CCME

2022 External Quality Review

MOLINA HEALTHCARE OF MISSISSIPPI

Submitted: December 2, 2022

Prepared on behalf of the
Mississippi Division of Medicaid

Table of Contents

EXECUTIVE SUMMARY

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

The goals of the review were to:

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

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

Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements 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 quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration

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

Molina strives to ensure quality services to members, both directly and indirectly, by implementing and reviewing policies and procedures annually. The Policy and Procedure Committee collaborates with department leadership to implement policies that comply with state and federal laws, regulations, and contractual requirements.

Staffing is sufficient to ensure health care products and services required by the State of Mississippi are provided to members. In-state and out-of-state positions are clearly denoted on Molina's Organizational Chart.

The Molina Healthcare, Inc. 2022 Compliance Work Plan guides activities to increase awareness of the compliance program through continued education. The role of the Compliance Officer and Compliance Committee is clearly identified in Molina's committee materials reviewed.

Molina's policies address processes and requirements for ensuring the privacy and confidentiality of Protected Health Information (PHI). Molina obtains the written authorization of the member or authorized representative to use and disclose member information when necessary.

A review of Molina's documentation found that is has infrastructure capable of meeting DOM contractual requirements, as well as information system requirements. ISCA documentation indicates the organization's personnel and systems have the capabilities to perform the Medicaid processing required by DOM. One notable area 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. The organization has an extensive Disaster Recovery plan that is tested and updated.

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 Medical Director has overall responsibility for credentialing processes and chairs the Professional Review Committee (PRC), which serves as the Credentialing Committee. The PRC reports to the Quality Improvement Committee (QIC) and meets at least quarterly. The PRC transitioned to a regional model in February 2022, and membership includes practitioners with a variety of specialties. Molina has established policies and procedures for initial credentialing and recredentialing of practitioners and organizational providers. However, this review found that Molina has not corrected deficiencies identified during the previous EQR related to conducting initial credentialing site visits. Further, Molina staff confirmed that initial credentialing site visits have not been conducted for any providers in the time Molina has had network providers in Mississippi. This is the third consecutive year this finding has been noted. Molina did implement a process to ensure collection of fingerprints from applicable CHIP providers in response to Corrective Action from the previous EQR.

Geographic access standards are defined in policies and are compliant with contractual requirements. Molina evaluates the geographic adequacy of its network by running quarterly Geographic Access assessments, and the most recent Geographic Access assessment confirmed appropriate parameters were used. Molina's Access to Care policy (MHMS-QI-006) defines appointment access standards and indicates appointment and after-hour accessibility audits are conducted for Primary Care Providers (PCPs), high volume/high impact specialists, and behavioral healthcare practitioners. The policy does not define the frequency of the audits or who conducts the audits. The policy contained an incorrect appointment access standard for specialist appointments. Also, inconsistencies in appointment access timeframes were noted when comparing the policy to additional documents, including the CAN and CHIP Member Handbooks and CAN and CHIP Provider Manuals. In addition to Geographic Access assessments, Molina considers member complaints, grievances, out of network requests, etc., when evaluating network adequacy. Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients.

Molina has established processes to ensure its network can meet the cultural and linguistic needs of members by collecting practitioner demographic and language data, language services offered by provider practices, languages spoken by providers, and assessing the network against member race/ethnicity and language information. Molina also analyzes complaints related to member cultural and linguistic needs.

Appropriate processes are in place for initial and ongoing provider education that are based on CCO processes and procedures, state and federal regulations, and accrediting

body standards. Provider education is conducted through onsite provider visits, regional workshops, bulletins, newsletters, webinars, mailings, website updates, and Provider Manuals. The CAN and CHIP Provider Manuals are comprehensive and include links to listings of covered benefits on Molina's website. Review of the benefit information available using the links revealed errors in documentation related to the limitations for home health services (CAN) and the limitations and requirements for Radiology/X-ray services (CHIP). The CAN Provider Manual did not include information about the Pain Safety Initiative that was found in the CHIP Provider Manual.

Network providers are educated about medical record documentation and maintenance standards. Molina policy addresses processes for evaluating provider compliance with the medical record documentation and maintenance standards. However, Molina confirmed a medical record audit has not been conducted and an audit is planned for Q2 2023.

Molina's provider satisfaction survey was administered by SPH Analytics using a sample size of 1,500 providers. A total of 164 surveys was collected for a response rate of 10.9%. This is higher than the 2020 rate of 7% but is below the National Committee for Quality Assurance (NCQA) target rate of 40%. Improvement was noted for overall satisfaction, pharmacy, coordination of care, utilization, and quality management composite scores. Results were presented to the Member & Provider Satisfaction Committee in March 2022 and to the QIC in April 2022.

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 found on Molina's website, in the Member Handbooks, and in Policy MHMS-ME-003, Member Rights and Responsibilities. The New Member Welcome Packet is provided within 14 days after Molina receives the member's enrollment data from DOM. The packet includes all contractually required information, such as an introduction letter, ID card, Member Handbook, and instructions to access the Provider Directory.

Information for prior approval requirements for medical, behavioral health (BH), and pharmaceutical services is included in the CAN and CHIP Member Handbooks. Page 38 of the CAN Member Handbook indicates Home Health Services have no limit on the number of visits, however; the list of covered benefits on the website indicates a limit of 25 visits per year. DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year. For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to location (as noted in benefit information on Molina's CHIP website) and states prior authorization is required for these services. Onsite discussion with Molina staff indicated prior authorization is required only for advanced imaging services and not for routine X-rays.

The CAN and CHIP Member Handbooks indicate members are informed of changes to programs and benefits 30 calendar days prior to implementation. Information on the appropriate level of care for a routine, urgent, or emergent health care needs for medical, dental, and behavioral health services is clearly outlined in the Member Handbooks and on Molina's website.

Molina defines grievance processes and requirements in Policy MHMS-MRT-01, Member Complaints and Grievances. Information about grievance requirements and processes are found in the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and on Molina's website.

Policy MHMS-MRT-01, Member Complaints and Grievances, includes the process followed if Molina needs to request an extension for resolving a grievance. The policy does not mention allowing the member the right to file a grievance if they disagree with the request for the extension. The grievance notice sent to CAN members when Molina has requested an extension does notify the member of their right to file a grievance if they disagree with the extension.

The CAN and CHIP grievance files reflect staff acknowledged the grievances consistently, resolve grievances within the required timeframe, and notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files.

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.

For the Adult CAHPS, the response rate was low, at 10.2% (137 out of 1344). This was lower than last year's response rate of 10.3% and lower than the SPH average response rate of 14.8%. Getting Needed Care and Customer Service rates improved, as well as the rating of health care, doctor communication, and rating of personal doctor. Other domains showed a decline. The child survey also showed a low response rate of 7.3% (375 out of 5161). This rate was lower than last year's rate of 10.2% and lower than the SPH average response rate of 12.8%. The Getting Need Care and the Rating of Health Care rates improved. The Rating of Health Plan, Customer Service, Getting Care Quickly, and all other domains declined. The largest decline was Coordination of Care.

Quality Improvement

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

Molina submitted the 2022 Quality Improvement Program Description for review. This Program Description is updated annually and submitted to the QIC for approval. Molina

provides information to members and providers about the QI Program via the website. The website contains information regarding the 2021 Healthcare Effectiveness Data Informational Sheet (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates, and links for guides regarding Accessing Quality Health Care. The guide provided for CAN members titled "Guide to Accessing Quality Health Care" appears to be out of date—it is dated 2020. However, the guide provided for CHIP members was dated 2022.

Molina submitted the 2021 and 2022 CAN and CHIP Work Plans for review. The Work Plans clearly document planned activities, responsible parties, timelines, action plans or benchmark goals, and the status of each activity. The Work Plan is updated on a quarterly basis. In the 2022 Work Plan, Section 5 – Availability of Practitioners, the standards used to measure geographic distribution of PCPs were incorrect and did not meet contractual requirements.

Molina's QIC is responsible for the implementation and ongoing monitoring of the QI activities. This committee is also responsible for the development of the QI Program Description, Work Plans, and the QI Program Evaluation.

Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby and Well-Child Services, address EPSDT and Well-Baby Well-Child services, how Molina tracks services, and follow-up with members who have not received or are behind in getting services. These policies also include the process followed for tracking follow-up treatment and referrals. Per Policy QI-003 and QI-005, follow-up activities are to be documented on the EPSDT and Well-Baby Well-Child tracker. Molina provided copies of these tracking reports; however, these reports did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs and not corrected.

CCME received the 2021 QI Program Evaluation. This QI Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. This continues to be an issue and was identified in the 2020 and 2021 EQRs and not corrected.

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. PM validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS® measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted the validation following the CMS-developed protocol for validating PMs. The final PM

validation results reflected the measurement period of January 1 through December 31, 2021.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Molina's NCQA-licensed organization. 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) 2021.

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

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Childhood Immunization Status (cis)			
DTaP	59.12%	69.34%	10.22%
Pneumococcal Conjugate	57.18%	68.13%	10.95%
Asthma Medication Ratio (amr)			
12-18 Years	54.55%	65.28%	10.73%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	36.59%	59.02%	22.43%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	25.24%	42.33%	17.09%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	16.5%	33.13%	16.63%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	28.47%	46.88%	18.41%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	18.75%	31.7%	12.95%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	49.12%	67.95%	18.83%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	25.65%	37.32%	11.67%
Blood Glucose and Cholesterol Testing (1-11)	8.38%	19.62%	11.24%

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Well-Child Visits in the First 30 Months of Life (W30)			
15 Months-30 Months	51.23%	62.67%	11.44%
Substantial Decrease in Rate (>10% decrease)			
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	52.05%	30.61%	-21.44%
Continuation and Maintenance (C&M) Phase	60.66%	38.46%	-22.20%

The CHIP HEDIS rates were also compared. *Table 2: CHIP HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with a substantial increase in rate from 2020 to 2021. No measures were noted to have a substantial decrease.

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Childhood Immunization Status (cis)			
VZV	81.01%	91.22%	10.21%
Combination #3	58.86%	69.12%	10.26%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (12-17)	48.65%	62.96%	14.31%
Cholesterol Testing (12-17)	22.97%	35.19%	12.22%
Blood Glucose and Cholesterol Testing (12-17)	21.62%	33.33%	11.71%
Annual Dental Visit (adv)			
2-3 Years	41.74%	52.63%	10.89%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	59.46%	74.36%	14.90%
Total	50.82%	67.19%	16.37%
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	64.05%	78.38%	14.33%
15 Months-30 Months	58.82%	74.50%	15.68%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2021 and the previous year (2020). The changes from 2020 to 2021 are reported in the table that follows. There were no rates that showed a substantial (>10%) improvement. The rates shown in red indicate substantial (>10%) decline.

Table 3: CAN Non-HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Decrease in Rate (>10% decrease)			
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	54.93	37.26	-17.67
Total	54.92	37.25	-17.67

For the CHIP non-HEDIS measures, there were several measures not reported by Molina or not enough data was available for reporting. None of the measures that could be compared showed a substantial increase or decrease.

The validation of the 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 project methodology.

For this review, Molina submitted the same seven CAN PIPs that were submitted for the 2021 EQR. The PIP topics include Behavioral Health Readmissions, Asthma, Pharmacotherapy Management of COPD Exacerbation, Follow-up 7 and 30 Days after Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 4: Behavioral Health Readmissions CAN 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 a decline in readmissions from Q1 2022 at 24.4% to Q2 2022 at 15%. The goal is 14%. The enrollment in high-risk case management for unique readmitted patients is reported to be 100%.	
Previous Validation Score	**Current Validation Score**

Behavioral Health Readmissions	
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Community connectors • Primary care initiative • Scheduling process changed • Onsite discharge planning • Transition of Care letters sent to members • Patient Outreach	

Table 5: Asthma Medication Ratio CAN 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 declined from 81.4% to 72.3% but is still above the goal rate of 71.3%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Asthma education video on proper use of the inhaler • Monitoring of the non-compliant members and encourage providers to contact members to close the gap in care • Telephone call campaign to encourage members to get their annual wellness exams • Provider toolkits and educational materials • Member educational materials	

Table 6: Pharmacotherapy Management of COPD Exacerbation CAN 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. For systemic corticosteroid, the rate improved from 36.4% to 46.3% with a goal of 67%. The bronchodilator rate improved from 54.6% to 71.6% with a goal of 81.8%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Pharmacotherapy Management of COPD Exacerbation (PCE)
• Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products. • 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 7: Follow-up 7 and 30 Days after Hospitalization for Mental Illness CAN 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 24.24% to 30.22%. The goal rate is 28.32%. For 30-day follow up, the rate also improved from 31.8% to 49.1% with a goal of 50%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• TOC Coaches: Once notified of assigned admitted members, the TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan. • Discharge planning checklist • Processes to improve efficiency of scheduling follow-up appointments • Provider Education	

Table 8: Prenatal and Postpartum Care CAN 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 the percentage of deliveries that had a postpartum visit on or between 21-56 days of delivery. For prenatal care, the rate improved from 90.2% to 90.4% with a goal of 93.6%. The post-partum rate improved from 34.7% to 42% with a goal of 74.3%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member incentives-Gift cards and car seats • Member outreach events • Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize electric breast pump for the first 6 months of their child's life.	

Table 9: Sickle Cell Disease CAN 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 declined from 7.5% to 4% with a goal of 15.9%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Internal monitoring and tracking for inpatient care and ED visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration: 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. • Member educational materials	

Table 10: Obesity CAN PIP

Obesity	
The Obesity PIP focuses on the child population. The BMI percentile, Nutrition, and Counseling HEDIS rates are utilized. For BMI Percentile, the rate went from 9.7% to 17.1% with a goal of 61.3%. The nutrition rate went from 4.3% to 8.1% with a goal of 52.3%. The counseling rate improved from 4.1% to 7.9% with a goal of 57.4%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member Incentives • Member outreach and member events for awareness and education	

This year, Molina submitted the same four CHIP PIPs that were submitted last year. The topics included Adolescent Well Care/Well Child, Asthma Medication Ratio, Obesity, and Follow-up After Hospitalization for Mental Illness. All the CHIP PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each project's status and the interventions is also included.

Table 11: Well Care/Well Child CHIP 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 six or more well care/well child visits during the first 0-15 months of life. The baseline rate was 42.59% with a goal of 55.79%. The most recent rates were 57% in Q1 and 60.33% in Q2. The last four rates have been above the goal rate.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Provider education with periodic face-to-face visits offering HEDIS toolkits, non-compliant member list, provider portal training and HEDIS Tip Sheets for well visits. • Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale. • Member incentives provided on the day of the screening.	

Table 12: Asthma Medication Ration CHIP 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 rate was presented at 84.5% with a goal of 71.28%. The last two rates are also above the goal rate with a rate of 81.82% in Q1 and 88.15% in Q2.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of the inhaler • Telephone campaigns to encourage members to get their annual wellness exams • Provider education with toolkits and assistance with member outreach	

Table 13: Obesity CHIP PIP

Obesity- Ages 3 to 19
The Obesity PIP aims 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 BMI documentation rate improved from 9.36% in Q1 to 15.28% in Q2. The goal rate is 61.31%. The nutrition counseling rate also improved from 4.36% to 8.43% with a goal of 52.3%. Counseling for physical activity improved from 3.89% to 8.11% with a goal of 57.42%. The BMI percentile goal is 61.31%; the Nutrition goal rate is 52.31%; and the physical activity counseling goal is 57.42%.

Obesity- Ages 3 to 19	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider toolkits to help facilitate tracking reports and address areas needed • Member education, community outreach, and incentives	

Table 14: Follow-up After Hospitalization for Mental Illness CHIP 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 improved from 31.25% in Q1 2022 to 62.5% in Q2 2022. The goal is 50%. The 7-day baseline rate improved from 12.5% to 35.4%-, which is over the goal of 28.32%.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care collaborative on-site discharge planning • Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation • Implementation of a Discharge Planning Checklist • Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge	

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 Molina's CAN and CHIP Utilization Management (UM) Programs included the Health Care Services Program Description, pharmacy description, relevant policies, clinical determination process, Member Handbooks, Provider Manuals, and a sample review of approval, denial, and care management files.

Molina's Chief Medical Officer (CMO) has authority and oversight responsibility of the UM Program. The Behavioral Health Medical Director and Pharmacy Director provide clinical oversight of their respective programs and collaborative efforts occur as needed with the CMO.

Licensed and qualified clinical staff utilize external and internal guidelines such as Milliman Clinical Guidelines (MCG) and state guidelines when making UM determinations. Initial clinical reviews are conducted by Mississippi licensed clinicians and Level II Clinical Reviews are performed by Mississippi licensed physicians or appropriate healthcare practitioners. The Pharmacy Services Program Description indicates licensed pharmacists issue pharmacy determinations.

The 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. Information regarding the process for filing an appeal was also found in the Can and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and on Molina's website. These documents incorrectly inform the member that a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification template.

Policy and Procedure MHMS-MRT-02, Standard Member Appeals, and Policy and Procedure MHMS-MRT-03, Expedited Member Appeals, correctly documents the resolution timeframe for standard and expedited appeals. Both policies include the process followed if the member or Molina requests more time to complete the review. However, these polices do not include the member's right to file a grievance if they disagree with this extension. Also, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and Molina's website do not include the member's right to file a grievance if they disagree with the extension.

Overall, the review of CAN and CHIP appeals files reflected Molina consistently processes standard and expedited appeal requests according to guidelines in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Two CAN files and three CHIP files were not processed following the guidelines.

As explained in the 2021 HCS Annual Evaluation Executive Summary and Molina Healthcare Program Description, annual Inter-rater Reliability Testing is conducted for physicians, nurses, pharmacists, and Behavioral Health Medical Directors. Quarterly testing is conducted for Behavioral Health Clinical staff. Also, monthly audits are conducted to ensure consistency and quality assurance of clinical application for UM reviewers.

Molina's Healthcare Integrated Care Management Program provides physical and behavioral health care coordination for members. Additionally, Molina's Health Management Program focuses on enhancing disease prevention education, health promotion, and enhanced disease management as described in the Healthcare Services Program Description and Quality Improvement Program Description. Members are stratified through various data driven methodologies. During onsite discussion, Molina indicated members are stratified and re-stratified monthly through a predictive modeling

tool that analyzes several factors such as social determinants of health, claims, admissions, clinical notes, etc.

Qualified staff complete a Health Risk Assessment (HRA), after which an Individualized Care Plan is developed within 30 days. The care manager, member, guardian (if applicable), and any applicable interdisciplinary team members complete the Individualized Care Plan. Members receive specified care management services according to their risk level.

Delegation

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

Molina implements written agreements with each delegate using the Molina Healthcare of Mississippi, Inc. Delegation Services Addendum (DSA) document. The DSA specifies the activities that are being delegated and corresponding requirements. It includes general terms and conditions of the delegation, related to policies and procedures, pre-delegation assessment, ongoing monitoring and assessment, requirements for sub-delegation, reporting requirements, audits, compliance, and confidentiality. Information in the DSA addresses actions that may be taken for substandard performance by the delegate, which may include corrective action and/or revocation of delegation.

As noted in Policy DO001, Delegation Pre Assessment Audits, all potential delegates are subjected to a pre-delegation assessment to determine the delegate's ability to meet established criteria for the functions being delegated. Pre-delegation assessments are presented to the Delegation Oversight Committee (DOC) for review and determination. Processes for conducting ongoing monitoring and evaluation of delegates for continued compliance with all required standards are documented in Policy DO002, Performance Monitoring and Annual Audits of Delegation. Annual audits include a sample file review, when applicable. Upon completion of the annual evaluation, Delegation Oversight staff finalize audit summaries and worksheets, including Corrective Action Plans if necessary. The finalized documents are presented to the DOC for review and a determination regarding continued delegation.

Issues noted in the documentation of delegate oversight included lack of documentation of pre-delegation assessment for CVS/Caremark and failure to monitor credentialing delegates to whom initial credentialing site visits are delegated for conducting the site visits. The issue related to monitoring applicable vendors for conducting site visits is an uncorrected deficiency from the previous EQR.

Quality Improvement Plans and Recommendations from Previous EQR

For the previous EQR, six standards were scored as "Partially Met" and two standards were scored as "Not Met" for CAN. Eight standards were scored as "Partially Met" and

two standards were scored as "Not Met" for CHIP. The following is a high-level summary of those deficiencies:

- For CAN and CHIP, Molina reported that a process for conducting initial credentialing site visits had not been established, which is a repeat finding from the previous EQR.
- For CHIP, none of Molina's policies or addenda addressed the requirement for obtaining fingerprints for CHIP providers designated as high risk by DOM. This was a repeat finding from the previous EQR.
- For CAN, the review of credentialing and recredentialing files revealed issues related to conducting initial site visits. For CHIP, the files revealed issues related to fingerprinting for CHIP providers designated as high risk by DOM (a repeat finding from the previous EQR).
- The printed Provider Directories for CAN and CHIP did not include all required elements.
- The Standards of Medical Record Documentation policy did not provide detailed information about procedures for assessing provider compliance with medical record documentation standards (CAN and CHIP).
- Policies did not address how Molina tracks provider or member compliance with treatments or referrals needed for abnormal conditions identified through the EPSDT (CAN) and Well-Baby and Well-Child (CHIP) services, and the tracking reports did not include the treatment and/or referrals made for any abnormal findings. These were issues that were identified during the previous EQR.
- For CAN and CHIP, the Quality Improvement Program 2020 Annual Evaluation did not include 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.
- Issues were noted with documentation of requirements for extensions of authorization timelines in the Timeliness of UM Decision Making and Notification policy (CAN and CHIP).
- Policy MHMS-MRT-02, Standard Member Appeals, indicated it applied to both CAN and CHIP. However, it did not include documentation about the process for CHIP members to request an Independent External Review.
- Documentation of Molina's processes for addressing continuity of care when CAN and CHIP members disenroll from the health plan could not be identified.

- The CAN and CHIP Credentialing Delegation Requirements policy did not address site visits for providers credentialing by delegated credentialing entities. For CHIP, the policy did not address collection of fingerprints for CHIP providers designated as high risk by DOM.
- CAN and CHIP file review worksheets for credentialing delegates did not include an indication that delegates are monitored for conducting site visits at initial credentialing. For CHIP, the worksheets did not indicate the delegate is monitored for collecting fingerprints for CHIP providers designated as high-risk by DOM.

Following the 2021 EQR, Molina submitted its response to the Corrective Action Plan on January 31, 2021. Additional documentation was submitted on February 23, 2022, and March 21, 2022. The Corrective Action Plan was accepted on March 22, 2022. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Corrective Action Plans were not implemented for initial credentialing site visits, monitoring to ensure applicable credentialing delegates are conducting site visits, documentation of tracking and follow-up of issues found during EPSDT/Well Baby and Well Child services, and including results or status of all QI activities in the QI Program Evaluation. **Of note, all of these issues have been identified in each of the three consecutive EQRs conducted for Molina.**

Conclusions

Molina meets some of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 15: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Molina's compliance scores relative to each of the 11 Subpart D and QAPI standards above.

Table 15: Compliance Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Molina CAN and CHIP	
			Number of Standards Scored as "Met"	2022 Overall Score
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)	Provider Services, Section II. B	18	14	77.7%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	36	36	100%

Category	Report Section	Total Number of Standards	Molina CAN and CHIP	
			Number of Standards Scored as "Met"	2022 Overall Score
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	26	26	100%
Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	77	73	94.8%
Confidentiality *(§ 438.224)*	Administration, Section I. E	2	2	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Section V. C	40	38	95%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	4	2	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	20	20	100%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	8	8	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	38	34	89%

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

As noted in the table above, deficiencies were noted in the following areas:

- For Availability of Services and Assurances of Adequate Capacity and Services, Molina has not developed and implemented processes to monitor and track provider limitations on panel size to determine providers that are not accepting new patients.
- For Provider Selection, Molina has not developed and implemented a process for conducting initial credentialing site visits. **This is a repeat finding from both the 2020 and 2021 EQRs.**
- For Grievance and Appeal Systems:
    - Molina's Standard Member Appeals and Expedited Member Appeals policies, CAN and CHIP Member Handbooks and Provider Manuals, Molina's website, and additional documents incorrectly state verbal appeals must be followed by signed written appeals.
    - Policy MHMS-MRT-02, Standard Member Appeals, lists the information that must be included in appeal acknowledgement letters. However, the CAN standard appeal acknowledgement letter template does not include the statement of offering a State Fair Hearing or the offering of the one-page "Grievance/Appeal

Form" as mentioned in the policy. The CHIP standard appeal acknowledgement letter template does not include the statement of offering the one-page "Grievance/Appeal Form" as mentioned in the policy.

  - Policy MHMS-MRT-02, Standard Member Appeals, which is applicable for CAN and CHIP, mentions the offering of a State Fair Hearing is included in the acknowledgement letter. However, State Fair Hearings are not available to CHIP members.

- For Sub-contractual Relationships and Delegation, evidence was not provided of pre-delegation assessment for one delegate, and annual evaluation of credentialing delegates to whom site visits are delegated did not include assessing the delegate for conducting the site visits. **This is a repeat finding from both the 2020 and 2021 EQRs.**

- For Quality Assessment and Performance Improvement Program:
  - CAN Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, addresses EPSDT services, how Molina tracks services, and follow-up with members who have not received or are behind in getting services. This policy also includes the process followed for tracking follow-up treatment and referrals. Per the policy, follow-up activities are to be documented on the EPSDT tracker. Molina provided the EPSDT tracking report, but the report did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. **This was an issue previously identified in both the 2020 and 2021 EQRs for CAN.**
  - For CHIP, Policy MHMS-QI-005, Well-Baby and Well-Child Services, did not include Molina's process for tracking treatments or referrals needed for abnormal findings during the Well-Child and Well-Baby service. During the onsite Molina indicated the wrong policy had been uploaded and provided the correct draft policy after the onsite. The process added to policy MHMS-QI-005 indicates follow-up activities will be included on the Well-Baby and Well-Child tracking report. However, the Molina provided the Well-Baby Well-Child tracking report Molina provided did not include the documentation of the follow-up activities. **This was an issue identified in both the 2020 and 2021 EQRs.**
  - The QI Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. Specifically, the omissions were related to results of the appointment access audit completed for PCPs and behavioral health, Geo Access Reports, Provider Directory analysis, and credentialing activities. **This continues to be an issue and was identified in both the 2020 and in the 2021 EQRs.**

Table 16, Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2021 review. For 2022, 212 out of 222 standards received a score of "Met." Four standards were scored as "Partially Met" and six standards were scored as "Not Met."

Table 16: Scoring Overview--CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	Percentage "Met"
Administration							
2021	31	0	0	0	0	31	100%
2022	30	0	0	0	0	30	100%
Provider Services							
2021	81	2	1	0	0	84	96.4%
2022	79	2	3	0	0	84	94%
Member Services							
2021	33	0	0	0	0	33	100%
2022	32	1	0	0	0	33	97%
Quality Improvement							
2021	17	2	0	0	0	19	89.5%
2022	17	0	2	0	0	19	89.5%
Utilization Management							
2021	53	2	0	0	0	55	96.4%
2022	53	1	0	0	0	54	98.1%
Delegation							
2021	1	0	1	0	0	2	50%
2022	1	0	1	0	0	2	50%
Totals							
2021	**216**	**6**	**2**	**0**	**0**	**224**	**96%**
2022	**212**	**4**	**6**	**0**	**0**	**222**	**95.5%**

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

Table 17, Scoring Overview—CHIP, provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2021 review. For 2022, 211 out of 221 standards received a score of "Met." Four standards were scored as "Partially Met" and six standards were scored as "Not Met."

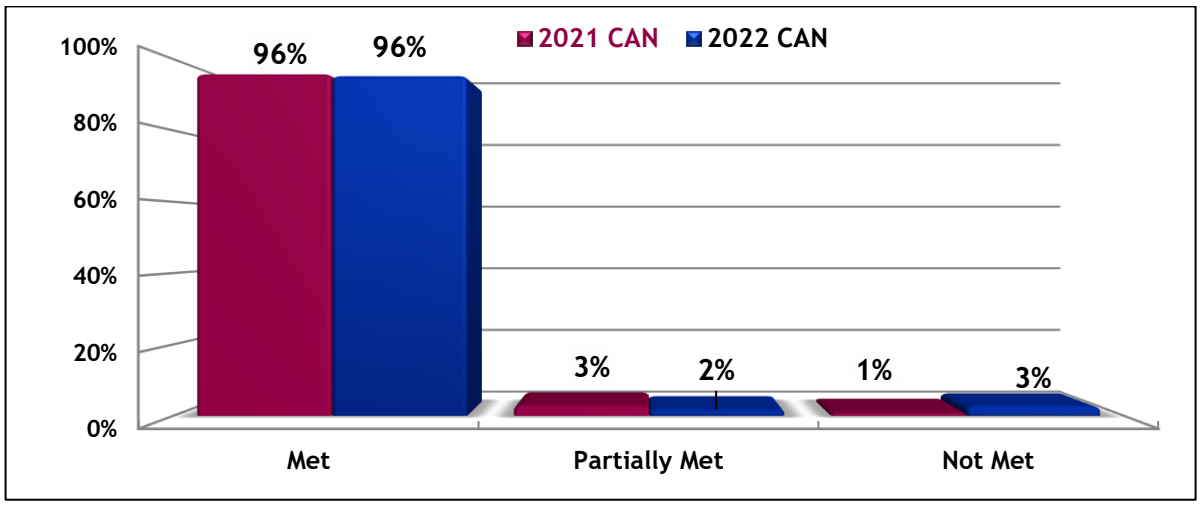
Table 17: Scoring Overview--CHIP

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	Percentage "Met"
Administration							
2021	31	0	0	0	0	31	100%
2022	30	0	0	0	0	30	100%
Provider Services							
2021	78	3	1	0	1	83	95.1%
2022	78	2	3	0	0	83	94%
Member Services							
2021	29	0	0	4	0	33	100%
2022	32	1	0	0	0	33	97%
Quality Improvement							
2021	17	2	0	0	0	19	89.5%
2022	17	0	2	0	0	19	89.5%
Utilization Management							
2021	52	3	0	0	0	55	94.5%
2022	53	1	0	0	0	54	98.1%
Delegation							
2021	1	0	1	0	0	2	50%
2022	1	0	1	0	0	2	50%
Totals							
2021	**208**	**8**	**2**	**4**	**1**	**223**	**95%**
2022	**211**	**4**	**6**	**0**	**0**	**221**	**95.5%**

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

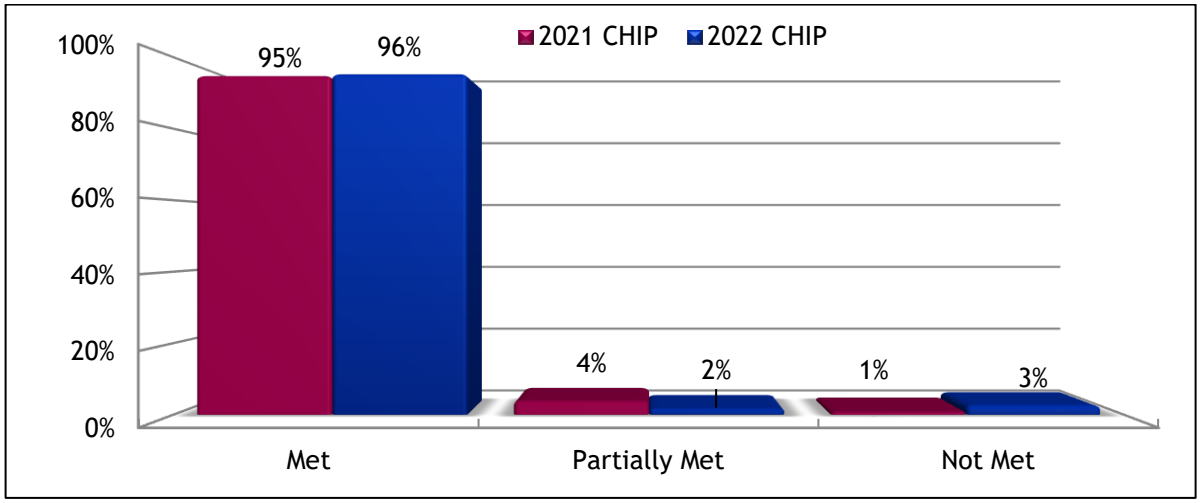
The 2022 Annual EQRs for CAN and CHIP show that Molina achieved "Met" scores for 96% of the standards reviewed. The figures that follow provide a comparison of the current review results to the 2021 review results for both CAN and CHIP.

Figure 1: Annual EQR Review Results for CAN



Scores were rounded to the nearest whole number

Figure 2: Annual EQR Review Results for CHIP



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 18: Evaluation of Quality

Strengths Related to Quality
• Molina formed a Policy and Procedure Committee to ensure the timely review and revision of policies annually. • Molina's website includes provider resources about interpreter services, downloadable cultural competency training information, provider tools, and more. • Initial provider orientation topics are comprehensive and based on applicable state and federal regulations and accrediting body standards. New Provider Orientation documents include information to ensure providers understand health plan operations and requirements. • Molina outlined multiple community outreach initiatives to address areas of need specific to preventive health and chronic disease management and education. • Molina's HEDIS auditor found that the CCO was fully compliant with all information system Standards and determined that Molina 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 measures in the scope of the validation of PMs. • There were several CAN and CHIP HEDIS MY 2021 measure rates were strengths for Molina since their rates had a greater than 10% improvement. • PIP reports included the CMS elements and integrated corrective actions from the previous review • Random case audits occur monthly to monitor the clinical application of medical necessity criteria. • For denial files, the majority of second level reviews were completed by the appropriate physician reviewer on the same day as the initial review.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting appointment and after-hour accessibility audits or the department or entity that conducts the audits.	• Corrective Action: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits.
• The CHIP Provider Manual includes information about Pain Safety Initiative (PSI) Resources and a link for additional information on Molina's website. This information is not included in the CAN Provider Manual. Onsite discussion confirmed this program is applicable to CAN.	• Recommendation: Include information about Pain Safety Initiative (PSI) Resources and a link for additional information on Molina's website in the CAN Provider Manual.
• For the provider satisfaction survey conducted by SPH Analytics, the sample size was 1,500. SPH Analytics collected 164 surveys, which is a response rate of 10.9%. This is higher than the 2020 rate of 7% but remains below the NCQA target rate of 40%.	• Recommendation: Determine if there are additional methods to increase provider satisfaction survey response rates.
• The CAN Member Handbook, page 38, indicates Home Health Services have no limit on the number of visits. However, benefit information on Molina's CAN website does list a limit on the number of visits.	• Corrective Action: Correct the number of visits allowed for Home Health Services in the CAN Member Handbook.
• For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to location (as noted in benefit information on	• Corrective Action: Revise the benefit information in the CHIP Member Handbook to provide complete and correct information about restrictions on

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
Molina's CHIP website) and states prior authorization is required for these services. Onsite discussion with Molina staff indicated prior authorization is required only for advanced imaging services and not for routine x-rays.	location and prior authorization requirements for Radiology/X-ray services.
• Molina provides information to members and providers about the QI Program via the website. The website contained information regarding the 2021 HEDIS and CAHPS rates, and links for guides regarding Accessing Quality Health Care. The guide provided for CAN members titled "Guide to Accessing Quality Health Care" appears to be out of date. The guide is dated 2020. However, the guide provided for the CHIP members is dated 2022.	• Recommendation: Update the information provided to CAN members on Molina's website regarding quality guides.
• In the 2022 QI Work Plan, Section 5 - Availability of Practitioners, the standards used to measure the geographic distribution of Primary Care Practitioners were incorrect and do not meet contractual requirements.	• Recommendation: Correct the standards used to measure geographic distribution of PCPs in the 2022 QI Work Plan.
• The QIC Charter defines a quorum as at least 51% of committee members with no less than half of Community Network Provider participants necessary to enact and/or implement decisions. It was noted that the 1st Quarter 2022 meeting did not have a quorum present. Molina pointed out this was an error in the minutes.	• Recommendation: Ensure attendance is documented correctly for each committee meeting. Correct the QIC 1st Quarter 2022 meeting minutes to demonstrate the committee members present and that the quorum requirements were met.
• Molina is not tracking member follow-up treatment and referrals needed when an abnormal finding on an EPSDT and Well-Baby Well-Child exam as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)*. This was an issue identified during the 2020 and 2021 EQR and not corrected.	• Corrective Action Plan: To ensure compliance with the *CAN* and *CHIP Contracts*, implement a system for tracking members identified with an abnormal finding on an EPSDT exam that includes the diagnosis, treatments, and referrals needed to address the abnormal findings as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)*.
• The 2021 QI Program Evaluation was incomplete and did not contain the results or status of all QI activities completed or underway in 2021 as required by the *CAN Contract, Section 10 (D) (8)* and the *CHIP Contract, Section 9 (D) (8)*. This continues to be an issue and was identified in the 2020 and in the 2021 EQR and not corrected.	• Corrective Action Plan: Correct the 2021 Quality Improvement Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the *CAN Contract, Section 10* and *Exhibit G* and the *CHIP Contract, Section 9*, and *Exhibit F*.
• Several CAN and CHIP HEDIS MY 2021 measure rates and non-HEDIS Adult Core Set measure rates were determined to be areas of opportunities for Molina since their rates had a greater than 10% decline.	• Recommendation: Work proactively with DOM for clarification on measures that are required to be reported as well as work with the Molina corporate teams to ensure the list of measures required for reporting are provided. Improve processes around calculation, reporting, and verification of the rates reported for the DOM required Adult and Child Core set measures.
• Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information.	• Recommendation: Include a reference to the *CHIP Contract, Section 8 (A)* in the Source of Decision for Policy 154.01, Individualized Care Development Procedure Addendum.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Policy DO002, Performance Monitoring and Annual Audits of Delegation, states Molina ensures continued compliance with delegation standards through ongoing monitoring and annual audits. CCME reviewed the delegate oversight documents provided by Molina. The following issues were identified: ○ For CVS/Caremark, documentation included reports of routine monitoring and delegate reporting, but no documentation of a pre-delegation assessment was provided. The date of initial delegation was noted by the CCO as 10/1/21. ○ For March Vision Care, the credentialing file review worksheet did not include evidence of monitoring the delegate for conducting initial site visits. The documentation indicated site visits are delegated to March Vision Care, and the health plan policy is that an initial credentialing site visit is to be conducted for all delegates. This is a repeated finding from the previous EQR.	• Corrective Action Plan: Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained. • Corrective Action Plan: When site visits are delegated to a credentialing delegate, ensure they are monitored for conducting the site visits according to health plan policy.

Table 19: Evaluation of Timeliness

Strengths Related to Timeliness
• 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%. • The CAN and CHIP grievance files reflect staff acknowledged the grievances consistently, resolve grievances within the required timeframe, and grievant notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files. • Utilization Management Decisions are processed in a timely manner.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
• Policy MHMS-MRT-01, Member Complaints and Grievances, includes the process followed if Molina needs to request an extension for resolving a grievance. The policy does not mention allowing the member the right to file a grievance if they disagree with the request for the extension.	• Recommendation: Include in Policy MHMS-MRT-01, Member Complaints and Grievance, the member right to file a grievance if they disagree with Molina's request for an extension for resolving the grievance.
• Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals, do not include the member's right to file a grievance if they disagree with Molina's request for an extension. Also, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and Molina's website do not include the member	• Recommendation: Include in policy, the Member Handbooks, Provider Manuals and on Molina's website, the members right to file a grievance if they disagree with Molina's request for an extension.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
right to file a grievance if they disagree with the extension.	
• Page 57 of the CHIP Member Handbook provides information regarding the continuation of benefits while an Independent External Review. However, the timeframe for requesting the continuation of benefits is not mentioned.	• Recommendation: Update the CHIP Member Handbook and include the timeframe for requesting the continuation of benefits during Molina's appeal process and during the Independent External Review process.

Table 20: Evaluation of Access to Care

Strengths Related to Access to Care
• The Molina Healthcare of Mississippi Fraud, Waste, and Abuse Plan effectively outlines their process for detecting, preventing, investigating, and reporting of potential health care fraud, waste, and abuse. • Molina routinely monitors the geographic adequacy of its network using appropriate geographic access standards and considers additional factors such as member complaints, grievances, and out of network requests. • Molina outlined multiple community outreach initiatives to address areas of need specific to preventive health and chronic disease management and education.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Molina is not following processes defined in the Addendum to Policy CR 01, Credentialing Program Policy, for conducting initial site visits of private practitioner offices and other patient care settings at initial credentialing, when the provider location has changed, and when a complaint has been lodged against a specific provider (within 60 days of the complaint). The plan reported that no site visits have been conducted for any providers in the time Molina has had network providers in Mississippi. This is the third consecutive year this finding has been noted. • None of the CAN and CHIP initial credentialing files included evidence of site visits at initial credentialing.	• Corrective Action Plan: To comply with requirements in the *CAN Contract, Section 7 (E) (3)* and the *CHIP Contract, Section 7 (E) 3*, develop a work plan/schedule immediately for completing the site visits for all providers for whom Molina has completed the credentialing process. Conduct site visits for all applicable providers.
• Molina has not implemented a process to track and monitor provider limitations on panel size to determine providers that are not accepting new patients.	• Corrective Action Plan: Develop and implement a process to monitor provider panel limitations to ensure members have appropriate choice among providers.
• Policy MHMS-QI-006, Access to Care, lists an incorrect timeframe of 20-30 calendar days for specialist appointments. The *CAN Contract, Section 7 (B) (2)* and *CHIP Contract, Section 7 (B) (2)* states the timeframe is "Not to exceed 45 calendar days." • Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents:	• Corrective Action Plan: Correct the timeframe for specialty appointments in Policy MHMS-QI-006, Access to Care. • Corrective Action Plan: Revise the applicable CAN and CHIP Member Handbooks and/or CAN and CHIP Provider Manuals to reflect the correct appointment access standards for PCP well care appointments, PCP routine sick appointments, specialist

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
○ For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but page 36 of the CAN Member Handbook and page 37 of the CHIP Member Handbook list the requirement as 21 days for adults and 14 days for children. ○ For PCP routine sick appointments, the policy correctly lists the timeframe as seven calendar days, but page 35 of the CAN Member Handbook lists the requirement as 14 days. ○ For specialist appointments, the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)* state the timeframe is 45 calendar days, but the CAN Member Handbook, page 36 and the CHIP Member Handbook, page 37 list the timeframe as 21 days. ○ For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CAN Provider Manual, page 60, and the CHIP Provider Manual, page 76, state the timeframe is 14 days. • The CAN Provider Manual and the CHIP Provider Manual do not include the appointment access requirements for routine and urgent dental appointments.	appointments, and Behavioral Health/Substance Use routine appointments. • Corrective Action Plan: Add the appointment access standards for routine and urgent dental appointments to the CAN and CHIP Provider Manuals.
• A link in the CAN Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Home Health Services, the list of covered benefits on the website link indicates a limit of 25 visits per year. However, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year.	• Corrective Action Plan: Revise the CAN benefit information on the website to provide complete and correct information about the number of visits allowed for home health services.
• A link in the CHIP Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Radiology/X-rays, the list of covered benefits on the website link indicates these services must be conducted in a physician's office or hospital outpatient department. However, the CHIP Member Handbook, page 40, does not include the restriction to location.	• Corrective Action Plan: Revise the CHIP benefit information on the website to provide complete and correct information about restrictions on location requirements for Radiology/X-ray services.
• Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and Molina's website incorrectly inform the member that a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification template.	• Corrective Action Plan: Remove the requirement that a member must follow-up a verbal request for an appeal with a written request from Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals, the CAN and CHIP Member Handbooks, CAN and CHIP Provider Manuals, the appeal request forms, and on Molina's website.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Policy MHMS-MRT-02, Standard Member Appeals, includes the information that is included in the acknowledgement letter. However, the CAN and CHIP standard appeal acknowledgement letter template does not include the statement offering a State Fair Hearing, which is not applicable for CHIP, or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy.	• Corrective Action Plan: Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.
• Two CAN files and three CHIP files were not processed following the Appeal policies and guidelines.	• Recommendation: Reeducate staff to ensure complete understanding that a verbal request for an appeal no longer requires the member to follow-up that request with a written request. Also, improve the documentation in the appeal files regarding Molina's need to request an extension for resolution. • Recommendation: Reeducate staff to ensure complete understanding regarding when member consent is needed for appeal requests. Develop a quality check process before resolutions notices are sent to ensure the correct notices are sent to CHIP members. Also, develop a process for handling appeals when staff are on PTO to ensure timeframes are met and members are allowed the full timeframe for submitting additional information.

METHODOLOGY

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

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

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 July 24, 2022, for review at the CCME offices (see *Attachment 1*). The second segment was a virtual onsite review conducted on October 19, 2022, and October 20, 2022. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Molina's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*, and the Contract requirements between 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 Healthcare strives to ensure quality services are provided to members by implementing and reviewing policies and procedures annually. A Policy and Procedure Committee collaborates with department leadership to implement policies that include state and federal laws, regulations, and contractual requirements. Policies are forwarded to DOM for final approval and then stored in SharePoint for convenient staff access.

A review of the Organizational Chart found that staffing is in place to ensure health care products and services required by DOM are provided to members. Mississippi-based and non-Mississippi based positions are clearly denoted. An interim Member and Provider Contact Center Manager is in place until the recently vacated position is filled.

Molina increases awareness of fraud, waste, and abuse (FWA) and the compliance program through continued education as noted in the 2022 Compliance Work Plan. The roles of the Compliance Officer and Compliance Committee are clearly identified in committee minutes, the committee charter, and policy. The Molina Healthcare Code of Business Conduct and Ethics emphasizes the expectation that business be conducted in accordance with applicable laws, rules, and contract requirements as well as ethical business and professional practices. Information for reporting suspected or actual FWA are clearly outlined in multiple forums for employees, members, and providers. Policies are in place detailing Molina's approach to internal auditing and responses to violations.

The pharmacy lock-in program is outlined in Policy MHMS-PH-004, Pharmacy Lock-In Program, which details processes and requirements for identifying members who display high controlled substance use and/or fraudulent sale or transfer of pharmaceutical products.

Health Information Systems

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

Molina provided appropriate documentation to demonstrate that is has infrastructure capable of meeting contractual requirements as well as information system requirements. Molina's Information Systems Capabilities Assessment documentation indicates the organization's personnel and systems have the capabilities to perform the Medicaid processing required by DOM. One notable area in which the organization demonstrates this is 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.

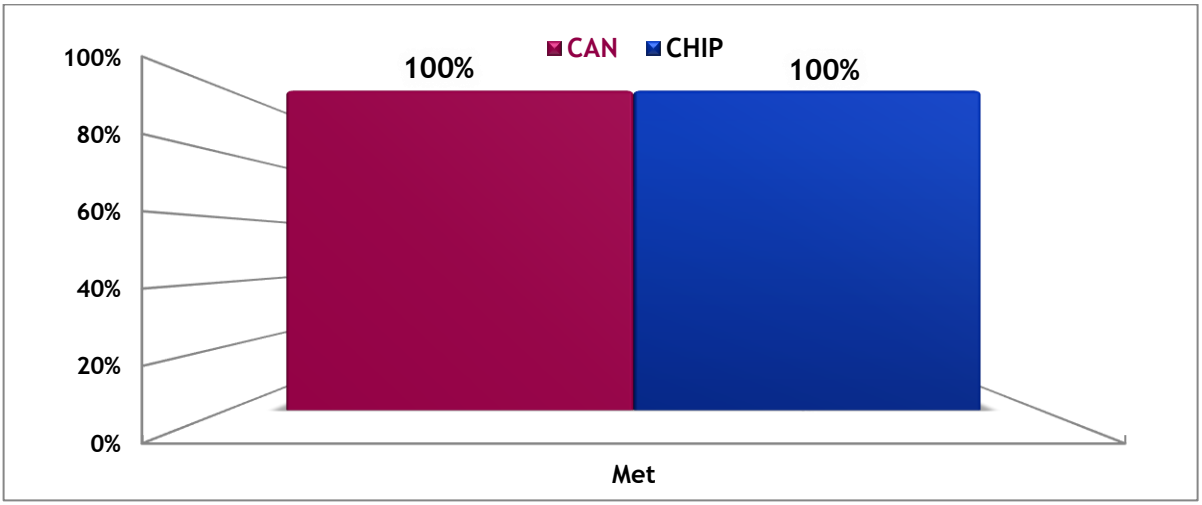
Confidentiality

§ 438.224

Confidentiality, privacy, and protected health information (PHI) are addressed in a policy that describes processes for the protection of PHI, including medical records, use, and disclosure of PHI for only those purposes permitted or required by law. Molina obtains the written authorization of the member or authorized representative.

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 formed a Policy and Procedure Committee to ensure the timely, annual review and revision of policies.
- Molina exceeds contractual claims processing requirements with an average of more than 99% of clean claims processed within 30 days and a 90-day average of 100%.
- The Molina Healthcare of Mississippi Fraud, Waste, and Abuse Plan effectively outlines the process for detecting, preventing, investigating, and reporting of potential health care FWA.

II. Provider Services

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

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

Provider Credentialing and Selection

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

Molina's Medical Director has overall responsibility for the credentialing process and chairs the Professional Review Committee (PRC), which serves as the Credentialing Committee for Molina. The PRC reports to the Quality Improvement Committee (QIC) and meets at least quarterly. As noted in Molina's documentation, the PRC transitioned to a regional model in February 2022. Current members of the regional PRC include providers with specialties of Family Medicine, Infectious Disease, Preventive Medicine, Psychiatry,

Gastroenterology, OBGYN, and Pediatrics. Review of PRC minutes confirmed the presence of a quorum for each meeting and adequate member attendance.

Molina has established policies and procedures for initial credentialing and recredentialing of practitioners and organizational providers. State specific requirements are found in addenda to the policies. The findings of this EQR confirmed Molina has not corrected some deficiencies identified during the previous EQR related to conducting initial credentialing site visits. Molina staff confirmed during onsite discussion that a process for conducting site visits at initial credentialing per the addendum to Policy CR 01, Credentialing Program Policy, has not been developed or implemented. During the onsite discussion, Molina indicated that they had attempted to contract with a vendor to conduct site visits; however, this was unsuccessful. The plan further confirmed that site visits for initial credentialing have not been conducted for any providers in the time Molina has had network providers in Mississippi. Of note, this is the third consecutive EQR this finding has been noted for Molina. On the previous year's corrective action documentation, Molina stated, "It is difficult to provide an estimated timeline for when all needed site visits will be completed…However, we will work to complete any needed site visits by the end of July 2022." See *Table 21: Previous Provider Credentialing and Selection CAP Items* for additional information related to the previous year's findings and Molina's response.

Table 21: Previous Provider Credentialing and Selection CAP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing – CAN	
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.	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. 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 is finalized. This is a repeat finding from the previous EQR. *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).*
Molina's Response: Molina has consulted with 3 different vendors regarding site visits and fingerprinting, and all three have either confirmed that they do not perform related services or that they cannot perform the services within proposed time frames (i.e., prior to when uniform credentialing goes live in Mississippi). Molina has since shifted its focus to discussing how this could all be handled internally by Molina. A final process still has not been developed, but Molina is making progress. Several additional internal meetings have	

Standard	EQR Comments
been held and work is underway on identifying providers subject to these requirements and the best methods of completing these requirements. Molina can provide additional details on the processes once it is finalized. 2.24.2022- Document CAP Item #1 uploaded to the portal.	
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.	Addendum B of Policy CR 01, Credentialing Program Policy, and Addendum B – Molina Healthcare of Mississippi State Specific Credentialing Requirements, 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 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 is finalized. **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 a repeat finding from the previous EQR.** *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 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).*
Molina's Response: Molina has consulted with 3 different vendors regarding site visits and fingerprinting, and all three have either confirmed that they do not perform related services or that they cannot perform the services within proposed time frames (i.e., prior to when uniform credentialing goes live in Mississippi). Molina has since shifted its focus to discussing how this could all be handled internally by Molina. A final process still has not been developed, but Molina is making progress. Several additional internal meetings have been held and work is underway on identifying providers subject to these requirements and the best methods of completing these requirements. Molina can provide additional details on the processes once it is finalized. 2.24.2022- Document CAP Item# 9 uploaded to the portal.	

None of the initial CAN or CHIP credentialing files included evidence of site visits at initial credentialing. However, Molina has implemented a process to ensure collection of fingerprints from applicable CHIP providers in response to Corrective Action from the previous EQR. See *Table 22: Previous Provider Credentialing and Selection CAP Items* for the previous deficiency and Molina's response.

Table 22: Previous Provider Credentialing and Selection CAP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing – CHIP	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	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.** *Corrective Action Plan: Ensure credentialing files for CHIP providers designated as high risk by DOM include evidence of collection of fingerprints.*
Molina's Response: Molina has consulted with 3 different vendors regarding site visits and fingerprinting, and all three have either confirmed that they do not perform related services or that they cannot perform the services within proposed time frames (i.e., prior to when uniform credentialing goes live in Mississippi). Molina has since shifted its focus to discussing how this could all be handled internally by Molina. A final process still has not been developed, but Molina is making progress. Several additional internal meetings have been held and work is underway on identifying providers subject to these requirements and the best methods of completing these requirements. Molina can provide additional details on the processes once it is finalized. 2.24.2022- Document CAP Item# 10 uploaded to the portal.	

Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events, describes processes for identifying, tracking, reviewing, resolving, and reporting potential quality of care issues. The processes followed for provider terminations initiated by Molina are found in Procedure MHMS-PC-09, MHMS Provider Termination Process. As noted in the procedure, 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)*. Molina notifies DOM of provider terminations within 48 hours.

Availability of Services and Assurances of Adequate Capacity and Services

§ 438.206, § 438.207, § 457.1230

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, define geographic access standards for CAN and CHIP Primary Care Providers (PCPs), specialists, hospitals, dental providers, etc. The access standards listed in the policies are compliant with contractual requirements. Molina runs quarterly Geographic Access Assessment Reports to evaluate the adequacy of its network and compliance with geographic accessibility requirements. Molina provided Geographic Access Reports dated April 2022 that confirm use of appropriate standards to assess the network and that the network is evaluated by county and by metro, micro, and rural categories. Additional considerations in determining the adequacy of the network include member complaints, grievances, out of network requests, etc.

Policy MHMS-QI-006, Access to Care, defines appointment access standards and indicates appointment and after-hour accessibility audits are conducted for a sample of PCPs, high volume specialists (OB/GYNs), high impact specialists (Oncologists), and behavioral healthcare practitioners. The policy does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Ongoing monitoring and evaluation include a review of member complaints related to accessibility, scheduling process, wait times and delays. Review of the policy revealed an incorrect appointment access standard for specialist appointments. The policy defines the standards as 20-30 calendar days. However, the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)* state the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, inconsistencies in appointment access timeframes were noted when comparing the policy to additional documents:

- For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CAN Member Handbook, page 36, and the CHIP Member Handbook, page 37, list the requirement as 21 days for adults and 14 days for children.
- For PCP routine sick appointments, the policy correctly lists the timeframe as seven calendar days, but the CAN Member Handbook, page 35, lists the requirement as 14 days.
- For specialist appointments, the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)* state the timeframe is 45 calendar days, but the CAN Member Handbook, page 36, and the CHIP Member Handbook, page 37, list the timeframe as 21 days.
- For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CAN Provider Manual, page 60, and the CHIP Provider Manual, page 76, state the timeframe is 14 days.
- The CAN and CHIP Provider Manuals do not include the appointment access requirements for routine and urgent dental appointments.

An additional component in evaluating the network is assessing the network's ability to meet the cultural and linguistic needs of members. To assess this, Molina conducts various activities, including but not limited to collecting practitioner race/ethnicity and language data, information about dedicated language services offered by practices in the network, including languages spoken by providers in the web-based Provider Directories, annually assessing the network against member race/ethnicity and language information, and collecting and analyzing complaints related to member cultural and linguistic needs. When network gaps are identified, Molina implements interventions to address the identified gaps.

During onsite discussion, Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for provider orientation are found in CAN Policy MHMS-NM-008, Provider Education and Training, and CHIP Policy MHMS-NM-018, Provider Education and Training. Initial provider orientation is conducted within 30 days of the provider's active date and is based on CCO processes and procedures, state and federal regulations, and accrediting body standards. As noted in the policies, Molina's Provider Services staff develop, conduct, and evaluate provider education programs in collaboration with applicable CCO departments and external entities, including DOM. Topics included in initial provider orientation are included in the policies. Molina has developed new provider orientation documents for CAN and CHIP that are comprehensive and include a wealth of topics providers will need to understand health plan operations and requirements, provider roles and responsibilities, etc. Processes for ongoing provider education are found in CAN Policy MHMS-NM-008, Provider Education and Training, and CHIP Policy MHMS-NM-018, Provider Education and Training. Ongoing provider education is conducted in a variety of ways, including onsite provider visits, regional workshops, bulletins and newsletters, webinars, mailings, updates on the website, and through the Provider Manual. Molina also conducts provider workshops in collaboration with DOM.

The CAN and CHIP Provider Manuals provide comprehensive information about the health plan, various CCO departments and services, processes and requirements, key contact information, and information about the functions of, and how to access, the secure provider portal. The Provider Manuals include links to listings of covered benefits on Molina's website. When comparing the information available using these links to benefit information in the CAN and CHIP Member Handbooks, errors were noted in the limitations for home health services (CAN) and in the limitations and requirements for Radiology/X-ray services (CHIP). It was noted that the CHIP Provider Manual includes information about Pain Safety Initiative Resources and a link for additional information on Molina's website, but this information is not included in the CAN Provider Manual.

Molina's CAN and CHIP websites are a rich resource for providers and include information about available interpreter services and how to access those services, cultural competency training information, provider tools, and downloadable information.

Policy MHMS-PC-01, MHMS Provider Directory Requirements, includes processes for maintenance and revision of Provider Directories. As noted in the policy, the printed Provider Directory is updated at least every six months, and the online directory is updated nightly. The CAN and CHIP Provider Directories and online "Find a Doctor" tools include all required elements. Molina corrected a previously identified deficiency related

to contents of the Provider Directory. See *Table 23: Previous Provider Education CAP Items* for the deficiency and Molina's response.

Table 23: Previous Provider Education CAP Items

Standard	EQR Comments
II C. Provider Education – CAN	
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	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. *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).*
Molina's Response: Document Process for Providers' Abilities to Accommodate Physical Disabilities uploaded to the portal. 2.24.2022- Uploaded to the portal document MS_Medicaid_sample_2_16_2022. Estimated time of completions is February 25, 2022.	
II C. Provider Education – CHIP	
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	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. *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.*
Molina's Response: Document Process for Providers' Abilities to Accommodate Physical Disabilities uploaded to the portal. 2.24.2022- Uploaded to the portal document MS_Medicaid_sample_2_16_2022. Estimated time of completion is February 25, 2022.	

Network providers are educated about medical record documentation and maintenance standards using various forums, including provider orientation materials, Provider Manuals, and the website. Policy MHMS-QI-124, Standards of Medical Record Documentation, describes processes for evaluating provider compliance with the medical record documentation and maintenance standards. The policy states Molina audits medical records "from a representative sample of network providers every three years" and describes the process followed for conducting the audits, reporting results to providers, follow-up actions for non-compliant providers, and reporting internally to appropriate committees. Onsite discussion confirmed Molina has not yet conducted a medical record audit but plans to conduct an audit in Q2 2023. This review confirmed Molina corrected the previously identified issues noted in *Table 24: Previous Provider Practitioner Medical Records CAP Items.*

Table 24: Previous Provider Practitioner Medical Records CAP Items

Standard	EQR Comments
II F. Practitioner Medical Records – CAN	
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	Policy MHMS-QI-124, Standards of Medical Record Documentation, did 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. 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. *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.*
Molina's Response: Quality Improvement will collaborate with the Chief Medical Officer, Healthcare Services, and Provider Services to update Policy MHMS-QI-124 Standards of Medical Records Documentation by including the following elements: 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. Next, the draft policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2022). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2022 meeting. 2.24.2022- Molina's Response: For this we reference policy MHMS-SIU-104, Conduct Clinic Coding Medical Records Audits, which falls within the Special Investigation Unit (SIU). The SIU team manages medical record investigations and audits to assure provider compliance with medical record documentation standards. 3.21.2022- Draft Policy uploaded to portal. Policy will be reviewed by QIC for approval by end of Q2 2022.	
II F. Practitioner Medical Records – CHIP	
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	Policy MHMS-QI-124, Standards of Medical Record Documentation, did 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. 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. *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.*

Standard	EQR Comments
Molina's Response: Quality Improvement will collaborate with the Chief Medical Officer, Healthcare Services, and Provider Services to update Policy MHMS-QI-124 Standards of Medical Records Documentation by including the following elements: 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. Next, the draft policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2022). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2022 meeting. 2.24.2022- Molina's Response: For this we reference policy MHMS-SIU-104, Conduct Clinic Coding Medical Records Audits, which falls within the Special Investigation Unit (SIU). The SIU team manages medical record investigations and audits to assure provider compliance with medical record documentation standards. 3.21.2022- Draft Policy uploaded to portal. Policy will be reviewed by QIC for approval by end of Q2 2022.	

Practice Guidelines

§ 438.236, § 457.1233

Molina adopts preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) to ensure providers have current treatment and diagnostic information about clinical and preventive health topics and to reduce variation in practice. The guidelines are disseminated to practitioners through initial provider orientation processes, Provider Manuals, newsletters, special mailings, fax blasts, and the CCO website. Printed copies are provided upon request. Processes for review adoption, and implementation of PHGs and CPGs are found in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. Selected guidelines are evidence-based, recommended by national clinically based organizations, and relevant to member demographics and healthcare needs. The guidelines are initially reviewed and approved by the National Quality Improvement Committee, and the CCO's QIC approves and adopts the guidelines for health plan use. Adopted guidelines are reviewed and revised as needed at least every two years by the QIC. Review of Molina's information confirmed Molina has adopted CPGs for an array of common diagnoses and conditions.

Provider Satisfaction Survey Validation

The provider satisfaction survey was administered by SPH Analytics on behalf of Molina. The sample size was 1,500. SPH Analytics collected 164 surveys, which is a response rate of 10.9%. This is higher than the 2020 rate of 7% but is below the National Committee for Quality Assurance (NCQA) target rate of 40%.

Improvement was noted for overall satisfaction, pharmacy, coordination of care, utilization, and quality management composite scores.

Results were presented to the Member and Provider Satisfaction Committee March 2022 and to the QIC in April 2022.

Table 25 below offers the section of the worksheet that needs improvement, the reason, and the recommendation.

Table 25: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,500. SPH Analytics collected 164 surveys which is a response rate of 10.9%. This is higher than the 2020 rate of 7%. It remains below the NCQA target rate of 40%.	Determine if there are additional methods to increase provider response rates.

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

Figure 4: Provider Services Findings

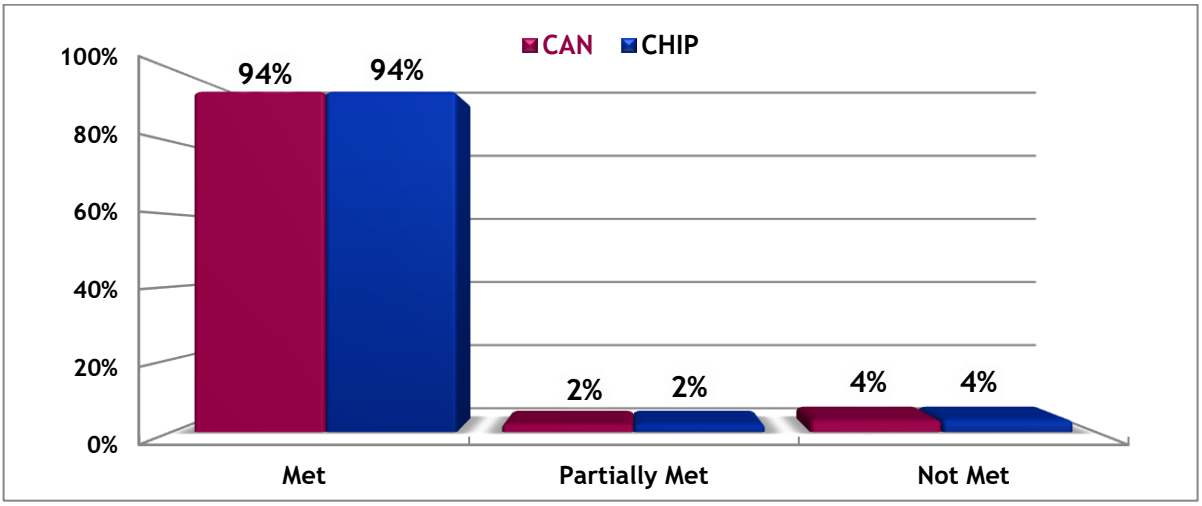


Table 26: Provider Services

Section	Standard	CAN 2022 Review	CHIP 2022 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
	Verification of information on the applicant, including: Site assessment	Not Met	Not Met

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Adequacy of the Provider Network	The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Not Met	Not Met
	The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Partially Met
Provider Education	Initial provider education includes: CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	Partially Met	Partially Met

Strengths

- Molina routinely monitors the geographic adequacy of its network using appropriate geographic access standards and considers additional factors such as member complaints, grievances, and out of network requests.
- Molina's website includes provider resources about interpreter services, downloadable cultural competency training information, provider tools, and more.
- Initial provider orientation topics are comprehensive and based on applicable state and federal regulations and accrediting body standards. New Provider Orientation documents include information to ensure providers understand health plan operations and requirements.

Weaknesses

- Molina is not following processes defined in the Addendum to Policy CR 01, Credentialing Program Policy, for conducting initial site visits of private practitioner offices and other patient care settings at initial credentialing, when the provider location has changed, and when a complaint has been lodged against a specific provider (within 60 days of the complaint). This is the third consecutive year this finding has been noted. The plan reported that no site visits have been conducted for any providers in the time Molina has had network providers in Mississippi.

- None of the CAN and CHIP initial credentialing files included evidence of site visits at initial credentialing. Onsite discussion confirmed Molina has not implemented a process for conducting site visits at initial credentialing.
- No process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients.
- Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting appointment and after-hour accessibility audits or the department or entity that conducts the audits.
- In Policy MHMS-QI-006, Access to Care, the timeframe for specialist appointments is specified as 20-30 calendar days. The *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)* list the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents:
    - For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CAN Member Handbook, page 36, and the CHIP Member Handbook, page 37, list the requirement as 21 days for adults and 14 days for children.
    - For PCP routine sick appointments, the policy correctly lists the timeframe as seven calendar days, but the CAN Member Handbook, page 35, lists the requirement as 14 days.
    - For specialist appointments, the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)* state the timeframe is 45 calendar days, but the CAN Member Handbook, page 36, and the CHIP Member Handbook, page 37, list the timeframe as 21 days.
    - For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CAN Provider Manual, page 60, and the CHIP Provider Manual, page 76, state the timeframe is 14 days.
- The CAN and CHIP Provider Manuals do not include the appointment access requirements for routine and urgent dental appointments.
- A link in the CAN Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Home Health Services, the list of covered benefits on the website link indicates a limit of 25 visits per year. However, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year.
- A link in the CHIP Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Radiology/X-rays, the list of covered benefits on the website link indicates these services must be conducted in a physician's office or hospital

outpatient department. However, the CHIP Member Handbook, page 40, does not include the restriction to location.

- The CHIP Provider Manual includes information about Pain Safety Initiative (PSI) Resources and a link for additional information on Molina's website. This information is not included in the CAN Provider Manual. Onsite discussion confirmed this program is applicable to CAN.
- For the provider satisfaction survey conducted by SPH Analytics, the sample size was 1,500. SPH Analytics collected 164 surveys, which is a response rate of 10.9%. This is higher than the 2020 rate of 7% but remains below the NCQA target rate of 40%.

Corrective Actions

- To comply with requirements in the *CAN Contract, Section 7 (E) (3)* and the *CHIP Contract, Section 7 (E) 3,* develop a work plan/schedule immediately for completing the site visits for all providers for whom Molina has completed the credentialing process. Conduct site visits for all applicable providers.
- Develop and implement a process to monitor provider panel limitations to ensure members have appropriate choice among providers.
- Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits.
- Correct the timeframe for specialty appointments in Policy MHMS-QI-006, Access to Care.
- Revise the applicable CAN and CHIP Member Handbooks and/or CAN and CHIP Provider Manuals to reflect the correct appointment access standards for PCP well care appointments, PCP routine sick appointments, specialist appointments, and Behavioral Health/Substance Use routine appointments.
- Add the appointment access standards for routine and urgent dental appointments to the CAN and CHIP Provider Manuals.
- Revise the CAN benefit information on the website to provide complete and correct information about the number of visits allowed for home health services.
- Revise the CHIP benefit information on the website to provide complete and correct information about restrictions on location for Radiology/X-ray services.

Recommendations

- Include information about Pain Safety Initiative (PSI) Resources and a link for additional information on Molina's website and in the CAN Provider Manual.
- Determine if there are additional methods to increase provider satisfaction survey response rates.

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 were found on Molina's website, in the Member Handbook, and in Policy MHMS-ME-003, Member Rights and Responsibilities. The New Member Welcome Packet is provided within 14 days after Molina receives the member's enrollment data from DOM. The packet includes all contractually required information such as an introduction letter, ID card, Member Handbook, and instructions for accessing the Provider Directory.

Information about prior authorization requirements for medical, behavioral health, and pharmaceutical services is included in the CAN and CHIP Member Handbooks. The CAN Member Handbook, page 38, indicates Home Health Services have no limit on the number of visits, however; the list of covered benefits on the website indicates a limit of 25 visits per year. Of note, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year. For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to location (as noted in benefit information on Molina's CHIP website) and states prior authorization is required for these services. Onsite discussion with Molina staff indicated prior authorization is required only for advanced imaging services and not for routine x-rays.

The CAN and CHIP Member Handbooks indicate that members are informed of changes to programs and benefits within 30 calendar days prior to implementation. Information on the appropriate level of care for routine, urgent, or emergent needs is clearly outlined in the Member Handbook and on the Molina's website. The CAN and CHIP Member Handbooks describe the role of the Care Management team, areas of support provided, and how a Care Manager may be requested by any member.

A Call Center and a 24-Hour Nurse Advice Line are available for members. The 24-Hour Nurse Advice Line is staffed with mental health professionals who can address the member's urgent behavioral health needs. Policy MHMS-ME-008, Enrollment Reports, and Policy MHMS-ME-009, Enrollment Accounting, describes instances when Molina can request a member to be disenrolled. Policy ME-013, CHIP Disenrollment, provide information for CHIP members to disenroll from services.

During the onsite, staff shared instances of member education, community initiatives, and resources available specific to preventive health and chronic disease management. Members can access the CAN website or Member Handbook for information on recommended preventive health services.

Grievances

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

Molina defines grievance processes and requirements in Policy MHMS-MRT-01, Member Complaints and Grievances. Information about grievance requirements and processes are found in the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and on Molina's website.

Policy MHMS-MRT-01 includes the process followed if Molina needs to request an extension for resolving the grievance. The policy does not mention allowing the member the right to file a grievance if they disagree with the request for the extension. Molina's grievance notice sent to CAN members when Molina has requested an extension does not notify the member of their right to file a grievance if they disagree with the extension. The CAN and CHIP grievance files reflect staff acknowledged the grievances consistently, resolve grievances within the required timeframe, and grievant notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files.

Grievance logs are maintained, categorized, and reported internally to establish areas of potential quality improvement.

Member Satisfaction Survey Validation

Member Satisfaction Survey validation 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.

For the Adult CAHPS, the response rate was low at 10.2% (137 out of 1344). This was lower than last year's response rate of 10.3% and lower than the SPH average response rate of 14.8%. Getting Needed Care and Customer Service rates improved, as well as the rating of health care, doctor communication, and the rating of personal doctor. Other domains showed a decline. The child survey also showed a low response rate of 7.3% (375 out of 5161). This rate was lower than last year's rate of 10.2% and lower than the SPH average response rate of 12.8%. The Getting Need Care and the Rating of Health Care rate improved. The Rating of Health Plan, Customer Service, Getting Care Quickly, and all other domains declined. The largest decline was Coordination of Care.

The element regarding response rate was considered "Met" as the following conditions are satisfied: (1) The response rate was calculated and presented in the documentation and (2) Molina offered evidence of interventions to increase the response rate if it is below the target rate of 40%. CCME offered the following recommendations.

Table 27: Adult CAHPS Survey Recommendation

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 10.2% (137 out of 1344). This is lower than last year's rate of 10.3% and lower than the SPH average response rate of 14.8%.	Continue to determine ways to advertise surveys and increase response rates.

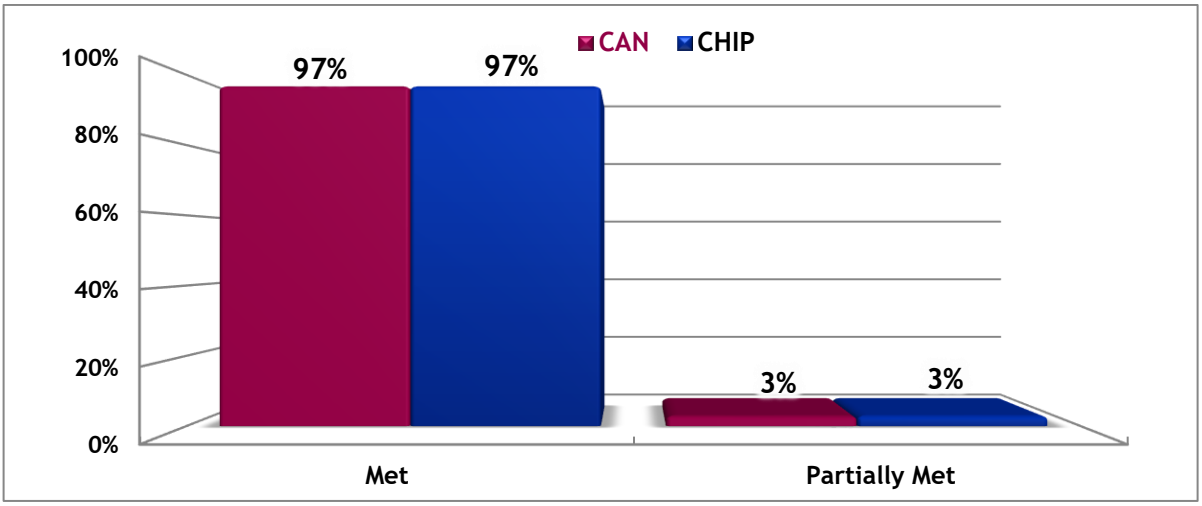
Table 28: Child CAHPS Survey Recommendation

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 7.3% (375 out of 5161). This is lower than last year's rate of 10.2% and lower than the SPH average response rate of 12.8%.	Continue to determine ways to advertise surveys and increase response rates.

Molina conducted an analysis and key driver assessment of the survey results and presented this analysis to the Member/Provider Satisfaction Committee. Results are also shared with providers in the Provider newsletter.

As noted in *Figure 5: Member Services Findings*, Molina achieved "Met" scores for 97% of the Member Services Standards.

Figure 5: Member Services Findings



Strengths

- The CAN and CHIP Member Handbooks describe the role of the Care Management team, areas of support provided, and how a Care Manager may be requested by any member.
- The CAN and CHIP grievance files reflect staff acknowledge grievances consistently, resolve grievances within the required timeframe, and grievant notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files.
- Molina outlined multiple community outreach initiatives to address areas of need specific to preventive health and chronic disease management and education.

Weaknesses

- The CAN Member Handbook, page 38, indicates Home Health Services have no limit on the number of visits; however, benefit information on Molina's CAN website does list a limit on the number of visits. Of note, DOM staff reported that visits for Home Health Services are allowed up to a maximum of 36 visits per year.
- For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to location (as noted in benefit information on Molina's CHIP website) and states prior authorization is required for these services. Onsite discussion with Molina staff indicated prior authorization is required only for advanced imaging services and not for routine X-rays.
- Policy MHMS-MRT-01, Member Complaints and Grievances, includes the process followed if Molina needs to request an extension for resolving the grievance. The policy does not mention allowing the member the right to file a grievance if they disagree with the request for the extension.

Corrective Actions

- Correct the number of visits allowed for Home Health Services in the CAN Member Handbook.
- Revise the benefit information in the CHIP Member Handbook to provide complete and correct information about restrictions on location and prior authorization requirements for Radiology/X-ray services.

Recommendations

- Include in Policy and Procedure MHMS-MRT-01, Member Complaints and Grievance the members right to file a grievance if they disagree with Molina's request and extension for resolving the grievance.

IV. Quality Improvement

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

For this EQR, Molina submitted the 2022 Quality Improvement Program Description for review. This QI Program Description is updated annually and submitted to the QIC for approval. The QI Program Description details the QI program's scope, goals, objectives, structure, and functions for the plan. Molina provides information to members and providers about the QI Program via the website. The website contained information regarding the 2021 HEDIS and CAHPS rates, and links for guides regarding Accessing Quality Health Care. The guide provided for the CAN members titled "Guide to Accessing Quality Health Care" appears to be out of date. This guide is dated 2020. However, the guide provided for the CHIP members was dated 2022.

A goal of QI activities is to reduce healthcare disparities. Molina's Health Equity and Cultural Competency Plan 2022 described in the QI Program Description provides a summary of the plan to address healthcare disparities through tools and needed trainings.

Molina submitted the 2021 and 2022 CAN and CHIP Work Plans for review. The Work Plans clearly document planned activities, responsible parties, timelines, action plans or benchmark goals, and status for each activity. The Work Plan is updated on a quarterly basis.

In the 2022 Work Plan, Section 5 – Availability of Practitioners, the standards used to measure the geographic distribution of Primary Care Practitioners (PCPs) are incorrect and do not meet contractual requirements. Molina's 2022 Work Plan indicates the geographic distribution of PCPs for members residing in Urban counties is being measured as one PCP within 20 miles. The Contract requires PCPs in Urban counties to be measured as two PCPs within 15 miles.

Molina's 2022 Work Plan indicates the geographic distribution of primary care practitioners for members residing in Rural counties is being measured as one PCP within 30 miles. The Contract requires PCPs in Rural counties to be measured as two PCPs within 30 miles. A review of the Geographic Access Assessment Reports conducted by Molina indicated that PCPs are being measured in accordance with the contractual requirements.

The QIC is responsible for the implementation and ongoing monitoring of the QI activities. This committee is also responsible for the development of the QI Program Description, Work Plans, and the Program Evaluation. The Chief Medical Officer (CMO) provides clinical guidance for the QI Program and co-chairs the QIC. Other members of the committee include a behavioral health practitioner and other senior leaders. Participating practitioners serve on the QIC and are responsible for providing review and feedback on clinical issues. The 2021-2022 QIC Membership list show the participating

practitioners as external voting members specializing in pediatrics, psychiatry, and internal medicine. The QIC Charter defines a quorum as at least 51% of committee members with no less than half of Community Network Provider participants necessary to enact and/or implement decisions. It was noted that the first quarter 2022 meeting did not have a quorum present. Only two of the five network providers were present for the meeting. Molina pointed out this was an error in the minutes.

The *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)* require that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments, and/or referrals for members. Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby and Well-Child Services, address EPSDT and Well-Baby Well-Child services, how Molina tracks services, and follow-up with members who have not received or are behind in getting services. These policies also include the process for tracking follow-up treatment and referrals. Per Policy QI- 003 and QI-005, follow-up activities are to be documented on the EPSDT and Well-Baby Well-Child tracker. Molina provided copies of these tracking reports. However, these reports did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs and not corrected. The table below provides an overview of the issues identified during the previous EQR and Molina's response.

Table 29: Previous EPSDT and Well Baby Well Child Follow-Up 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: 4.3 Diagnosis and/or treatment for children.	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.

Standard	EQR Comments
	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.
Molina Response: The process for EPSDT tracking follow-up treatment and referrals includes the following: First, members who receive an abnormal finding during their EPSDT screening are identified via claims data and ICD 10/z codes on a monthly basis. The contact info on the member and provider, with dates of service, is listed. Follow-up is 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 which is also documented in the tracker. An example of the current tracker is uploaded to the portal. (File Name: Molina-EPSDT-Well Child Exam Tracker-MSCAN-CHIP-December 2021). Quality Improvement working with Healthcare Services and Salesforce Call Center to assist with calls to members and scheduling follow-up appointments, if needed (by February 2022). To increase productivity and decrease member abrasion, QI has been collaborating with the Enterprise Information Management team to create an automated tracking dashboard that displays recent/previous calls made to members' parents with documented results of the contact (by March 2022). **2.24.2022-** Molina's Response: Language regarding the process for tracking treatments or referrals needed for abnormal findings for EPSDT services has been added as a draft to Policy MHMS-QI-003. The draft policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by 2nd Quarter 2022). Upon approval, the policy will then be presented to the Quality Improvement Committee (QIC) for review and approval (by 3rd Quarter 2022).	
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: 4.3 Diagnosis and/or treatment for children.	Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, 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. *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.*
Molina Response: The process for Well-Baby/Well Child tracking follow-up treatment and referrals includes the following: First, members who receive an abnormal finding during their Well-Baby/Well Child screening are identified via claims data and ICD 10/z codes on a monthly basis. The contact info on the member and provider, with dates of service, is listed. Follow-up is 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 which is also documented in the tracker. An example of the current tracker is uploaded to the portal. (File Name: Molina-EPSDT-Well Child Exam Tracker-MSCAN-CHIP-December 2021). Quality Improvement is collaborating with Healthcare Services and Salesforce Call Center to assist with calls to members and scheduling follow-up appointments, if needed (by February 2022). To increase productivity and decrease member abrasion, QI has been working with the EIM team to create an automated tracking dashboard that displays recent/previous calls made to members' parents with documented results of the contact (by March 2022).	

Standard	EQR Comments
2.24.2022- Molina's Response: Language regarding the process for tracking treatments or referrals needed for abnormal findings for Well-Baby/Well Child Services has been added as a draft to Policy MHMS-QI-005. The draft policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by 2nd Quarter 2022). Upon approval, the policy will then be presented to the Quality Improvement Committee (QIC) for review and approval (by 3rd Quarter 2022).	

The *CAN Contract, Section 10 (D) (8)* and the *CHIP Contract, Section 9 (D) (8)* require the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI Program. The *CAN Contract, Exhibit G (7)* and *CHIP Contract, Exhibit F* further define the requirements for the QI Program Evaluation. CCME received the 2021 QI Program Evaluation two days before the onsite. This QI Program Evaluation had been approved by the QIC in April 2022 and the Board in May 2022. There was a note on each page indicating the document was revised in October 2022. Molina indicated there were minor revisions made to the Evaluation. The QI Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the evaluation:

- In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions that a root cause analysis was completed; however, it was not included in the Evaluation.
- The Geographic Access Assessment Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing activities (reference Section 19.0, 2021 work plan) were not included in the QI Program Evaluation.
- The Delegation Oversight activities were incomplete.

After the Onsite, Molina submitted another copy of the 2021 QI Program Evaluation. Additional information had been added related to delegation oversight. However, this Evaluation is also incomplete. This continues to be an issue and was identified in the 2020 and 2021 EQRs and has not been corrected. The table that follows provides an overview of the previous deficiency and Molina's response.

Table 30: Previous QI Program Evaluation 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.	The Quality Improvement Program 2020 Annual Evaluation did not include 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. *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.*
Molina Response: To comply with requirements of Section 10 (D) and Exhibit G, per the CAN Contract, Molina will ensure the 2021 QI Program Evaluation (expected by February 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, results of performance improvement projects, 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, and any analysis to demonstrate the overall effectiveness of the QI program. During the virtual onsite discussion, information was relayed that the 2021 QI Program Evaluation would include the required components since the evaluation is conducted annually. Also, during that discussion, CCME requested Molina to provide an outline/template of the program evaluation which was provided. Molina is currently collecting data sets from multiple sources to obtain information for the QI Evaluation program. Additionally, we are collaborating with our corporate counterparts to ensure data set collection for compliance requirements and the aforementioned components are included in the report. The template of the program evaluation is uploaded to the portal. (File Name: EQR CAP Items 5 and 14_TEMPLATE_2021 Annual QI Program Evaluation).	
IV F. Annual Evaluation of the Quality Improvement Program - CHIP	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually	The Quality Improvement Program 2020 Annual Evaluation did not include 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. *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	EQR Comments
IV F. Annual Evaluation of the Quality Improvement Program - CAN	
	performance, and any analysis to demonstrate the overall effectiveness of the QI program.
Molina Response: To comply with requirements of Section 10 (D) and Exhibit G, per the CAN Contract, Molina will ensure the 2021 QI Program Evaluation (expected by February 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, results of performance improvement projects, 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, and any analysis to demonstrate the overall effectiveness of the QI program. During our onsite discussion, information was relayed that the 2021 QI Program Evaluation would include the required components since the evaluation is conducted annually. Also, during that discussion, CCME requested Molina to provide an outline/template of the program evaluation which was provided. Molina is currently collecting data sets from multiple sources to obtain information for the QI Evaluation program. Additionally, we are collaborating with our corporate counterparts to ensure data set collection for compliance requirements and the aforementioned components are included in the report. The template of the program evaluation is uploaded to the portal. (File Name: EQR CAP Items 5 and 14_TEMPLATE_2021 Annual QI Program Evaluation).	

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 Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the PM rates following the CMS-developed protocol for validating PMs. The final PM validation results reflected the measurement period of January 1 through December 31, 2021.

Per the contract between the CCOs and DOM, the CCOs were required to submit HEDIS data to NCQA. To ensure the 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 (FARs), information systems compliance tools, and Interactive Data Submission System (IDSS) files approved by Molina's NCQA-licensed organization. Aqurate found that the CCO's information systems and processes were compliant with the applicable standards and HEDIS reporting requirements for HEDIS MY 2021.

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

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

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

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

Performance Measure Documentation — Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by 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 the CCO was acceptable.

All relevant CAN HEDIS PMs were compared for the current review year (MY 2021) to the previous year (MY 2020), and the changes from 2020 to 2021 are reported in *Table 31: CAN HEDIS Performance Measure Results*. Rate changes shown in green indicate substantial (>10%) improvement, and rate changes shown in red indicate substantial (>10%) decline.

Table 31: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	49.56%	45.34%	-4.22%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
BMI Percentile	49.15%	54.26%	5.11%
Counseling for Nutrition	40.63%	44.28%	3.65%
Counseling for Physical Activity	35.52%	41.36%	5.84%
Childhood Immunization Status (cis)			
DTaP	59.12%	69.34%	10.22%
IPV	79.81%	82.48%	2.67%
MMR	77.37%	85.64%	8.27%
HiB	73.48%	80.29%	6.81%
Hepatitis B	79.32%	80.29%	0.97%
VZV	76.89%	83.45%	6.56%
Pneumococcal Conjugate	57.18%	68.13%	10.95%
Hepatitis A	69.83%	75.18%	5.35%
Rotavirus	60.58%	69.83%	9.25%
Influenza	26.76%	27.01%	0.25%
Combination #3	51.58%	61.07%	9.49%
Combination #7	40.15%	49.15%	9.00%
Combination #10	17.27%	20.68%	3.41%
Immunizations for Adolescents (ima)			
Meningococcal	45.74%	47.69%	1.95%
Tdap	58.64%	63.99%	5.35%
HPV	11.92%	11.19%	-0.73%
Combination #1	43.55%	46.47%	2.92%
Combination #2	10.22%	10.95%	0.73%
Lead Screening in Children (lsc)	66.67%	71.29%	4.62%
Breast Cancer Screening (bcs)	36.36%	33.33%	-3.03%
Cervical Cancer Screening (ccs)	47.93%	52.31%	4.38%
Chlamydia Screening in Women (chl)			
16-20 Years	48.26%	47.74%	-0.52%
21-24 Years	63.2%	62.11%	-1.09%
Total	53.13%	52.19%	-0.94%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
16-20 Years	76.98%	76.18%	-0.80%
21-24 Years	66.42%	65.23%	-1.19%
65+ Years	NA	NA	NA
Total	75.29%	74.02%	-1.27%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	54.39%	60.48%	6.09%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Bronchodilator	80.70%	80.65%	-0.05%
Asthma Medication Ratio (amr)			
5-11 Years	75.53%	77.07%	1.54%
12-18 Years	54.55%	65.28%	10.73%
19-50 Years	NA	46.03%	NA
51-64 Years	NA	NA	NA
Total	62.89%	64.75%	1.86%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	47.2%	50.12%	2.92%
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	76.00%	NA
Statin Adherence 80% - 21-75 years (Male)	NA	85.96%	NA
Received Statin Therapy - 40-75 years (Female)	NA	76.92%	NA
Statin Adherence 80% - 40-75 years (Female)	NA	85.00%	NA
Received Statin Therapy - Total	78.95%	76.38%	-2.57%
Statin Adherence 80% - Total	86.67%	85.57%	-1.10%
Cardiac Rehabilitation (cre)			
Initiation - 18-64 Years	1.39%	2.22%	0.83%
Engagement1 - 18-64 Years	2.78%	4.44%	1.66%
Engagement2 - 18-64 Years	1.39%	3.33%	1.94%
Achievement - 18-64 Years	0.00%	1.11%	1.11%
Initiation - 65+ years	NA	NA	NA
Engagement1 - 65+ Years	NA	NA	NA
Engagement2 - 65+ Years	NA	NA	NA
Achievement - 65+ Years	NA	NA	NA
Initiation - Total	1.39%	2.22%	0.83%
Engagement1 - Total	2.78%	4.44%	1.66%
Engagement2 - Total	0.00%	1.11%	1.11%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	82.00%	82.00%	0%
HbA1c Poor Control (>9.0%)	55.96%	62.53%	6.57%
HbA1c Control (<8.0%)	36.25%	30.17%	-6.08%
Eye Exam (Retinal) Performed	49.15%	53.28%	4.13%
Blood Pressure Control (<140/90 mm Hg)	51.82%	53.77%	1.95%
Kidney Health Evaluation for Patients With Diabetes (KED)			
18-64 Years	14.54%	17.04%	2.50%
65-74 Years	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
75-85 Years	NA	NA	NA
Total	14.54%	17.04%	2.50%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	52.14%	51.36%	-0.78%
Statin Adherence 80%	77.05%	77.06%	0.01%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	74.76%	75.31%	0.55%
Effective Continuation Phase Treatment	58.89%	61.18%	2.29%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	52.05%	30.61%	-21.44%
Continuation and Maintenance (C&M) Phase	60.66%	38.46%	-22.20%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	62.5%	59.32%	-3.18%
6-17 years - 7-Day Follow-Up	35.12%	37.08%	1.96%
18-64 years - 30-Day Follow-Up	45.52%	51.68%	6.16%
18-64 years - 7-Day Follow-Up	24.55%	23.32%	-1.23%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	53.37%	55.74%	2.37%
7-Day Follow-Up	29.44%	30.63%	1.19%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	36.59%	59.02%	22.43%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	24.39%	27.87%	3.48%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	25.24%	42.33%	17.09%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	16.5%	33.13%	16.63%
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)	28.47%	46.88%	18.41%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	18.75%	31.7%	12.95%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	27.67%	31.00%	3.33%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	21.28%	14.00%	-7.28%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	27.37%	29.52%	2.15%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	21.05%	13.33%	-7.72%
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	6.00%	6.94%	0.94%
7-Day Follow-Up: 18+ Years	3.00%	4.17%	1.17%
30-Day Follow-Up: Total	5.45%	6.29%	0.84%
7-Day Follow-Up: Total	2.73%	3.77%	1.04%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	71.19%	70.60%	-0.59%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	49.12%	67.95%	18.83%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	59.25%	51.50%	-7.75%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	25.65%	37.32%	11.67%
Cholesterol Testing (1-11)	13.09%	22.01%	8.92%
Blood Glucose and Cholesterol Testing (1-11)	8.38%	19.62%	11.24%
Blood Glucose Testing (12-17)	37.59%	43.67%	6.08%
Cholesterol Testing (12-17)	25.53%	26.68%	1.15%
Blood Glucose and Cholesterol Testing (12-17)	21.99%	23.72%	1.73%
Blood Glucose Testing (Total)	32.77%	41.38%	8.61%
Cholesterol Testing (Total)	20.51%	25.00%	4.49%
Blood Glucose and Cholesterol Testing (Total)	16.49%	22.24%	5.75%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.21%	1.30%	0.09%
Appropriate Treatment for Children with URI (uri)			
3 Months-17 Years	77.08%	75.83%	-1.25%
18-64 Years	54.81%	55.35%	0.54%
65+ Years	NA	NA	NA
Total	74.74%	73.88%	-0.86%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 Months-17 Years	59.10%	51.50%	-7.60%
18-64 Years	33.24%	29.48%	-3.76%
65+ Years	NA	NA	NA
Total	55.84%	48.25%	-7.59%
Use of Imaging Studies for Low Back Pain (lbp)	71.96%	67.49%	-4.47%
Use of Opioids at High Dosage (hdo)	4.76%	3.42%	-1.34%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	18.10%	13.39%	-4.71%
Multiple Pharmacies	3.82%	1.59%	-2.23%
Multiple Prescribers and Multiple Pharmacies	2.80%	0.80%	-2.0%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	11.52%	9.34%	-2.18%
18-64 years - >=31 Days covered	4.43%	3.42%	-1.01%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	11.52%	9.34%	-2.18%
Total - >=31 Days covered	4.43%	3.42%	-1.01%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	83.06%	82.23%	-0.83%
45-64 Years	85.38%	85.92%	0.54%
65+ Years	NA	NA	NA
Total	83.59%	83.15%	-0.44%
Annual Dental Visit (adv)			
2-3 Years	35.57%	44.25%	8.68%
4-6 Years	50.05%	51.85%	1.80%
7-10 Years	53.45%	53.61%	0.16%
11-14 Years	50.16%	50.16%	0%
15-18 Years	44.37%	44.71%	0.34%
19-20 Years	31.30%	32.80%	1.50%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Total	48.14%	49.13%	0.99%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	60.42%	64.21%	3.79%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	2.08%	2.11%	0.03%
Total: Initiation of AOD Treatment: 13-17 Years	55.56%	62.86%	7.3%
Total: Engagement of AOD Treatment: 13-17 Years	1.85%	4.76%	2.91%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	51.16%	41.78%	-9.38%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	2.79%	3.29%	0.50%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	47.15%	47.73%	0.58%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	22.76%	23.86%	1.10%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	43.79%	38.76%	-5.03%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.97%	3.72%	-1.25%
Total: Initiation of AOD Treatment: 18+ Years	44.66%	38.71%	-5.95%
Total: Engagement of AOD Treatment: 18+ Years	7.44%	7.03%	-0.41%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	51.98%	43.25%	-8.73%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	2.64%	4.29%	1.65%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	46.4%	48.33%	1.93%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	22.4%	23.33%	0.93%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	45.42%	42.03%	-3.39%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.68%	3.51%	-1.17%
Total: Initiation of AOD Treatment: Total	45.43%	40.99%	-4.44%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Total: Engagement of AOD Treatment: Total	7.05%	6.82%	-0.23%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	95.38%	91.24%	-4.14%
Postpartum Care	66.42%	63.50%	-2.92%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
6-11 years	49.00%	57.98%	8.98%
12-17 years	63.28%	60.30%	-2.98%
Total	57.02%	59.43%	2.41%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	50.09%	54.68%	4.59%
15 Months-30 Months	51.23%	62.67%	11.44%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	33.71%	38.37%	4.66%
12-17 Years	28.33%	32.46%	4.13%
18-21 Years	14.73%	14.80%	0.07%
Total	30.78%	34.86%	4.08%

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

As shown, the following rates showed a substantial (>10%) improvement or decline:

- Childhood Immunization Status (CIS), the DTaP indicator and the Pneumococcal Conjugate indicator improved by over 10 percentage points.
- The Asthma Medication Ratio (AMR), the 12-18 Years indicator improved by 10.73 percentage points.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM), the 30 days (6-17) indicator improved by 22.43 percentage points, the 30 days (18-64) indictor improved by 17.09 percentage points, the 7 days (18-64) indicator improved by 16.63 percentage points, the 30 days (Total) indicator improved by 18.41 percentage points, and the 7 days (Total) indicator improved by 12.95 percentage points.
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) improved by 18.83 percentage points.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), the Blood Glucose Testing (1-11) indicator improved by 11.67 percentage points and the Blood Glucose and Cholesterol Testing (1-11) indicator improved by 11.42 percentage points.
- Well-Child Visits in the First 30 Months of Life (W30), the 15 Months-30 Months indicator improved by 11.44 percentage points.

- The Follow-Up Care for Children Prescribed ADHD Medication (ADD), the Initiation Phase indicator declined by 21.44 percentage points and the Continuation and Maintenance (C&M) indicator declined by 22.20 percentage points.

All relevant CHIP HEDIS performance measures were compared for MY 2021 and the previous year (2020), and the change from 2020 to 2021 is reported in the table that follows. Rate changes shown in green indicate a substantial (>10%) improvement and rate changes shown in red indicate a substantial (>10%) decline.

Table 32: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	49.64%	52.80%	3.16%
Counseling for Nutrition	40.88%	43.55%	2.67%
Counseling for Physical Activity	37.71%	40.63%	2.92%
Childhood Immunization Status (cis)			
DTaP	68.35%	77.34%	8.99%
IPV	82.28%	86.69%	4.41%
MMR	85.44%	92.07%	6.63%
HiB	81.01%	84.42%	3.41%
Hepatitis B	76.58%	83.85%	7.27%
VZV	81.01%	91.22%	10.21%
Pneumococcal Conjugate	72.15%	76.20%	4.05%
Hepatitis A	81.65%	84.99%	3.34%
Rotavirus	70.89%	79.89%	9.00%
Influenza	29.11%	33.99%	4.88%
Combination #3	58.86%	69.12%	10.26%
Combination #7	49.37%	58.92%	9.55%
Combination #10	18.35%	27.20%	8.85%
Immunizations for Adolescents (ima)			
Meningococcal	42.54%	45.26%	2.72%
Tdap/Td	61.57%	62.04%	0.47%
HPV	14.18%	15.57%	1.39%
Combination #1	41.04%	44.28%	3.24%
Combination #2	13.81%	15.09%	1.28%
Lead Screening in Children (lsc)	77.85%	77.90%	0.05%
Chlamydia Screening in Women (chl)			
16-20 Years	37.99%	38.94%	0.95%

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
21-24 Years	NA	NA	NA
Total	37.99%	38.94%	0.95%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	79.16%	78.37%	-0.79%
18-64 years	76.92%	74.65%	-2.27%
65+ years	NA	NA	NA
Total	79.10%	78.21%	-0.89%
Asthma Medication Ratio (amr)			
5-11 Years	NA	87.39%	NA
12-18 Years	NA	78.64%	NA
19-50 Years	NA	NA	NA
51-64 Years	NA	NA	NA
Total	NA	83.18%	NA
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	NA	NA	NA
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	NA
Comprehensive Diabetes Care (cdc)			
Comprehensive Diabetes Care - HbA1c Testing	NA	NA	NA
Comprehensive Diabetes Care - Poor HbA1c Control	NA	NA	NA
Comprehensive Diabetes Care - HbA1c Control (<8%)	NA	NA	NA
Comprehensive Diabetes Care - Eye Exams	NA	NA	NA
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	NA	NA	NA
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (18-64)	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (18-64)	NA	NA	NA
Cardiac Rehabilitation - Engagement2 (18-64)	NA	NA	NA
Cardiac Rehabilitation - Achievement (18-64)	NA	NA	NA
Cardiac Rehabilitation - Initiation (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (65+)	NA	NA	NA
Cardiac Rehabilitation - Engagement2 (65+)	NA	NA	NA
Cardiac Rehabilitation - Achievement (65+)	NA	NA	NA
Cardiac Rehabilitation - Initiation (Total)	NA	NA	NA
Cardiac Rehabilitation - Engagement1 (Total)	NA	NA	NA
Cardiac Rehabilitation - Engagement2 (Total)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (ked)			

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Kidney Health Evaluation for Patients With Diabetes (18-64)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (65-74)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	NA	NA	NA
Statin Therapy for Patients With Diabetes (spd)			
Statin Therapy for Patients With Diabetes - Received Statin Therapy	NA	NA	NA
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	NA	NA	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	NA	NA	NA
Effective Continuation Phase Treatment	NA	NA	NA
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	NA	32.98%	NA
Continuation and Maintenance (C&M) Phase	NA	48.05%	NA
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	51.11%	55.68%	4.57%
6-17 years - 7-Day Follow-Up	28.89%	34.09%	5.20%
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	52.13%	56.67%	4.54%
Total-7-day Follow-Up	29.79%	34.44%	4.65%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NA	NA	NA
6-17 years - 7-Day Follow-Up	NA	NA	NA
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	NA	NA	NA
Total-7-day Follow-Up	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
Pharmacotherapy for Opioid Use Disorder (16-64)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	NA	NA	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NA	NA	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	26.92%	30.23%	3.31%
Cholesterol Testing (1-11)	23.08%	18.60%	-4.48%
Blood Glucose and Cholesterol Testing (1-11)	17.31%	18.60%	1.29%
Blood Glucose Testing (12-17)	48.65%	62.96%	14.31%
Cholesterol Testing (12-17)	22.97%	35.19%	12.22%
Blood Glucose and Cholesterol Testing (12-17)	21.62%	33.33%	11.71%
Blood Glucose Testing (Total)	39.68%	48.45%	8.77%
Cholesterol Testing (Total)	23.02%	27.84%	4.82%
Blood Glucose and Cholesterol Testing (Total)	19.84%	26.80%	6.96%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.83%	1.25%	0.42%
Appropriate Treatment or Children with URI (uri)			
3 months-17 Years	71.87%	65.90%	-5.97%
18-64 Years	72.00%	62.32%	-9.68%
65+ Years	NA	NA	NA
Total	71.87%	65.79%	-6.08%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (aab)			
3 Months - 17 Years	38.92%	31.22%	-7.7%
18-64 Years	NA	NA	NA
65+ Years	NA	NA	NA
Total	38.10%	30.80%	-7.30%
Use of Imaging Studies for Low Back Pain (lbp)	NA	NA	NA
Use of Opioids at High Dosage (hdo)	NA	NA	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NA	9.09%	NA
18-64 years - >=31 Days covered	NA	3.03%	NA
65+ - >=15 Days covered	NA	NA	NA
65+ - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	NA	9.09%	NA
Total - >=31 Days covered	NA	3.03%	NA
Access/Availability of Care			
Annual Dental Visit (adv)			

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
2-3 Years	41.74%	52.63%	10.89%
4-6 Years	60.08%	64.10%	4.02%
7-10 Years	65.22%	66.57%	1.35%
11-14 Years	61.25%	63.32%	2.07%
15-18 Years	51.96%	52.35%	0.39%
19-20 Years	38.60%	40.91%	2.31%
Total	58.00%	60.47%	2.47%
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	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	51.43%	NA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	2.86%	NA	NA
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	NA	NA	NA
Postpartum Care	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
12-17 Years	59.46%	74.36%	14.90%
Total	50.82%	67.19%	16.37%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	64.05%	78.38%	14.33%
15 Months-30 Months	58.82%	74.50%	15.68%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	38.81%	40.50%	1.69%
12-17 Years	31.56%	35.53%	3.97%
18-21 Years	18.84%	20.40%	1.56%
Total	34.60%	37.15%	2.55%

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

The following HEDIS MY 2021 measure rates had a greater than 10% improvement:

- Childhood Immunization Status (CIS), the VZV indicator improved by 10.21 percentage points and the Combination #3 indicator improved by 10.26 percentage points.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), the Blood Glucose Testing (12-17) indicator improved by 14.31 percentage points, the Cholesterol Testing (12-17) indicator improved by 12.22 percentage points and the Blood Glucose and Cholesterol Testing (12-17) indicator improved by 11.71 percentage points.
- Annual Dental Visit (ADV), the 2-3 Years indicator improved by 10.89 percentage points.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), the 12-17 Years indicator improved by 14.90 percentage points and the Total indicator improved by 16.37 percentage points.
- Well-Child Visits in the First 30 Months of Life (W30), the First 15 Months indicator improved by 14.33 percentage points and the 15 Months-30 Months indicator improved by 15.68 percentage points.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2021 and the previous year (2020). In the prior year, Molina did not report two CAN non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). For MY 2021, Molina did not report the three new Adult and Child core set measures until repeated requests were made. The table that follows provides an overview of the CAN non-HEDIS measure rates with the change from 2020 to 2021, as

applicable, noted. Rate changes shown in green indicate a substantial (>10%) improvement and rate changes shown in red indicate a substantial (>10%) decline.

Table 33: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate	MY 2021 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
COLORECTAL CANCER SCREENING (COL-AD)			
Ages 50 - 64	-	24.88%	-
Ages 65 - 75	-	NA	-
Total	-	24.86%	-
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-65	0.79%	0.69%	-0.10%
Ages 65+	NA	NA	NA
Total	0.79%	0.69%	-0.10%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception - 3 days	13.02%	12.60%	-0.42%
Most or moderately effective contraception - 60 days	53.28%	48.15%	-5.13%
LARC - 3 Days	0.68%	0.49%	-0.19%
LARC - 60 Days Reported	10.13%	9.31%	-0.82%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception Rate	27.90%	24.26%	-3.64%
LARC Rate	3.70%	3.33%	-0.37%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	23.74	27.85	4.11
Ages 65+	NA	0.00%	NA
Total	23.74	27.84	4.10
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	58.16	54.22	-3.94
Ages 65+	NA	0.00	NA
Total	58.14	54.18	-3.96
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	54.93	37.26	-17.67
Ages 65+	NA	0.00	NA

Measure	MY 2020 Rate	MY 2021 Rate	Change
Total	54.92	37.25	-17.67
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	4.24	4.52	0.28
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	17.12%	13.57%	-3.55%
Ages 65+	NA	0%	NA
Total	16.81%	13.38%	-3.43%
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	4.66%	4.79%	0.13%
Ages 65+	NA	NA	NA
Total	4.66%	4.79%	0.13%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	5.18%	4.52%	-0.66%
Ages 65+	NA	NA	NA
Total	5.18%	4.52%	-0.66%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	51.03%	54.18%	3.15%
Prescription for Buprenorphine	49.48%	53.51%	4.03%
Prescription for Oral Naltrexone	1.55%	1.00%	-0.55%
Prescription for Long-acting, injectable naltrexone	0.52%	0.00%	-0.52%
Prescription for Methadone	0.00%	0.00%	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%	1.10%	0.45%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	26.53%	30.00%	3.47%
Age 2 Screening	40.39%	45.53%	5.14%
Age 3 Screening	35.75%	37.75%	2.00%
Total Screening	28.43%	37.05%	8.62%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception - 3 days	2.22%	1.34%	-0.88%
Most or moderately effective contraception - 60 days	53.02%	46.98%	-6.04%

Measure	MY 2020 Rate	MY 2021 Rate	Change
LARC - 3 Days	0.81%	0.67%	-0.14%
LARC - 60 Days Reported	11.90%	12.53%	0.63%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception Rate	29.30%	27.41%	-1.89%
LARC Rate	2.51%	2.91%	0.40%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	NR	8.94%	NA
Numerator 2 All Four Molars Sealed	NR	4.79%	NA
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	-	0.10%	-
Ages 1-2	-	12.93%	-
Ages 3-5	-	30.35%	-
Ages 6-7	-	35.52%	-
Ages 8-9	-	35.82%	-
Ages 10-11	-	34.40%	-
Ages 12-14	-	30.19%	-
Ages 15-18	-	23.47%	-
Ages 19-20	-	13.24%	-
Total Ages <1-20	-	25.26%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	-	7.73%	-
Ages 3-5	-	9.64%	-
Ages 6-7	-	10.21%	-
Ages 8-9	-	10.44%	-
Ages 10-11	-	9.72%	-
Ages 12-14	-	7.57%	-
Ages 15-18	-	5.61%	-
Ages 19-20	-	2.90%	-
Total Ages 1-20	-	8.36%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	-	1.67%	-
Ages 3-5	-	5.61%	-
Ages 6-7	-	7.53%	-
Ages 8-9	-	8.06%	-
Ages 10-11	-	7.24%	-
Ages 12-14	-	5.53%	-

Measure	MY 2020 Rate	MY 2021 Rate	Change
Ages 15-18	-	4.19%	-
Ages 19-20	-	2.32%	-
Total Ages 1-20	-	5.10%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	-	0.00%	-
Ages 3-5	-	0.03%	-
Ages 6-7	-	0.00%	-
Ages 8-9	-	0.00%	-
Ages 10-11	-	0.00%	-
Ages 12-14	-	0.00%	-
Ages 15-18	-	0.00%	-
Ages 19-20	-	0.00%	-
Total Ages 1-20	-	0.00%	-

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

There were no measure rates that could be compared that showed a substantial increase. The Heart Failure Admission Rate (PQI-08), the Ages 18 - 64 and Total indicators fell by 17.67% member months per 100,000 member months.

For the CHIP non-HEDIS measures, there were several measures not reported by Molina or not enough data was available for reporting. In the prior year (MY2020), Molina did not report two CHIP non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). For MY 2021, Molina did not report the SFM measure and the two new Child core set measures until repeated requests were made. None of the measures that could be compared showed a substantial increase or decrease, as noted in *Table 34: CHIP Non-HEDIS Performance Measure Rates*.

Table 34: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate	MY 2021 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.23%	0.72%	0.49%
Ages 65+	NA	NA	NA
Total	0.23%	0.72%	0.49%

Measure	MY 2020 Rate	MY 2021 Rate	Change
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	9.49	10.18	0.69
Ages 65+	NA	NA	NA
Total	9.49	10.18	0.69
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	0.00	0.00	0.00
Ages 65+	NA	NA	NA
Total	0.00	0.00	0.00
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	0.00	0.00	0.00
Care of Acute and Chronic Conditions			
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	NA	NA	NA
Prescription for Buprenorphine	NA	NA	NA
Prescription for Oral Naltrexone	NA	NA	NA
Prescription for Long-acting, injectable naltrexone	NA	NA	NA
Prescription for Methadone	NA	NA	NA
Child Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	0.56%	0.64%	0.08%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	NA	NA	NA

Measure	MY 2020 Rate	MY 2021 Rate	Change
Age 2 Screening	51.27%	56.18	4.91%
Age 3 Screening	46.19%	41.65	-4.54%
Total Screening	48.33%	47.42	-0.91%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception - 3 days	NA	NA	NA
Most or moderately effective contraception - 60 days	NA	NA	NA
LARC - 3 Days	NA	NA	NA
LARC - 60 Days Reported	NA	NA	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	24.54%	25.15%	0.61%
LARC Rate	1.71%	1.42%	-0.29%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	NR	0.00%	NA
Numerator 2 All Four Molars Sealed	NR	0.00%	NA
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	-	NA	-
Ages 1-2	-	20.05%	-
Ages 3-5	-	43.26%	-
Ages 6-7	-	49.83%	-
Ages 8-9	-	47.38%	-
Ages 10-11	-	48.39%	-
Ages 12-14	-	41.18%	-
Ages 15-18	-	31.51%	-
Ages 19-20	-	19.50%	-
Total Ages <1-20	-	40.01%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	-	10.29%	-
Ages 3-5	-	13.14%	-
Ages 6-7	-	15.01%	-
Ages 8-9	-	15.97%	-
Ages 10-11	-	13.34%	-
Ages 12-14	-	12.38%	-
Ages 15-18	-	8.01%	-
Ages 19-20	-	4.21%	-

Measure	MY 2020 Rate	MY 2021 Rate	Change
Total Ages 1-20	-	12.04%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	-	2.23%	-
Ages 3-5	-	7.92%	-
Ages 6-7	-	11.48%	-
Ages 8-9	-	11.94%	-
Ages 10-11	-	9.83%	-
Ages 12-14	-	9.20%	-
Ages 15-18	-	6.04%	-
Ages 19-20	-	4.21%	-
Total Ages 1-20	-	8.48%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	-	0%	-
Ages 3-5	-	0%	-
Ages 6-7	-	0%	-
Ages 8-9	-	0%	-
Ages 10-11	-	0%	-
Ages 12-14	-	0%	-
Ages 15-18	-	0%	-
Ages 19-20	-	0%	-
Total Ages 1-20	-	0%	-

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

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

For this review, Molina submitted the same seven CAN PIPs that were submitted for the 2021 EQR. Topics for PIPs include Behavioral Health Readmissions, Asthma, Pharmacotherapy Management of COPD Exacerbation, Follow-up 7 and 30 Days after Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 35: Behavioral Health Readmissions CAN 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 BH Readmissions for Hinds County showed a decline in readmissions from Q1 2022 at 24.4% to Q2 2022 at 15%. The goal is 14%. The enrollment in high-risk case management for unique readmitted patients is reported to be 100%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Community connectors • Primary care initiative • Scheduling process changed • Onsite discharge planning • Transition of Care letters sent to members • Patient Outreach	

Table 36: Asthma Medication Ratio CAN PIP

Asthma Medication Ratio	
The aim for the Asthma PIP is to increase the compliance rate for 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 declined from 81.4% to 72.3% but is still above the goal rate of 71.3%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Asthma Medication Ratio
• Asthma education video on proper use of the inhaler • Monitoring of the non-compliant members and encourage providers to contact members to close the gap in care • Telephone call campaign to encourage members to get their annual wellness exams • Provider toolkits and educational materials • Member educational materials

Table 37: Pharmacotherapy Management of COPD Exacerbation CAN 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. For systemic corticosteroid, the rate improved from 36.4% to 46.3% with a goal of 67%. The bronchodilator rate improved from 54.6% to 71.6% with a goal of 81.8%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products. • 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 38: Follow-up 7 and 30 Days after Hospitalization for Mental Illness CAN 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 24.24% to 30.22%. The goal rate is 28.32%. For 30-day follow up, the rate also improved from 31.8% to 49.1% with a goal of 50%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• TOC Coaches: Once notified of assigned admitted members, the TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan. • Discharge planning checklist • Processes to improve efficiency of scheduling follow-up appointments • Provider Education	

Table 39: Prenatal and Postpartum Care CAN 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 to improve the percentage of deliveries that had a postpartum visit on or between 21-56 days of delivery. For prenatal care, the rate improved from 90.2% to 90.4% with a goal of 93.6%. The post-partum rate improved from 34.7% to 42% with a goal of 74.3%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member incentives-Gift cards and car seats • Member outreach events • Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize electric breast pump for the first 6 months of their child's life.	

Table 40: Sickle Cell Disease CAN PIP

Sickle Cell Disease	
The aim for the Sickle Cell Disease (SCD) PIP is to increase the rate of case management services for members with SCD. The rate declined from 7.5% to 4% with a goal of 15.9%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Internal monitoring and tracking for inpatient care and Emergency Department visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration: 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. • Member educational materials	

Table 41: Obesity CAN PIP

Obesity
The Obesity PIP focuses on the child population. The BMI percentile, Nutrition, and Counseling HEDIS rates are utilized. For BMI Percentile, the rate went from 9.7% to 17.1% with a goal of 61.3%. The nutrition rate went from 4.3% to 8.1% with a goal of 52.3%. The counseling rate improved from 4.1% to 7.9% with a goal of 57.4%.

Obesity	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member Incentives • Member outreach and member events for awareness and education	

CCME provided a Recommendation for the Sickle Cell Disease PIP as displayed in *Table 42: CAN Performance Improvement Project Recommendation*.

Table 42: CAN Performance Improvement Project Recommendation

Project	Section	Reason	Recommendation
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The Case Management Enrollment rate declined from 7.5% to 4% with a goal of 15.9%.	Continue working on member and plan related barriers to improve enrollment rates including internal collaboration and identification of members as well as member awareness and SCD pediatric to adult transition of care.

CHIP PIP Validation Results

Molina submitted the same four PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care/Well Child, Asthma Medication Ratio, Obesity, and Follow-up After Hospitalization for Mental Illness. All the CHIP PIPs scored in the "High Confidence in Reported Results" range as noted in the tables that follow. A summary of each project's status and the interventions is also included.

Table 43: Well Care/Well Child CHIP 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 was 42.59% with a goal of 55.79%. The most recent rates were 57% in Q1 and 60.33% in Q2. The last four rates have been above the goal rate.

Adolescent Well Care/Well Child	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Provider education with periodic face-to-face visits offering HEDIS toolkits, non-compliant member list, provider portal training and HEDIS Tip Sheets for well visits • Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale • Member incentives provided on the day of the screening	

Table 44: Asthma Medication Ration CHIP 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 rate was presented at 84.5% with a goal of 71.28%. The last two rates are also above the goal rate, with a rate of 81.82% in Q1 and 88.15% in Q2.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of the inhaler • Telephone campaigns to encourage members to get their annual wellness exams • Provider education with toolkits and assistance with member outreach	

Table 45: Obesity CHIP 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 BMI documentation rate improved from 9.36% in Q1 to 15.28% in Q2. The goal rate is 61.31%. The nutrition counseling rate also improved from 4.36% to 8.43% with a goal of 52.3%. Counseling for physical activity improved from 3.89% to 8.11% with a goal of 57.42%. 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**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Obesity- Ages 3 to 19
• Provider toolkits to help facilitate tracking reports and address areas needed • Member education, community outreach, and incentives

Table 46: Follow-up After Hospitalization for Mental Illness CHIP 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 improved from 31.25% in Q1 2022 to 62.5% in Q2 2022. The goal is 50%. The 7-day baseline rate improved from 12.5% to 35.4%- this is over the goal of 28.32%.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care collaborative on-site discharge planning • Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation • Implementation of a Discharge Planning Checklist. • Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge	

There were no Recommendations or Corrective Actions needed for the CHIP PIPs. Details of the validation activities for the PMs and PIPs, and specific outcomes related to each activity, may be found in *Attachment 3, CCME EQR Validation Worksheets*.

For this review period, 90% of the standards for CAN and CHIP received a "Met" score. The standards related to the tracking of EPSDT, and Well-Baby Well-Child services and the QI Program Evaluation received "Not Met" scores.

Figure 6: Quality Improvement Findings

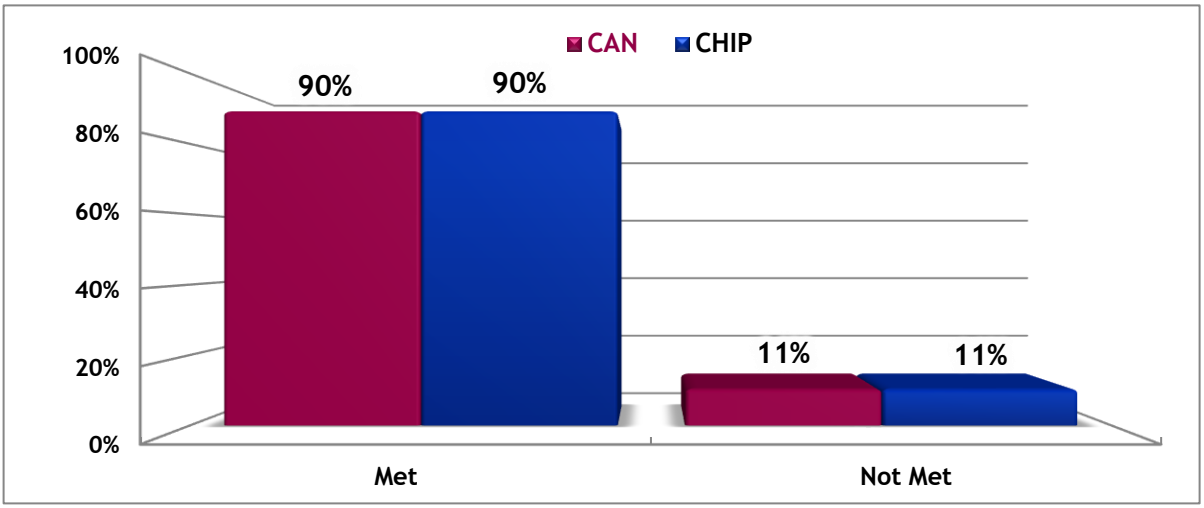


Table 47: Quality Improvement

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Provider Participation in Quality Improvement Activities	The CCO tracks provider compliance with EPSDT and Well Baby and Well Child service provision requirements for: Diagnosis and/or treatment for children	Not Met	Not Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program is prepared annually	Not Met	Not Met

Strengths

- Molina's HEDIS auditor found that the CCO was fully compliant with all information system Standards and determined that Molina 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 measures in the scope of the validation of PMs.
- The following CAN HEDIS MY 2021 measure rates were Strengths for Molina since their rates had a greater than 10% improvement:
    - Childhood Immunization Status (CIS), the DTaP indicator and the Pneumococcal Conjugate indicator improved by over 10 percentage points.

  - Asthma Medication Ratio (AMR), the 12-18 Years indicator improved by 10.73 percentage points.
  - Follow-Up After Emergency Department Visit for Mental Illness (FUM), the 30 days (6-17) indicator improved by 22.43 percentage points, the 30 days (18-64) indictor improved by 17.09 percentage points, the 7 days (18-64) indicator improved by 16.63 percentage points, the 30 days (Total) indicator improved by 18.41 percentage points, and the 7 days (Total) indicator improved by 12.95 percentage points.
  - Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) improved by 18.83 percentage points.
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), the Blood Glucose Testing (1-11) indicator improved by 11.67 percentage points and the Blood Glucose and Cholesterol Testing (1-11) indicator improved by 11.42 percentage points.
  - Well-Child Visits in the First 30 Months of Life (W30), the 15 Months-30 Months indicator improved by 11.44 percentage points.

- The following CHIP HEDIS MY 2021 measure rates were strengths for Molina since their rates had a greater than 10% improvement:
  - Childhood Immunization Status (CIS), the VZV indicator improved by 10.21 percentage points and the Combination #3 indicator improved by 10.26 percentage points.
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), the Blood Glucose Testing (12-17) indicator improved by 14.31 percentage points, the Cholesterol Testing (12-17) indicator improved by 12.22 percentage points and the Blood Glucose and Cholesterol Testing (12-17) indicator improved by 11.71 percentage points.
  - Annual Dental Visit (ADV), the 2-3 Years indicator improved by 10.89 percentage points.
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), the 12-17 Years indicator improved by 14.90 percentage points and the Total indicator improved by 16.37 percentage points.
  - Well-Child Visits in the First 30 Months of Life (W30), the First 15 Months indicator improved by 14.33 percentage points and the 15 Months-30 Months indicator improved by 15.68 percentage points.
- PIP reports included the CMS elements and integrated Corrective Actions from the previous review.

Weaknesses

- Molina provides information to members and providers about the QI Program via the website. The website contained information regarding the 2021 HEDIS and CAHPS rates and links for guides regarding Accessing Quality Health Care. The guide provided for the CAN members titled "Guide to Accessing Quality Health Care" appears to be out of date. This guide is dated 2020. However, the guide provided for the CHIP members was dated 2022.
- In the 2022 QI Work Plan, Section 5 – Availability of Practitioners, the standards used to measure the geographic distribution of PCPs were incorrect and do not meet the contractual requirements.
- The QIC Charter defines the quorum as at least 51% of committee members with no less than half of Community Network Provider participants necessary to enact and/or implement decisions. It was noted that the first quarter 2022 meeting did not have a quorum present. Molina pointed out this was an error in the minutes.
- Molina is not tracking member follow-up treatment and referrals needed for abnormal findings on an EPSDT and Well-Baby Well-Child exam, as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D)*. This was an issue identified during the 2020 and 2021 EQR that has not been corrected.
- The 2021 QI Program Evaluation was incomplete and did not contain the results or status of all QI activities completed or underway in 2021, as required by the *CAN Contract, Section 10 (D) (8)* and the *CHIP Contract, Section 9 (D) (8)*. This continues to be an issue and was identified in the 2020 and in the 2021 EQR and not corrected.
- The following CAN HEDIS MY 2021 measure rates and non-HEDIS Adult Core Set measure rates were determined to be areas of opportunity for Molina since their rates had a greater than 10% decline:
    - Follow-Up Care for Children Prescribed ADHD Medication (ADD), the Initiation Phase indicator declined by 21.44 percentage points and the Continuation and Maintenance (C&M) indicator declined by 22.20 percentage points.
    - Heart Failure Admission Rate (PQI-08) the Ages 18 - 64 and Total indicators fell by 17.67 member months per 100,000 member months.
- In the prior year, Molina did not report two CAN and CHIP non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). For CAN MY 2021, Molina did not report the three new Adult and Child core set measures until repeated requests were made. For CHIP MY 2021, Molina did not report the SFM measure and the two new Child core set measures.

Corrective Actions

- To ensure compliance with the contractual requirements, implement a system for tracking members identified with an abnormal finding on an EPSDT exam that includes the diagnosis, treatment, and referrals needed to address the abnormal findings, as required by the *CAN Contract, Section 5 (D)* and the *CHIP Contract, Section 5 (D).*
- Correct the 2021 QI Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the *CAN Contract, Section 10* and *Exhibit G* and the *CHIP Contract, Section 9,* and *Exhibit F.*

Recommendations

- Update the information provided to CAN members on Molina's website regarding quality guides.
- Correct the standards used to measure geographic distribution of PCPs in the 2022 QI Work Plan.
- Ensure attendance is documented correctly for each committee meeting. Correct the QIC first quarter 2022 meeting minutes to demonstrate the committee members present and the quorum requirements were met.
- Work proactively with DOM for clarification on measures that are required to be reported as well as work with the Molina corporate teams to ensure the list of measures required for reporting are provided. Improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures.

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 Molina's CAN and CHIP Utilization Management (UM) Program included the program description, pharmacy description, relevant policies, clinical determination processes, Member Handbooks, Provider Manuals, and a sample of approval, denial, and care management files.

Molina's Health Care Services Program Description outlines the UM program scope, lines of responsibility for staff, and objectives for behavioral health and physical health services for members. Also, Molina's Pharmacy Program Description describes the pharmaceutical services offered for CAN and CHIP members through the Molina Healthcare Pharmacy Services Department. CVS Caremark is the health plan's pharmacy benefit manager.

Within Molina's UM Program, the Chief Medical Officer (CMO) has authority and oversight responsibility of the program. Various roles of the Medical Director/CMO include serving as committee chair on various committees such as the Credentialing Committee, Healthcare Services Committee, etc. Additional roles include, but are not limited to, conducting Level II reviews, case staffing, implementing appropriate clinical practice guidelines, etc. The Behavioral Health Medical Director and Pharmacy Director provide clinical oversight of their respective programs and collaborative efforts occur as needed with the CMO.

Molina's network providers and practitioners participate in the policy development process and clinical criteria implementation through various committees such as the Health Care Services Committee, P&T Committee, and Clinical Policy Committees. Additionally, reviewers use evidenced based clinical guidelines in performing UM determinations that are reviewed and approved annually by the Healthcare Services Committee.

Coverage and Authorization of Services

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

Initial clinical reviews are conducted by licensed and qualified UM reviewers who use evidenced based clinical guidelines such as MCG, State guidelines, etc., for UM determinations as described in the Health Care Services Program Description, Policy 365.01, Clinical Criteria for Making UM Decisions, and Policy HCS 365, Clinical Criteria for UM Decision Making. Additionally, individual member conditions and circumstances are considered during UM reviews to address specific member needs.

Level II clinical reviews are performed by Mississippi licensed physicians or appropriate healthcare practitioners. The Pharmacy Services Program Description identifies that a licensed pharmacist makes pharmacy determinations. Additionally, within behavioral health services, clinical oversight is provided by the Healthcare Services Director or Manager of Behavioral Health who holds a license as a prepared practitioner along with five years of post-master's clinical experience.

A review of the sample of CAN and CHIP approval and denial files reflect that licensed clinical staff and Medical Directors appropriately issue UM determinations. Also, the files reflect that individualized clinical needs are taken into consideration and clinical consultations occurred appropriately with the Medical Director as described in Policy HCS.65.01, Clinical Criteria for UM Decision Making, and Molina's Health Care Services Program Description.

The timeliness for the completion of authorizations is specified in the Health Care Services Program Description and Policy MHMS-HCS-UM-383, Timeliness of UM Decisions and Making Notifications. CCME identified an issue with Policy MHMS-HCS-UM-383 regarding the timeframe for extensions during the previous EQR. Molina addressed this

deficiency and corrected the policy. The table that follows provides an overview of the corrective action.

Table 48: Previous Utilization Management (UM) Program CAP Items

Standard	EQR Comments
V A. Utilization Management (UM) Program – CAN	
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	CCME identified the following issues on pages two, seven, and 11 of Policy MHMS-HCS-UM-383, Timeliness of UM Decision Making and Notification, related to extensions of urgent 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. According to requirements in the *CAN Contract, Section 5 (J) (6)* "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." *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).*
Molina's Response: Policy MHMS-HCS-UM 383 was updated to reflect that the supporting documentation listed in the policy (on the identified pages) to include the correct timeframe as defined by CAN Contract Section 5(j)(6) "the 24-hour period may be extended up to 14 calendar days upon request of the member, or the Provider, or if the contractor requests an extension from the Division"	
V A. Utilization Management (UM) Program – CHIP	
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	CCME identified the following issues on pages two, seven, and 11 of Policy MHMS-HCS-UM-383.1, Timeliness of UM Decision Making and Notification, related to extensions of urgent 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 must request an extension from DOM. 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." *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*

Standard	EQR Comments
	authorization requests and to indicate that Molina must request an extension from DOM, according to requirements in the CHIP Contract, Section 5 (I) (4).
Molina's Response: Policy MHMS-HCS-UM 383 was updated to reflect that the supporting documentation is in listed in the policy (on the identified pages) to include the correct timeframe as defined by CHIP Contract, Section 5 (I) (4) "the 24-hour period may be extended up to 14 calendar days upon request of the member, or the Provider, or if the contractor requests an extension from the Division"	

The review of the CAN and CHIP approval files reflect that most of the clinical determinations and notifications were completed in a timely manner. One CHIP approval file was not completed in a timely manner.

Review of the CAN and CHIP denial files reflect timeliness in completing UM determinations, and the adverse benefit decisions were promptly communicated to the provider and member. Additionally, Member and Provider Appeal forms were attached to the Adverse Benefit Determination notices to aid in completion of the appeal process if requested.

As explained in the 2021 HCS Annual Evaluation Executive Summary and Molina Healthcare Program Description, annual Inter-rater Reliability Testing (IRR) is conducted for physicians, nurses, pharmacists, and behavioral health medical directors. Results yielded a passing 90% threshold score, except for the Mississippi Medical Directors who scored 87%. Per onsite discussion, the health plan conducted a refresher training on clinical criteria and a retest occurred with the personnel that did not pass the initial IRR testing. The behavioral health clinical staff also a receive quarterly IRR testing and received a passing score. Additionally, monthly audits are conducted to ensure consistency and quality assurance of clinical application.

Appeals

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

Policy MHMS-MRT-02, Standard Member Appeals, outlines processes and requirements for handling member appeals of Adverse Benefit Determinations. Policy MHMS-MRT-03, Expedited Member Appeals, includes the process followed when a member, provider, or authorized representative requests an expedited appeal. The procedures for filing an appeal are described in Policy MHMS-MRT-02 and Policy MHMS-MRT-03. Information regarding the process for filing an appeal was also found in the CAN and CHIP Member Handbooks, CAN and CHIP Provider Manuals, and on Molina's website. These documents along with the website, several appeal request forms, and the Adverse Benefit Notification template incorrectly indicate that a verbal appeal must be followed by a signed written appeal.

Policy MHMS-MRT-02, Standard Member Appeals, defines information that must be included in appeal acknowledgement letters. However, the standard appeal acknowledgement letter template does not include the statement offering a State Fair Hearing, which is not applicable for CHIP, or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy.

Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals, correctly documents the resolution timeframe for standard and expedited appeals. Both policies include the process followed if the member or Molina requests more time to complete the review. However, these polices do not include the member's right to file a grievance if they disagree with this extension. Also, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and Molina's website do not include the member's right to file a grievance if they disagree with the extension. However, Molina's notice sent to CAN and CHIP members when Molina requests an extension does notify the member of their right to file a grievance if they disagree with the extension.

During the previous EQR, CCME found that Policy MHMS-MRT-02, Standard Member Appeals, which applies to both the CAN and CHIP programs, did not include the process for CHIP members to request an Independent External Review. The policy received with the desk materials did not contain the corrected language. This was discussed during the onsite, and Molina informed CCME that the wrong policy had been provided. Following the onsite, another copy of Policy MHMS-MRT-02, Standard Member Appeals, was provided and included the correct information regarding a CHIP member's right to request an Independent External Review. The table that follows provides an overview of the previously identified deficiency and Molina's response.

Table 49: Previous Appeals CAP Items

Standard	EQR Comments
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: 1.6 Written notice of the appeal resolution;	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 Independent External Review, which applies to CHIP members, is not listed as a reference. *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.*

Standard	EQR Comments
Molina's Response: The 'Reference' list on MHMS-MRT-02 has been updated to include MHMS-MRT-05. MHMS-MRT-02 has also been updated to include Independent External Review language; specifically bullet 26 under the Procedure section.	

The CHIP Member Handbook, page 57, provides information regarding continuation of benefits while an Independent External Review takes place. However, the timeframe for requesting the continuation of benefits is not mentioned. This information is included in the Appeal Request Form attached to the Adverse Benefit Determination notice.

Overall, the review of CAN and CHIP appeal files reflected Molina consistently processes standard and expedited appeal requests according to the guidelines in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. There were two CAN files that were not processed following the guidelines. Those issues include:

- One file required the member to submit their verbal appeal request in writing even though the member requested an expedited appeal.
- For one file, Molina notified the member that an extension for resolution was needed on the same day as the resolution notice was mailed.

There were three CHIP files that were not processed following the guidelines in Molina's policy. Those issues include:

- One file required the member consent even though the request was made by the member's mother.
- The resolution notice for one file did not offer the member the right to request an Independent External Review. The letter incorrectly stated the member has the right to file a State Fair Hearing, which is not allowed for CHIP members.
- For one file, Molina requested an extension on March 4, 2022, asking for 14 additional days to resolve the appeal. The appeal was closed on March 16, 2022, and should not have been closed until March 20, 2022, which was the end of the 14-day extension. Molina responded to this issue and mentioned that day 43 and 44 would fall on the weekend and the Specialist was on PTO on days 41 and 42. The appeal was closed on day 40 to avoid being late. Molina's policy does not mention how appeals should be processed if a staff member is on PTO.

Care Management

42 CFR § 208, 42 CFR § 457.1230 (c)

The Health Care Services Program Description and relevant policies provide a descriptive overview of Molina's Care Management Program, processes, guidelines, and procedures in

providing care management services to members. Molina's Healthcare Integrated Care Management Program offers physical and behavioral health care coordination for members to promote access to care to community resources. Additionally, the program focuses on enhancing disease prevention education, health promotion, and enhanced disease management as described in the Health Care Services Program Description and Quality Improvement Program Description.

Members are stratified through various data driven methodologies. During onsite discussion, it was indicated that members are stratified and re-stratified monthly through a predictive modeling tool that analyzes several factors, such as social determinants of health, claims, admissions, clinical notes, etc. This will initiate a care management referral to the respective medical or behavioral health care management departments and an initial outreach occurs within five calendar days to the prospective member.

Molina completes a Health Risk Assessment (HRA) within 30 calendars days according to requirements in the *CAN Contract, Section 9 (A)* and the *CHIP Contract, Section 8 (A)*. Once the HRA is completed, an Individualized Care Plan is developed with the interdisciplinary care team consisting of nurses, care managers, physicians, social workers, guardian, member, etc., as described in Policy HCS-54.01, Individualized Care Plan Development Procedure Addendum. This stated policy reflects that HRAs are completed by a qualified health professional and an Individualized Care Plan is developed within 30 days of completion of the HRA. Also, onsite discussion identified that an Individualized Care Plan is completed within the CAN and CHIP contractual timeframes. Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information.

Molina's members are stratified to various risk levels and receive specified care management services according to their risk level. Review of the sample Care Management files reflects appropriate services were provided to members based upon their level of care need.

Molina addressed previously identified issues related to processes for addressing continuity of care when the member disenrolls from the health plan. See *Table 50: Previous Care Management CAP Items* for the issues identified during the previous EQR and Molina's response to the items.

Table 50: Previous Care Management CAP Items

Standard	EQR Comments
V D. Care Management - CAN	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	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)*. *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).*
Molina's Response: MHMS-HCS-CM-406 Transition to Other Care When Benefits End uploaded to the portal	
V D. Care Management - CHIP	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	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. *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).*
Molina's Response: Uploaded to the portal document: MHMS-HCS-CM-406 Transition to Other Care When Benefits End	

As noted in *Figure 7: Utilization Management Findings*, Molina achieved "Met" scores for 98% of the Utilization Management standards for both CAN and CHIP.

Figure 7: Utilization Management Findings

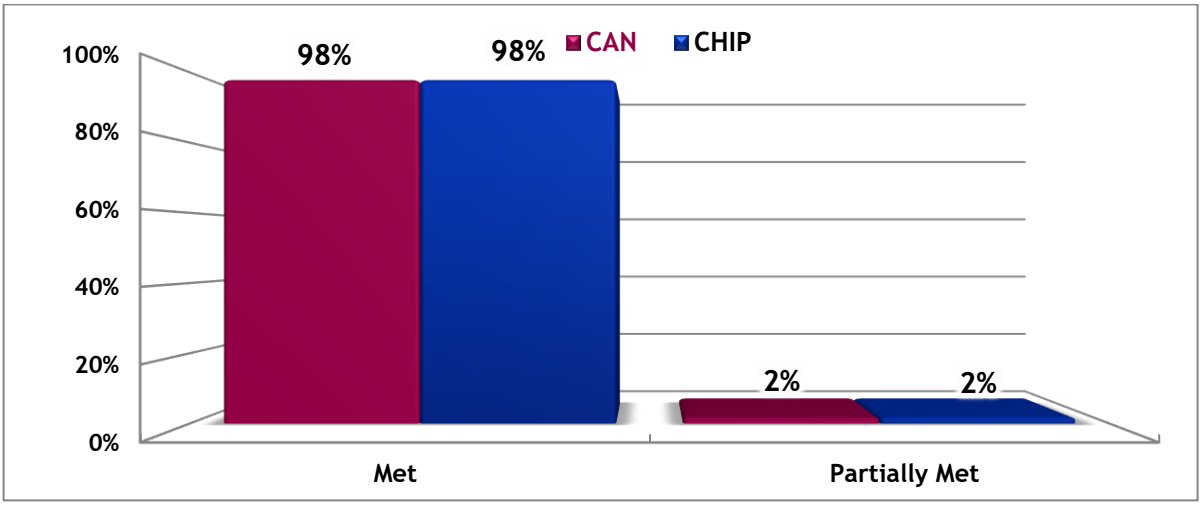


Table 51: Utilization Management

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Appeals	The Coordinated Care Organization (CCO) formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: The procedure for filing an appeal	Partially Met	Partially Met

Strengths

- Random case audits occur monthly to monitor the clinical application of medical necessity criteria.
- For denial files, the majority of second level reviews were completed by the appropriate physician reviewer on the same day as the initial review.
- Requests for authorization are processed in a timely manner.

Weaknesses

- Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and Molina's website incorrectly indicate a verbal appeal must be followed by a signed written appeal. In addition, several appeal request forms and the Adverse Benefit Notification template also incorrectly indicate a verbal appeal must be followed by a signed written appeal.

- Policy MHMS-MRT-02, Standard Member Appeals, lists the information that must be included in appeal acknowledgement letters. However, the CAN standard appeal acknowledgement letter template does not include the statement of offering a State Fair Hearing or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy. The CHIP standard appeal acknowledgement letter template does not include the statement of offering the one-page "Grievance/Appeal Form" as mentioned in the policy.
- Policy MHMS-MRT-02, Standard Member Appeals, which is applicable for CAN and CHIP, mentions the offering of a State Fair Hearing is included in the acknowledgement letter. However, State Fair Hearings are not available to CHIP members.
- Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals, do not include the member's right to file a grievance if they disagree with Molina's request for an extension. Also, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and Molina's website do not include the member's right to file a grievance if they disagree with the extension.
- The CHIP Member Handbook, page 57, provides information regarding the continuation of benefits while an Independent External Review is pending. However, the timeframe for requesting the continuation of benefits is not mentioned.
- Two CAN and three CHIP appeal files were not processed following the appeal policies and guidelines.
- Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information.

Corrective Actions

- Update Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals. the CAN and CHIP Member Handbooks, CAN and CHIP Provider Manuals, the appeal request forms, and Molina's website to remove the requirement that a member must follow a verbal request for an appeal with a written request.
- Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.

Recommendations

- Include in policy, the Member Handbooks, Provider Manuals, and on Molina's website the members right to file a grievance if they disagree with Molina's request for an extension.

- Update the CHIP Member Handbook and include the timeframe for requesting the continuation of benefits during Molina's appeal process and during the Independent External Review process.
- Reeducate staff to ensure complete understanding that a verbal request for an appeal no longer requires the member to follow-up with a written request. Also, improve the documentation in the appeal files regarding Molina's need to request an extension for resolution.
- Reeducate staff to ensure complete understanding regarding when member consent is needed for appeal requests. Develop a quality check process before resolutions notices are sent to ensure the correct notices are sent to CHIP members. Also, develop a process for handling appeals when staff are on paid time off to ensure timeframes are met and members are allowed the full timeframe for submitting additional information.
- Include a reference to the *CHIP Contract, Section 8 (A)* in the Source of Decision for Policy 154.01, Individualized Care Development Procedure Addendum.

VI. Delegation

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

The review of Delegation activities examined the submitted list of delegates, delegation agreements, delegation monitoring processes, and documentation of oversight conducted for each delegated entity.

Molina reported 15 current delegation agreements, as shown in *Table 52, Delegated Entities and Services*.

Table 52: Delegated Entities and Services

Delegated Entities	Delegated Services
March Vision Care	Claims, Credentialing, Call Center (Vision Administration)
MTM	Claims, Driver Validation, Call Center (Non-Emergent Transportation)
Progeny	Care Management, Utilization Management
SKYGEN	Claims, Credentialing, Call Center, Utilization Management (Dental Administration)
CVS/ Caremark	Pharmacy Benefit Management (Claims only)
Memorial Hospital at Gulfport North Mississippi Health Services, Inc Magnolia Regional Health Care Singing River Medical Center Baptist Memorial Medical Group	Credentialing/Recredentialing

Delegated Entities	Delegated Services
Hattiesburg Clinic Ochsner Hancock Medical Group George Regional Health System Mississippi Physician's Care Network University Mississippi Medical Center	

Molina implements written agreements with each delegate using the Molina Healthcare of Mississippi, Inc. Delegation Services Addendum (DSA) document. The DSA specifies the activities that are being delegated and corresponding requirements. It includes general terms and conditions of the delegation, related to policies and procedures, pre-delegation assessment, ongoing monitoring and assessment, requirements for sub-delegation, reporting requirements, audits, compliance, and confidentiality. Information in the DSA addresses actions that may be taken for substandard performance by the delegate, which may include corrective action and/or revocation of delegation.

As noted in Policy DO001, Delegation Pre Assessment Audits, all potential delegates are subjected to a pre-delegation assessment to determine the delegate's ability to meet established criteria for the functions being delegated. Pre-delegation assessments are presented to the Delegation Oversight Committee (DOC) for review and determination. Processes for conducting ongoing monitoring and evaluation of delegates for continued compliance with all required standards are documented in Policy DO002, Performance Monitoring and Annual Audits of Delegation. Annual audits include a sample file review, when applicable. Upon completion of the annual evaluation, Delegation Oversight staff finalize audit summaries and worksheets, including Corrective Action Plans if necessary. The finalized documents are presented to the DOC for review and a determination regarding continued delegation.

CCME reviewed the documentation of delegate oversight provided by Molina. Issues identified included:

- For CVS/Caremark, no documentation of pre-delegation assessment was submitted. The initial delegation date was 10/1/21.
- For March Vision Care, the credentialing file review worksheet indicates site visits are delegated to March Vision Care but did not include evidence of monitoring the delegate for conducting initial site visits. This is a repeat finding from the previous EQR. See *Table 53: Previous Delegation CAP Items* for the previous finding and Molina's response.

Table 53: 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.	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. 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. *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 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.*
Molina's Response: Molina has consulted with 3 different vendors regarding site visits and fingerprinting, and all three have either confirmed that they do not perform related services or that they cannot perform the services within proposed time frames (i.e., prior to when uniform credentialing goes live in Mississippi). Molina has since shifted its focus to discussing how this could all be handled internally by Molina. A final process still has not been developed, but Molina is making progress. Several additional internal meetings have been held and work is underway on identifying providers subject to these requirements and also the best methods of completing these requirements. Molina can provide additional details on the processes once it is finalized. 2.24.2022- Document CAP Item# 8 uploaded to the portal.	
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.	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. File review worksheets for credentialing delegates 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. *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.*

Standard	EQR Comments
VI Delegation - CAN	
Molina's Response: Molina has consulted with 3 different vendors regarding site visits and fingerprinting, and all three have either confirmed that they do not perform related services or that they cannot perform the services within proposed time frames (i.e. prior to when uniform credentialing goes live in Mississippi). Molina has since shifted its focus to discussing how this could all be handled internally by Molina. A final process still has not been developed, but Molina is making progress. Several additional internal meetings have been held and work is underway on identifying providers subject to these requirements and also the best methods of completing these requirements. Molina can provide additional details on the processes once it is finalized. 2.24.2022- Document CAP Item #18 uploaded to the portal.	

As indicated in *Figure 8, Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met." The standards scored as "Not Met" were due to uncorrected deficiencies from the previous EQR.

Figure 8: Delegation Findings

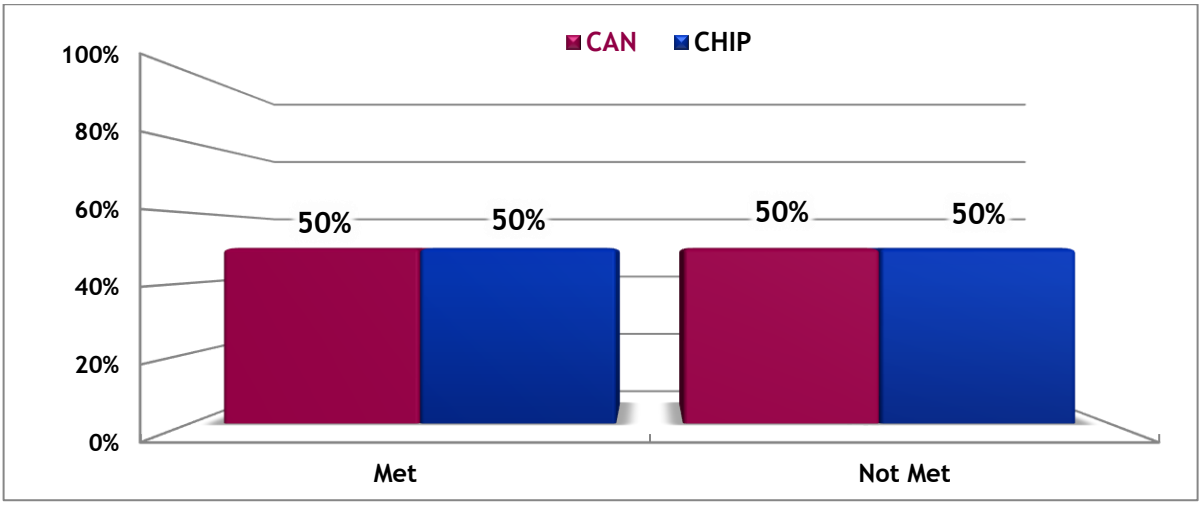


Table 54: Delegation

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Delegation	The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	Not Met	Not Met

Weaknesses

- Policy DO002, Performance Monitoring and Annual Audits of Delegation, states Molina ensures continued compliance with delegation standards through ongoing monitoring

and annual audits. CCME reviewed the delegate oversight documents provided by Molina. The following issues were identified:

- For CVS/Caremark, documentation included reports of routine monitoring and delegate reporting, but no documentation of a pre-delegation assessment was provided. The date of initial delegation was noted by the CCO as 10/1/21.
- For March Vision Care, the credentialing file review worksheet did not include evidence of monitoring the delegate for conducting initial site visits. The documentation indicated site visits are delegated to March Vision Care, and the health plan policy is that an initial credentialing site visit is to be conducted for all delegates. This is a repeated finding from the previous EQR.

Corrective Actions

- Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained.
- When site visits are delegated to a credentialing delegate, ensure they are monitored for conducting the site visits according to health plan policy.

ATTACHMENTS

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

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

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

June 23, 2022

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 2022 External Quality Review (EQR) of Molina Healthcare of Mississippi is being initiated. The review will include the MississippiCAN (MSCAN) and Mississippi CHIP (MS CHIP) Programs and will be conducted by The Carolinas Center for Medical Excellence (CCME).

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

The virtual onsite visit will be conducted on **October 19, 2022** and **October 20, 2022** for the MississippiCAN and Mississippi CHIP 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 **July 25, 2022**.

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

Molina Healthcare of Mississippi

External Quality Review 2022 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

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

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

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

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

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

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

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

    a. For all projects with non-HEDIS measures:

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

b. For projects with measures derived from medical record abstraction:
   - full documentation of the abstraction process and tool used during abstraction.

c. For projects with measures derived from administrative electronic systems:
   - full source code documentation of how the measure was processed and calculated for the PIP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31. A sample provider contract for the MSCAN Program.

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

h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of August 2021 through July 2022.

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

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

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

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

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

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

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

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

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

ii. Two OB/GYNs;
iii. Two specialists;
iv. Two behavioral health providers
v. Two network hospitals; and
vi. One file for each additional type of facility in the network.

c. Twenty-five medical necessity denial files for the MSCAN Program made in the months of August 2021 through July 2022. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of August 2021 through July 2022, including any medical information and approval criteria used in the decision.

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

These materials:

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

Molina Healthcare of Mississippi

External Quality Review 2022 for Mississippi CHIP

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the Mississippi CHIP (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. If applicable, identify staff members who are assigned only to MSCAN and staff members are assigned only 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 CHIP members.

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

8. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for 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 2021 and 2022.

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

d. 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.
e. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction.
f. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP.

12. Minutes of <u>all committee meetings</u> within the past year for committees reviewing or taking action on 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. <u>Please indicate which members are voting members and include committee charters if available</u>.

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 2021 and 2022 .

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

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

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

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

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the 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 (Geo Access) reports and provider appointment and after-hours access monitoring.

27. Preventive health 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 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 CHIP Program, a list of physicians currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual for the 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 August 2021 through July 2022.

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

Date of Initial Delegation	Name of Delegated Entity	Functions Delegated	Methods of Oversight

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

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

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

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

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

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

37. Provide electronic copies of the following files for the CHIP program:
    a. Credentialing files (<u>including provider office site visits as appropriate</u>) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.

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

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

These materials:

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

II. Attachment 2: Materials Requested for Onsite Review

Molina Healthcare of Mississippi
MississippiCAN and CHIP

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Quarter 1 2022 Provider Newsletter

3. A copy of the Grievance Extension letter template for CAN and CHIP.

4. A copy of the EPSDT and Well Baby Well Child tracking reports.

5. All four CHIP PIP reports that include all baseline (2021) and remeasurement data (available 2022 quarters) in a single report

6. 2021 QI Program Evaluation Draft

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

III. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN and CHIP
- Member Satisfaction Survey Validation CAN
- Member Satisfaction Survey Validation CHIP
- HEDIS PM Validation CAN
- **ADULT CORE SET MEASURES CAN**
- **CHILD CORE SET MEASURES CAN**
- HEDIS PM Validation CHIP
- **ADULT CORE SET MEASURES CHIP**
- **CHILD CORE SET MEASURES CHIP**
- PIP Validation CAN
- PIP Validation CHIP

CCME EQR Survey Validation Worksheet

Plan Name	**Molina CAN/CHIP**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2021
Review Performed	2022

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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

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

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,500. SPH Analytics collected 164 surveys which is a response rate of 10.9%. This is higher than the 2020 rate of 7% but remains below the NCQA target rate of 40%. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2021 **Recommendation**: Determine if there are additional methods to increase provider response rates.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Provider Satisfaction Survey Final Report by SPH Analytics 2021

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 10.2% (137 out of 1344). This is lower than last year's rate of 10.3% and lower than the SPH average response rate of 14.8%. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult ***Recommendation:*** Continue to determine ways to advertise surveys and increase response rates.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult

Results Elements		Validation Comments and Conclusions
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Adult

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 7.3% (375 out of 5161). This is lower than last year's rate of 10.2% and lower than the SPH average response rate of 12.8%. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid ***Recommendation:*** *Continue to determine ways to advertise surveys and increase response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate of 12.0% (197 out of 1645). This is lower than the SPH BoB rate of 12.8% and the NCQA target rate of 40%. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid ***Recommendation:*** *Continue to determine ways to advertise surveys and increase response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* 2021 SPH Analytics Member Satisfaction Report- Child Medicaid

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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 MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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
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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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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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
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S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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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%.*
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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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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 MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**ALL HEDIS MEASURES**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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:	**TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2022**
Review Performed:	**10/19/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**ASTHMA (AMR)**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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)**	**MET**	The rate declined from 81.4% to 72.3% but is still above the goal rate of 71.3%.
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**	AMR rate above goal indicates interventions are maintaining improvement in rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	p-values are presented in report
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:	**BEHAVIORAL HEALTH READMISSIONS FOR HINDS COUNTY**
Reporting Year:	2021/2022
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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)**	**MET**	BH Readmissions for Hinds County showed a decline in readmissions from Q1 2022 at 24.4% to Q2 2022 at 15%. The goal is 14%. Enrollment in high-risk case management for unique readmitted patients is reported to be 100%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions including community connectors, BH task force, primary care initiative, scheduling process changed, onsite d/c planning, ToC letters to members, and patient outreach. .
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	p-values are 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:	**COPD**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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)**	**MET**	For systemic corticosteroid, the rate improved from 36.4% to 46.3% with a goal of 67%. The bronchodilator rate improved from 54.6% to 71.6% with a goal of 81.8%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions focused on member education, ToC connections, and follow-up with lost contacts.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	p-values are 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
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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)**	**MET**	The 7-day rate improved from 24.24% to 30.22%. The goal rate is 28.32%. For 30-day follow up, the rate also improved from 31.8% to 49.1% with a goal of 50%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions focused on member education, outreach bundle process, and the /c planning checklist.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	p-values are 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
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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)**	**MET**	For BMI Percentile, the rate went from 9.7% to 17.1% with a goal of 61.3%. The nutrition rate went from 4.3% to 8.1% with a goal of 52.3%. The counseling rate improved from 4.1% to 7.9% with a goal of 57.4%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions including provider education, member outreach/incentives, and member events.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	p-values are 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:	**PRENATAL AND POSTPARTUM CARE - PPC**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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)**	**MET**	For prenatal care, the rate improved from 90.2% to 90.4% with a goal of 93.6%. The post-partum rate improved from 34.7% to 42% with a goal of 74.3%.
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 appears to be related to interventions focused on provider education, member incentives, Project 500, and the electric breast pump program.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	p-values are 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
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis is 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 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)**	**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 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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 is 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 are reported.
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 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 are 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 are 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**	The Case Management Enrollment rate declined from 7.5% to 4% with a goal of 15.9%. ***Recommendation:*** *Continue working on member and plan related barriers to improve enrollment rates including internal collaboration and identification of members as well as member awareness and SCD pediatric to adult transition of care.*
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)**	**MET**	p-values are 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	0
9.2	NA	NA
9.3	1	1
9.4	NA	NA

Project Score	74
Project Possible Score	75
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 CHIP**
Name of PIP:	**ASTHMA (AMR)**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	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 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 is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 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 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 and additional remeasurements are 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)**	**MET**	Baseline and repeat measurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis is included in the report for the quarterly rates.
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)**	**MET**	The last two rates are also above the goal rate, with a rate of 81.82% in Q1 and 88.15% in Q2.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to ToC coaches assessments, case management, member education, and provider education.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Rates have been sustained above the goal rate for several remeasurements.

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	5	5

Project Score	85
Project Possible Score	85
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- 7 AND 30 DAY**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	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.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 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 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**	Results are presented in table and narrative 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**	Baseline and remeasurement rates are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis is included in the report for the quarterly rates.
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)**	**MET**	The 30-day rate improved from 31.25% in Q1 2022 to 62.5% in Q2 2022. The goal is 50%. The seven-day baseline rate improved from 12.5% to 35.4%- this is over the goal of 28.32%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to onsite discharge planning, the bundle process, post d/c follow-up, behavioral health provider engagement, discharge checklist, and engagement with CMHCs.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
High Confidence in Reported Results

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**OBESITY**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	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.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 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 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**	Results are reported in narrative and chart/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**	Baseline and remeasurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis is included in the report for the baseline and quarterly rates.
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)**	**MET**	The BMI documentation rate improved from 9.36% in Q1 to 15.28% in Q2. The goal rate is 61.31%. The nutrition counseling rate also improved from 4.36% to 8.43% with a goal of 52.3%. Counseling for physical activity improved from 3.89% to 8.11% with a goal of 57.42%. The BMI percentile goal is 61.31%; the Nutrition goal rate is 52.31%; and the physical activity counseling goal is 57.42%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to community events, member incentives, provider education, and collaboration with external organizations.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
High Confidence in Reported Results

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**WELL CARE/WELL CHILD VISITS**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	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.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are 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 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 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**	Results are displayed in table and chart 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**	Baseline and repeat measurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis is included in the report for rates over time (quarters).
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)**	**MET**	The baseline rate was 42.59% with a goal of 55.79%. The most recent rates were 57% in Q1 and 60.33% in Q2.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to provider education, incentives for ages 1 to 15, member outreach, member engagement/community events, and pop-up resource centers.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	The last four rates have been above the goal rate.

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	5	5

Project Score	85
Project Possible Score	85
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:	2022

ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					The Molina Policy and Procedure Committee was formed to review and revise policies with leadership from each Department. Once final drafts are complete, policies are sent to DOM for final approval and stored in SharePoint for staff access.
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					Bridget Galatas is Molina's Plan President.
1.2 *Chief Operating Officer;	X					Keshia Lymuel is the Chief Operating Officer.
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 Matt Hall.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					The Provider Services Director is Chinwe Nichols.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					
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 Associate Vice President Quality Improvement.
1.11 *Marketing, member communication, and/or public relations staff;	X					The Manager of Communications is Tiffany Hollis-Johnson.
1.12 *Medical Director;	X					Thomas Joiner, M.D. is the Chief Medical Officer.
1.13 *Compliance Officer.	X					Latasha McGill is the 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)*						
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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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 are 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 Healthcare Effectiveness Data and Information Set (HEDIS) performance data is generated using the National Committee for Quality Assurance-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. During the virtual site review it was discussed that Molina should improve monitoring and communication with the corporate team for DOM requirements for measure reporting.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Molina's Information Technology 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, a data copy is stored 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					Policy C-01.1, Written Policies and Procedures, Compliance Plan, and Standards of Conduct, states that Molina's Compliance Officer reviews and amends the Compliance Plan at least annually and as needed, to reflect changes in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						law, the healthcare market, structure of the company, identified risks, and industry practice.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Molina Healthcare Code of Business Conduct and Ethics emphasizes the expectation that business be conducted in accordance with applicable laws, rules, and contract requirements, as well as ethical business and professional practices.
2.2 Identification of the Compliance Officer;						The Compliance Officer is identified on Molina's Organizational Chart and Compliance Committee Membership List. Applicable roles and responsibilities are addressed in the 2022 Compliance Work Plan.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						Policy C-01.3, Effective Training and Education, as well as the Compliance Work Plan outline areas of required employee training. The ILearn Compliance Course training platform is used for the completion and tracking of required training for all new employees within thirty days from their date of hire as well as annually thereafter.
2.5 Lines of communication;						
2.6 Enforcement and accessibility;						Molina issues corrective action plans as part of correcting incidents of non-compliance, whether those incidents are self-identified or identified by an outside body (e.g., a regulator or enforcement agency).

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Internal monitoring and auditing;						Policy C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks, describes processes for routine monitoring and auditing of compliance risks, prompt responses to issues, the investigation of potential problems, correction of identified problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with federal, state, and local rules and regulations.
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					The Compliance Plan indicates that the Compliance Committee reports quarterly to the Board of Directors and monthly meetings are held with subsidiary compliance officers and subsidiary senior management. Policy C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, denote that the Compliance Committee shall be comprised of individuals from the Board of Directors and/or Senior Management and meets at least on a quarterly basis or more frequently as necessary, to enable reasonable oversight of the compliance program.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The Molina Healthcare of Mississippi Fraud, Waste, and Abuse Plan effectively outlines the health plan's approach to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy MHMS-PH-004, Pharmacy Lock-In Program, outlines processes and requirements for the Pharmacy Lock-In Program and the identification of members who display high controlled substance use and/or fraudulent sale or transfer of pharmaceutical products.
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy HP-03, Privacy and Confidentiality of Protected Health Information (PHI), describes how Molina protects the confidentiality of PHI.

PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.			X			Credentialing processes and requirements for practitioners are found in Policy CR 01, Credentialing Program Policy. Credentialing processes and requirements for organizational providers are found in Policy CR 02, Assessment of Organizational Providers Policy. Addendum B – Molina Healthcare of Mississippi State Specific

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Credentialing Requirements provides additional state-specific information. The Addendum to Policy CR 01, Credentialing Program Policy, states Molina conducts initial site visits of private practitioner offices and other patient care settings at initial credentialing, when the provider location has changed, and when a complaint has been lodged against a specific provider (within 60 days of the complaint). The addendum, page 6, indicates this applies to "All Practitioners." However, during onsite discussion, Molina confirmed that they had unsuccessfully attempted to contract with a vendor to conduct site visits and an internal process has not been successfully developed for conducting site visits. The plan reported that no site visits have been conducted for any providers in the time Molina has had network providers in Mississippi. This is the third consecutive year this finding has been noted. On the previous year's corrective action documentation, Molina stated, "It is difficult to provide an estimated timeline for when all needed site visits will be completed…However, we will work to complete any needed site visits by the end of July 2022." *Corrective Action Plan: To comply with requirements in the CAN Contract, Section 7 (E) (3), develop a work plan/schedule for completing the site visits for all providers for whom Molina has completed the credentialing*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process immediately. Conduct site visits for all applicable providers.
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					As stated in Policy CR 01, Molina's Medical Director has overall responsibility for credentialing processes. The Professional Review Committee (PRC) serves as the Credentialing Committee for Molina. The PRC is chaired by the Medical Director and meets at least quarterly, but usually more often. PRC membership includes at least four network practitioners from a range of specialties. The quorum is defined as the presence of four voting practitioners. The PRC reports to the Quality Improvement Committee (QIC). Molina's documentation and onsite discussion confirmed the PRC transitioned to a regional PRC model in February 2022. Current members of the regional PRC include providers with specialties of Family Medicine, Infectious Disease, Preventive Medicine, Psychiatry, Gastroenterology, OBGYN, and Pediatrics. Review of PRC minutes confirmed the presence of a quorum for each meeting and no issues with member attendance.
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:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice insurance coverage / claims history;	X					
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;						
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			None of the initial credentialing files included evidence of site visits at initial credentialing. Onsite discussion confirmed Molina has not implemented a process for conducting site visits at initial credentialing. *Corrective Action Plan: To comply with requirements in the CAN Contract, Section 7 (E) (3), develop a work plan/schedule for completing the site visits for all providers for whom Molina has completed the credentialing*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process immediately. Conduct site visits for all applicable providers.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
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 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					None of the recredentialing files contained information that a site visit was warranted.
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating	X					The processes followed for provider terminations initiated by Molina (with or without cause) are found in Procedure MHMS-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
a practitioner's affiliation with the CCO for serious quality of care or service issues.						PC-09, MHMS Provider Termination Process. As noted in the procedure, 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 for cause, or for any other reason, Molina submits a copy of the provider termination notification to DOM within 48 hours. When 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. Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events, describes processes for identifying, tracking, reviewing, resolving, and reporting potential quality of care issues. Review is first conducted by a Senior Specialist, Quality Registered Nurse, and then by a Medical Director. If necessary, the issue may be subjected to Peer Review by the PRC. Severity levels are identified as well as potential corrective actions, up to and including termination from the network.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					Initial credentialing and recredentialing files for organizational providers were compliant with all required credentialing elements.
II B. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
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.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					As noted in the CAN Provider Manual, participating providers can verify a member's eligibility and confirm the PCP assignment by contacting Provider Services and through the Molina Provider Portal. Non-participating providers can verify member eligibility by contacting the Member and Provider Services Call Center.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.			X			During onsite discussion, Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients. *Corrective Action Plan: Develop and implement a process to monitor provider panel limitations to ensure members have appropriate choice among providers.*
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, defines geographic access standards for CAN PCPs which are compliant with contractual requirements. Molina runs quarterly Geographic Access Assessment Reports to evaluate compliance with geographic accessibility requirements. The submitted Geographic Access Assessments Reports confirm that the network is evaluated

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by county and by metro, micro, and rural categories.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, defines geographic access standards for CAN specialists, hospitals, dental providers, etc. Standards documented in the policy are compliant with contractual requirements. Molina runs quarterly Geographic Access Assessment Reports to evaluate compliance with geographic accessibility requirements. The submitted Geographic Access Assessment Report dated April 2022 confirms that the network is evaluated by county and by metro, micro, and rural categories.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Molina runs quarterly Geographic Access Assessment Reports to evaluate network adequacy. Additional considerations in determining the adequacy of the network include member complaints, grievances, out of network requests, etc.
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					Molina monitors and evaluates its network's ability to meet members cultural and linguistic needs by conducting various activities, including: •Collecting practitioner race/ethnicity and language data voluntarily through the initial credentialing process and collecting information about dedicated language services offered by practices in the network.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Including information in the web-based Provider Directories, such as languages spoken and language services available through the practice. •Providing directory information to members through the Contact Center. •Conducting an annual evaluation of the network, including extracting member race/ethnicity and language information from internal systems, the U.S. Census Bureau, and/or Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results. •Collecting and analyzing complaints related to member cultural and linguistic needs. •Comparing member and practitioner data to identify network gaps and developing and implementing interventions to address identified gaps. Molina's website includes provider resources such as information about available interpreter services and how to access those services, downloadable cultural competency training information, provider tools ("A Physician's Practical Guide to Culturally Competent Care" and "Industry Collaborative Effort (ICE) - Better Communication, Better Care"), and downloadable information about the Americans with Disability Act (ADA), Members who are Blind or have Low Vision, Service Animals, and Tips for Communicating with People with Disabilities & Seniors. Information about cultural

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						competence is also noted in the CAN Provider Manual.
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				Policy MHMS-QI-006, Access to Care, indicates appointment and after-hour accessibility audits are conducted for a sample of PCPs, high volume specialists (OB/GYNs), high impact specialists (Oncology), and behavioral healthcare practitioners. Ongoing monitoring and evaluation include a review of member complaints related to accessibility, scheduling process, wait times and delays which is also conducted on an ongoing basis. The Policy does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Appointment access standards are defined in Policy MHMS-QI-006, Access to Care. Most appointment access standards listed in the policy are consistent with the contractual requirements. However, the timeframe for specialist appointments is specified as 20-30 calendar days. The *CAN Contract, Section 7 (B) 2* lists the timeframe for specialty appointments as "Not to exceed 45 calendar days."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents: •For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CAN Member Handbook, page 36, lists the requirement as 21 days for adults and 14 days for children. •For PCP routine sick appointments, the policy correctly lists the timeframe as seven calendar days, but the CAN Member Handbook, page 35, lists the requirement as 14 days. •For specialist appointments, the *CAN Contract, Section 7 (B) (2)* states the timeframe is 45 calendar days, but the CAN Member Handbook, page 36, lists the timeframe as 21 days. •For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CAN Provider Manual, page 60, states the timeframe is 14 days. •The CAN Provider Manual does not include the appointment access requirements for routine and urgent dental appointments. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits. Correct the timeframe for specialty appointments in Policy MHMS-QI-006, Access to Care. Revise the*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						applicable CAN Member Handbook and/or CAN Provider Manual to reflect the correct appointment access standards for PCP well care appointments, PCP routine sick appointments, specialist appointments, and Behavioral Health/Substance Use routine appointments. Add the appointment access standards for routine and urgent dental appointments to the CAN Provider Manual.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Processes for provider orientation are found in Policy MHMS-NM-008, Provider Education and Training. Initial provider orientation is conducted within 30 days of the provider's active date and is based on CCO processes and procedures, applicable state and federal regulations, and accrediting body standards. Topics included in initial provider orientation are included in the policy. The MississippiCAN New Provider Orientation document is comprehensive and includes a wealth of topics providers will need to understand health plan operations and requirements, and provider roles and responsibilities.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					The CAN Provider Manual includes information about the Healthcare Services Department, including Case Management services and Health Management (Health Education and Disease Management). Additionally, information is

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						included specifically about Care Management, PCP responsibilities related to Care Management referrals, and Care Manager roles and responsibilities.
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				A link in the CAN Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Home Health Services, the list of covered benefits on the website link indicates a limit of 25 visits per year. However, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year. *Corrective Action Plan: Revise the CAN benefit information on the website to provide complete and correct information about the number of visits allowed for home health services.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					The CAN Provider Manual provides detailed information about Early Periodic Screening Diagnosis and Treatment (EPSDT) services, including components of screenings, and processes to follow if the member needs

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						additional evaluation. The manual includes information that the standards and periodicity schedule follow the recommendations from the AAP and Bright Futures and includes a link to access the MississippiCAN EPSDT Periodicity Examination Schedule and details regarding EPSDT services on DOM's website.
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					The CAN Provider Manual includes Pharmacy Program information, including preferred and non-preferred drugs, submitting prior authorization requests, emergency medication supply, limitations and step therapy requirements, non-formulary medications, generic substitutions, new drugs, non-covered medications, patient safety notifications, and specialty pharmaceuticals. The CHIP Provider Manual includes information about Pain Safety Initiative (PSI) resources and a link for additional information on Molina's website. The CAN Provider Manual does not include information about this initiative. Onsite discussion confirmed this program is applicable to CAN.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Include information about Pain Safety Initiative (PSI) Resources and a link for additional information on Molina's website and in the CAN Provider Manual.
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					Providers are informed they can contact Molina to obtain clinical criteria used for decision-making, that they are required to comply with core elements and standards of care and comply with and participate in Molina's Quality Improvement Program.
2.17 A description of the provider web portal;	X					The CAN Provider Manual includes key contact information. Information about accessing the secure provider portal and functions of the portal is found throughout the manual.
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					The CAN Provider Directory and online "Find a Doctor" tool include all required elements. Policy MHMS-PC-01, MHMS Provider Directory Requirements, includes processes for maintenance and revision of Provider Directories. As noted in the policy, the printed Provider Directory is updated at least every six months, and the online directory is updated nightly.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Processes for ongoing provider education are found in Policy MHMS-NM-008, Provider Education and Training. As noted in the policy, Molina's Provider Services staff develop, conduct, and evaluate provider education programs in collaboration with applicable CCO departments and external entities, including DOM. Ongoing provider education is conducted in a variety of ways, including onsite provider visits, regional workshops, bulletins and newsletters, webinars, mailings, website updates, and through the Provider Manual. Molina also conducts provider workshops in collaboration with DOM.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Molina adopts preventive health guidelines (PHGs) to ensure providers have current treatment and diagnostic information about preventive health topics and to reduce variation in practice.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, details processes for PHG selection, adoption, and implementation of the guidelines, which are responsibilities of the NQIC, along with input from physicians and other health professionals. Selected guidelines are evidence-based, recommended by national clinically based organizations, and relevant to member demographics and healthcare needs. Once selected and approved by the NQIC, the CCO's QIC approves and adopts the PHGs for plan use. The PHGs are reviewed and updated as needed at least every two years.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					As noted in Policy MHMS-QI-018, the guidelines are disseminated to practitioners through initial provider orientation processes, Provider Manuals, newsletters, special mailings, fax blasts, and the CCO website. Printed copies are provided upon request.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 *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					Molina adopts Clinical Practice Guidelines (CPGs) to ensure practitioners have current treatment and diagnostic information about important clinical topics and to reduce practice variation. Processes for review and adoption of CPGs are found in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. The NQIC selects, reviews, and approves CPGs. The guidelines define expected standards of practice, are evidence-based, are recommended by national clinically based organizations and are relevant to member demographics and healthcare needs. The CCO's QIC reviews and adopts the guidelines recommended by the NQIC. Adopted guidelines are reviewed and revised as needed at least every two years by the QIC. Review of Molina's information confirmed Molina has adopted CPGs for an array of common diagnoses and conditions.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	X					As noted in Policy MHMS-QI-018, the guidelines are disseminated to practitioners through initial provider orientation processes, Provider Manuals, newsletters, special mailings, fax blasts, and the CCO website. Printed copies are provided 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 provider medical record documentation standards and standards for medical record maintenance, storage, and confidentiality. The policy notes that medical record guidelines are distributed to practitioners through various forums, including orientation materials, Provider Manuals, and the CCO website.
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, describes processes for evaluating provider compliance with the medical record documentation and maintenance standards. The policy states Molina audits medical records "from a representative sample of network providers every three years" and describes the process followed for conducting the audits, reporting results to providers, follow-up actions for non-compliant providers, and reporting internally to appropriate committees. Onsite discussion confirmed Molina has not yet conducted a Medical Record Audit but plans to conduct an audit in Q2 2023.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					The sample size was 1,500. SPH Analytics collected 164 surveys, which is a response rate of 10.9%. This is higher than the 2020 rate of 7%. It remains below the NCQA target rate of 40%. *Recommendation: Determine if there are additional methods to increase provider response rates.*
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 March 2022 and QIC in April 2022 meeting.

MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policies and the Molina website clearly outline member rights and responsibilities and procedures to inform members of their rights

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and responsibilities as detailed in policy MHMS-ME-003, Member Rights and Responsibilities.
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 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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 non-participating 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;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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, indicates that members are provided a New Member Welcome Packet within 14 days after Molina receives the member's enrollment data from DOM. It includes all contractually required information such as an introduction letter, CAN ID card, Member Handbook, and instructions to access the Provider Directory.
1.1 Full disclosure of benefits and services included and excluded in coverage;						The CAN Member Handbook, page 38, indicates Home Health Services have no limit on the number of visits. Benefit information on Molina's CAN website does list a limit of 25 visits. Of note, DOM staff reported during the onsite that visits for Home Health Services are allowed up to a maximum of 36 visits per year. *Corrective Action Plan: Correct the number of visits allowed for Home Health Services in the CAN Member Handbook.*
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Processes and requirements for prior approval of medical, behavioral health, and pharmaceutical services is described in the CAN Member Handbook. Services that require prior approval are indicated in the benefits grid.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						
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;						The CAN Member Handbook indicates that members are informed of changes to programs and benefits within 30 calendar days prior to implementation.
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, call center, nurse advice line, and member portal;						The CAN 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.
1.13 A description of EPSDT services;						Information on EPSDT eligibility for members under 21 years of age to obtain Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services may be found in the CAN Member Handbook.
1.14 Procedures for disenrolling from the CCO;						
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 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;						The CAN Member Handbook describes the role of the Care Management team, areas of support provided, and how a Care Manager may be requested by any member.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.19 Information about advance directives;						
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					
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					Policies MHMS-CE-01, Marketing, and MHMS-COMM-01, Member Communication Standards, describe and outline processes that Molina uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements.
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					Molina's website provides contact information for Member Services, the Nurse Advice Line, and Relay 711 for members with hearing and speech limitations, in addition to the CAN Member Handbook and member ID card.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	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 Member Services Call Center, Provider Services Call Center, and 24-Hour Nurse Advice Line are available.
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					
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					
III E. Preventive Health and Chronic Disease Management Education						
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					
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					Screening, preventive measures, medically necessary diagnostic, and treatment services are provided for members under 21 years of age as noted in Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO identifies children eligible for recommended EPSDT services 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					Generalizability of the survey results is difficult to discern due to the low response rate of 10.2% (137 out of 1344). This is lower than last year's rate of 10.3% and lower than the SPH average response rate of 14.8%. *Recommendation: Continue to determine ways to advertise Member Satisfaction Surveys to increase response rates.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					
3. The CCO reports results of the member satisfaction survey to providers.	X					
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					
III G. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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					Policy MHMS-MRT-01, Member Complaints and Grievances describes the process Molina uses for receiving, processing, and responding to grievances from members.
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					Policy MHMS-MRT-01, Member Complaints and Grievances, includes the process followed if Molina needs to request an extension for resolving a grievance. The policy does not mention allowing the member the right to file a grievance if they disagree with the request for the extension. Molina's grievance notice sent to CAN members when Molina has requested an extension does notify the member of their right to file a grievance if they disagree with the extension. *Recommendation: Include in Policy MHMS-MRT-01, Member Complaints and Grievance the members right to file a grievance if they disagree with Molina's request and extension for resolving the grievance.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The CAN grievance files reflect staff acknowledge grievances consistently, resolve grievances within the required timeframe, and grievant notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files.
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						
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The Quality Improvement Program Description is updated annually and submitted to the Quality Improvement Committee (QIC) for approval. The Program Description details the QI Program's scope, goals, objectives, structure, and functions for the plan. Molina provides information to members and providers about the QI program via the website. The website contained information regarding the 2021 HEDIS and CAHPS rates, and links for guides regarding Accessing Quality Health Care. The guide provided for CAN members titled "Guide to Accessing Quality Health Care" appears to be out of date. This guide is dated 2020. However, the guide provided for CHIP members is dated 2022. *Recommendation: Update the information provided to CAN members on Molina's website regarding quality guides.*
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	X					The QI Program Description describes numerous data sources used to identify and monitor trends of potential over and underutilization.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
analysis that demonstrate potential health care delivery problems.						
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 submitted the 2021 and 2022 CAN Work Plans for review. The Work Plans clearly document planned activities, responsible parties, timelines, action plans or benchmark goals, and status for each activity. The Work Plan is updated on a quarterly basis. On the 2022 Work Plan, Section 5 – Availability of Practitioners, the standards used to measure the geographic distribution of Primary Care Practitioners (PCPs) were incorrect and do not meet contractual requirements. Molina's 2022 Work Plan indicates the geographic distribution of primary care practitioners for members residing in Urban counties is being measures as one PCP within 20 miles. The contractual requirement for measuring PCPs in Urban counties is two PCPs within 15 miles. Also, Molina's 2022 Work Plan indicates the geographic distribution of primary care practitioners for members residing in Rural counties is being measures as one PCP within 30 miles. The contractual requirement for measuring PCPs in Rural counties is two PCPs within 30 miles. A review of the Geo Access Reports conducted by Molina indicated that PCPs are being measured in accordance with the MS Contract requirements. *Recommendation: Correct the standards used to measure PCPs in the 2022 QI work Plan.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Molina's QIC is responsible for the implementation and ongoing monitoring of QI activities. This committee is also responsible for the development of the QI Program Description, work plans, and the QI Program Evaluation.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Officer (CMO) provides clinical guidance for the QI Program and co-chairs the QIC. Other members of the committee include a behavioral health practitioner and other senior leaders. Participating practitioners serve on the QIC and are responsible for providing review and feedback on clinical issues. The 2021-2022 QIC Membership list show the participating practitioners as external voting members specializing in pediatrics, psychiatry, and internal medicine. The QIC Charter defines a quorum as at least 51% of committee members with no less than half of Community Network Provider participants necessary to enact and/or implement decisions. It was noted that the first quarter 2022 meeting did not have a quorum present. Only two of the five network providers were present for the meeting. Molina pointed out this was an error in the minutes. *Recommendation: Ensure attendance is documented correctly for each committee meeting. Correct the QIC first quarter 2022 meeting minutes to demonstrate the committee members present and the quorum requirements were met.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *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 (PM) 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. There were no concerns with Molina's data processing, integration, and measure production for the reported CMS Adult and Child Core Set measures. Aqurate determined that Molina followed the measure specifications and produced reportable rates for all measures in the scope of the validation. In the prior year, Molina did not report two CAN non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). For CAN MY 2021, Molina did not report the three new Adult and Child core set measures until repeated requests were made. *Recommendation: Work proactively with DOM for clarification on measures that are required to be reported as well as work with the Molina corporate teams to ensure the list of measures required for reporting are provided. Improve processes around calculation, reporting and*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						verification of the rates reported for the DOM required Adult and Child Core set measures.
IV D. Quality Improvement Projects *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					For this review, the same seven CAN Performance Improvement Projects (PIPs) submitted for the 2021 EQR were also submitted and validated for this EQR. Topics for PIPs include Behavioral Health Readmissions, Asthma, Pharmacotherapy Management of COPD Exacerbation, Follow-up 7, and 30 Days 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					All the CAN PIPs scored in the "High Confidence in Reported Results" range. All the CAN PIPs showed improvement in the rates except the Sickle Cell Disease PIP. The Case Management Enrollment rate declined from 7.5% to 4% with a goal of 15.9%. *Recommendation: Continue working on member and plan related barriers to improve enrollment rates including internal collaboration and identification of members as well as member awareness and SCD pediatric to adult transition of care.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per Policy 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:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment addresses EPSDT services, how Molina tracks services, and follow-up with members who have not received or are behind in getting services. This policy also includes the process followed for tracking follow-up treatment and referrals. Per Policy QI-003, follow-up activities are to be documented on the EPSDT tracker. Molina provided the EPSDT tracking report. However, this report did not include documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified in the 2020 and 2021 EQRs. The *CAN Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's EPSDT tracking system does not meet this contractual requirement. *Corrective Action Plan: Implement a system for tracking members identified with an abnormal finding on an EPSDT exam that includes the diagnosis, treatments, and referrals needed to address the abnormal findings as required by the CAN Contract, Section 5 (D).*
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.			X			CCME received the 2021 QI Program Evaluation two days before the onsite. This Evaluation had been approved by the QIC in April 2022 and the Board in May 2022. There was a note on each page that indicates the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The QI Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the evaluation:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions a root cause analysis was completed. However, it was not included in the QI Program Evaluation. •The Geographic Access Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing activities (reference Section 19.0, 2021 work plan) were not included in the QI Program Evaluation. •The Delegation Oversight activities were incomplete. After the Onsite, Molina submitted another copy of the 2021 QI Program Evaluation. Additional information had been added related to the delegation oversight. However, this QI Program Evaluation is also incomplete. This continues to be an issue and was identified in the 2020 and in the 2021 EQR. The *CAN Contract, Section 10 (D) (8)* requires the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Exhibit G (7)*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						further define the requirements for the QI Program Evaluation. *Corrective Action Plan: Correct the 2021 Quality Improvement Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the CAN Contract, Section 10, and Exhibit G.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Health Care Services Program Description outlines the program's scope, lines of responsibility for staff, and objectives for behavioral health and physical health services for members. The Pharmacy Program Description outlines the pharmacy program for Mississippi members through the Molina Healthcare Pharmacy Services Department. Additionally, Policy HCS-365-01, Clinical Criteria for UM Decision Making and Policy HCS 365, Clinical Criteria for Decision Making outline the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines in applying clinical criteria in Utilization Management (UM) decision making.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Reviewers utilize several evidenced clinical guidelines such as Milliman Clinical Guidelines (MCG), State guidelines, etc. that are reviewed and approved annually by the Healthcare Services Committee as described in the Health Care Services Program Description and Policy 365.01, Clinical Criteria for Making UM Decisions, and Policy HCS 365, Clinical Criteria for UM Decision Making. Additionally, individual conditions are also considered during UM reviews to address specific member needs.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					As described in the Molina Healthcare Services Program Description and Policy HCS 365.01, Clinical Criteria for UM Decision Making Procedure, Molina incorporates the highest level and most current scientific evidence available in applying clinical criteria. During onsite discussion, it was highlighted that clinical staff and network providers serve on the committees that provide input on implementation of policy development and clinical criteria.
1.6 The appeal process, including a mechanism for expedited appeal;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					As described in Policy HCS-362,-Monitoring to Ensure Appropriate Utilization, and Molina's Healthcare Services Program Description, Molina's clinical decisions are based solely on appropriateness of level of care and coverage. Additionally, it states that there are no rewards or financial incentives for physicians and practitioners conducting UM reviews. This policy statement is provided annually to providers, members, and employees.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					As described in the 2022 Healthcare Services Program Description and in Policy HCS-370.01, Practitioner Access to Plan Physician Reviewer, there are many roles and responsibilities of the Medical Director/Chief Medical Officer (CMO), including serving as the chair of various committees such as the Credentialing Committee, Healthcare Services Committee, etc. Additional roles include but not limited to conducting Level II reviews, case staffing, implementing appropriate clinical practice guidelines, etc.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 122*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The sample of UM approval files reviewed reflect that determinations are consistent with utilizing clinical guidelines such as MCG,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						relevant clinical information, and evidenced based criteria as described in Policy HCS-365.01, Clinical Criteria for UM Decision Making.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Approval files reflect that individualized clinical needs are taken into consideration and clinical consultations occurred appropriately with the Medical Director as described in Policy HCS-.65.01, Clinical Criteria for UM Decision Making, and Molina's Health Care Services Program Description.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Annual Inter-rater Reliability (IRR) testing is conducted for physicians, nurses, pharmacists, and behavioral health medical directors. Results yielded a passing 90% threshold score, except for the Mississippi Medical Directors. Per onsite discussion, it was indicated that the personnel that did not pass the initial IRR testing received a refresher training on clinical criteria and were retested. Additionally, it was reported that behavioral health clinical staff also receive quarterly IRR testing and received a passing score. Monthly audits are conducted to ensure consistency and quality assurance of clinical application.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					The Pharmacy Program Description and Policy MHMS-PH-001, Pharmacy Prior Authorizations, describe Molina's process and procedures for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						prior authorization of medications and indicate prior authorizations are processed within 24 hours. Additionally, Molina may approve non formulary medications when there is an adverse event reaction to preferred medications, contraindications to preferred medications, and documentation of therapeutic failure of preferred drugs. Policy MHMH-PH-001, Pharmacy Prior Authorization, states a three-day emergency supply may be immediately available to members when there is a pending an authorization.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Initial clinical reviews are conducted by Mississippi licensed clinicians, and Level II Clinical Reviews are performed by Mississippi-licensed physicians or appropriate healthcare practitioners. The Pharmacy Services Program Description identifies that pharmacy determinations are made by licensed pharmacists. Review of the approval files reflect that the UM determinations were appropriately made by appropriate staff.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					
10. Denials						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.1 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 reflect that additional clinical information is requested if needed prior to making an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					
V C. Appeals *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					Policy MHMS-MRT-02, Standard Member Appeals, outlines processes and requirements for handling member appeals of Adverse Benefit Determinations. Policy MHMS-MRT-03, Expedited Member Appeals, includes the process followed when a member, provider or authorized representative requests an expedited appeal.
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 in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Information regarding the process for filing an appeal was also found in the CAN Member Handbook, the CAN Provider Manual, and on Molina's website. These documents incorrectly indicate that a verbal appeal must

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification template. Also, Policy MHMS-MRT-02, Standard Member Appeals, documents information that must be included in appeal acknowledgement letters. However, the CAN standard appeal acknowledgement letter template does not include the statement offering a State Fair Hearing or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy. *Corrective Action: Remove the requirement that a member must follow a verbal appeal request with a written request from Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, CAN Provider Manual, the appeal request forms, and on Molina's website. Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy MHMS-MRT-03, Expedited Member Appeals, details the process Molina follows for processing a request for expedited resolution of an appeal.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals, correctly document the resolution timeframe for standard and expedited appeals. Both policies include the process followed if the member or Molina requests more time to complete the review. However, these polices do not include the member's right to file a grievance if they disagree with the extension. Also, the CAN Member Handbook, CAN Provider Manual, and Molina's website do not include the member's right to file a grievance if they disagree with the extension. However, the notice sent to CAN members when Molina requests an extension does notify the member of their right to file a grievance if they disagree with the extension. *Recommendation: Include in policy, the Member Handbook, Provider Manual, and on Molina's website the members right to file a grievance if they disagree with Molina's request for an extension.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO applies the appeal policies and procedures as formulated.	X					Overall, the review of the sample of CAN appeal files reflected Molina consistently processes standard and expedited appeal requests according to guidelines in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Two files were not processed following the guidelines. The noted issues include: •In one file, the member was required to submit their verbal appeal request in writing even though the member requested an expedited appeal. •For one file, Molina notified the member that an extension for resolution was needed on the same day as the resolution notice was mailed. *Recommendation: Reeducate staff to ensure complete understanding that a verbal request for an appeal no longer requires the member to follow the request with a written request. Also, improve the documentation in the appeal files regarding Molina's need to request an extension for resolution.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Molina's Healthcare Integrated Care Management Program within the Healthcare Services Program provides physical and behavioral care coordination to members. Additionally, Molina's Health Management Program focuses on enhancing disease prevention education, health promotion, and enhanced disease management as described in the Health Care Services Program Description and Quality Improvement Program Description 2022.
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					
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					As outlined in Policy HCS-154.01, Individualized Care Plan Development, Health Risk Assessments are completed by qualified staff and an Individualized Care Plan is developed within 30

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						days of completion of the Health Risk Assessment.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Members are stratified through various data driven methodologies. During onsite discussion, Molina staff indicated members are re-stratified monthly through a predictive modeling tool that analyzes several factors such as social determinants of health, claims, admissions, clinical notes, etc.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
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;						
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,						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					The Health Promotion and Disease Management Program offered by Molina includes various activities such as member education, telephonic coaching, and minimal care coordination to aid in self-management and wellness of members.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					
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					Molina's Transition of Care Program's approach to monitoring new members and managing members that are transitioning within various care settings, such as inpatient treatment and long-term care settings, is explained in Policy HCS-CM-068, Molina Transitions Care Policy and Procedure, Policy MHMS-HCS-CM-042, Coordination of Care and Referral Procedures for Behavioral Health Services Policy and Procedure, and the Health Care Services Program Description.
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					The interdisciplinary transitional care team consists of a collaborative team of care managers, social workers, nurses, behavioral health staff, primary care physicians, etc. to ensure continuity of care and a successful transition for members within their home or community settings.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					An analysis and written summary of the Utilization Management Program is developed annually. The Health Care Services Program Evaluation was reviewed and approved by the QIC on September 29, 2022.

DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Molina Healthcare of Mississippi, Inc. Delegation Services Addendum (DSA), is used as the delegation agreement between Molina and each delegated entity. The DSA addresses the following topics: •General terms and conditions, including policies and procedures, pre-delegation assessment, ongoing review and assessment, sub-delegation, reporting requirements, audits, compliance, confidentiality.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Remedies for substandard performance, which may include corrective action and/or revocation of delegation •Activities to be delegated and corresponding requirements.
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			As noted in Policy DO001, Delegation Pre Assessment Audits, all potential delegates are subjected to a pre-delegation assessment to determine abilities to meet established criteria for the functions to be delegated. Pre-delegation assessments are presented to the Delegation Oversight Committee (DOC) for review and determination. Policy DO002, Performance Monitoring and Annual Audits of Delegation, states Molina ensures continued compliance with delegation standards through ongoing monitoring and annual audits. All annual audits include a sample file review for the applicable functions. Delegation Oversight Staff (DOS) finalize audit summaries and worksheets, including a Corrective Action Plan if necessary. The finalized documents are presented to the next DOC for review and a determination regarding continued delegation with the entity. CCME reviewed the delegate oversight documents provided by Molina. The following issues were identified: •For CVS/Caremark, documentation included reports of routine monitoring and delegate reporting, but no documentation of a pre-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						delegation assessment was provided. The date of initial delegation was noted by the CCO as 10/1/21. •For March Vision Care, the credentialing file review worksheet did not include evidence of monitoring the delegate for conducting initial site visits. The documentation indicated site visits are delegated to March Vision Care. The addendum to Policy CR 01, Credentialing Program Policy, states initial credentialing site visits are required for all providers. This is a repeat finding from the previous EQR. *Corrective Action: Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained. When site visits are delegated to a credentialing delegate, ensure they are monitored for conducting the site visits according to health plan policy.*

CCME CHIP Data Collection Tool

Plan Name:	**Molina Healthcare CHIP**
Review Performed:	2022

ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					The Molina Policy and Procedure Committee was formed to review and revise policies with leadership from each department. Once final drafts are complete, policies are sent to DOM for final approval, and stored in SharePoint for staff access.
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					Bridget Galatas is Molina's Plan President.
1.2 *Chief Operating Officer;	X					Keshia Lymuel is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Edward Mohr is the Chief Financial Officer.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					The Chief Information Officer for Centene is Matt Hall.
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					The Provider Services Director is Chinwe Nichols.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					
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 Associate Vice President Quality Improvement.
1.11 *Marketing and/or Public Relations;	X					The Manager of Communications is Tiffany Hollis-Johnson.
1.12 *Medical Director;	X					Thomas Joiner, M.D. is the Chief Medical Officer.
1.13 *Compliance Officer.	X					Latasha McGill is the AVP of Compliance.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					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 are 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. During the virtual site review, it was discussed that Molina should improve monitoring and communication with the corporate team for DOM requirements for measure reporting.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Molina's Information Technology infrastructure incorporates technology (clustering, SAN storage, data replication) to provide resilience and minimize outages. In the event there are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						issues with Molina's primary data center, a data copy is stored 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					Policy C-01.1, Written Policies and Procedures, Compliance Plan, and Standards of Conduct, states that Molina's Compliance Officer reviews and amends the Compliance Plan at least annually and as needed, to reflect changes in law, the healthcare market, structure of the company, identified risks, and industry practice.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Molina Healthcare Code of Business Conduct and Ethics emphasizes the expectation that business be conducted in accordance with applicable laws, rules, and contract requirements, as well as ethical business and professional practices.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The Compliance Officer is identified on Molina's Organizational Chart and Compliance Committee Membership List. Applicable roles and responsibilities are addressed in the 2022 Compliance Work Plan.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						Policy C-01.3 Effective Training and Education as well as the Compliance Work Plan outline areas of required employee training. The ILearn

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Compliance Course training platform is used for the completion and tracking of required training for all new employees within thirty days from their date of hire as well as annually thereafter.
2.5 Lines of communication;						
2.6 Enforcement and accessibility;						Molina issues corrective action plans as part of correcting incidents of non-compliance, whether those incidents are self-identified or identified by an outside body (e.g., a regulator or enforcement agency).
2.7 Internal monitoring and auditing;						Policy C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks, describes processes for routine monitoring and auditing of compliance risks, prompt responses to issues, the investigation of potential problems, correction of identified problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with federal, state, and local rules and regulations.
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					The Compliance Plan indicates that the Compliance Committee reports quarterly to the Board of Directors and monthly meetings are held with subsidiary compliance officers and subsidiary senior management. Policy C-01.2, Compliance Officer, Compliance Committee,

Standard	Score					Comments
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						and High-Level Oversight, denote that the Compliance Committee shall be comprised of individuals from the Board of Directors and/or Senior Management and meets at least on a quarterly basis or more frequently as necessary, to enable reasonable oversight of the compliance program.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The Molina Healthcare of Mississippi Fraud, Waste, and Abuse Plan effectively outlines the health plan's approach to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse.
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					Policy MHMS-PH-004, Pharmacy Lock-In Program, outlines processes and requirements for the Pharmacy Lock-In Program and the identification of members who display high controlled substance use and/or fraudulent sale or transfer of pharmaceutical products.
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy HP-03, Privacy and Confidentiality of Protected Health Information (PHI), describes how Molina protects the confidentiality of PHI.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.			X			Credentialing processes and requirements for practitioners are found in Policy CR 01, Credentialing Program Policy. Credentialing processes and requirements for organizational providers are found in Policy CR 02, Assessment of Organizational Providers Policy. Addendum B – Molina Healthcare of Mississippi State Specific Credentialing Requirements provides additional state-specific information. The Addendum to Policy CR 01, Credentialing Program Policy, states Molina conducts initial site visits of private practitioner offices and other patient care settings at initial credentialing, when the provider location has changed, and if a complaint has been lodged against a specific provider (within 60 days of the complaint). The addendum, page 6, indicates this applies to "All Practitioners." However, during onsite discussion, Molina confirmed that they had unsuccessfully attempted to contract with a vendor to conduct site visits and an internal process has not been successfully developed for conducting site visits. The plan reported that no site visits have been conducted for any providers in the time Molina has had network providers in Mississippi. This is the third consecutive year this finding has been noted. On the previous year's corrective action documentation, Molina

Standard	Score					Comments
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						stated, "It is difficult to provide an estimated timeline for when all needed site visits will be completed…However, we will work to complete any needed site visits by the end of July 2022." *Corrective Action Plan: To comply with requirements in the CHIP Contract, Section 7 (E) (3), develop a work plan/schedule for completing the site visits for all providers for whom Molina has completed the credentialing process immediately. Conduct site visits for all applicable providers.*
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					As stated in Policy CR 01, Molina's Medical Director has overall responsibility for the credentialing process. The Professional Review Committee (PRC) serves as the Credentialing Committee for Molina. The PRC is chaired by the Medical Director and meets at least quarterly, but usually more often. PRC membership includes at least four network practitioners from a range of specialties. The quorum is defined as the presence of four voting practitioners. The PRC reports to the Quality Improvement Committee (QIC). As noted in Molina's documentation, the PRC transitioned to a regional PRC model in February 2022. Current members of the regional PRC include providers with specialties of Family Medicine, Infectious Disease, Preventive Medicine, Psychiatry, Gastroenterology, OBGYN, and Pediatrics.

Standard	Score					Comments
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						Review of PRC minutes confirmed the presence of a quorum for each meeting and no issues with member attendance.
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 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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
3.1.15 Fingerprints, when applicable.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Site assessment.			X			None of the files included evidence of site visits at initial credentialing. Onsite discussion confirmed Molina has not implemented a process for conducting site visits at initial credentialing. *Corrective Action Plan: To comply with requirements in the CHIP Contract, Section 7 (E) (3), develop a work plan/schedule immediately for completing the site visits for all providers for whom Molina has completed the credentialing process. Conduct site visits for all applicable providers.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					

Standard	Score					Comments
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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					None of the recredentialing files contained information that a site visit was warranted.
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					The processes followed for provider terminations initiated by Molina (with or without cause) are found in Procedure MHMS-PC-09, MHMS Provider Termination Process. As noted in the procedure, 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 for cause, or for any other reason, Molina submits a copy of the provider termination notification to DOM within 48 hours. When 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. Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events, describes processes for identifying, tracking, reviewing, resolving, and reporting potential quality of care issues. Review is first conducted by a Senior Specialist, Quality Registered Nurse, and then by a Medical Director. If necessary, the issue may be subjected to Peer Review by the PRC. Severity

Standard	Score					Comments
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						levels are identified as well as potential corrective actions, up to and including termination from the network.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					Initial credentialing and recredentialing files for organizational providers were compliant with all required credentialing elements.
II B. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
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					As noted in the CHIP Provider Manual, participating providers can verify a member's eligibility and confirm the PCP assignment by contacting Provider Services and through the Molina Provider Portal. Non-participating providers can verify member eligibility by contacting the Member and Provider Services Call Center.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.			X			During onsite discussion, Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients. *Corrective Action Plan: Develop and implement a process to monitor provider panel limitations*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to ensure members have appropriate choice among 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					Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, defines geographic access standards for CHIP PCPs which are compliant with contractual requirements. Molina runs quarterly Geographic Access Assessment Reports to evaluate compliance with geographic accessibility requirements. The submitted Geographic Access Assessment Reports confirm that the network is evaluated by county and by metro, micro, and rural categories.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, defines geographic access standards for CHIP specialists, hospitals, dental providers, etc. Standards documented in the policy are compliant with contractual requirements. Molina runs quarterly Geographic Access Assessment Reports to evaluate compliance with geographic accessibility requirements. The submitted Geographic Access report dated April 2022 confirms that the network is evaluated by county and by metro, micro, and rural categories.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Molina runs quarterly Geographic Access Assessment Reports to evaluate network adequacy. Additional considerations in determining the adequacy of the network include member complaints, grievances, out of network requests, etc.
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					Molina monitors and evaluates its network's ability to meet members cultural and linguistic needs by conducting various activities, including: •Collecting practitioner race/ethnicity and language data voluntarily through the initial credentialing process and collecting information about dedicated language services offered by practices in the network. •Including information in the web-based Provider Directories such as languages spoken and language services available through the practice. •Providing directory information to members through the Contact Center. •Conducting an annual evaluation of the network, including extracting member race/ethnicity and language information from internal systems, the U.S. Census Bureau, and/or CAHPS survey results. •Collecting and analyzing complaints related to member cultural and linguistic needs. •Comparing member and practitioner data to identify network gaps and developing and implementing interventions to address identified gaps.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina's website includes provider resources such as information about available interpreter services and how to access those services, downloadable cultural competency training information, provider tools ("A Physician's Practical Guide to Culturally Competent Care" and "Industry Collaborative Effort (ICE) - Better Communication, Better Care"), and downloadable information about the Americans with Disability Act (ADA), Members who are Blind or have Low Vision, Service Animals, and Tips for Communicating with People with Disabilities & Seniors. Information about cultural competence is also noted in the CHIP Provider Manual.
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 written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MHMS-QI-006, Access to Care, indicates appointment and after-hour accessibility audits are conducted for a sample of PCPs, high volume specialists (OB/GYNs), high impact specialists (Oncology), and behavioral healthcare practitioners. Ongoing monitoring and evaluation include a review of member complaints related to accessibility, scheduling process, wait times and delays which is also conducted on an ongoing basis. The Policy does not indicate the frequency for conducting the appointment and after-hour accessibility audits

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or the department or entity that conducts the audits. Appointment access standards are defined in Policy MHMS-QI-006, Access to Care. Most appointment access standards listed in the policy are consistent with the contractual requirements. However, the timeframe for specialist appointments is specified as 20-30 calendar days. The *CHIP Contract, Section 7 (B) (2)* lists the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents: •For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CHIP Member Handbook, page 37, lists the requirement as 21 days for adults and 14 days for children. •For specialist appointments, the *CHIP Contract, Section 7 (B) (2)* states the timeframe is 45 calendar days, but the CHIP Member Handbook, page 37, lists the timeframe as 21 days. •For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CHIP Provider Manual, page 76, states the timeframe is 14 days.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The CHIP Provider Manual does not include the appointment access requirements for routine and urgent dental appointments. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits. Correct the timeframe for specialty appointments in Policy MHMS-QI-006, Access to Care. Revise the applicable CHIP Member Handbook and/or CHIP Provider Manual to reflect the correct appointment access standards for PCP well care appointments, specialist appointments, and Behavioral Health/Substance Use routine appointments. Add the appointment access standards for routine and urgent dental appointments to the CHIP Provider Manual.*
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Processes for provider orientation are found in Policy MHMS-NM-018, Provider Education and Training. Initial provider orientation is conducted within 30 days of the provider's active date and is based on CCO processes and procedures, applicable state and federal regulations, and accrediting body standards. Topics included in initial provider orientation are included in the policy. The Mississippi CHIP Provider Orientation document is comprehensive and includes a

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						wealth of topics providers will need to understand health plan operations and requirements, and provider roles and responsibilities.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					The CHIP Provider Manual includes information about the Healthcare Services Department, including Case Management services and Health Management (Health Education and Disease Management). Additionally, information is included specifically about Care Management, PCP responsibilities related to Care Management referrals, and Care Manager roles and responsibilities.
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				A link in the CHIP Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Radiology/X-rays, the list of covered benefits on the website link indicates these services must be conducted in a physician's office or hospital outpatient department. However, the CHIP Member Handbook, page 40, does not include the restriction to location. *Corrective Action Plan: Revise the CHIP benefit information on the website to provide complete and correct information about restrictions on location requirements for Radiology/X-ray services.*

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					The CHIP Provider Manual includes information about EPSDT/Well Child services required for members through the end of the month in which the member turns 19 years old. Information includes components of screenings and processes to follow if additional evaluation is needed. The manual states, "All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act."
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					The CHIP Provider Manual includes Pharmacy Program information, including the Pharmacy and Therapeutics Committee, pharmacy network, drug formulary, submitting prior authorization requests, limitations and step

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						therapy requirements, non-formulary medications, generic substitutions, new drugs, non-covered medications, patient safety notifications, and specialty pharmaceuticals. Additionally, it includes information about Pain Safety Initiative (PSI) Resources and a link for additional information on Molina's website.
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					Providers are informed they can contact Molina to obtain clinical criteria used for decision-making. Providers are also informed that network providers are required to comply with core elements and standards of care, and to comply with and participate in Molina's QI Program.
2.17 A description of the provider web portal;	X					The CHIP Provider Manual includes key contact information. Information about accessing the secure provider portal and functions of the portal is found throughout the manual.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					The CHIP Provider Directory and online "Find a Doctor" tool include all required elements. Policy MHMS-PC-01, MHMS Provider Directory Requirements, includes processes for maintenance and revision of Provider Directories. As noted in the policy, the printed Provider Directory is updated at least every six months, and the online directory is updated nightly.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Processes for ongoing provider education are found in Policy MHMS-NM-018, Provider Education and Training. As noted in the policy, Molina's Provider Services staff develop, conduct, and evaluate provider education programs in collaboration with applicable CCO departments and external entities, including DOM. Ongoing provider education is conducted in a variety of ways, including onsite provider visits, regional workshops, bulletins and newsletters, webinars, mailings, website updates e, and the Provider Manual. Molina also conducts provider workshops in collaboration with DOM.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with	X					Molina adopts PHGs to ensure providers have current treatment and diagnostic information

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
national standards and covered benefits and that are periodically reviewed and/or updated.						about preventive health topics and to reduce variation in practice. Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, details processes for PHG selection, adoption, and implementation of the guidelines, which are responsibilities of the NQIC, along with input from physicians and other health professionals. Selected guidelines are evidence-based, recommended by national clinically based organizations, and relevant to member demographics and healthcare needs. Once selected and approved by the NQIC, the CCO's QIC approves and adopts the PHGs for plan use. The PHGs are reviewed and updated as needed at least every two years.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					As noted in Policy MHMS-QI-018, the guidelines are disseminated to practitioners through initial provider orientation processes, Provider Manuals, newsletters, special mailings, fax blasts, and the CCO website. Printed copies are provided upon request.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 developed in conjunction with pertinent network specialists.	X					Molina adopts CPGs to ensure practitioners have current treatment and diagnostic information about important clinical topics and to reduce practice variation. Processes for review and adoption of CPGs are found in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. The NQIC selects, reviews, and approves CPGs. The guidelines define expected standards of practice, are evidence-based, are recommended by national clinically based organizations, and are relevant to member demographics and healthcare needs. The CCO's QIC reviews and adopts the guidelines recommended by the NQIC. Adopted guidelines are reviewed and revised as needed and at least every two years by the QIC. Review of Molina's information confirmed Molina has adopted clinical practice guidelines for an array of common diagnoses and conditions.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness	X					As noted in Policy MHMS-QI-018, the guidelines are disseminated to practitioners through initial provider orientation processes, Provider

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
management to providers with the expectation that they will be followed for CCO members.						Manuals, newsletters, special mailings, fax blasts, and the CCO website. Printed copies are provided 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 provider medical record documentation standards and standards for medical record maintenance, storage, and confidentiality. The policy notes that medical record guidelines are distributed to practitioners through various forums, including orientation materials, Provider Manuals, and the CCO website.
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, describes processes for evaluating provider compliance with the medical record documentation and maintenance standards. The policy states Molina audits medical records "from a representative sample of network providers every three years" and describes the process followed for conducting the audits, reporting results to providers, follow-up actions for non-compliant providers, and reporting internally to appropriate committees. Onsite discussion confirmed Molina has not yet conducted a Medical Record Audit but plans to conduct an audit in Q2 2023.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					The sample size was 1,500. SPH Analytics collected 164 surveys which is a response rate

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of 10.9%. This is higher than the 2020 rate of 7%. It remains below the NCQA target rate of 40%. *Recommendation: Determine if there are additional methods to increase provider response rates.*
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 March 2022 and QIC in April 2022 meeting.

MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policies and the Molina website clearly outline member rights and responsibilities and procedures to inform members of their rights and responsibilities as detailed in policy MHMS-ME-003, Member Rights and Responsibilities.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and dignity;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 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.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:		X				Policy MHMS-ME-012, CHIP Information Packet, indicates that members are provided a New Member Welcome Packet within 14 days after Molina receives the member's enrollment data from DOM. It includes all contractually required information such as an introduction letter, CHIP 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;						For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						location (as noted in benefit information on Molina's CHIP website) and states that a prior authorization is required for these services. Onsite discussion with Molina staff indicated prior authorization is required only for advanced imaging services and not for routine X-rays. *Corrective Action Plan: Revise the benefit information in the CHIP Member Handbook to provide complete and correct information about restrictions on location and prior authorization requirements for Radiology/X-ray services.*
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;						Processes and requirements for prior approval of medical, behavioral health, and pharmaceutical services are described in the CHIP Member Handbook. Services that require prior approval are indicated in the benefits grid.

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;						
1.6 Policies and procedures for accessing specialty/referral care;						
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;						The CHIP Member Handbook where benefit changes are indicates that members are informed of changes to programs and benefits within thirty calendar days prior to implementation.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						The CHIP Member Handbook includes toll-free telephone numbers, hours of operation, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						descriptions of services provided by Member Services and the 24-Hour Nurse Advice Line.
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;						
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
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;						
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;						The CHIP Member Handbook describes the role of the Care Management team, areas of support provided, and how a Care Manager may be requested by any member.
1.19 Information about advance directives;	X					
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policies MHMS-CE-01, Marketing, and MHMS-COMM-01, Member Communication Standards, describe and outline processes that Molina uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements.
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					Molina's website provides contact information for Member Services, the Nurse Advice Line, and Relay 711 for members with hearing and speech limitations, in addition to the CHIP Member Handbook and member ID card.
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						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					A Member Services Call Center, Provider Services Call Center, and 24-Hour Nurse Advice Line are available.
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					
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
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					
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					Generalizability of the Child CAHPS Survey results is difficult to discern due to the low response rate of 7.3% (375 out of 5161). This is lower than last year's rate of 10.2% and lower than the SPH average response rate of 12.8%.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Continue to determine ways to advertise CHILD CAHPS Survey to increase response rates.
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					
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 *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260*						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MHMS-MRT-01, Member Complaints and Grievances describes the process Molina uses for receiving, processing, and responding to grievances from members.
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					Policy MHMS-MRT-01, Member Complaints and Grievances, includes the process followed if Molina needs to request an extension for resolving the grievance. The policy does not mention allowing the member the right to file a grievance if they disagree with the request for the extension. Molina's grievance notices sent to CHIP members when Molina has requested an

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						extension do notify members of their right to file a grievance if they disagree with the extension. *Recommendation: Include in Policy MHMS-MRT-01, Member Complaints and Grievance, the members right to file a grievance if they disagree with Molina's request and extension for resolving the grievance.*
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					The CHIP grievance files reflect staff acknowledge grievances consistently, resolve grievances within the required timeframe, and grievant notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files.
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					

QUALITY IMPROVEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Molina submitted the 2022 Quality Improvement Program Description for review. This QI Program Description is updated annually and submitted to the QIC for approval. The Program Description describes the QI program's scope, goals, objectives, structure, and functions for the plan. Molina provides information to members and providers about the QI Program via the website.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The QI Program Description describes numerous data sources used to identify and monitor trends of potential over and underutilization.
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 submitted the 2021 and 2022 CHIP Work Plans for review. The Work Plans clearly document planned activities, responsible parties, timelines, action plans or benchmark goals, and status for each activity. The Work Plan is updated on a quarterly basis. On the 2022 Work Plan, Section 5 – Availability of Practitioners, the standards used to measure the geographic distribution of PCPs were incorrect and do not meet contractual requirements. Molina's 2022 work plan indicates the geographic distribution of PCPs for members residing in Urban counties is being measures as one PCP within 20 miles. The Contract requirement for measuring PCPs in Urban counties is two PCPs within 15 miles. Also, Molina's 2022 Work Plan indicates the geographic distribution of primary care practitioners for members residing in Rural counties is being measures as one PCP within 30 miles. The Contract requirement for measuring PCPs in Rural counties is two PCPs within 30 miles. A review of the Geographic Access Reports conducted by Molina indicated that PCPs are being measured in accordance with the MS Contract requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Correct the standards used to measure PCPs in the 2022 QI work Plan.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Molina's QIC is responsible for the implementation and ongoing monitoring of QI activities. This committee is also responsible for the development of the QI Program Description, work plans, and the QI Program Evaluation.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The CMO provides clinical guidance for the QI Program and co-chairs the QIC. Other members of the committee include a behavioral health practitioner and other senior leaders. Participating practitioners serve on the QIC and are responsible for providing review and feedback on clinical issues. The 2021-2022 QIC Membership list show the participating practitioners as external voting members specializing in pediatrics, psychiatry, and internal medicine. The QIC Charter defines a quorum as at least 51% of committee members with no less than half of Community Network Provider participants necessary to enact and/or implement decisions. It was noted that the first quarter 2022 meeting did not have a quorum present. Only two of the five network providers were present for the meeting. Molina pointed out this was an error in the minutes. *Recommendation: Ensure attendance is documented correctly for each committee meeting. Correct the QIC first quarter 2022*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meeting minutes to demonstrate the committee members present and the quorum requirements were met.
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *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 PM 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. There were no concerns with Molina's data processing, integration, and measure production for the reported CMS Adult and Child Core Set measures. Aqurate determined that Molina followed the measure specifications and produced reportable rates for all measures in the scope of the validation. In the prior year, Molina did not report two CHIP non-HEDIS measures as required by DOM. The measures were Elective Delivery (PC-01) and Sealant Receipt on Permanent First Molars (SFM-CH). For CHIP MY 2021, Molina did not report the SFM measure and the two new Child core set measures. *Recommendation: Work proactively with DOM for clarification on measures that are required*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to be reported as well as work with the Molina corporate teams to ensure the list of measures required for reporting are provided. 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 *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 the same four PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care/Well Child, Asthma Medication Ratio, 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 Reported 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					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per Policy 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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						participating practitioners/providers no less than annually.
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						
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			For CHIP, Molina follows Policy MHMS-QI-005, Well-Baby and Well-Child Services, regarding tracking Well-Baby and Well-Child Services. This policy did not include Molina's process for tracking treatments or referrals needed for abnormal findings during the Well-Child and Well-Baby service. This was an issue identified during the previous EQR and not corrected. During the onsite, Molina indicated the wrong policy had been uploaded. The correct draft policy was provided after the onsite. The process added to Policy MHMS-QI-005 indicates follow-up activities will be included on the Well-Baby and Well-Child tracking report. Molina provided the Well-Baby Well-Child tracking report. However, this report did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The *MS CHIP Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's Well-Baby Well-Child tracking system does not meet this contractual requirement. *Corrective Action Plan: Implement a system for tracking members identified with an abnormal finding on a Well-Baby Well-Child exam that includes the diagnosis, treatments, and referrals needed to address the abnormal findings as required by the CHIP Contract, Section 5 (D).*
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.			X			CCME received the 2021 QI Program Evaluation two days before the onsite. This QI Program Evaluation had been approved by the QIC in April 2022 and the Board in May 2022. There was a note on each page that indicates the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the Evaluation: •In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions that a root cause analysis was completed; however, not included in the QI Program Evaluation. •The Geographic Access Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing activities (reference Section 19.0, 2021 work plan) were not included in the Program Evaluation. •The Delegation Oversight activities were incomplete. After the onsite, Molina submitted another copy of the 2021 QI Program Evaluation. Additional information had been added related to delegation oversight. However, this Evaluation is also incomplete. This continues to be an issue and was identified in the 2020 and in the 2021 EQR. The *CHIP Contract, Section 9 (D) (8)* requires the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Exhibit F (C) (6)* further define the requirements for the QI Program Evaluation.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Correct the 2021 Quality Improvement Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the CHIP Contract, Section 9, and Exhibit F.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to:	X					The 2022 Molina Health Care Services Program Description outlines the program scope, lines of responsibility for staff, and objectives for behavioral health and physical health services for members. Additionally, the Pharmacy Program Description outlines the pharmacy program for Mississippi members through the Molina Healthcare Pharmacy Services Department.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Guidelines/standards to be used in making utilization management decisions;	X					UM reviewers utilize several evidenced based clinical guidelines, such as Milliman Clinical Guidelines (MCG), State guidelines, etc. when making authorization determinations. The clinical criteria process is reviewed and approved annually by the Healthcare Services Committee.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
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					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Responsibilities of the CMO and other Medical Directors include but are not limited to supervising medical necessity decisions, conducting Level II reviews, and participating in plan committees as described in the 2022 Molina Health Care Services Program Description. The Behavioral Health Medical Director and the Pharmacy Director have clinical oversight of their respective programs and collaborative efforts occur as needed with the Chief Medical Director.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The sample of UM approval files reviewed reflect that determinations are consistent with utilizing clinical guidelines such as MCG, relevant clinical information, and evidenced based criteria as described in Policy HCS-365.01, Clinical Criteria for UM Decision Making.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Approval files reflect that individualized clinical needs are taken into consideration and that clinical consultations occurred appropriately with the Medical Director, as described in Policy HCS-365.01, Clinical Criteria for UM Decision Making, and the Health Care Services Program Description.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Molina's process and procedures for prior authorization of medications are outlined in the Pharmacy Program Description and Policy MHMS-PH-001, Pharmacy Prior Authorizations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Prior authorizations are processed within 24 hours. Additionally, a pharmacist may dispense a three-day emergency supply pending an authorization.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Initial clinical reviews are conducted by Mississippi licensed clinicians, and Level II Clinical Reviews are performed by Mississippi-licensed physicians or appropriate healthcare practitioners. The Pharmacy Services Program Description identifies that pharmacy determinations are made by licensed pharmacists. Review of the approval files reflect that the UM determinations were appropriately made by appropriate staff.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the approval files reflect that determinations were completed within three calendar days/two business days for standard requests and 24 hours for expedited/urgent requests. However, one CHIP file was not completed within the contract requirement timelines.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is	X					UM denial files reflected that additional clinical information is requested if needed prior to making an adverse benefit determination.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
made to obtain all pertinent information prior to making the decision to deny services.						
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					
V C. Appeals *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					Policy MHMS-MRT-02, Standard Member Appeals, outlines processes and requirements for handling member appeals of Adverse Benefit Determinations. Policy MHMS-MRT-03, Expedited Member Appeals, includes the process followed when a member, provider, or authorized representative requests an expedited appeal.
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 in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Information regarding the process for filing an appeal was also found in the CHIP Member Handbook, the CHIP Provider Manual, and on Molina's website. These documents incorrectly indicate a verbal appeal must be followed by a signed written appeal.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification letter. Also, Policy MHMS-MRT-02, Standard Member Appeals, includes information that must be included in appeal acknowledgement letters. However, the CHIP standard appeal acknowledgement letter template does not include the statement of offering the one-page "Grievance/Appeal Form" as mentioned in the policy. Also, this policy mentions the offering of a State Fair Hearing as being included in the acknowledgement letter. However, a State Fair Hearing is not applicable for CHIP. *Corrective Action: Remove the requirement that a member must follow-up a verbal request for an appeal with a written request from Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, CHIP Provider Manual, the appeal request forms, and on Molina's website. Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.*
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
expertise who has not previously reviewed the case;						
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy MHMS-MRT-03, Expedited Member Appeals, details the process Molina follows for processing a request for expedited resolution of an appeal.
1.5 Timeliness guidelines for resolution of the appeal;	X					Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals, correctly document the resolution timeframe for standard and expedited appeals. Both policies include the process followed if the member or Molina requests more time to complete the review. However, these polices do not include the member's right to file a grievance if they disagree with the extension. Also, the CHIP Member Handbook, the CHIP Provider Manual, and Molina's website do not include the member's right to file a grievance if they disagree with the extension. However, the notice sent to CHIP members when Molina requests an extension does notify the member of their right to file a grievance if they disagree with the extension. *Recommendation: Include in policy, the Member Handbook, Provider Manual, and on Molina's website the members right to file a grievance if they disagree with Molina's request for an extension.*
1.6 Written notice of the appeal resolution;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					The CHIP Member Handbook, page 57, provides information regarding continuation of benefits while an Independent External Review is pending. However, the timeframe for requesting the continuation of benefits is not mentioned. This information is included in the Appeal Request Form attached to the Adverse Benefit Determination notice. *Recommendation: Update the CHIP Member Handbook to include the timeframe for requesting continuation of benefits during Molina's appeal process and during the Independent External Review process.*
2. The CCO applies the appeal policies and procedures as formulated.	X					Overall, the review of the sample of CHIP appeal files reflected Molina consistently processes standard and expedited appeal requests according to guidelines in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Three files were not processed following the guidelines in Molina's policy. The noted issues include: •In one file, member consent was requested even though the appeal was filed by the member's mother. •The resolution notice for one file did not offer the member the right to request an Independent External Review. The letter incorrectly stated the member has the right to file a State Fair Hearing, which is not available for CHIP members.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•In one file, Molina request an extension on March 4, 2022, asking for 14 additional days to resolve the appeal. The appeal was closed on March 16, 2022, and should not have been closed until March 20, 2022, which was the end of the 14-day extension. Molina responded to this issue and mentioned that day 43 and 44 would fall on the weekend and the Specialist was on PTO day 41 and 42. The appeal was closed on day 40 to avoid being late. Molina's policy does not mention how appeals should be processed if a staff member is on paid time off. *Recommendation: Reeducate staff to ensure complete understanding regarding when member consent is needed. Develop a quality check process before resolution notices are sent to ensure the correct notices are sent to CHIP members. Also, develop a process for handling appeals when staff are on paid time off to ensure timeframes are met and members are allowed the full timeframe for submitting additional information.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Eligible members for the Care Management program are identified through community referrals, self-referrals, claims data, hospital discharge data, and practitioner referrals as described in the Health Care Services Program Description. Additionally, predictive modeling is used to identify and stratify eligible members to an appropriate level of care management services. During the onsite discussion, it was stated that members are contacted within five days of initiation of a referral.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					As outlined in Policy HCS-154.01, Individualized Care Plan Development, Health Risk Assessments are completed by qualified staff and an Individualized Care Plan is developed

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						within 30 days of completion of the Health Risk Assessment. Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the CHIP Contract, Section 8 (A) in the Source of Decision information. *Recommendation: Include a reference to the CHIP Contract, Section 8 (A) in the Source of Decision for Policy 154.01, Individualized Care Development Procedure Addendum.*
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Review of the care management files identified that members were stratified appropriately as their health needs changed.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
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
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
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					
9. The CCO provides members assigned to the high risk level all the services included in the low and	X					Review of the sample of Care Management files reflected that members assigned to high-risk

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
medium risk levels and the specific services required by the contract.						levels received appropriate services as described in the Health Care Services Program Description and Policy HCS 151, Risk Stratification and Member Procedure Addendum.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
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					The Health Promotion and Disease Management Level I Program offered by Molina includes various activities such as member education, telephonic coaching, and minimal care coordination is provided to aid in self-management and wellness of members.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					
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					Molina's Transition of Care Program's approach to monitoring new members and managing members that are transitioning within various care settings, such as inpatient treatment and long-term care settings, is explained in Policy HCS-CM-068, Molina Transitions Care Policy and Procedure, Policy MHMS-HCS-CM-042, Coordination of Care and Referral Procedures for Behavioral Health Services Policy and Procedure, and the Health Care Services Program Description.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
implements the transition of care plan, and provides oversight to the transition process.						
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					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					An annual evaluation of the UM program is completed, and during onsite discussion, it was indicated that the 2021 Health Care Services Annual Evaluation was approved by the QIC on September 29, 2022.

DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Molina Healthcare of Mississippi, Inc. Delegation Services Addendum (DSA), is used as the delegation agreement between Molina and each delegated entity. The DSA addresses the following topics: •General terms and conditions, including policies and procedures, pre-delegation assessment, ongoing review and assessment,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sub-delegation, reporting requirements, audits, compliance, confidentiality. •Remedies for substandard performance, which may include corrective action and/or revocation of delegation •Activities to be delegated and corresponding requirements
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			As noted in Policy DO001, Delegation Pre Assessment Audits, all potential delegates are subjected to a pre-delegation assessment to determine abilities to meet established criteria for the functions to be delegated. Pre-delegation assessments are presented to the DOC for review and determination. Policy DO002, Performance Monitoring and Annual Audits of Delegation, states Molina ensures continued compliance with delegation standards through ongoing monitoring and annual audits. All annual audits include a sample file review for the applicable functions. Delegation Oversight Staff (DOS) finalize audit summaries and worksheets, including a Corrective Action Plan if necessary. The finalized documents are presented to the next DOC for review and a determination regarding continued delegation with the entity. CCME reviewed the delegate oversight documents provided by Molina. The following issues were identified: •For CVS/Caremark, documentation included reports of routine monitoring and delegate

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reporting, but no documentation of a pre-delegation assessment was provided. The date of initial delegation was noted by the CCO as 10/1/21. •For March Vision Care, the credentialing file review worksheet did not include evidence of monitoring the delegate for conducting initial site visits. The documentation indicated site visits are delegated to March Vision Care. The addendum to Policy CR 01, Credentialing Program Policy, states initial credentialing site visits are required for all providers. This is a repeated finding from the previous EQR. *Corrective Action: Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained. When site visits are delegated to a credentialing delegate, ensure they are monitored for conducting the site visits according to health plan policy.*