 4.2.3 Board certification if claimed by the applicant; | X | | | | | |
| 4.2.4 Malpractice claims since the previous credentialing event; | X | | | | | |
| 4.2.5 Practitioner attestation statement; | X | | | | | |
| 4.2.6 Re-query the National Practitioner Data Bank (NPDB); | X | | | | | |
| 4.2.7 Re-query the System for Award Management (SAM); | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List; | X | | | | | |
| 4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)); | X | | | | | |
| 4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF); | X | | | | | |
| 4.2.11 Re-query of the National Plan and Provider Enumeration (NPPES); | X | | | | | |
| 4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services; | X | | | | | |
| 4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility; | X | | | | | |
| 4.3 Provider office site reassessment, when applicable. | X | | | | | |
| 4.4 Review of practitioner profiling activities. | X | | | | | |
| 5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues. | X | | | | | Procedure MHMS-PC-09, MHMS Provider Termination Process, states:<br>•When a provider chooses to leave the network, Molina will give DOM 60 days prior notice of the termination date.<br>•Molina must terminate any provider for cause for any reasons set forth in *42 CFR 455.416*, |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *455.420, 1001.1001* and *MS Code Ann. 43-13-121(7)*. When Molina terminates a provider, Molina will give DOM 60 days prior notice of its intent to terminate a provider and will submit a provider termination work plan to DOM within 10 business days of the notification.<br>•In instances where DOM terminates a provider for cause, Molina terminates the provider upon notification from DOM and submits a copy of the provider termination notification to DOM within 48 hours. |
| 6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities. | | X | | | | One Initial Credentialing file for a mental health clinic did not include evidence of fingerprinting for the owner, who holds 100% ownership. Refer to the *CHIP Contract, Section 7 (E) (6)*. **This is a repeat finding from the previous EQR.**<br><br>*Corrective Action Plan: Ensure credentialing files for CHIP providers designated as high risk by DOM include evidence of collection of fingerprints.* |
| **II B. Adequacy of the Provider Network**<br>*42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* | | | | | | |
| 1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements. | | | | | | |
| 1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned. | X | | | | | |

| STANDARD | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|
| | | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | 1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment. | X | | | | | Nonparticipating providers can verify member enrollment by contacting the Member and Provider Contact Center. |
| | 1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients. | X | | | | | Open and closed provider panels are monitored through Geo Access reports. Staff also monitor provider panel status routinely to ensure providers aren't overloaded with assigned members and to ensure members have adequate choice of providers. |
| | 1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties. | X | | | | | Standards for access to PCPs are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. The standards documented in the policies are compliant with contractual requirements. Quarterly Geographic Access Assessment Report are run using correct parameters to assess compliance with geographic accessibility requirements. |
| | 1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. | X | | | | | Standards for access to specialists and other provider types are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. The standards documented in the policies are compliant with contractual requirements. Quarterly Geographic Access Assessment Report are run using correct parameters to assess |

| STANDARD | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|
| | | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | | compliance with geographic accessibility requirements. |
| | 1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly. | X | | | | | Quarterly Geographic Access Assessment Reports are run to assess compliance with geographic accessibility requirements. Results are reviewed and the results, including any deficiencies, barriers to improvement, and/or successes since the prior quarter's report, are reported to the Executive Quality Improvement Committee (EQIC). Member complaints about network access may also be used in order to identify where the provider network may not be adequate. |
| | 1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations. | X | | | | | Processes for ensuring network providers can serve members with special needs, including foreign language and cultural requirements, are addressed in Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness. Molina uses various data sources to assess the language needs and cultural backgrounds of its membership.<br>The Molina website includes resources about culturally and linguistically appropriate services. The information addresses interpreter services and includes downloadable/printable resources, trainings about culturally competent healthcare, and links to additional external resources. |
| | 1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand. | X | | | | | |

| STANDARD | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|
| | | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. Practitioner Accessibility | | | | | | | |
| | 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. | X | | | | | Documentation in Policy MHMS-QI-006, Access to Care, indicates Molina conducts appointment and after-hour accessibility audits on a sample of PCPs, high-volume specialists (OBGYN), high-impact specialists (oncology), and behavioral health providers. Ongoing monitoring includes member complaints related to accessibility, scheduling processes, wait times, and delays. The following are not defined in the policy:<br>•The frequency of conducting appointment access and after hours audits. Onsite discussion confirmed the audits are conducted quarterly.<br>•The department or entity that conducts the audits. Onsite discussion revealed the audits are conducted by the Quality HEDIS Call Center.<br>The appointment access standards listed in the policy are compliant with Contractual requirements; however, the policy does not include the appointment access timeframe for urgent care providers. Onsite discussion confirmed the appointment access requirement for urgent care providers is within 24 hours.<br>The CHIP Appointment Availability Reports for Q2 2021 indicate appropriate parameters are used. The CHIP 2nd Quarter 2021 QI Work Plans document correct appointment access standards. |

| STANDARD | | SCORE | | | | | COMMENTS |
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| | | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | | *Recommendation: Revise Policy MHMS-QI-006, Access to Care, to include the frequency of conducting appointment access and after hours audits, which department or entity that conducts the audits, and the appointment access timeframe for urgent care providers.* |
| **II C. Provider Education**<br>*42 CFR § 438.414, 42 CFR § 457.1260* | | | | | | | |
| 1. The CCO formulates and acts within policies and procedures related to initial education of providers. | | X | | | | | Molina's Provider Services staff develop, conduct, and evaluate provider education and training programs. Input is received from all applicable internal departments and external organizations, including DOM, as needed to determine specific training topics. Initial provider orientation is conducted within 30 days following the date the provider is active (contracting and credentialing processes are complete provider is configured and loaded into the QNXT system). Ongoing training is conducted annually, quarterly, or on an as-needed basis.<br><br>Policy MHMS-NM-018, Provider Education and Training, lists some of the topics that are covered in provider training sessions, including but not limited to:<br>•A general overview of Molina, hours of operation, key phone numbers, the plan website, the web portal, and the online provider directory |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | •Provider roles and collaboration with Molina to ensure members receive appropriate care and access to services<br>•Cultural competency and resources<br>•Provider Guidelines, including covered services, claims processes, authorizations, and referrals<br>•Member eligibility, rights, and responsibilities<br>•Confidentiality requirements and the Fraud and Abuse Prevention policy<br>Molina staff reported that most education provided virtually, but some face to face provider interactions are being conducted. Provider preference is considered along with positive COVID-19 cases in the area prior to conducting face-to-face interactions with providers. |
| 2. Initial provider education includes: | | | | | | |
| 2.1 A description of the Care Management system and protocols, including transitional care management; | X | | | | | |
| 2.2 Billing and reimbursement practices; | X | | | | | |
| 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; | X | | | | | |

| STANDARD | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|
| | | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | 2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs; | X | | | | | |
| | 2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments; | X | | | | | |
| | 2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services; | X | | | | | |
| | 2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services; | X | | | | | |
| | 2.8 Medical record handling, availability, retention and confidentiality; | X | | | | | |
| | 2.9 Provider and member grievance and appeal procedures, including provider disputes; | X | | | | | |
| | 2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete; | X | | | | | |
| | 2.11 Prior authorization requirements including the definition of medically necessary; | X | | | | | |
| | 2.12 A description of the role of a PCP and the reassignment of a member to another PCP; | X | | | | | |
| | 2.13 The process for communicating the provider's limitations on panel size to the CCO; | X | | | | | |
| | 2.14 Medical record documentation requirements; | X | | | | | |
| | 2.15 Information regarding available translation services and how to access those services; | X | | | | | |
| | 2.16 Provider performance expectations including quality and utilization management criteria and processes; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.17 A description of the provider web portal; | X | | | | | |
| 2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business. | X | | | | | |
| 3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements. | | X | | | | As stated in Policy MHMS-PC-01, MHMS Provider Directory Requirements, Molina maintains Provider Directories that include information for PCPs, hospitals, specialists, ancillary services, behavioral health/substance use disorder facilities, and pharmacies. Copies of the Provider Directories are available in State Medicaid Regional Offices and WIC offices, and members may access the Provider Directories on Molina's website. Included in the policy are elements that must be included in the Provider Directories. The paper Provider Directory is updated at least every six months and the online directory is updated nightly.<br>A review of the online Provider Directory confirmed all required elements are included. A review of the print version of the Provider Directory revealed the directory did not include an indication regarding providers' abilities to accommodate people with physical disabilities.<br>On a quarterly basis, all contracted providers are contacted by telephone, mail, or email to determine if updates are needed to the current provider demographic data, such as changes, additions, or closures of office locations •changes in office hours, phone and fax numbers, or email addresses; addition or |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | termination of a provider; changes in Tax ID and/or NPI; and panel changes.<br><br>*Corrective Action: Develop and implement a process to include providers' abilities to accommodate people with physical disabilities in the print version of the Provider Directory.* |
| 4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures. | X | | | | | |
| **II D. Primary and Secondary Preventive Health Guidelines**<br>*42 CFR § 438.236, 42 CFR § 457.1233(c)* | | | | | | |
| 1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated. | X | | | | | Molina adopts preventive health guidelines (PHGs) to provide up-to-date information about important preventive health topics to providers and to reduce inter-provider variation. The PHGs are selected based on scientific evidence and recommendations made by national clinically based organizations and are focused on age- and condition-specific recommendations that are relevant to Molina's membership population.<br>The National Quality Improvement Committee (NQIC), with participation from physicians and other health professionals, is responsible for the selection, review, and approval of PHGs.<br>These processes are documented in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines: |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members. | X | | | | | Provider Services staff inform newly contracted providers about the PHGs in the Provider Manual and/or distribute them during the orientation visit. Printed copies of the guidelines are available upon request. Information about the PHGs is included in the CHIP Provider Manual and indicates that annual notification of the availability of the PHGs is published in the Molina Provider Newsletter. Information about the PHGs was noted in the Second Quarter 2021 Provider Newsletter. The guidelines are available on Molina's website. |
| 3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics: | | | | | | |
| 3.1 Pediatric and adolescent preventive care with a focus on Well- Baby and Well-Child services; | X | | | | | |
| 3.2 Recommended childhood immunizations; | X | | | | | |
| 3.3 Pregnancy care; | X | | | | | |
| 3.4 Recommendations specific to member high-risk groups; | X | | | | | |
| 3.5 Behavioral health. | X | | | | | |
| **II E. Clinical Practice Guidelines for Disease and Chronic Illness Management** *42 CFR § 438.236, 42 CFR § 457.1233(c)* | | | | | | |
| 1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are | X | | | | | As stated in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines: |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| developed in conjunction with pertinent network specialists. | | | | | | •Molina adopts Clinical Practice Guidelines (CPGs) that provide up-to-date treatment and diagnostic information about important clinical topics and to reduce inter-provider variation in care. The CPGs are specific to the demographics and needs of Molina's member population.<br>•The National Quality Improvement Committee (NQIC), with participation from physicians and other health professionals, is responsible for the selection, review, and approval of CPGs.<br>•The adopted CPGs are based on scientific evidence and recommendations made by national clinically-based organizations. The CPGs are reviewed for approval and adoption through Molina's Quality Improvement Committee and are reviewed and updated at least every 2 years. |
| 2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO members. | X | | | | | Provider Services staff inform newly contracted providers about the CPGs in the Provider Manual and/or distribute them during the orientation visit. The CPGs are also disseminated through newsletters, bulletins, and are available on Molina's website. Printed copies are available upon request. |
| **II F. Practitioner Medical Records** | | | | | | |
| 1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians. | X | | | | | Policy MHMS-QI-124, Standards of Medical Record Documentation, defines minimum standards for maintenance of member medical records and lists elements that must be included in member medical records. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Medical record maintenance and documentation standards are included in the CHIP Provider Manual. The Molina website refers the reader to the Provider Manual for the list of medical record documentation elements. |
| 2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers. | | X | | | | Policy MHMS-QI-124, Standards of Medical Record Documentation, states Molina has an established medical record review process, and that "results of medical record reviews (as applicable through HEDIS or Potential Quality of Care processes) are evaluated to identify specific practitioner deficiencies and opportunities for improvement throughout the network." The policy indicates results of medical record reviews may be used for monitoring, recredentialing, and other quality improvement activities.<br>However, the policy didn't provide detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc. Onsite discussion did not provide clear information about the medical record review process. Additional information was requested to be submitted after the completion of the onsite but no additional information was provided. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *Corrective Action Plan: Corrective Action Plan: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to include detailed information about procedures for assessing provider compliance with medical record documentation standards, such as the frequency of conducting assessments, which department or staff conduct the audits, etc.* |
| **II G. Provider Satisfaction Survey** | | | | | | |
| 1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol. | X | | | | | Provider satisfaction was validated using the CMS Protocol 6. Administration or Validation of Quality of Care Surveys. The sample size was 1,500. SPH Analytics collected 129 surveys (44 mail, 45 internet, and 40 phone) from the eligible provider population from September to October 2020. The mail/internet survey response rate is 6.6%, and the phone survey response rate is 6.8%. The rate in the previous survey was 15.6%. Low response rates for the provider satisfaction survey may affect generalizability of the results.<br><br>*Recommendation: Generate new initiatives to advertise the provider satisfaction survey and gather more responses for providers.* |
| 2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems. | X | | | | | |
| 3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified. | X | | | | | Results were presented to the MPSC June 2021 meeting. Root cause analysis was conducted and presented in the MPSC minutes. |

## III. MEMBER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **III A. Member Rights and Responsibilities**<br>*42 CFR § 438.100, 42 CFR § 457.1220* | | | | | | |
| | | | | | | |
| 1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities. | X | | | | | Member Rights and Responsibilities are outlined in the Member Handbook, on the website, in member materials, and in policies and procedures. |
| 2. Member rights include, but are not limited to, the right: | X | | | | | |
| 2.1 To be treated with respect and dignity; | | | | | | |
| 2.2 To privacy and confidentiality, both in their person and in their medical information; | | | | | | |
| 2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; | | | | | | |
| 2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment; | | | | | | |
| 2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected; | | | | | | |
| 2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| services free of charge and be notified that oral interpretation is available and how to access those services; | | | | | | |
| 2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations; | | | | | | |
| 2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member; | | | | | | |
| 2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210. | | | | | | |
| 3. Member responsibilities include the responsibility: | X | | | | | |
| 3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services; | | | | | | |
| 3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care; | | | | | | |
| 3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services; | | | | | | |
| 3.4 To show courtesy and respect to providers and staff; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.5 To inform the CCO of changes in family size, address changes, or other health care coverage. | | | | | | |
| **III B. Member Program Education**<br>*42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)* | | | | | | |
| 1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including: | X | | | | | Policy MHMS-ME-002, Member Information Packet, states members are provided a New Member Welcome Packet within 14 days after Molina receives the member's enrollment data from DOM. The Welcome Packet includes all contractually-required information such as an introduction letter, ID card, Member Handbook, and instructions to access the Provider Directory. |
| 1.1 Full disclosure of benefits and services included and excluded in their coverage; | | | | | | |
| 1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP; | | | | | | |
| 1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary. | | | | | | |
| 1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums; | | | | | | |
| 1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.4 Procedures for and restrictions on obtaining out-of-network medical care; | | | | | | |
| 1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services; | | | | | | Information on appropriate level of care for routine, urgent, or emergent care needs is clearly outlined in the Member Handbook and on Molina's website. |
| 1.6 Policies and procedures for accessing specialty/referral care; | | | | | | Information on obtaining prescription medications and durable medical equipment is available in the Member Handbook. Members may view the Preferred Drug List and website that includes participating pharmacies or the number for Member Services to obtain this information. |
| 1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions; | | | | | | |
| 1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers; | | | | | | |
| 1.9 A description of the member's identification card and how to use the card; | | | | | | |
| 1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.11 Procedure for making appointments and information regarding provider access standards; | | | | | | |
| 1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal; | | | | | | The Member Handbook includes toll-free telephone numbers, hours of operation, and descriptions of services provided by Member Services and the 24-Hour Nurse Advice Line. The handbook includes information about accessing the secure Member Portal and performing self-service functions, such as viewing a benefit summary, changing the PCP, updating contact information, and requesting a new ID Card. |
| 1.13 A description of the Well-Baby and Well-Child services which include: | | | | | | |
| 1.13.1 Comprehensive health and development history (including assessment of both physical and mental development); | | | | | | |
| 1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI); | | | | | | |
| 1.13.3 Comprehensive unclothed physical exam; | | | | | | |
| 1.13.4 Immunizations appropriate to age and health history; | | | | | | |
| 1.13.5 Assessment of nutritional status; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings); | | | | | | |
| 1.13.7 Vision screening; | | | | | | |
| 1.13.8 Hearing screening; | | | | | | |
| 1.13.9 Dental and oral health assessment; | | | | | | |
| 1.13.10 Developmental and behavioral assessment; | | | | | | |
| 1.13.11 Health education and anticipatory guidance; and | | | | | | |
| 1.13.12 Counseling/education and referral for identified problems. | | | | | | |
| 1.14 Procedures for disenrolling from the CCO; | | | | | | The Member Handbook provides information on the requirements for disenrollment and instructs members to call Member Services or DOM to terminate their membership. |
| 1.15 Procedures for filing complaints/grievances and appeals; | | | | | | |
| 1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.17 Instructions on reporting suspected cases of fraud and abuse; | | | | | | |
| 1.18 Information regarding the Care Management Program and how to contact the Care Management team; | | | | | | |
| 1.19 Information about advance directives; | X | | | | | An Advanced Directive is correctly described and defined in the Member Handbook. |
| 1.20 Additional information as required by the contract and by federal regulation. | | | | | | |
| 2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network. | X | | | | | |
| 3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages. | X | | | | | |
| 4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages. | X | | | | | |
| 5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed. | X | | | | | |
| **III C. Call Center** | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals. | X | | | | | A toll-free number is available to the Molina Members Services Call Center, Provider Services Call Center, and a 24-Hour Nurse Advice Line. |
| 2. Call Center scripts are in-place and staff receive training as required by the contract. | X | | | | | |
| 3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee. | X | | | | | Call Center communication is monitored and evaluated for provider and member services staff to evaluate the quality of call handling. No less than 3% of calls are randomly selected monthly. |
| **III D. Member Enrollment and Disenrollment** *42 CFR § 438.56* | | | | | | |
| 1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed. | X | | | | | |
| 2. Member disenrollment is conducted in a manner consistent with contract requirements. | X | | | | | Policy MHMS-ME-008, Enrollment Reports, and Policy MHMS-ME-009, Enrollment Accounting, describe instances when Molina can request a member to be disenrolled. |
| **III E. Preventive Health and Chronic Disease Management Education** | | | | | | |
| 1. The CCO informs members about available preventive health and chronic disease management services and encourages members to utilize these benefits. | X | | | | | Policy MHMS-QI-125, Member Education and Prevention (ME), describes the process Molina uses to provide health education to new and established members. Members can access the website or Member Handbook for information on recommended preventive health services, available case management programs, and instructions to obtain educational support for medical, behavioral health, and pharmaceutical |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | services. Additionally, the plan sends targeted and general mailings and makes calls to eligible members reminding them of screenings and well visits. |
| 2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program. | X | | | | | |
| 3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits. | X | | | | | |
| 4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion. | X | | | | | |
| **III F. Member Satisfaction Survey** | | | | | | |
| 1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. | | | | | X | Per the Molina Healthcare of Mississippi Member and Provider Satisfaction Committee minutes from June 30, 2021, the CHIP CAHPS will be conducted starting in Measurement Year 2021, Reporting Year 2022. |
| 2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems. | | | | | X | |
| 3. The CCO reports the results of the member satisfaction survey to providers. | | | | | X | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 4. The CCO reports the results of the member satisfaction survey and the impact of measures taken to address quality problems that were identified to the appropriate committee. | | | | | X | |
| **III G. Grievances**<br>*42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260* | | | | | | |
| 1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: | X | | | | | |
| 1.1 Definition of a grievance and who may file a grievance; | X | | | | | |
| 1.2 The procedure for filing and handling a grievance; | X | | | | | |
| 1.3 Timeliness guidelines for resolution of the grievance; | X | | | | | |
| 1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process; | X | | | | | |
| 1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract; | X | | | | | |
| 2. The CCO applies the grievance policy and procedure as formulated. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Grievance logs are maintained, categorized, and reported internally to establish areas of potential quality improvement. |
| 4. Grievances are managed in accordance with the CCO confidentiality policies and procedures. | X | | | | | |
| **III H. Practitioner Changes** | | | | | | |
| 1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction. | X | | | | | |
| 2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee. | X | | | | | |

## IV. QUALITY IMPROVEMENT

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **IV A. Quality Improvement (QI) Program**<br>*42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)* | | | | | | |
| 1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members. | X | | | | | The 2021 Quality Improvement Program Description covers the CAN and CHIP populations, is updated annually, and submitted to the Quality Improvement |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Committee and the Board of Directors for approval.<br>The program description includes the programs goals, objectives, structure, and scope of activities. Molina reviews and modifies the QI program objectives as needed on an on-going basis and formally at least yearly.<br>Providers and members are informed about QI activities through Molina's website and in the Provider Manual. A description of the QI program is provided and informs providers they may request more information about initiatives, and/or the progress toward meeting quality goals by calling Provider Services. |
| 2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities. | X | | | | | A goal of QI activities is to reduce healthcare disparities. Molina's Cultural Competency Plan described in the QI program description provides a summary of the plan to address healthcare disparities through tools and needed trainings. |
| 3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems. | X | | | | | |
| 4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s). | X | | | | | Molina provided the 2020 and 2021 QI work plans for review. The work plans included the QI activities across several sections, responsible parties, timelines, action plans/goals, and the results/status for each activity. Results for the CAN and CHIP lines of business are clearly delineated in the work plans. Last year there |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | were several errors noted in the work plan. Molina addressed these errors in their corrective action plan and implemented the changes in the Q2 2021 QI work plan. Section seven of the Q2 2021 QI work plan includes information for measuring appointment access for Behavioral Health providers. In the "Action Plan/Benchmark Goal" column there is one set of appointment standards and in the "Results" column there is another set. This was discussed during the onsite and Molina indicated this was an error and the "Action Plan/Benchmark Goal" column should be deleted. |
| **IV B. Quality Improvement Committee** | | | | | | |
| 1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities. | X | | | | | The Quality Improvement Committee (QIC) is the committee responsible for the oversight, implementation, coordination, and integration of all QI activities. This committee sets the strategic direction for all QI activities. The QIC receives reports from all QI subcommittees, and advises and directs the committees on the focus and implementation of the program and work plan. These subcommittees include the Professional Review Committee, Healthcare Services Committee, and the Delegation Oversight Committee. |
| 2. The composition of the QI Committee reflects the membership required by the contract. | X | | | | | The Chief Medical Officer and the Quality Lead co-chair the QIC. Voting members include Molina's senior leaders representing all departments of the organization and four network providers. Their specialties include |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | pediatrics, OB/GYN, and internal medicine. During the previous EQR, CCME recommended Molina recruit additional network providers to service on the QIC. Molina responded and indicated they were seeking additional network providers to serve on the QIC. The identification of those providers should be completed by Q4 2021. In the September 2021 meeting minutes, it was noted a new network provider was added. |
| 3. The QI Committee meets at regular intervals. | X | | | | | The committee co-chairs convene and preside over regularly scheduled quarterly meetings and convene special meetings as needed. A quorum of at least 51% of the committee members with no less than half of network provider participants are necessary to enact or implement decisions. It was noted for the Q and Q3 2020 meetings, there was not a quorum because only one network provider attended the meeting.<br><br>*Recommendation: Continue to recruit additional network providers to serve on the QIC.* |
| 4. Minutes are maintained that document proceedings of the QI Committee. | X | | | | | |
| **IV C. Performance Measures**<br>*42 CFR §438.330 (c) and §457.1240 (b)* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures." | X | | | | | The performance measure validation found that Molina was fully compliant with all information system standards and determined that Molina submitted valid and reportable rates for all HEDIS measures in scope of this audit.<br>There were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Molina followed the measure specifications and produced reportable rates for all measures in the scope of the validation.<br>Source code review and primary source verification demonstrated concerns in the reporting of the Diabetes Short -Term Complications Admission Rate (PQI01-AD), Heart Failure Admission Rate (PQI-08), and the Asthma in Younger Adults Admission Rate (PQI15-AD). The reported numerator was based on admissions instead of discharges. This led to the inclusion of discharges that were after the end of the measurement period. Also, the source code review identified concerns with identifying exclusions for the Percentage Of Eligibles Who Received Preventive Dental Services (PDENT-CH). No process was in place for MY 2020 to identify exclusions for the denominator. Improvement of processes around calculation, reporting, and verification of the rates reported for the Adult and Child Core Set measures is needed. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Molina did not report two non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.<br><br>*Recommendation: Work proactively with DOM for clarification on measures that are required to be reported. Improve processes around calculation, reporting and verification of the rates reported for the DOM-required Adult and Child Core set measures.* |
| **IV D. Quality Improvement Projects**<br>*42 CFR §438.330 (d) and §457.1240 (b)* | | | | | | |
| 1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM. | X | | | | | Molina submitted four PIPs for validation. Topics included Well Care/Well Child, Asthma, Obesity, and Follow-up After Hospitalization For Mental Illness. |
| 2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects." | X | | | | | All the CHIP PIPs scored in the "High Confidence in Report Results" range and met the validation requirements. |
| **IV E. Provider Participation in Quality Improvement Activities** | | | | | | |
| 1. The CCO requires its providers to actively participate in QI activities. | X | | | | | Molina's Provider Manual includes details regarding their Quality Management program. Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | care rendered by providers. Such participation includes but is not limited to: Access to Care Standards, Site and Medical Record-Keeping Practice Reviews, and Delivery of Patient Care Information. |
| 2. Providers receive interpretation of their QI performance data and feedback regarding QI activities. | X | | | | | Provider HEDIS profile reports are generated to provide feedback on performance. Providers received performance reports during monthly meetings and through Molinas's provider portal. |
| 3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines. | X | | | | | The Provider Manual includes information regarding provider performance monitoring. Molina monitors compliance with the established performance standards at least annually. Within 30 calendar days of the review, a copy of the review report and a letter is sent to the medical group notifying them of their results. Performance below Molina's standards may result in corrective action.<br>Per policy and procedure MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina annually measures performance against at least two important aspects of the clinical practice guidelines. Results are reported to the participating practitioners/providers no less than annually. |
| 4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: | | | | | | Molina's Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, was provided. Molina generates member |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | targeted lists that identify members due for a Well-Baby and Well-Child service and targets those members with written notifications, telephone reminders, assistance with transportation, and collaborating with providers. |
| 4.1 Initial visits for newborns; | X | | | | | |
| 4.2 Well-Baby and Well-Child screenings and results; | X | | | | | |
| 4.3 Diagnosis and/or treatment for children. | | X | | | | Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services addresses Well-Baby and Well-Child services, how Molina tracks those services, and follow-up with members who have not received or are behind in getting services. The policy did not address how Molina tracks provider or member compliance with treatments or referrals needed for abnormal conditions identified through Well-Baby and Well-Child services. Also, the tracking reports did not include the treatment and/or referrals made for any abnormal findings. This was an issue found during the previous EQR. Molina addressed the corrective action and indicated once the member is identified, follow-up will be provided via letter or call to determine if the member received a referral, received treatment, missed any follow-up appointments, and/or needed assistance with securing an appointment with an appropriate specialist. A draft template was also included that |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | addressed the deficiencies. However, this tracking report template was not implemented.<br><br>*Corrective Action: Include Molina's process for tracking treatments or referrals needed for abnormal findings during the Well-Child and Well-Baby service. Also, include the follow-up on the Well-Child Well-Baby tracking report.* |
| **IV F. Annual Evaluation of the Quality Improvement Program**<br>*42 CFR §438.330 (e)(2) and §457.1240 (b)* | | | | | | |
| 1. A written summary and assessment of the effectiveness of the QI program is prepared annually. | | X | | | | Annually, Molina completes an evaluation of the QI program to assess the overall effectiveness of the organization's QI processes for its CAN and CHIP members. The Quality Improvement Program 2020 Annual Evaluation was provided as evidence of this evaluation. The evaluation included an executive summary that provided a brief overview of the evaluation and areas of focus and or recommendation for next year (2021). The evaluation also included several appendices that covered the results of the CLAS analysis, population assessment, quality performance measures report, potential quality of care issues and the member and provider experience report.<br>Areas not included in the evaluation were the results and analysis of availability of practitioners, accessibility of services, continuity and coordination of medical care, provider directory analysis, results of |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | delegation oversight, and credentialing activities. The performance improvement projects were included in the executive summary; however, the information was incomplete. There was no mention of the barriers and interventions to address the barriers. Most of the target rates were listed as "TBD." These were the same or similar errors found during the previous EQR. Molina addressed these errors and indicated the 2021 QI Program Evaluation is expected to be completed by 1st or 2nd quarter 2022 and the evaluation will include all required elements outlined in the contract.<br><br>*Corrective Action: Correct the 2020 QI Program Evaluation and include a description and results of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.* |
| 2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM. | X | | | | | |

## V. UTILIZATION MANAGEMENT

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **V A. Utilization Management (UM) Program** | | | | | | |
| 1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to: | X | | | | | The CHIP HCS Program Description Addendum outlines the objectives, scope, and staff roles for physical health, behavioral health, and pharmaceutical services. Departmental policies provide guidance on utilization management (UM) processes and requirements. |
| 1.1 Structure of the program; | X | | | | | The UM Program is structured within the Health Care Services (HCS) Program, where the key functions are eligibility and oversight, resource management, and quality management.<br>The Associate Vice President (AVP) of HCS, in consultation with the Chief Medical Officer (CMO), have authority and responsibility for HCS program development and implementation, as stated in the HCS Program Description. |
| 1.2 Lines of responsibility and accountability; | X | | | | | |
| 1.3 Guidelines/standards to be used in making utilization management decisions; | X | | | | | Policy MHMS-HCS-UM-365.1, Clinical Criteria for Utilization Management Decision Making, states Molina "uses objective evidence based clinical criteria to determine medical necessity and appropriateness of requested services." Reviewers use clinical records, consider the member's individual circumstances, and use a hierarchy of decision-making guidelines that include, but are |

| STANDARD | | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|---|
| | | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | | not limited to, state specific guidelines, InterQual, MCG, and Molina Clinical Policies. |
| | 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification; | | X | | | | Standards for timeliness of UM decisions are described in the HCS Program Description and in Policy MHMS-HCS-UM-383.1, Timeliness of UM Decision Making and Notification. However, CCME identified the following issues on pages two, seven, and 11 of the policy related to extensions of urgent prior authorization requests:<br>•Incorrect documentation indicating that requests can be extended up to 48 hours and a decision must be made no later than 72 hours.<br>•No documentation that Molina must request an extension from DOM.<br>According to requirements in *CHIP Contract, Section 5 (I) (4)*, "the 24 hour period may be extended up to 14 additional calendar days upon request of the Member, or the Provider, or if Contractor requests an extension from the Division."<br>*Corrective Action Plan: Edit Policy MHMS-HCS-UM-383.1, Timeliness of UM Decision Making and Notification, to reflect the correct timeframe requirements for extensions of urgent prior authorization requests and to indicate that Molina must request an extension from DOM, according to requirements in the CHIP Contract, Section 5 (I) (4).* |
| | 1.5 Consideration of new technology; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.6 The appeal process, including a mechanism for expedited appeal; | X | | | | | |
| 1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services. | X | | | | | |
| 2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee. | X | | | | | The 2021 HCS Program Description describes the roles and responsibilities of the Chief Medical Officer and other Medical Directors. Responsibilities include but are not limited to supervising medical necessity decisions, conducting Level II reviews, and participating in plan committees.<br>The Behavioral Health Medical Director and the Pharmacy Director collaborate with the Medical Director and CMO and have clinical oversight of the respective programs. |
| 3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions. | X | | | | | The HCS programs are evaluated annually and updated as needed. Molina confirmed the 2020 HCS Program Evaluation was presented to the Health Care Services Committee and the QIC and was approved on March 4, 2021.<br><br>Policy MHMS-HCS-UM-300.1, Healthcare Services Committee, and the HCS Program Evaluation indicate external network providers participate on the HCSC where clinical policies and UM criteria and guidelines are discussed. Onsite discussion confirmed two network providers participate on the HCSC and meeting minutes reflect their attendance. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **V B. Medical Necessity Determinations**<br>*42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.* | | | | | | |
| 1. Services that require prior authorization by the CCO include only the services specified by the Mississippi Division of Medicaid. | X | | | | | |
| 2. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations. | X | | | | | The HCS Program Description and departmental policies outline processes used to make UM determinations. Molina utilizes health plan approved policies and utilization decision-making criteria such as InterQual® or MCG to make physical health and behavioral health determinations. Additionally, ASAM criteria is used for behavioral health reviews. Onsite discussions confirmed Molina stopped using InterQual in Q1 2021. |
| 3. Utilization management decisions are made using predetermined standards/criteria and all available medical information. | X | | | | | Review of UM approval files reflect consistent decision-making, according to an established hierarchy, utilizing standards such as InterQual and MCG, Molina's Policies, clinical guideline, pharmacy guidelines and relevant medical information. |
| 4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions. | X | | | | | Policy MHMS-HCS-UM-325.1, Service Authorization, indicates members' individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Physician reviewers are encouraged to recognize members' unique needs or limitations of the local delivery system.<br>Approval files reflect that physician reviewers will use manual criteria and their clinical professional |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | judgement to consider the member's individual circumstances when InterQual and MCG criteria are not met. |
| 5. Utilization management standards/criteria are consistently applied to all members across all reviewers. | X | | | | | Annual inter-rater reliability testing is conducted for physicians, nurse reviewers, and behavioral health reviewers, as described in the HCS Program Description. The minimum compliance goal is 85% for physician and pharmacy reviewers and 90% for nurses. The 2020 HCS Program Evaluation reported all reviewers achieved passing scores after remediation and refresher training.<br>During the onsite, Molina reported a full-time nurse auditor was hired to ensure staff performance is consistent by reviewing UM documentation, engaging with UM staff and presenting audit findings during weekly UM huddles. |
| 6. Pharmacy Requirements | | | | | | |
| 6.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List. | X | | | | | Molina uses the Universal Preferred Drug List required by DOM. A link to access the most current version of PDL is available on Molina's website. The user is automatically directed to DOM's website, where the PDL is available in a searchable, electronic format. Additionally, the PDL can be downloaded and printed, or hard copies can be requested by calling Members Services. |
| 6.2 The CCO has established policies and procedures for the prior authorization of medications. | X | | | | | Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures, describes that CVS Caremark is the pharmacy benefit manager and is |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | responsible for implementing all pharmaceutical services for Molina, including but not limited to prior authorizations and pharmacy network management. Molina ensures a 3-day supply of medication will be approved while a prior authorization request is pending. |
| 7. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations. | X | | | | | The HCS Program Description and Policy MHMS-HCS-UM-384.1, Post Service Review –Emergency Care Visits, describe emergency and post-stabilization service requirements and the member's ability to access them. Molina does not require prior authorization for physical or behavioral health emergency services. Additionally, the Member Handbook and the website provide instructions for members to freely access emergent and urgent care services. |
| 8. Utilization management standards/criteria are available to providers. | X | | | | | |
| 9. Utilization management decisions are made by appropriately trained reviewers. | X | | | | | The HCS Program Description and Policy MHMS-HCS-UM-364.1, Appropriate Professionals Making UM Decisions, describe Molina's approach for ensuring UM decisions are rendered by qualified staff who are trained in the principles, procedures, and standards of utilization and medical necessity review. Initial clinical reviews are performed by Mississippi-licensed nurses and Level II clinical reviews are performed by Mississippi-licensed physicians or other appropriate healthcare practitioners. Non-licensed staff perform intake and initial screenings that do not |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | require clinical interpretation and are required to refer clinical cases to clinical staff members. |
| 10. Initial utilization decisions are made promptly after all necessary information is received. | X | | | | | Review of approval files reflected physical and behavioral health utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within 3 calendar days/2 business days.<br>The HCS Program Evaluation documented a 95% to 99% compliance rate for processing prior authorizations. During the onsite, Molina staff reported workflow changes were made that included training reviewers on different components of UM processes. |
| 11. Denials | | | | | | |
| 11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services. | X | | | | | UM denial files reflected clinical reviewers request additional clinical information from providers when needed prior to making an adverse benefit determination. |
| 11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist. | X | | | | | Denial files indicated Molina ensures denial decisions are made by appropriate physicians. |
| 11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal. | X | | | | | |
| **V C. Appeals**<br>*42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: | X | | | | | Molina's processes for handling and processing member appeals are described in the Health Care Services (HCS) Program Description and related policies. Appeals are processed, tracked, and handled according to requirements in the *CAN Contract, Section 11 (O)*. Additionally, appeals information is provided in the Provider Manual, Member Handbook, and the member tab of the website. |
| 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal; | X | | | | | |
| 1.2 The procedure for filing an appeal; | X | | | | | Procedures for filing an appeal are described and outlined in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Molina ensures CHIP members and their representative have access to appeal information, processes, and procedures by making it available on the website. Members are informed that translators are available, and Molina offers assistance with filing an appeal.<br>Adverse Benefit Determination notices include appeal information and instructions according to *CHIP Contract, Section 6 (K)*.<br>Onsite discussion confirmed Molina is aware of changes to the appeal process, according to *CFR 438.402 (c) (3)*, which no longer requires a member's verbal appeal to be followed by a signed written appeal. Molina will ensure appeals documents are updated upon approval from DOM. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case; | X | | | | | |
| 1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay; | X | | | | | |
| 1.5 Timeliness guidelines for resolution of the appeal; | X | | | | | Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals, correctly documents the resolution timeframe for standard and expedited appeals according to requirements in *CHIP Contract, Section E(D)*. Standard appeal requests are resolved within 30 calendar days, expedited appeals are resolved within 72 hours and either timeframe can be extended up to 14 calendar days by the member or by the plan. |
| 1.6 Written notice of the appeal resolution; | | X | | | | The CHIP appeal resolution notice for decisions that are upheld includes the results of the resolution process and instructions to request an Independent External Review.<br>The header on Policy MHMS-MRT-02, Standard Member Appeals, indicates that it applies to both CAN and CHIP lines of business. However, CCME could not identify documentation about the process for CHIP members to request an Independent External Review in the policy. Additionally, Policy MHMS-MRT-05, Member |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | Independent External Review, which applies to CHIP members, is not listed as a reference.<br>*Corrective Action Plan: Edit Policy MHMS-MRT-02, Standard Member Appeals, to include information on the Independent External Review process for CHIP members and include Policy MHMS-MRT-05, Member Independent External Review to the list of references.* |
| 1.7 Other requirements as specified in the contract. | X | | | | | The letter template for notification of upheld decisions has instructions for members to request continuation of benefits while Independent External Review is pending, according to requirements in the *CHIP Contract, Exhibit E (D)*. However, as mentioned in Standard C 1.6, information regarding Independent External Reviews is not documented in a policy. |
| 2. The CCO applies the appeal policies and procedures as formulated. | X | | | | | Appeal files reflect staff are following processes outlined in the *CHIP Contract* and Molina's policies. Review of appeal files reflected timely acknowledgement, resolution, and notification of determinations. Members receive appropriate acknowledgement of their request and are informed when an extension is required. |
| 3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Minutes from SQIC and QIC meetings include presentation and discussion of appeals. |
| 4. Appeals are managed in accordance with the CCO confidentiality policies and procedures. | X | | | | | |
| **V D. Care Management** | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| *42 CFR § 208, 42 CFR § 457.1230 (c)* | | | | | | |
| 1. The CCO has developed and implemented a Care Management and a Population Health Program. | X | | | | | The Integrated Care Management Program, outlined in the HCS Program Description, and the Population Health Management Program, outlined in the Population Health Strategy, describe Molina's processes for ensuring and promoting access and delivery of care management services for all members. |
| 2. The CCO uses varying sources to identify members who may benefit from Care Management. | X | | | | | |
| 3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level. | X | | | | | A health risk assessment will be completed within 30 calendar days after a member is identified, and an Individualized Care Plan (ICP) will be completed within 30 calendar days after the health risk assessment, as described in Policy MHMS-HCS-CM-054, Individualized Care Plan Development. |
| 4. The detailed health risk assessment includes all required elements: | | | | | | The HCS Program Description indicates the detailed health risk assessment includes identifying the severity of the member's condition, evaluating co-morbidities and complex health conditions, demographic information, current providers, and a treatment plan, if available. |
| 4.1 Identification of the severity of the member's conditions/disease state; | X | | | | | |
| 4.2 Evaluation of co-morbidities or multiple complex health care conditions; | X | | | | | |
| 4.3 Demographic information; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 4.4 Member's current treatment provider and treatment plan, if available. | X | | | | | The ICP is developed in conjunction with the member, the member's caregiver, PCP, and other members of the health care team. Behavioral health care needs and coordination are incorporated into the ICP. |
| 5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment. | X | | | | | Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriately trained for the member's health condition and are completed within 30 days of the HRA. |
| 6. The risk level assignment is periodically updated as the member's health status or needs change. | X | | | | | |
| 7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions: | X | | | | | Molina uses care management techniques to ensure members have access to required services such as assistance with care coordination, information about available services, and how access to those services. Review of CM files reflected appropriate CM activities. |
| 7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team; | | | | | | |
| 7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health; | | | | | | |
| 7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care; | | | | | | |
| 7.5 Coordination of discharge planning; | | | | | | |
| 7.6 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services; | | | | | | |
| 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; | | | | | | |
| 7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs; | | | | | | |
| 7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate. | | | | | | |
| 8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| 9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract. | X | | | | | |
| 10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan. | | X | | | | During the onsite, CCME discussed that documentation of Molina's processes for addressing continuity of care when a member disenrolls from the health plan could not be identified, according to requirements in the *CHIP Contract, Section 8 (A) (3)*. Molina's staff explained that they are following that requirement; however, no supporting documentation was provided.<br><br>*Corrective Action Plan: Include in a policy or other document Molina's processes for addressing continuity of care when a member disenrolls from the health plan, according to requirements in the CHIP Contract, Section 8 (A) (3).* |
| 11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants. | X | | | | | Molina's Level 1 CM is the Health Promotion and Disease Management program, which includes activities such as member education, coordination of medical transportation, and scheduling medical appointments. Telephonic health coaching is provided to members with low acuity conditions and focuses on disease prevention and education. |
| **V E. Transitional Care Management** | | | | | | |
| 1. The CCO monitors continuity and coordination of care between PCPs and other service providers. | X | | | | | Policy MHMS-QI-004, Monitoring Continuity of Care, states, "At least annually, Molina collects data from various sources to monitor the |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | collaboration of care between the behavioral healthcare and medical healthcare delivery systems and the continuity and coordination of care that members receive between medical care practitioners and across the health care network". The 2020 and 2021 QI Work Plan indicate Molina monitors continuity and coordination of care between the PCPs and other service providers. |
| 2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting. | X | | | | | The HCS Program Description and Policy HCS-CM-068.1, Molina Transitions of Care, describe Molina's approach for ensuring transitional care management services are provided to eligible members and outline processes and requirements for managing transitions of care across healthcare and community settings. |
| 3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements the transition of care plan, and provides oversight to the transition process. | X | | | | | Molina's Multidisciplinary Team coordinates and manages required services to ensure continuity of care and prevent duplication of services as members return to their home or other community setting. Policy HCS-CM-068.1, Molina Transitions of Care, explains that the team includes RN Care Managers, Behavioral Staff, and Social Services Specialists. |
| 4. The CCO meets other Transition of Care Requirements. | X | | | | | |
| **V F. Annual Evaluation of the Utilization Management Program** | | | | | | |
| 1. A written summary and assessment of the effectiveness of the UM program is prepared annually. | X | | | | | Molina performs an evaluation of the HCS Program annually. The 2020 HCS Program Evaluation provides a summary of UM program activities, reports and analyzes measurement outcomes, |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | determines the overall effectiveness of the UM Program and offers recommendation for improvement for 2021. The HCS Program Evaluation consists of an Executive Summary which is accompanied by Appendices A through H reporting on such activities as provider satisfaction and the Behavioral Taskforce Summary. |
| 2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM. | X | | | | | The HCS Program Evaluation was approved by the QIC on April 7, 2021. |

## VI. DELEGATION

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| **VI. DELEGATION**<br>*42 CFR § 438.230 and 42 CFR § 457.1233(b)* | | | | | | |
| 1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions. | X | | | | | Molina has delegation agreements in place with the following vendors:<br>•SKYGEN—dental benefit administration<br>•CareMark—pharmacy benefit administration<br>•March Vision—vision network, claims administration, call center services<br>•MTM—non-emergent medical transportation and customer service<br><br>The following are delegated credentialing entities:<br>•Baptist Memorial Medical Group (BMMG)<br>•George Regional Health System (GRHS) |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | •Hattiesburg Clinic, PA (HBC)<br>•Memorial Hospital at Gulfport (MGP)<br>•Mississippi Physicians Care Network (MPCN)<br>•Magnolia Regional Health Center (MRHC)<br>•North Mississippi Health Services (NMHS)<br>•Oschner Health System (OCH)<br>•Premier Health (SRMC)<br>•University of Mississippi Medical Center (UMMC)<br><br>Delegation agreements were provided for each of Molina's delegates. The agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations. |
| 2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions. | | | X | | | Processes and requirements for delegation of services and activities are found in various policies that address topics such as pre-assessment audits, delegation requirements, performance monitoring and annual oversight, and corrective action and/or termination of delegation agreements. Policy DO005, Credentialing Delegation Requirements, does not address site visits for providers credentialing by delegated credentialing entities nor does it address collection of fingerprints for CHIP providers designated as high risk by DOM. As noted in the Provider Services section of this EQR, Molina has not yet finalized processes for office site visits or collection of fingerprints at initial credentialing for applicable providers. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | N/A | Not Evaluated | |
| | | | | | | As confirmed during onsite discussion, Molina's Healthcare Delegation Oversight team conducts annual oversight and ongoing monitoring for each of its delegates. Documentation of monitoring and oversight activities was submitted. The documentation revealed appropriate metrics are reviewed for claims, UM, call centers, etc. File review worksheets for credentialing delegates include most of the required credentialing elements; however, the tools do not include an indication that the delegate is monitored for conducting site visits or collecting fingerprints for CHIP providers designated as high-risk by DOM. Based on the findings of the current EQR, it is evident that Molina did not address or correct the findings from the 2020 EQR.<br><br>*Corrective Action: When the processes for conducting initial credentialing site visits for both CAN and CHIP providers and collecting fingerprints at initial credentialing for CHIP providers designated as high risk by DOM are finalized, ensure that Policy DO005, Credentialing Delegation Requirements, is updated to include whether the delegates or Molina itself will be responsible for these activities for providers who are credentialed by delegated credentialing entities. If the credentialing delegate is responsible for these activities, ensure delegated credentialing file review worksheets include evidence that the delegate is monitored for these activities and that credentialing files include evidence of this.* |