Constellation Quality Health

Molina Healthcare of Mississippi

2023 External Quality Review

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Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Molina Healthcare of Mississippi (Molina). This report contains a description of the process and the results of the 2023 External Quality Review (EQR) conducted by Constellation Quality Health, formerly The Carolinas Center for Medical Excellence, 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 virtual onsite visit; a compliance review, including validation of performance improvement projects (PIPs) and performance measures, validation of network adequacy, validation of member and provider satisfaction surveys; and an Information Systems Capability 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)*
- Disenrollment *(§ 438.56)*
- Enrollee Rights *(§ 438.100)*
- Emergency and Post Stabilization Service *(§ 438.114)*

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

To assess Molina's compliance with standards set forth in *42 CFR Part 438* and *457*, Constellation Quality Health'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

Policies are developed to guide staff in conducting activities and to ensure compliance with laws, contracts, regulatory or accreditation requirements, and business processes. Appropriate processes are in place for policy development and ongoing management. Policies are stored in an accessible location for employees, and education is provided about new and revised policies.

The Organizational Chart delineates the reporting structure and lines of responsibility within the health plan and displays in-state and out-of-state personnel. All key positions are filled, and few vacancies were noted.

The 2023 Molina Healthcare Compliance Plan, the related Mississippi Addendum, the Molina Healthcare of Mississippi, Inc. 2023 Fraud, Waste, and Abuse Plan, policies, and procedures document activities to ensure Molina complies with laws, regulations, and contractual requirements and to guard against fraud, waste, and abuse (FWA). Formal compliance training is provided at employment and annually for all staff. The Molina Healthcare of Mississippi Inc. Code of Business Conduct and Ethics provides additional information about appropriate and ethical business practices and conduct. Molina encourages open communication between

employees and the Compliance Officer and enforces a no-retaliation policy for employees who make good-faith reports of actual or suspected noncompliance.

Molina's executive-level Compliance Committee provides tactical support and accountability to the compliance program. This EQR revealed that different names were noted for this committee in various documents. The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states the Compliance Officer chairs the committee. However, onsite discussion confirmed that the committee is chaired by the Associate Vice President of Compliance.

Molina provided appropriate documentation to demonstrate its infrastructure is capable of meeting DOM's information system requirements and has proper redundancies in the forms of a disaster recovery policy and procedure and a business continuity plan that incorporate resilience and robustness for the purpose of data preservation in case of a disaster. Molina's ISCA documentation indicates the organization's personnel and systems can perform the Medicaid data processing required by DOM for claims, encounters, and overall enrollment processing. Molina's 30-day claims processing rate exceeds the State's 90-day requirement.

Appropriate processes are in place for ensuring the confidentiality of protected health information and are documented in policies, program descriptions, the Code of Conduct, CAN and CHIP Member Handbooks, and CAN and CHIP Provider Manuals.

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

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. Ongoing education is conducted for all providers. The CAN and CHIP Provider Manuals are comprehensive resources for providers and include information needed to function appropriately within Molina's network. Issues were noted with documentation about the limit on the number of home health visits.

Network providers are educated about the availability of preventive health and clinical practice guidelines. The guidelines are disseminated to practitioners in various ways, and printed copies are available upon request. In addition, network providers are educated about medical record documentation standards through orientation materials. Molina completed its first medical record audit on October 31, 2023. Processes are in place to address any deficiencies with applicable providers.

Molina's 2022 provider satisfaction survey was administered by SPH Analytics. Of 1,500 providers included in the random sample, 75 providers responded, creating a response rate of

5%. This is a decrease from the previous year's rate of 10.9%. This very low response rate may not reflect the population of providers and results should be interpreted with caution.

Overall, Molina met the requirements of the Network Adequacy Validation. The results of the Telephone Access Study conducted by Constellation Quality Health in Q1 2023 identified weaknesses regarding the provider contact information and the availability of routine and urgent appointments.

Constellation Quality Health conducted a validation review of Molina's provider network following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." Processes are in place for maintaining the CAN and CHIP Provider Directories. This review confirmed the directories included all required elements. Molina Provider Data Management staff seek updates about contact information, office locations, etc. from all providers on a quarterly basis. Printed Provider Directories are updated at least every six months and online directories are updated nightly.

CAN and CHIP geographic access standards for primary care providers, specialists, and other provider types are found in health plan policies and are compliant with contractual requirements. Molina runs quarterly Geographic Access Assessment Reports to evaluate compliance with geographic accessibility requirements. Additionally, Molina considers member complaints, grievances, out of network requests, etc. when assessing network adequacy. Action is taken to address any identified issues.

Network provider appointment access standards are documented in health plan policy, Provider Manuals, and Member Handbooks. This review revealed several issues with the documentation, specifically related to appointment access standards for specialists, routine and follow-up visits with Behavioral Health/Substance Use Disorder providers, and emergency providers. Policy MHMS-QI-006, Access to Care, states appointment and after-hour accessibility audits are conducted to assess compliance with the appointment access standards. However, 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. This is an uncorrected deficiency from the previous EQR.

Overall, Molina met the requirements of the Network Adequacy Validation.

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 are appropriately documented in policy, in Member Handbooks, and on the CCO's website. However, member responsibilities were incompletely documented in policy

and on the website. In addition to the Member Handbooks and website, members are educated about their rights and responsibilities in member newsletters and mailings.

Members are educated about the health plan, coverage, programs, and services via new member packets, Member Handbooks, newsletters, etc. The CAN and CHIP Member Handbooks are comprehensive resources for members; however, minor issues were noted in documentation of some benefits. The Member Handbooks describe services available from the Member Services Call Center and the 24-Hour Nurse Advice Line as well as functions available through the MyMolina.com member portal.

Molina provides health education to members and encourages members to utilize preventive health services through Member Handbooks, newsletters, mailings, the website, the member portal, and telephone alerts. In addition, Molina provides education through local health fairs and other community events. Call Center staff see system alerts about the member's past-due or needed services so that they can be reminded to get the recommended services.

Molina produces member materials at appropriate reading levels to enhance member understanding and provides the materials in alternate languages and formats. Interpreter and translation services are available at no cost. Relay 711 is available for members with hearing difficulties. Contact Center staff use interactive scripts, which are approved by DOM prior to use and are reviewed at least annually, when interacting with members. Call Center staff training is provided at least quarterly. Molina monitors a percentage of member calls for compliance with customer care guidelines and monitors Call Center metrics. The CCO successfully implemented interventions to address failure to meet Call Center metrics in 2021 and 2022.

Molina documents in policy its processes for notifying affected members of a provider's termination from the network. However, Molina staff confirmed a corresponding policy does not exist to describe processes for notifying members about changes in programs and benefits.

Molina provides information about filing and processing grievances in health plan policies, CAN and CHIP Member Handbooks and Provider Manuals, and on Molina's website. Grievance terminology is defined and the process for grievance filing by members and authorized representatives. Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals include the member's right to file a grievance if they disagree with the request for an appeal or grievance extension. Molina's grievance logs are categorized with trends reported quarterly to the Quality Improvement and Health Equity Transformation Committee.

The sample grievance files reviewed were acknowledged and resolved in a timely manner. However, it appears that grievances are being closed rather than requesting extensions when additional information is needed. Some resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no information about the steps taken was provided. Instead, the member was asked to contact Molina. Molina explained that this letter template is used when additional information is needed from the grievant, but the file is being closed to meet the resolution timeframe requirement.

Molina contracts with Press Ganey, a certified vendor, to conduct both the child and adult member satisfaction surveys, which were fielded from February through May 2022. Low response rates for the member satisfaction surveys may affect the generalizability of the results. For Reporting Year 2022, the adult response rate was 10.8%, an improvement from the previous year's rate of 10.2%. Findings showed improvement in rating of health plan, getting needed care, rating of health care, getting care quickly, coordination of care, and rating of personal doctor. The largest decline was in the rating of specialists. The child response rate was 7.7% for 2022, an improvement over the previous year's response rate of 7.3%. Improvement was shown for rating of health plan, ease of filling out forms, getting care quickly, how well doctors communicate, and coordination of care. The largest decline was in the rating of specialists.

Quality Improvement

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

Molina's Quality Improvement (QI) Program focuses on the health care and services that CAN and CHIP members receive. The 2023 Quality Improvement Program Description describes the QI Program Molina has implemented. Six appendices were listed in the table of contents but are not included in the document. Also, the section titled "Implementing a Credentialing Program" indicates Molina maintains a comprehensive and detailed credentialing program. DOM has instituted a centralized credentialing process for all Medicaid providers. Therefore, the information listed in this section of the QI Program Description does not reflect Molina's responsibilities related to credentialing and recredentialing network providers.

The Quality Improvement and Health Equity Transformation Committee is responsible for the implementation and ongoing monitoring of the QI Program. It was discussed onsite that this committee was previously known as the Quality Improvement Committee. However, the committee meeting minutes were not updated to reflect the new name.

The QI Work Plan is developed annually after the completion of the Quality Improvement Program Annual Evaluation from the previous year. The 2022 and 2023 QI Work Plans were received. Molina's 2023 QI Work Plan includes the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will

be considered the first year for this trending activity. Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one. Also, there were several errors or missing information in the 2023 QI Work Plan.

Providers receive interpretation of their QI performance data and feedback. Molina provided an example of the Gaps in Care Report generated for network providers to identify members that are non-compliant or have identified gaps in care.

Molina adopts and disseminates clinical practice and preventive health guidelines that focus on key topics relevant to the health plan's members. 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. During the onsite, Constellation Quality Health questioned Molina on which of the "two important aspects" of the clinical practice guidelines were being measured and requested a copy of the annual report. Neither was provided.

Molina provides coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Well Baby/Well Child services and educates members and providers about the services and resources available. 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. The tracking system established by Molina includes outreach to members via phone or letters. There was no documentation that calls were made or that letters were sent to members in the 2023 tracker.

At least annually, Molina conducts a formal evaluation of the QI Program. The QI Program 2022 Annual Evaluation was provided but did not include the results of the Geo Access reports and the Provider Directory analysis. This continues to be an issue and was identified in the 2020, 2021, and 2022 EQR.

Validation of Performance Measure - All relevant HEDIS performance measures for the CAN and CHIP populations were compared for the current review year (MY2022) to the previous year (MY 2021) and the changes from 2021 to 2022 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial increases or decreases in rate from 2021 to 2022. A substantial increase or decrease is a rate change of greater than 10%.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescents (ima)			
Tdap	63.99%	76.40%	12.41%
Asthma Medication Ratio (amr)			
19-50 Years	46.03%	57.83%	11.80%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Continuation and Maintenance (C&M) Phase	38.46%	59.35%	20.89%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	31.00%	41.28%	10.28%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	14.00%	28.44%	14.44%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	29.52%	40.71%	11.19%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	13.33%	27.43%	14.10%
Substantial Decrease in Rate (>10% decrease)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	60.48%	48.65%	-11.83%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Statin Adherence 80% - 21-75 years (Male)	85.96%	39.18%	-46.78%
Statin Adherence 80% - 40-75 years (Female)	85.00%	44.26%	-40.74%
Statin Adherence 80% - Total	85.57%	41.14%	-44.43%
Statin Therapy for Patients with Diabetes (spd)			
Statin Adherence 80%	77.06%	38.46%	-38.60%
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	75.31%	59.77%	-15.54%
Effective Continuation Phase Treatment	61.18%	37.78%	-23.40%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	33.13%	19.26%	-13.87%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	49.59%	30.43%	-19.16%
Pharmacotherapy for Opioid Use Disorder (Total)	49.59%	30.43%	-19.16%

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	13.39%	24.18%	10.79%

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 and a decrease in rate from 2021 to 2022.

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Childhood Immunization Status (cis)			
Combination #7	58.92%	69.84%	10.92%
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	32.98%	43.87%	10.89%
Continuation and Maintenance (C&M) Phase	48.05%	60.00%	11.95%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	55.68%	68.42%	12.74%
Total-30-day Follow-Up	56.67%	68.69%	12.02%
Substantial Decrease in Rate (>10% improvement)			
Lead Screening in Children (lsc)	77.90%	63.81%	-14.09%
Appropriate Treatment for Upper Respiratory Infection (uri)			
18-64 Years	62.32%	50.52%	-11.80%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	74.36%	63.89%	-10.47%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY2022 and the previous year (MY2021). The changes from 2021 to 2022 are reported in the tables that follow. Rate changes shown in green indicate substantial (>10%) improvement and those shown in red indicate substantial (>10%) decline.

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

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	37.26	48.85	11.59
Total	37.25	48.83	11.58
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	8.94%	34.38%	25.44%
Numerator 2 All Four Molars Sealed	4.79%	21.91%	17.12%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Ages 3-5	30.35%	48.41%	18.06%
Ages 6-7	35.52%	54.93%	19.41%
Ages 8-9	35.82%	55.01%	19.19%
Ages 10-11	34.40%	52.41%	18.01%
Ages 12-14	30.19%	45.72%	15.53%
Ages 15-18	23.47%	37.24%	13.77%
Total Ages <1-20	25.26%	39.25%	13.99%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 3-5	9.64%	21.21%	11.57%
Ages 6-7	10.21%	24.22%	14.01%
Ages 8-9	10.44%	25.88%	15.44%
Ages 10-11	9.72%	21.75%	12.03%
Ages 12-14	7.57%	18.78%	11.21%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 3-5	5.61%	18.91%	13.30%
Ages 6-7	7.53%	23.30%	15.77%
Ages 8-9	8.06%	25.07%	17.01%
Ages 10-11	7.24%	21.35%	14.11%
Ages 12-14	5.53%	18.25%	12.72%
Total Ages 1-20	5.10%	16.04%	10.94%

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

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 3 Screening	41.65	53.24%	11.59%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	0.00%	26.20%	26.20%
Numerator 2 All Four Molars Sealed	0.00%	18.36%	18.36%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Ages 1-2	20.05%	31.95%	11.90%
Ages 3-5	43.26%	56.14%	12.88%
Ages 6-7	49.83%	65.24%	15.41%
Ages 8-9	47.38%	65.75%	18.37%
Ages 10-11	48.39%	62.55%	14.16%
Ages 12-14	41.18%	57.65%	16.47%
Ages 15-18	31.51%	45.66%	14.15%
Ages 19-20	19.50%	33.99%	14.49%
Total Ages <1-20	40.01%	54.62%	14.61%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 3-5	13.14%	28.45%	15.31%
Ages 6-7	15.01%	36.15%	21.14%
Ages 8-9	15.97%	36.77%	20.80%
Ages 10-11	13.34%	33.75%	20.41%
Ages 12-14	12.38%	27.65%	15.27%
Ages 15-18	8.01%	19.55%	11.54%
Ages 19-20	4.21%	10.00%	5.79%
Total Ages 1-20	12.04%	27.65%	15.61%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 3-5	7.92%	25.45%	17.53%
Ages 6-7	11.48%	34.44%	22.96%
Ages 8-9	11.94%	35.47%	23.53%
Ages 10-11	9.83%	32.67%	22.84%
Ages 12-14	9.20%	26.56%	17.36%
Ages 15-18	6.04%	18.61%	12.57%

Measure/Data Element	HEDIS MY 2021	HEDIS MY 2022	Change from 2021 to 2022
Total Ages 1-20	8.48%	25.92%	17.44%

Validation of Performance Improvement Projects – 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. The protocol validates project components and its documentation to provide an assessment of the overall study design and methodology. For this review, Molina submitted seven CAN PIPs, and all scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and interventions is also included.

Table 5: 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 latest report had Q1 2023 data with a readmission rate of 54.2% and increased from the Q4 2022 rate of 10.8%. Case management enrollment for the 13 readmitted members was 100%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Community connectors • Primary care initiative • Scheduling process changed • Onsite discharge planning • Transition of Care letters sent to members • Patient Outreach	

Table 6: 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 Asthma PIP focused on the AMR HEDIS rate for ages 5 to 64. Quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements, with a goal of 72.89%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Asthma Medication Ratio
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 7: Pharmacotherapy Management of COPD Exacerbation CAN PIP

Pharmacotherapy Management of COPD Exacerbation	
The COPD PIP utilizes the systemic corticosteroid HEDIS measure and the bronchodilator HEDIS measure. For Q1 to Q2 2023, there was an increase from 48.65% to 60.94% for steroid measure, with a goal of 53.43%, and an improvement from 59.46% to 79.69% for the bronchodilators, with a goal of 81.8%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products. • Provider Education Tools	

Table 8: Follow-up After Hospitalization for Mental Illness CAN PIP

Follow-up After Hospitalization for Mental Illness	
This PIP assesses 7- and 30-day follow up for members hospitalized for treatment of mental illness. For 30-day follow up, the rate improved from 34.34% to 44.73%, with a goal of 56.13%. The 7-day rate improved from 21.72% to 27.23% with a goal of 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• TOC Coaches: Once notified of assigned admitted members, the TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan. • Discharge planning checklist • Processes to improve efficiency of scheduling follow-up appointments • Provider Education	

Table 9: Obesity CAN PIP

Obesity	
This PIP utilizes the BMI percentile documentation and counseling for nutrition and physical activity HEDIS measures. For BMI percentile, there was improvement from Q1 to Q2 with rates of 14.44% increasing to 18.69%, with a goal of 61.31%. Counseling for nutrition improved 7.41% to 9.86% with a goal of 52.31%; counseling for physical activity improved 7.1% to 9.92%, with a goal of 57.42%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member Incentives • Member outreach and member events for awareness and education	

Table 10: Prenatal and Postpartum Care CAN PIP

Prenatal and Postpartum Care	
This PIP examines the rate of deliveries that received prenatal care within the first trimester and post-partum care visits within 84 days of delivery. For prenatal visits, the rate declined from 86.19% to 84.72%, and the goal is 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Provider Education • Member incentives-Gift cards and car seats • Member outreach events • Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize electric breast pump for the first 6 months of their child's life.	

Table 11: Sickle Cell Disease CAN PIP

Sickle Cell Disease	
This focuses on the percentage of members with Sickle Cell Disease that are enrolled in case management. The rate declined from 6.25% to 4.9%, with a goal of 15.9%.	
Previous Validation Score	Current Validation Score

Sickle Cell Disease	
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Internal monitoring and tracking for inpatient care and ED visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration with the MS Sickle Cell Foundation. • Member educational materials	

Molina submitted the same four CHIP PIPs for validation this year that were submitted last year and all scored in the "High Confidence in Reported Results" range, as noted in the tables that follow. A summary of each project's status and interventions is also included.

Table 12: Asthma Medication Ration CHIP PIP

Asthma Medication Ratio	
The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. Quarterly rates show a decline from 93.02% in Q1 2023 to 76.92% in Q2 2023. The rates are above the goal rate of 71.28% (benchmark should be adjusted now that several remeasurements are above it).	
Previous Validation Score	Current Validation Score
85/85=100% High Confidence in Reported Results	79/80= 99% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of the inhaler • Telephone campaigns to encourage members to get their annual wellness exams • Provider education with toolkits and assistance with member outreach	

Table 13: Follow-up After Hospitalization for Mental Illness CHIP PIP

Follow-up After Hospitalization for Mental Illness	
The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate for 6-17 year-olds improved from 46.43% in Q1 2023 to 59.18% in Q2 2023, with the goal of 56.13%. For the 7-day rate, the rate increased from 28.6% in Q1 to 34.7% in Q2, with the goal of 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results

Follow-up After Hospitalization for Mental Illness
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

Table 14: Obesity CHIP PIP

Obesity	
The Obesity PIP aims to increase the percentage of CHIP members who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. The BMI documentation rate improved from 11.29% in Q1 to 15.23% in Q2, with the goal rate of 61.31%. The nutrition counseling rate also improved from 5.68% to 8.96%, with a goal of 52.31%. Counseling for physical activity improved from 4.73% to 8.73%, with a goal of 57.42%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider toolkits to help facilitate tracking reports and address areas needed • Member education, community outreach, and incentives	

Table 15: Well Care/Well Child CHIP PIP

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 15 months of life. The most recent rates were 59.52% in Q1 and 63.16% in Q2, with the goal of 56.13%.	
Previous Validation Score	Current Validation Score
85/85=100% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Provider education with periodic face-to-face visits offering HEDIS toolkits, non-compliant member list, provider portal training, and HEDIS Tip Sheets for well visits. • Member/Community outreach with health fairs and community events as a primary source of meeting and informing members on a large scale. • Member incentives provided on the day of the screening.	

Utilization Management

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

The Health Care Services program is structured within Molina's CAN and CHIP Utilization Management (UM) program. The Health Care Services Program Description and various policies describe the CAN and CHIP UM Program scope, lines of responsibility, and process for physical health and behavioral health services. The Pharmacy Program Description outlines the Pharmacy Program for that is offered through the Molina Healthcare Pharmacy Services Department.

The Chief Medical Officer has authority and responsibility for the Health Care Services Program. The Behavioral Health Director and Pharmacy Director provide oversight over their respective programs. There are also several committees that provide oversight, and an annual review of the Health Care Services program is conducted.

Initial UM decisions are made by qualified professionals that are licensed within their respective healthcare professions. The UM reviewers use several evidence-based clinical guidelines in making clinical determinations. The clinical guidelines are reviewed and approved annually.

Constellation's review of a sample of CAN and CHIP UM approval determinations reflected that the determinations were consistent with clinical guidelines and made by appropriate licensed healthcare professionals. Determinations were communicated according to contractual regulations. The review of a sample of CAN and CHIP UM denial determinations indicated Molina provided the rationale for the adverse determination and the process for filing an appeal. However, the CAN and CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. This is no longer a contractual requirement.

The Health Care Services Program Description and Policy HCS-325.01, Service Authorization, indicate Molina follows state requirements for processing extensions for service authorizations. However, in describing the extension process, neither the Health Care Services Program Description nor Policy HCS-325.01 address the requirement for Molina to request an extension from DOM as contractually required.

The Healthcare Pharmacy Services Department is responsible for administering and monitoring pharmacy services for members. The CAN and CHIP Provider Manuals, CAN and CHIP Member Handbooks, Molina's website, and various policies provide an overview of the Preferred Drug List. However, the links to access the Preferred Drug List listing provided in the CHIP Member Handbook and CHIP Provider Manual were not functional.

Molina's Integrated Care Management Program offers care coordination and disease management services to Mississippi members. Various resources are used to identify potential candidates for the Care Management Program. Policy HCS-161.01, Health Risk Assessment Addendum, provides an overview of the health risk assessment process for members who are referred for case management services and applies to both CAN and CHIP. However, the policy does not identify the *CHIP Contract* in the Source of Decision information.

Molina provides transition of care services for new and existing members that are transitioning from various care settings, such as inpatient treatment and long-term care settings. The interdisciplinary transitional care team ensures continuity of care and a successful transition for members within their home or community settings through various methods and resources.

Processes for filing and managing appeals are outlined in Molina's policies, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and on Molina's website. For Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the "Procedure" section indicates notification is given to DOM of the need for additional information when the extension of an appeal is in the Member's best interest. During the onsite, it was shared that this is not done for standard appeals.

Delegation

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

Molina delegates to subcontractors and/or vendors to perform some health plan activities. Those delegated services include vision services, non-emergent transportation services, care management, utilization management, dental services, and pharmacy services.

Procedure DO-1.001, Delegation Oversight, contained an overview of the pre-delegation assessment and post-implementation and ongoing monitoring conducted as part of delegate oversight. This procedure indicates a comprehensive annual delegation oversight audit is conducted. Annual audits were conducted for all the delegates except CVS/Caremark. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation audit report was not provided, which was an issue previously identified during the 2022 EQR.

Corrective Action Plans and Recommendations from Previous EQR

During the 2022 EQR for CAN, four standards were scored as "Partially Met" and six standards were scored as "Not Met." For CHIP, four standards were scored as "Partially Met" and six standards were scored as "Not Met." The following provides a high-level summary of those deficiencies:

- Molina reported that no process has been implemented to track and monitor CAN and CHIP provider limitations on panel size to determine providers that are not accepting new patients.
- For CAN and CHIP, Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Also, 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, inconsistencies were noted in appointment access timeframes 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 and CHIP Member Handbooks 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 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 and CHIP Member Handbooks 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 and CHIP Provider Manuals 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.
- For CAN, the listing of covered benefits on Molina's website for Home Health Services 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.
- For CHIP, the listing of covered benefits on Molina's website for Radiology/X-rays indicates these services must be conducted in a physician's office or hospital outpatient department. However, the CHIP Member Handbook does not include the restriction to location. Additionally, the CHIP Member Handbook states that 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.
- For 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 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. This report did not include documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow-up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The *CAN Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's EPSDT tracking system does not meet this contractual requirement.

- 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 in the Well-Baby and Well-Child tracking report. Molina provided the Well-Baby Well-Child tracking report. However, this report did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The *CHIP Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's Well-Baby Well-Child tracking system does not meet this contractual requirement.
- For CAN, 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 indicated the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The QI Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the evaluation:
    - In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions a root cause analysis was completed. However, it was not included in the QI Program Evaluation.
    - The Geographic Access Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing

activities (reference Section 19.0, 2021 work plan) were not included in the QI Program Evaluation.

- The Delegation Oversight activities were incomplete.
- After the onsite, Molina submitted another copy of the 2021 QI Program Evaluation. Additional information was added related to delegation oversight. However, this QI Program Evaluation is also incomplete. This continues to be an issue and was identified in the 2020 and 2021 EQRs. The *CAN Contract, Section 10 (D) (8)* requires the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Exhibit G (7)* further defines the requirements for the QI Program Evaluation.

- For CHIP, 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 indicated the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the Evaluation:
  - In Section VIII – Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions that a root cause analysis was completed; however, 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 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 was also incomplete. This continues to be an issue and was identified in the 2020 and 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 defines the requirements for the QI Program Evaluation.

- For CAN and CHIP, 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 and CHIP Member Handbook, the CAN and CHIP Provider Manual, and on Molina's website. These documents incorrectly indicate that a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification template. Also, Policy MHMS-MRT-02, Standard Member Appeals, documents information that must be included in appeal acknowledgement letters. However, the CAN standard appeal acknowledgement letter template does not include the statement offering a State Fair Hearing or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy. For CHIP, the 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.
- For CAN and CHIP, delegate oversight documents provided by Molina were reviewed. 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 October 1, 2021.

There were several deficiencies identified during the previous EQR that were found to be uncorrected in the current EQR. These are addressed in the applicable sections of this report.

Conclusions

Six of the 13 categories displayed in *Table 16: Compliance Results for Part 438 Subpart D and QAPI Standards* received an overall score of 100% and met 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 16: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Molina's compliance scores relative to each of the 14 Subpart D and QAPI standards above.

Table 16: Compliance Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	30	26	87%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Coordination and Continuity of Care *(§ 438.208,* Availability of Services *(§ 438.206, § 457.1230)* and	Utilization Management, Section V. D	28	28	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	24	22	92%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	2	2	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	40	36	90%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	4	2	50%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	16	16	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	30	79%
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. D	2	2	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	6	4	67%
• Emergency and Post Stabilization Service *(§ 42 C.F.R. 438.114)*	Utilization Management, Section V. B	2	2	100%

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

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

- For Availability of Services and Assurances of Adequate Capacity and Services, issues were identified in appointment access standards in policy, the CAN Provider Manual, and the CHIP Provider Manual. Additionally, Molina's Access to Care policy (MHMS-QI-006) indicates appointment and after-hour accessibility audits are conducted but does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits.
- For Grievance and Appeal Systems, Molina's Standard Member Appeals policy states notification is given to the Division of the need for additional information and when the

extension of an appeal is in the Member's interest. However, during onsite discussion, Molina is not notifying DOM when an appeal is extended. Also, it appeared that grievances are being closed rather than requesting extensions when additional information is needed.

- For Coverage and Authorization of Services, CAN and CHIP Adverse Benefit Decision Letters include incorrect information about the process to file an appeal.
- For the Quality Assessment and Performance Improvement Program, Molina does not measure provider compliance with the Clinical Practice Guidelines, the QI Work Plan lacked goals for some activities and contained errors, and the annual evaluation was incomplete.
- For Sub contractual Relationships and Delegation, the annual oversight audits as required by the *CAN Contract, Section 15 (B)* and *CHIP Contract, Section 14 (B)* were not conducted for all delegated entities.
- For Enrollee Rights Requirements, member responsibilities were not completely documented in policy and on the CCO's website.

Table 17, Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2022 review. For CAN, 172 of 188 standards received a score of "Met." A total of 11 standards were scored as "Partially Met" and five standards were scored as "Not Met."

Table 17: Scoring Overview—CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	30	0	0	0	0	30	100%
2023	30	1	0	0	0	31	97%
Provider Services							
2022	79	2	3	0	0	84	94%
2023	46	0	3	0	0	49	94%
Member Services							
2022	32	1	0	0	0	33	97%
2023	28	5	0	0	0	33	85%
Quality Improvement							
2022	17	0	2	0	0	19	90%
2023	15	3	1	0	0	19	79%
Utilization Management							
2022	53	1	0	0	0	54	98%
2023	52	2	0	0	0	54	96%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Delegation							
2022	1	0	1	0	0	2	50%
2023	1	0	1	0	0	2	50%
Totals							
2022	212	4	6	0	0	222	95.5%
2023	172	11	5	0	0	188	91.5%

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

Table 18, Scoring Overview—CHIP, provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2022 review. For 2023, 172 out of 188 standards received a score of "Met." A total of 11 standards were scored as "Partially Met" and five standards were scored as "Not Met."

Table 18: Scoring Overview—CHIP

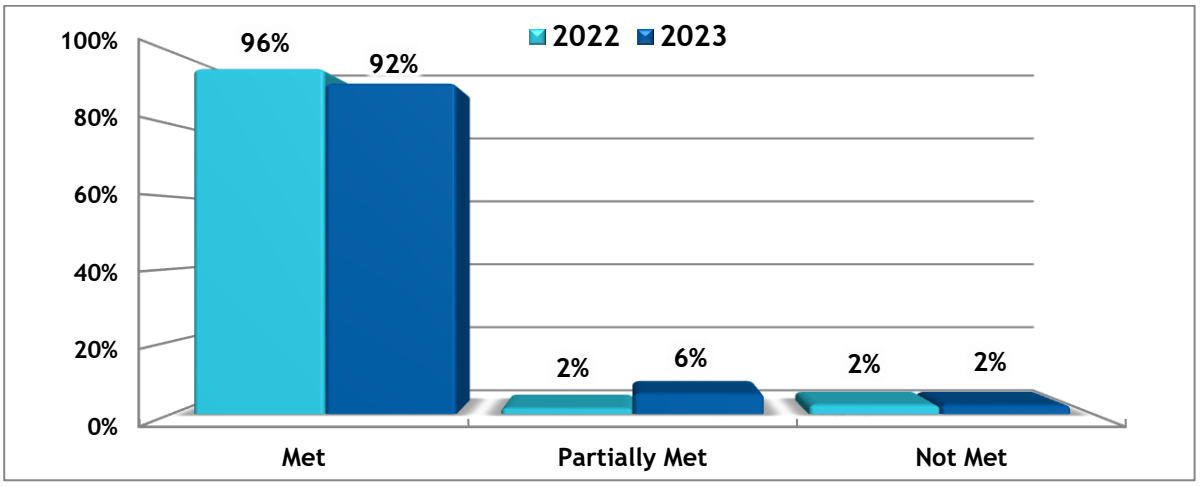
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	30	0	0	0	0	30	100%
2023	30	1	0	0	0	31	97%
Provider Services							
2022	78	2	3	0	0	83	94%
2023	44	1	2	0	0	47	96%
Member Services							
2022	32	1	0	0	0	33	97%
2023	27	5	0	0	0	32	84%
Quality Improvement							
2022	17	0	2	0	0	19	90%
2023	15	3	1	0	0	0	79%
Utilization Management							
2022	53	1	0	0	0	54	98%
2023	52	2	0	0	0	54	96%
Delegation							
2022	1	0	1	0	0	2	50%
2023	1	0	1	0	0	2	50%
Totals							
2022	211	4	6	0	0	221	95.5%
2023	172	11	5	0	0	188	91.5%

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

The 2023 Annual EQR for CAN shows that Molina achieved "Met" scores for 91.5% of the standards reviewed, and 5.9% of the standards were scored as "Partially Met." For CHIP, 91.5% of the standards were scored as "Met" and 6.4% were scored as "Partially Met."

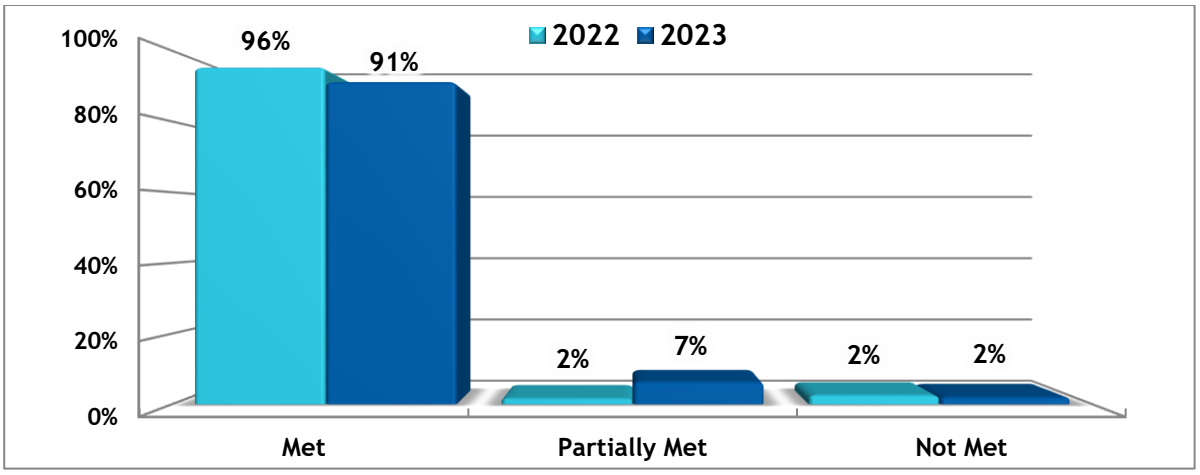
The charts that follow provide a comparison of the current review results to the 2022 review results for CAN and CHIP.

Figure 1: 2022 and 2023 Annual EQR Review Results for CAN



Scores were rounded to the nearest whole number.

Figure 2: 2022 and 2023 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 19: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for policy development and management. Staff are educated about new and revised policies, and policies are easily accessible by staff.	✓		
Key positions are filled, and few vacancies are noted. Staffing appears to be sufficient.	✓		
Data is duplicated to a secondary disaster recovery site to help ensure availability and integrity in the event of an incident at the primary data center.	✓		
Clean claim payment rates meet DOM requirements.		✓	
Molina's Information Technology organizational structure is clearly defined.	✓		
The 2023 Compliance Plan, the 2023 Compliance Plan Mississippi Addendum, the Molina Healthcare of Mississippi, Inc. 2023 Fraud, Waste, and Abuse Plan, and related policies and procedures document activities and processes to ensure compliance with laws, regulations, and contractual requirements, and to guard against fraud, waste, and abuse.	✓		
Compliance training is provided at employment and annually. The training covers pertinent topics and is mandatory.	✓		
Molina encourages open communication between employees and the Compliance Officer and enforces a no-retaliation policy for anyone making good faith reports of compliance issues and fraud, waste, and abuse.	✓		
Appropriate processes are in place and are well documented for maintaining and ensuring the confidentiality of protected health information.	✓		
Provider Services			
Molina ensures primary care providers are notified of members assigned to their panels and that all providers can verify member enrollment with the health plan.			✓
Molina tracks provider panel size limitations to ensure enough providers are accepting new patients.			✓
Health plan policies appropriately document geographic access standards for providers, and Geo Access reports demonstrate that appropriate parameters are used for measuring access. Molina takes action to address any identified network geographic access gaps, and will be implementing an additional resource, Quest Analytics, to identify gaps in real time.			✓
Molina evaluates the cultural competency of its provider network and takes action to address any identified issues. Related resources are available to providers.			✓
Molina's CAN and CHIP Provider Directories include all required elements.			✓
Initial provider orientation is conducted within 30 days of the provider's active date within the network, and ongoing education is conducted for all providers.	✓		

Strengths	Quality	Timeliness	Access to Care
Molina adopts preventive health and clinical practice guidelines and disseminates them to providers.	✓		
Medical record documentation guidelines are disseminated to providers, and Molina conducts activities to assess provider compliance with the guidelines.	✓		
Member Services			
Member rights are consistently documented in policy, CHIP and CAN Member Handbooks, and on the CCO's website. Members are educated about their rights in various ways.	✓		
Overall, the CAN and CHIP Member Handbooks are comprehensive resources for members to understand their coverage, health plan processes, etc.			✓
Member materials are written at an appropriate reading level, available in alternate formats, and can be translated into alternate languages.			✓
Molina routinely monitors Call Center staff performance and Call Center metrics. Interventions were implemented to address unmet goals in 2021 and 2022, resulting in improvement noted in 2023.	✓		
Call Center staff use interactive scripts and talking points for member calls. The scripts are reviewed at least annually for needed changes.	✓		
Call Center staff are provided with training on a quarterly basis.	✓		
Various methods are used to educate members about recommended preventive care services, screenings, etc.			✓
Adult and child member satisfaction survey results are examined internally.	✓		
Of the grievance file sample for the 2023 EQR, all were acknowledged and resolved in a timely manner.		✓	
Quality Improvement			
Molina's HEDIS auditor found that the CCO was fully compliant with all IS 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 CMS Adult and Child Core Set measures that were reported. The PM validation determined that Molina followed measure specifications and produced reportable rates for all measures in the scope of the PM validation.	✓		
The following HEDIS MY 2022 measure rates were strengths for Molina's CAN population since their rates had a greater than 10 percentage point improvement: • Immunizations for Adolescents (IMA), the Tdap indicator improved by over 12 percentage points. • Asthma Medication Ratio (AMR), the 19-50 Years indicator improved by over 11 percentage points. • Follow-Up Care for Children Prescribed ADHD Medication (ADD), the Continuation and Maintenance (C&M) Phase indicator improved by over 20 percentage points. • Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) rate improved over 10 percentage points for the following indicators: Age 18-64 (7 days and 30 days), 7 days total and 30 days total. • Heart Failure Admission Rate (PQI-08), the Age 18-64, and Total indicators improved by over 11 percentage points. • Sealant Receipt on Permanent First Molars (SFM-CH) the Numerator 1 At Least One Sealant and Numerator 2 All Four Molars Sealed indicators, improved by over 17 percentage points.	✓		

Strengths	Quality	Timeliness	Access to Care
• Oral Evaluation, Dental Services (OEV-CH) improved by over 13 percentage points for all but three (Age<1, Ages 1-2, and Ages 19-20) indicators. • Prevention: Topical Fluoride for Children (TLF-CH), the Rate 1 indicator improved by over 11 percentage points for five indicators (Ages 3-5, Ages 6-7, Ages 8-9, Ages 10-11, and Ages 12-14). The Rate 2 indicator improved by over 10 percentage points for all but three indicators (Ages 1-2, Ages 15-18, and Ages 19-20).			
The following HEDIS MY 2022 measure rates were strengths for Molina's CHIP population since their rates had a greater than 10 percentage point improvement: • Childhood Immunization Status (CIS) improved by over 10 percentage points for the Combination #7 indicator. • Follow-up Care for Children Prescribed ADHD Medication (ADD) rate improved by over 10 percentage points for both indicators. • Follow-Up After Hospitalization for Mental Illness (FUH) rate improved by over 12 percentage points for the Age 6-17 years 30 days Follow-Up and Total 30 days Follow-Up indicators. • Developmental Screening in the First 3 Years of Life (DEV-CH) the Age 3 Screening indicator improved by over 11 percentage points. • Sealant Receipt on Permanent First Molars (SFM-CH) both indicators improved by over 18 percentage points. • Oral Evaluation, Dental Services (OEV-CH) improved by over 11 percentage points for all but one indicator (Age<1). • Prevention: Topical Fluoride for Children (TLF-CH) the Rate 1 and Rate 2 indicators improved by over 11 percentage points for all but two indicators (Ages 1-2 and Ages 19-20).	✓		
All the CAN and CHIP PIPs scored in the High Confidence range.	✓		
Utilization Management			
Molina's program goal of 98% for timeliness of service authorization completion was met or exceeded monthly.		✓	
Approval files reflected that the approval decisions were communicated timely to the member and provider.		✓	
Molina's Community Connectors assist any social needs for members such as providing transportation, appointment support, addressing housing needs, and linkage to food assistance, etc.	✓		
All the appeal files reviewed for the 2023 EQR were addressed in a timely manner.		✓	

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Administration				
Policy MHMS-GC-28, Policy and Procedure Format and Review, indicates that newly created and revised policies and procedures are submitted to the Policy and Procedure Committee for review and approval. However, onsite discussion confirmed	Recommendation: Update Policy MHMS-GC-28, Policy and Procedure Format and Review, to include the additional committee review prior that may be conducted prior to review by the Policy and Procedure Committee.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
that policies may be reviewed by additional committees applicable to the department or functional area prior to review by the Policy and Procedure Committee.				
The 2023 Compliance Plan Mississippi Addendum incorrectly references the executive-level Compliance Committee as the Mississippi Compliance Committee. Charter Number: C-00b, Compliance Committee Charter - Management Level references the executive-level Compliance Committee as the Regulatory Compliance Committee.	Recommendation: Revise the specified documents to include the correct name for the executive-level Compliance Committee.	✓		
The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states the Compliance Officer chairs the Compliance Committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President, Compliance.	Corrective Action: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.	✓		
Policy MHMS-PH-005, Pharmacy Lock-In Program, does not define the timeframe for notifying members of their inclusion in the Lock-in Program.	Recommendation: Revise Policy MHMS-PH-005, Pharmacy Lock-In Program, to clearly describe the timing of making decisions to restrict members into the program and the timeframe for notifying members of the restriction.	✓		
Provider Services				
Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Issues noted with the policy include: • For specialists, the policy defines the appointment access standard as 20-30 calendar days. <u>This is an uncorrected deficiency from the previous EQR.</u> • For routine visits with Behavioral Health/Substance Use Disorder providers, the policy states the standard is 21 calendar days; however, it includes additional information that the initial visit must be scheduled within 10 business days.	Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care to address the identified deficiencies. Refer to the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2).*			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Issues were noted in the appointment access standards documented in the CAN Provider Manual and the CHIP Provider Manual. These include: • For routine visits with Behavioral Health/Substance Use Disorder providers, the CAN Provider Manual states the standard is 14 calendar days. <u>This is an uncorrected deficiency from the previous EQR.</u> • The CAN Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use Disorder providers is 7 calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge." • The CAN and CHIP Provider Manuals do not include the appointment access standard for Emergency Providers. • The CHIP Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use Disorder providers is 7 calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge."	Corrective Action Plan: Revise the CAN Provider Manual, and the CHIP Provider Manual to address the identified deficiencies. Refer to the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2).*			✓
Policy MHMS-QI-006, Access to Care, indicates appointment and after-hour accessibility audits are conducted, but does not indicate the frequency for conducting the audits or the department or entity that conducts the audits. <u>This is an uncorrected deficiency from the previous EQR.</u>	Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to identify the frequency for conducting the appointment and after-hour accessibility audits and the department or entity that conducts the audits.			✓
Molina's website at Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards does not define the limit on the number of	Corrective Action Plan: Revise the CAN benefits grid on the website to state the limit on the number of home health visits. Also, revise the "Molina Healthcare Benefits at a Glance MississippiCAN Covered			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
home health visits allowed, but states members under 21 can get additional visits if authorized but does not specify a limit on the number of visits. However, the Molina Healthcare Benefits at a Glance -MississippiCAN Covered Services document found by using the "view and print" link found on the same page shows a limit of 25 visits per year. This is an uncorrected deficiency from the previous EQR.	Services" document found by using the "view and print" link at Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards to include the correct limit for the number of home health services visits.			
Molina's website at Home > Members > CHIP > About CHIP > What's Covered > Benefits and Rewards does not define the limit on the number of home health visits allowed, but states home health services must be approved. The "Molina Healthcare Benefits at a Glance - CHIP Covered Services" document found by using the "view and print" link found on the same page correctly states the limit is 36 visits per year.	Corrective Action Plan: Revise the benefits grid on Molina's website at Home > Members > CHIP > About CHIP > What's Covered > Benefits and Rewards to list the limitation on the number of home health visits.			✓
Response rates for the provider satisfaction surveys remain low and may affect generalizability of the results.	Recommendation: Continue to seek ways to improve response rates for the provider satisfaction surveys.	✓		
Member Services				
Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN and CHIP web pages listing member responsibilities do not include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.	Corrective Action Plan: Revise Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN and CHIP web pages listing member responsibilities to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.	✓		
The CAN Member Handbook does not specify the limitation on the number of visits allowed for home health services.	Corrective Action Plan: Revise the CAN Member Handbook to state the limitation on the number of home health visits per year.			✓
Issues identified in benefits documentation in the CHIP Member Handbook include: • For Emergency Ambulance Services, the CHIP Member Handbook states, "Unlimited based on life threatening condition	Corrective Action Plan: Correct the identified issues with member benefit documentation.			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
present" and this is not stated on the benefits information on the CHIP website. Molina staff were unable to explain the restriction about life threatening conditions. • The CHIP Member Handbook, page 39, does not specify the number of visits allowed for home health services. • For Eye Care – Vision Services, the CHIP Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the CHIP website states, "1 eye exam and 1 pair of glasses annually."				
The CAN and CHIP Member Handbooks indicate members are informed of changes to programs and benefits within 30 calendar days prior to implementation. Molina staff confirmed there is no policy that addresses this requirement.	Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.			✓
Information about operations of the Member Services Contact Center is found in Policy MHMS-M&PCC-04, Member Services General Operations. As noted in the policy, the Member Services Contact Center hours of operation are 7:30 a.m. to 8:00 p.m., Monday through Friday and one weekend a month, excluding State holidays. As written in the policy, it appears that the call center is open until 8 p.m. one weekend per month. However, onsite discussion confirmed the weekend hours are 8 a.m. to 5 p.m.	Corrective Action Plan: Revise Policy MHMS-M&PCC-04, Member Services General Operations, to list the correct weekend hours of operation for the call center.			✓
Response rates for the member satisfaction surveys remain low and may affect generalizability of the results.	Recommendation: Continue to seek ways to improve response rates for the member satisfaction surveys.	✓		
It appears that grievances are being closed rather than requesting extensions when additional information is needed. Members were asked to call the Member Services Department rather than receiving details of the investigative steps taken to resolve the grievance.	Corrective Action: Ensure processes are in place to comply with Policy MHMS-MRT-01, Member Complaints and Grievances regarding the use of extensions when needed to obtain additional information needed to resolve a grievance.		✓	
Quality Management				

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The appendices were not included in the 2023 QI Program Description and the section regarding credentialing was incorrect regarding Molina's responsibilities related to credentialing and recredentialing network providers.	Recommendation: Add the appendices to the 2023 Quality Improvement Program Description and update or remove the section that describes the credentialing program.	✓		
The Quality Improvement and Health Equity Transformation Committee was previously known as the Quality Improvement Committee. However, the committee meeting minutes were not updated to reflect the new name.	Recommendation: Update the Quality Improvement and Health Equity Transformation Committee meeting minutes to reflect the new name for this committee.	✓		
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. Constellation Quality Health questioned Molina during the onsite regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided.	Corrective Action Plan: On an annual basis, measure provider performance against at least two of the clinical guidelines as required by the *CAN Contract, Section 10 (M)* and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.	✓		
The results columns in the 2023 QI Work Plan are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year (Y1). Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one.	Recommendation: Label the columns for the applicable year in the 2023 QI Work Plan (example: Y1= 2023, Y2=2024 etc.).	✓		
There were several errors or missing information in the 2023 QI Work Plan. Those included: • In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1. • The Availability of Practitioners section (PDF pages 16 – 28) and the Accessibility of Services section (PDF pages 29 – 30) lacked benchmark goals for each activity.	Corrective Action Plan: Correct the errors identified in the 2023 Quality Improvement Work Plan.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
• The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications which measure those scores apply. • The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists. • The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care practitioners instead of behavioral health practitioners. • The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. However, Policy MHMS-QI-006, Access to Care lists this timeframe as seven calendar days. • The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care. • In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days.				
The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for Molina's CAN population, since their	Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
rates had a greater than 10 percentage point decline: • Pharmacotherapy Management of COPD Exacerbation (PCE), the Systemic Corticosteroid indicator decreased by over 11 percentage points. • Statin Therapy for Patients with Cardiovascular Disease (SPC) the Statin Adherence 80% - 21-75 years (Male), Statin Adherence 80% - 40-75 years (Female), Statin Adherence 80% - Total indicators decreased by over 40 percentage points. • Statin Therapy for Patients with Diabetes (SPD) the Statin Adherence 80% indicator decreased by over 38 percentage points. • Antidepressant Medication Management (AMM) rate decreased for both indicators by over 15 percentage points. • Follow-Up After Emergency Department Visit for Mental Illness (FUM) 7 days (18-64) indicator decreased by over 13 percentage points. • Pharmacotherapy for Opioid Use Disorder (POD) the Age 16-64 and Total indicators decreased by over 19 percentage points. • Use of Opioids from Multiple Providers (UOP) the Multiple Prescribers indicator increased by over 10 percentage points. The rate increase indicates lower performance for this measure.				
The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for Molina's CHIP population, since their rates had a greater than 10 percentage point decline: • Lead Screening in Children (LSC) rate decreased by over 14 percentage points. • Appropriate Treatment for Upper Respiratory Infection (URI) rate	Recommendation: Monitor rates and implement interventions to improve the rates.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
decreased by over 11 percentage points for 18-64 Years indicator. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) rate decreased by over 10 percentage points for Age 12-17 years indicator.				
Four of seven CAN PIPs had a decrease in indicator rates and one CHIP PIP had a decrease in the indicator rates.	Recommendation: Asses the current interventions to determine if changes are needed.	✓		
At least annually, Molina conducts a formal evaluation of the Quality Improvement Program. The Quality Improvement Program 2022 Annual Evaluation was provided. This evaluation did not include the results of the Geo Access reports and the Provider Directory analysis. This continues to be an issue and was identified in the 2020, 2021, and 2022 EQR.	Corrective Action Plan: The results of all activities completed in 2022 and/or an update for the ongoing activities must be added to the Quality Improvement Program 2002 Annual Evaluation to meet the requirements in the *CAN Contract, Section 10*, and *Exhibit G* and in the *CHIP Contract, Section 9*, and *Exhibit F*.	✓		
Utilization Management				
The CAN and CHIP Health Care Services Program Description and Policy HCS-325.01, Service Authorization, indicate Molina follows state requirements for processing extensions for service authorizations. However, in describing the extension process, neither the Health Care Services Program Description nor the policy address the requirement for Molina to request an extension from DOM as required by contractual requirements.	Recommendation: Update the Health Care Services Program Description and Policy HCS-325.01 to indicate that for plan-requested extensions, Molina will request approval from DOM as required by the *CAN Contract, Section 5 (J) (6)* and *CHIP Contract, Section 5 (I) (1).*	✓		
The CAN and CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. This is no longer a contractual requirement.	Corrective Action: Update the CAN and CHIP Adverse Benefit Determination letters to remove the requirement that a member must follow a verbal appeal request with a written request	✓		
Links provided in the CHIP Provider Manual and CHIP Member Handbook to access the PDL result in an error message indicating, "Service Unavailable-DNS Failure."	Recommendation: Ensure the embedded links for the PDL in the CHIP Provider Manual and CHIP Member Handbook are functional.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy HCS-161.01, Health Risk Assessment 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 161.01, Health Risk Assessment Addendum.	✓		
Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the Procedure section indicates that notification is given to the Division of the need for additional information and when the extension of an appeal is in the Member's [best] interest. However, seven CAN and five CHIP files were extended based on the lack of the receipt of a signed Authorized Representative Form, and subsequently closed with no indication of notification to the Division found in the files.	Corrective Action: Ensure processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals, and the appropriate notification to the Division when appeal extensions are needed.	✓		
Delegation				
The annual delegation oversight audit of CVS/Caremark was not conducted as required by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B)*.	Corrective Action Plan: Conduct the annual delegation oversight audit of CVS/Caremark as required by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B)*.	✓		

METHODOLOGY

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

On July 5, 2023, Constellation Quality Health 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 Constellation Quality Health 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 Constellation Quality Health requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on August 4, 2023, for review at the Constellation Quality Health offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on November 1, 2023, and November 2, 2023. 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 are 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 spreadsheets included in each of the following sections.

A. Administration

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

The review for Administration includes policy and procedure management, staffing, information systems capabilities, compliance/program integrity, and confidentiality.

Policies are developed to guide staff in conducting activities and to ensure compliance with laws, contracts, regulatory or accreditation requirements, and business processes. Each policy is reviewed at least annually. Policy MHMS-GC-28, Policy and Procedure Format and Review, indicates newly created and revised policies and procedures are submitted to the Policy and Procedure Committee for review and approval. However, onsite discussion confirmed that policies may be reviewed by additional committees prior to review by the Policy and Procedure Committee. Upon final approval, policies are stored on a SharePoint site for staff access. Staff are educated about new and revised policies by departmental leadership and/or updates and training by the Compliance Department.

The Organizational Chart delineates the reporting structure and lines of responsibility within the health plan and displays in-state and out-of-state personnel. All key positions are filled, and very few vacancies were noted. Molina reported that recruitment efforts are ongoing to fill any vacant positions.

The 2023 Molina Healthcare Compliance Plan (Compliance Plan), the 2023 Compliance Plan Mississippi Addendum, the Molina Healthcare of Mississippi, Inc. 2023 Fraud, Waste, and Abuse Plan (FWA Plan), and related policies and procedures document activities to ensure Molina complies with laws, regulations, and contractual requirements and to guard against fraud, waste, and abuse (FWA). The Compliance Officer develops and implements the Compliance Program and reports to the corporate Chief Compliance Officer, the CCO President, and Board of Directors.

New employees are required to complete formal compliance training within 30 days of hire, and all employees must complete the training annually. At a minimum, compliance training covers the Compliance Plan, appropriate business conduct, FWA, the False Claims Act, whistleblower protections, confidentiality, reporting responsibilities and methods, and consequences of noncompliance. All staff are provided with the Molina Healthcare of Mississippi Inc. Code of Business Conduct and Ethics (Code of Conduct) that provides additional information about appropriate and ethical business practices and conduct. Employees must provide a written attestation that they have received and will comply with the Code of Conduct. Molina encourages open communication between employees and the Compliance Officer and provides contact information for reporting compliance issues. Molina also enforces a no-retaliation policy for employees who make good-faith reports of actual or suspected noncompliance.

Onsite discussion confirmed Molina has two Compliance Committees. The Regulatory Compliance Committee is a subcommittee of the Board of Directors and is responsible for overseeing the Compliance Program and compliance with state and federal requirements. The Compliance Committee is an executive-level committee that provides tactical support and accountability to the compliance program. Although Molina staff confirmed the executive-level committee is formally known as the Compliance Committee, different names were noted for this committee in various documents.

The Compliance Committee meets at least quarterly, and a quorum is established with the presence of a simple majority of voting members. The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states the Compliance Officer chairs the committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President of Compliance.

Detailed information about the Pharmacy Lock-in Program is found in Policy MHMS-PH-005, Pharmacy Lock-In Program. However, the policy does not define the timeframe for notifying members of their inclusion in the Lock-in Program.

Health Information Systems

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

Molina provided appropriate documentation to demonstrate its infrastructure is capable of meeting DOM's information system requirements and has proper redundancies in the forms of a disaster recovery policy and procedure and a business continuity plan that incorporate resilience and robustness for the purpose of data preservation in case of a disaster. Molina's ISCA documentation indicates the organization's personnel and systems can perform the Medicaid data processing required by DOM for claims, encounters, and overall enrollment processing. Molina's 30-day claims processing rate exceeds the State's 90-day requirement.

Confidentiality

§ 438.224

Policy and Procedure No. HP-03, Privacy and Confidentiality of Protected Health Information (PHI), addresses processes for the use, creation, collection, storage, transmission, access to, and disclosure of protected health information, including medical records, and other sensitive member information. This document, along with many other policies, program descriptions, the Code of Conduct, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals address the expectation for maintaining the confidentiality of member information.

As noted in *Figure 3: Administration Findings*, 97% of the Administration standards were scored as "Met" for both CAN and CHIP.

Figure 3: Administration Findings

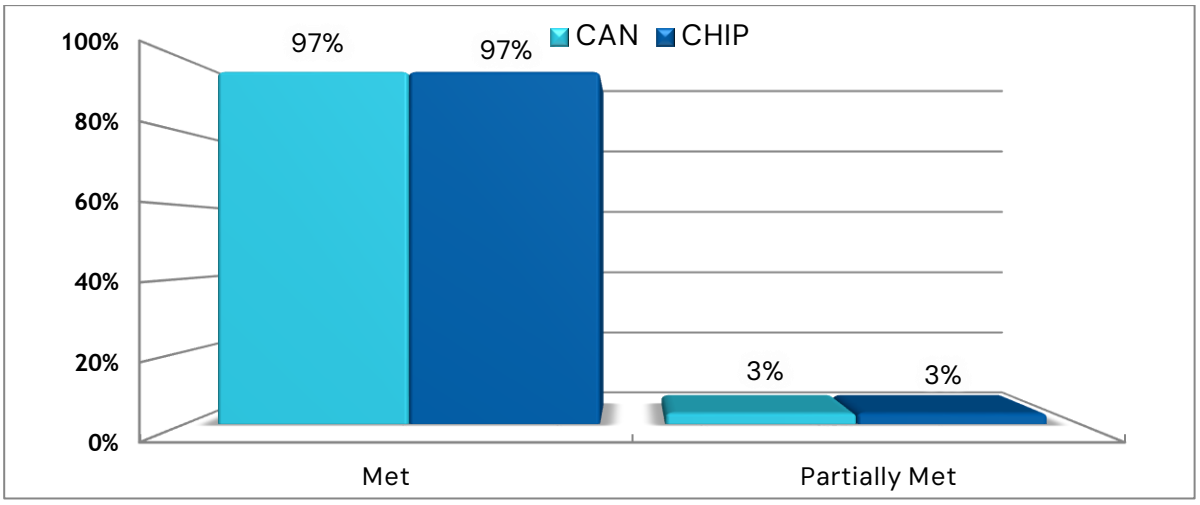


Table 20: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for policy development and management. Staff are educated about new and revised policies, and policies are stored on a SharePoint site for staff access.	✓		
Key positions are filled, and few vacancies are noted. Staffing appears to be sufficient.	✓		
Data is duplicated to a secondary disaster recovery site to help ensure availability and integrity in the event of an incident at the primary data center.	✓		
Clean claim payment rates meet DOM requirements.		✓	
Molina's Information Technology organizational structure is clearly defined.	✓		
The 2023 Compliance Plan, the 2023 Compliance Plan Mississippi Addendum, the Molina Healthcare of Mississippi, Inc. 2023 Fraud, Waste, and Abuse Plan, and related policies and procedures document activities and processes to ensure compliance with laws, regulations, and contractual requirements, and to guard against FWA.	✓		
Compliance training is provided at employment and annually. The training covers pertinent topics and is mandatory.	✓		
Molina encourages open communication between employees and the Compliance Officer and enforces a no-retaliation policy for anyone making good faith reports of compliance issues and fraud, waste, and abuse.	✓		
Appropriate processes are in place and are well documented for maintaining and ensuring the confidentiality of protected health information.	✓		

Table 21: Administration Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MHMS-GC-28, Policy and Procedure Format and Review, indicates that newly created and revised policies and procedures are submitted to the Policy and Procedure Committee for review and approval. However, onsite discussion confirmed that policies may be reviewed by additional committees applicable to the department or functional area prior to review by the Policy and Procedure Committee.	Recommendation: Update Policy MHMS-GC-28, Policy and Procedure Format and Review, to include the additional committee review prior that may be conducted prior to review by the Policy and Procedure Committee.	✓		
The 2023 Compliance Plan Mississippi Addendum incorrectly references the executive-level Compliance Committee as the Mississippi Compliance Committee. Charter Number: C-00b, Compliance Committee Charter - Management Level references the executive-level Compliance Committee as the Regulatory Compliance Committee.	Recommendation: Revise the documents specified above to include the correct name for the executive-level Compliance Committee.	✓		
The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states the Compliance Officer chairs the Compliance Committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President, Compliance.	Corrective Action: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.	✓		
Policy MHMS-PH-005, Pharmacy Lock-In Program, does not define the timeframe for notifying members of their inclusion in the Lock-in Program.	Recommendation: Revise Policy MHMS-PH-005, Pharmacy Lock-In Program, to clearly describe the timing of making decisions to restrict members into the program and the timeframe for notifying members of the restriction.	✓		

ADMINISTRATION—CAN

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies are developed to guide staff in conducting activities and to ensure compliance with laws, contracts, regulatory or accreditation requirements, and business processes. Each policy has a Business Owner, a senior leader from the department or functional area who is responsible for revising and maintaining the policy. All established policies and procedures are reviewed at least annually. Policy MHMS-GC-28, Policy and Procedure Format and Review, indicates that newly created and revised policies and procedures are submitted to the Policy and Procedure Committee for review and approval. However, onsite discussion confirmed that policies may be reviewed by additional committees applicable to the department or functional area prior to review by the Policy and Procedure Committee. Once final policy approval is received from DOM, the policy is uploaded to a SharePoint site for staff access. Staff are educated about new and revised policies by departmental leadership and/or updates and training by the Compliance Department. *Recommendation: Update Policy MHMS-GC-28, Policy and Procedure Format and Review, to include the additional committee review prior that may be*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducted prior to review by the Policy and Procedure Committee.
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 and Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Keshia Lymuel is the AVP, Health Plan Operations and serves as Chief Operating Officer.
1.3 Chief Financial Officer;	X					Edward Mohr is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Matt Hall is the Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Anquilla Howard, Director of Health Plan Operations, serves as the Claims Administrator.
1.6 *Provider Services Manager;	X					The Provider Services Manager is Tiffany Hollis-Johnson.
1.6.1 *Provider contracting and education;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Member Services Manager;	X					James Smith is the Manager, Member Services.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					Stephanie Cooper is the Manager of Appeals and Grievances.
1.9 Utilization Management Coordinator;	X					Chris Cauthen is the Director, Utilization Management.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Loleta Kellum is the Associate Vice President of Quality Improvement & Risk Adjustment and serves as the Quality Management Director.
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Thomas Joiner, MD is the Chief Medical Officer. Additional Medical Directors include James Rish, MD, Thomas Moore, MD, Carlos Latorre, and Scott Hambleton, MD. William Lugo, MD, is the Behavioral Health Medical Director.
1.13 *Compliance Officer.	X					Jeremy Ketchum is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					The Organizational Chart clearly delineates the reporting structure and lines of responsibility within the health plan. In addition, the Organizational Chart is formatted to display in-state and out-of-state personnel and key positions.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Very few vacancies were noted, and Molina reported recruitment efforts are ongoing to fill these positions.
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Mississippi DOM requires that 90% of clean claims are processed within 30 days and 99% of clean claims to be processed within 90 days. Molina meets these requirements, with an average of more than 90% of clean claims processed within 30 days and an average of more than 99% paid within 90 days. Molina has sufficient oversight of claims processing, with a focus on data completeness and accuracy.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina consistently ensures that both member demographic and enrollment information is maintained via daily reconciliation between their enrollment system and information provided in files received from the state's 834 files to track member eligibility and gaps in enrollment. In case a manual update is needed, Molina requires that only authorized personnel have access to member enrollment files and maintains a detailed change log and timestamp.
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 measure performance data is generated using National Committee for Quality Assurance (NCQA)–Certified HEDIS software. The state required non-HEDIS measures are also created with standard software. Molina performs data validation checks as well as rate reviews to ensure

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						consistency and accuracy of the data processing system.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Molina's IT infrastructure provides a resilient and robust system for its processes and mechanisms (clustering, SAN storage, and data replication and redundancy). Molina has established HITRUST Certification as well as Business Continuity and Disaster recovery policies and procedures to ensure mitigation of vulnerability in the case of a catastrophic event or emergency. Additionally, in the event there are issues with Molina's primary data center, there is a data copy at a disaster recovery site, updated monthly. The disaster recovery policy and procedure were last approved April 18th, 2023, with updates and approvals performed annually.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The 2023 Compliance Plan, the 2023 Compliance Plan Mississippi Addendum, the Molina Healthcare of Mississippi, Inc. 2023 Fraud, Waste, and Abuse Plan (FWA Plan), and related policies and procedures document activities and processes to ensure compliance with laws, regulations, and contractual requirements, and to guard against fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 Standards of conduct;						The Molina Healthcare of Mississippi Inc. Code of Business Conduct and Ethics (Code of Conduct) provides guidance to staff about appropriate and ethical business practices and conduct. The Code of Conduct includes a "Receipt and Acknowledgement" form. Molina reported that employees sign and return this form at hire and annually.
2.2 Identification of the Compliance Officer;						The roles and responsibilities of the Compliance Officer are documented throughout the Compliance Plan and the 2023 Compliance Plan Mississippi Addendum. As noted in the 2023 Compliance Plan Mississippi Addendum, the Compliance Officer is responsible for developing and implementing the Compliance Program and policies and procedures to ensure compliance with Mississippi requirements. The Compliance Officer reports to the corporate Chief Compliance Officer (or their designee), to the CCO's Plan President, and to the Board of Directors.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						A copy of the Code of Conduct is provided to new employees on the first day of employment, and they must attest that they have received, read, understand, and will comply with the Code of Conduct. New employees and newly appointed Board members are required to complete Compliance Training within 30 days, and all employees and Board

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members must complete the training annually. Compliance training is provided via both live and web-based sessions, and, at minimum, covers: • The Code of Conduct and the Compliance Plan • FWA, the False Claims Act, and Whistleblower protections • Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) • Reporting responsibilities for suspected non-compliance and methods of reporting • Consequences of non-compliance The Compliance Officer and Compliance Department staff receive ongoing training about industry current events and best practices. Detailed information about Compliance training is found in Procedure C-01.3, Effective Training and Education.
2.5 Lines of communication;						As noted in the 2023 Compliance Plan and 2023 Compliance Plan Mississippi Addendum, Molina encourages open communication between employees and the Compliance Officer. Contact information for reporting compliance issues is included in the Code of Conduct, Compliance Plan, and in policies and procedures. In addition, contact information is disseminated for the AlertLine, a third-party system that allows anonymous reporting. Molina enforces a no-retaliation policy for employees

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						who make good-faith reports of actual or suspected noncompliance. Detailed information about lines of communication is found in Procedure C-01.4, Effective Lines of Communication.
2.6 Enforcement and accessibility;						Molina publicizes disciplinary standards in Human Resources policies and procedures. Information about possible disciplinary consequences for non-compliance are also addressed in the Compliance Plan, the 2023 Compliance Plan Mississippi Addendum, and in the Code of Conduct. Detailed information about enforcement and accessibility is found in Procedure C-01.5, Well-Publicized Disciplinary Standards.
2.7 Internal monitoring and auditing;						Molina's internal monitoring and auditing activities include an annual Risk Assessment by functional area to determine compliance with Mississippi requirements and lessen risk. The results of the Annual Risk Assessment are used to develop an Audit Work Plan. In addition, Molina monitors Key Performance Indicators and uses results for internal audits, corrective action, and for the annual risk assessment. Detailed information about internal monitoring and auditing is found in Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Response to offenses and corrective action;						Molina initiates corrective action for violations and/or program deficiencies as soon as they are identified. The corrective action plans are documented in Molina's compliance and governance software (Compliance Central) to ensure corrective action plans are appropriately monitored, documented, and reported. Any corrective action plans required by DOM are managed by the Mississippi Compliance Officer and are documented in a manner/format specified by DOM. External corrective actions are documented in Compliance Central and monitored to ensure effective remediation. Detailed information about responses to offenses and corrective action is found in Procedure C-01.7, Prompt Response (Investigation and Corrective Action) to Compliance Issues.
2.9 Exclusion status monitoring.						As noted in the Compliance Plan, Molina completes pre-employment background checks and checks of suspension and exclusion lists maintained by the United States DHHS OIG General Services Administration (GSA), the CMS Preclusion List, and suspension and exclusion list maintained by state Medicaid agencies prior to employment. All employees, members of the Board, third-party employees, and contractors are screened monthly against all exclusion lists. The same checks are conducted for new vendors and subcontractors during initial engagement and then monthly.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional information about exclusion status monitoring is found in Policy C-03.0, Prohibited Affiliations. Procedure C-03.1, Prohibited Affiliations, defines the specific exclusion and sanction checks that are conducted.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				Onsite discussion confirmed Molina has two Compliance Committees: • The Regulatory Compliance Committee is a subcommittee of the Board of Directors and is responsible for overseeing the Compliance Program and compliance with state and federal requirements. • The Compliance Committee is an executive-level committee that provides tactical support and accountability to the compliance program. Although Molina staff confirmed the executive-level committee is formally known as the Compliance Committee, different names were noted for this committee, including: • The 2023 Compliance Plan Mississippi Addendum references the executive-level committee as the Mississippi Compliance Committee. • Charter Number: C-00b, Compliance Committee Charter - Management Level references the executive-level committee as the Regulatory Compliance Committee

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the documents specified above to include the correct name for the executive-level Compliance Committee. The Compliance Committee meets at least quarterly. The charter defines the membership of the executive-level Compliance Committee and states the quorum is defined as a simple majority of voting members. The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states all members of the executive-level Compliance Committee are voting members. It further states the Compliance Officer chairs the committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President of Compliance. Minutes for the Compliance Committee meetings for Q3 and Q4 of 2022 and Q1 and Q2 of 2023 reflected the presence of a quorum for each meeting and documented discussions that occurred during the meetings. No issues with member attendance were identified. *Corrective Action Plan: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Policy MHI-SIU-102, Opening and Conducting Investigations, and its related procedure thoroughly describe Special Investigation Unit processes for conducting investigations.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy MHI-SIU-101, Administrative Actions, and its related procedure, detail Molina's processes for provider payment suspensions and recoupments of overpayments.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Detailed information about the Pharmacy Lock-in Program is found in Policy MHMS-PH-005, Pharmacy Lock-In Program. The policy does not define the timeframe for notifying members of their inclusion in the Lock-in Program. Onsite discussion confirmed the decision to restrict members is made by the fifth day of each month, and letters are mailed to the affected members the next day. The restriction is effective immediately, and members may appeal the restriction. *Recommendation: Revise Policy MHMS-PH-005, Pharmacy Lock-In Program, to clearly describe the timing of making decisions to restrict members into the program and the timeframe for notifying members of the restriction.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 and Procedure No. HP-03, Privacy and Confidentiality of Protected Health Information, addresses processes for the use, creation, collection, storage, transmission, access to, and disclosure of protected health information, including medical records, and other sensitive member information. This document, along with many other policies, program descriptions, the Code of Conduct, the CAN Member Handbook, and the CAN Provider Manual address the expectation for maintaining the confidentiality of member information.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies are developed to guide staff in conducting activities and to ensure compliance with laws, contracts, regulatory or accreditation requirements, and business processes. Each policy has a Business Owner, a senior leader from the department or functional area who is responsible for revising and maintaining the policy. All established policies and procedures are reviewed at least annually. Policy MHMS-GC-28, Policy and Procedure Format and Review, indicates that newly created and revised policies and procedures are submitted to the Policy and Procedure Committee for review and approval. However, onsite discussion confirmed that policies may be reviewed by additional committees applicable to the department or functional area prior to review by the Policy and Procedure Committee. Once final policy approval is received from DOM, the policy is uploaded to a SharePoint site for staff access. Staff are educated about new and revised policies by departmental leadership and/or updated and training by the Compliance Department. *Recommendation: Update Policy MHMS-GC-28, Policy and Procedure Format and Review, to include the additional committee review prior that may be*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducted prior to review by the Policy and Procedure Committee.
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 and Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Keshia Lymuel is the Associate Vice President of Health Plan Operations and serves as Chief Operating Officer.
1.3 Chief Financial Officer;	X					Edward Mohr is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Matt Hall is the Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Anquilla Howard, Director of Health Plan Operations, serves as the Claims Administrator.
1.6 *Provider Services Manager;	X					The Provider Services Manager is Tiffany Hollis-Johnson.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 *Provider contracting and education;	X					
1.7 *Member Services Manager;	X					James Smith is the Manager of Member Services.
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					Stephanie Cooper is the Manager of Appeals and Grievances.
1.9 Utilization Management Coordinator;	X					Chris Cauthen is the Director of Utilization Management.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Loleta Kellum is the Associate Vice President of Quality Improvement & Risk Adjustment and serves as the Quality Management Director.
1.11 *Marketing and/or Public Relations;	X					
1.12 *Medical Director;	X					Thomas Joiner, MD, is the Chief Medical Officer. Additional Medical Directors include James Rish, MD, Thomas Moore, MD, Carlos Latorre, and Scott Hambleton, MD. William Lugo, MD, is the Behavioral Health Medical Director.
1.13 *Compliance Officer.	X					Jeremy Ketchum is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					The Organizational Chart clearly delineates the reporting structure and lines of responsibility within the health plan. In addition, the Organizational Chart

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is formatted to display in-state and out-of-state personnel and key positions. Very few vacancies were noted, and Molina reported recruitment efforts are ongoing to fill these positions.
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Mississippi DOM requires that 90% of clean claims are processed within 30 days and 99% of clean claims to be processed within 90 days. Molina meets these requirements, with an average of more than 90% of clean claims processed within 30 days and an average of more than 99% paid within 90 days. Molina has sufficient oversight of claims processing, with a focus on data completeness and accuracy.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina consistently ensures that both member demographic and enrollment information is maintained via daily reconciliation between their enrollment system and information provided in files received from the state's 834 files to track member eligibility and gaps in enrollment. In case a manual update is needed, Molina requires that only authorized personnel have access to member enrollment files and maintains a detailed change log and timestamp.
3. The CCO management information system is sufficient to support data reporting to the State and internally for	X					Molina's HEDIS measure performance data is generated using NCQA-Certified HEDIS software. The state required non-HEDIS measures are also

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
CCO quality improvement and utilization monitoring activities.						created with standard software. Molina performs data validation checks as well as rate reviews to ensure consistency and accuracy of the data processing system.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Molina's IT infrastructure provides a resilient and robust system for its processes and mechanisms (clustering, SAN storage, data replication and redundancy). Molina has established HITRUST Certification, as well as Business Continuity and Disaster recovery policies and procedures to ensure mitigation of vulnerability in the case of a catastrophic event or emergency. Additionally, in the event there are issues with Molina's primary data center, there is a data copy at a disaster recovery site, updated monthly. The disaster recovery policy and procedure were last approved April 18th, 2023, with updates and approvals performed annually.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					The 2023 Compliance Plan, the 2023 Compliance Plan Mississippi Addendum, the Molina Healthcare of Mississippi, Inc. 2023 Fraud, Waste, and Abuse Plan (FWA Plan), and related policies and procedures document activities and processes to ensure compliance with laws, regulations, and contractual requirements, and to guard against FWA.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 Standards of conduct;						The Molina Healthcare of Mississippi Inc. Code of Business Conduct and Ethics (Code of Conduct) provides guidance to staff about appropriate and ethical business practices and conduct. The Code of Conduct includes a "Receipt and Acknowledgement" form, which employees sign and return at hire and annually.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The roles and responsibilities of the Compliance Officer are documented throughout the Compliance Plan and the 2023 Compliance Plan Mississippi Addendum. As noted in the 2023 Compliance Plan Mississippi Addendum, the Compliance Officer is responsible for developing and implementing the Compliance Program and policies and procedures to ensure compliance with Mississippi requirements. The Compliance Officer reports to the corporate Chief Compliance Officer (or their designee), to the CCO's Plan President, and to the Board of Directors.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						A copy of the Code of Conduct is provided to new employees on the first day of employment and they must attest that they have received, read, understand, and will comply with it. New employees and newly appointed Board members are required to complete Compliance Training within 30 days, and all employees and Board members must complete the training annually.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Compliance training is provided via both live and web-based sessions, and, at minimum, covers: • The Code of Conduct and the Compliance Plan • FWA, the False Claims Act, and Whistleblower protections • Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) • Reporting responsibilities for suspected non-compliance and methods of reporting • Consequences of non-compliance The Compliance Officer and Compliance Department staff receive ongoing training about industry current events and best practices. Detailed information about Compliance training is found in Procedure C-01.3, Effective Training and Education.
2.5 Lines of communication;						As noted in the Compliance Plan and its Mississippi Addendum, Molina encourages open communication between employees and the Compliance Officer. Contact information for reporting compliance issues is included in the Code of Conduct, Compliance Plan, and in policies and procedures. In addition, contact information is disseminated for the AlertLine, a third-party reporting system that allows anonymous reporting. Molina enforces a no-retaliation policy for employees who make good-faith reports of actual or suspected noncompliance.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Detailed information about lines of communication is found in Procedure C-01.4, Effective Lines of Communication.
2.6 Enforcement and accessibility;						Molina publicizes disciplinary standards in Human Resources policies and procedures. Information about possible disciplinary consequences for non-compliance are also addressed in the Compliance Plan, the 2023 Compliance Plan Mississippi Addendum, and in the Code of Conduct. Detailed information about enforcement and accessibility is found in Procedure C-01.5, Well-Publicized Disciplinary Standards.
2.7 Internal monitoring and auditing;						Molina's internal monitoring and auditing activities include an annual Risk Assessment by functional area to determine compliance with Mississippi requirements and lessen risk. The results of the Annual Risk Assessment are used to develop an Audit Work Plan. In addition, Molina monitors Key Performance Indicators and uses results for internal audits, corrective action, and for the annual risk assessment. Detailed information about internal monitoring and auditing is found in Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks.
2.8 Response to offenses and corrective action;						Molina initiates corrective action for violations and/or program deficiencies as soon as they are identified. The corrective action plans are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documented in Molina's compliance and governance software (Compliance Central) to ensure corrective action plans are appropriately monitored, documented, and reported. Any corrective action plans required by DOM are managed by the Mississippi Compliance Officer and are documented in a manner/format specified by DOM. External corrective actions are documented in Compliance Central and monitored to ensure effective remediation. Detailed information about responses to offenses and corrective action is found in Procedure C-01.7, Prompt Response (Investigation and Corrective Action) to Compliance Issues.
2.9 Exclusion status monitoring.						As noted in the Compliance Plan, Molina completes pre-employment background checks and checks of suspension and exclusion lists maintained by the United States DHHS OIG General Services Administration (GSA), the CMS Preclusion List, and suspension and exclusion list maintained by state Medicaid agencies prior to employment. All employees, members of the Board, third-party employees, and contractors are screened monthly against all exclusion lists. The same checks are conducted for new vendors and subcontractors during initial engagement and then monthly. Additional information about exclusion status monitoring is found in Policy C-03.0, Prohibited Affiliations. Procedure C-03.1, Prohibited Affiliations,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						defines the specific exclusion and sanction checks that are conducted.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				Onsite discussion confirmed Molina has two Compliance Committees: • The Regulatory Compliance Committee is a subcommittee of the Board of Directors and is responsible for overseeing the Compliance Program and compliance with state and federal requirements. • The Compliance Committee is an executive-level committee that provides tactical support and accountability to the compliance program. Although Molina staff confirmed the executive-level committee is formally known as the Compliance Committee, different names were noted for this committee, as follows: • The 2023 Compliance Plan Mississippi Addendum references the executive-level committee as the Mississippi Compliance Committee. • Charter Number: C-00b, Compliance Committee Charter - Management Level references the executive-level committee as the Regulatory Compliance Committee *Recommendation: Revise the documents specified above to include the correct name for the executive-level Compliance Committee.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Compliance Committee meets at least quarterly. The charter defines the membership of the executive-level Compliance Committee and states the quorum is defined as a simple majority of voting members. The Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document states all members of the executive-level Compliance Committee are voting members. It further states the Compliance Officer chairs the committee. However, onsite discussion confirmed the committee is chaired by the Associate Vice President of Compliance. Minutes for the Compliance Committee meetings for Q3 and Q4 of 2022 and Q1 and Q2 of 2023 reflected the presence of a quorum for each meeting and documented discussions that occurred during the meetings. No issues with member attendance were identified. *Corrective Action Plan: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Policy MHI-SIU-102, Opening and Conducting Investigations, and its related procedure thoroughly describe Special Investigation Unit processes for conducting investigations.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy MHI-SIU-101, Administrative Actions, and its related Procedure, detail Molina's processes for provider payment suspensions and recoupments of overpayments.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Detailed information about the Pharmacy Lock-in Program is found in Policy MHMS-PH-005, Pharmacy Lock-In Program. The policy does not define the timeframe for notifying members of their inclusion in the Lock-in Program. Onsite discussion confirmed the decision to restrict members is made by the fifth day of each month, and letters are mailed to the affected members the next day. The restriction is effective immediately, and members may appeal the restriction. *Recommendation: Revise Policy MHMS-PH-005, Pharmacy Lock-In Program, to clearly describe the timing of making decisions to restrict members into the program and the timeframe for notifying members of the restriction.*
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and	X					Policy and Procedure No. HP-03, Privacy and Confidentiality of Protected Health Information (PHI),

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
procedures that are consistent with state and federal regulations regarding health information privacy.						addresses processes for the use, creation, collection, storage, transmission, access to, and disclosure of protected health information, including medical records, and other sensitive member information. This document, along with many other policies, program descriptions, the Code of Conduct, the CHIP Member Handbook, and the CHIP Provider Manual address the expectation for maintaining the confidentiality of member information.

B. Provider Services

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

The review for Provider Services includes adequacy of the provider network, provider education about health plan processes and requirements, development of and education about clinical practice and preventive health guidelines, provider medical record documentation standards and medical record audits, and the provider satisfaction survey.

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, applicable state and federal regulations, and accrediting body standards. Topics included in initial provider orientation are included in the policy. The CAN and CHIP Provider Manuals are comprehensive resources for providers and include information providers need to function appropriately within Molina's network. The CAN and CHIP Provider Manuals include key contact information as well as information about accessing the secure provider portal and functions of the portal.

The CAN and CHIP Provider Manuals include links to listings of covered benefits on Molina's website. For CAN, it was noted that a deficiency identified during the previous EQR related to documentation of the number of home health services visits per year was not corrected. See *Table 22: 2022 Provider Education CAP Items* for further details.

Table 22: 2022 Provider Education CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	A 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.	Molina's CAN benefits page on the website (Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards) states members under 21 can get additional home health visits if authorized but does not specify a limit on the number of visits. However, the "Molina Healthcare Benefits at a Glance -MississippiCAN Covered Services" document (using the "view and print" link found on the same web page) shows a limit of 25 visits per year.

Standard	EQR Comments	2023 EQR Findings
	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.	
Molina's 2022 Response: Molina has removed the 25 visits per year on the website to reflect content that will only be needed for members to understand their covered benefits. This information will be best suited for providers; we have included this information in the PA matrix guide located on the Molina provider website here https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx		
CHIP		
2. Initial provider education includes: 2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	A link in the CHIP Provider Manual takes the reader to a listing of covered benefits on Molina's website. For Radiology/X-rays, the list of covered benefits on the website link indicates these services must be conducted in a physician's office or hospital outpatient department. However, the CHIP Member Handbook, page 40, does not include the restriction on location. *Corrective Action Plan: Revise the CHIP benefit information on the website to provide complete and correct information about restrictions on location requirements for Radiology/X-ray services.*	The 2023 EQR confirmed this deficiency was corrected.
Molina's 2022 Response: Molina has removed any limitations for Radiology/X-ray services from the CHIP Member Website. https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx		

Network providers are educated about medical record documentation standards through orientation materials, Provider Manuals, and Molina's website. The standards for medical record documentation as well as requirements for medical record maintenance, storage, and confidentiality are found in Policy MHMS-QI-124, Standards of Medical Record Documentation. The policy describes processes for evaluating provider compliance with the medical record documentation and maintenance standards and indicates medical record audits are conducted at least every three years to assess provider compliance with the standards. The policy also addresses reporting results to providers, follow-up actions for non-compliant providers, and reporting internally to appropriate committees. Molina

provided results of the most recent medical record documentation audit dated October 31, 2023.

Practice Guidelines

§ 438.236, § 457.1233

Processes for review and adoption of preventive health (PHGs) and clinical practice guidelines (CPGs) are documented in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. The guidelines provide treatment and diagnostic information and expected standard of practice for providers to reduce variations in care. The review confirmed Molina has adopted PHGs for various member age groups and CPGs for an array of common diagnoses and conditions. The guidelines are disseminated to practitioners through the initial provider orientation processes, Provider Manuals, newsletters, special mailings, fax blasts, and the website. Printed copies are available upon request.

Provider Satisfaction Survey Validation

The 2022 provider satisfaction survey was administered by SPH Analytics. Of the 1,500 providers included in the random sample, 75 providers responded, creating a response rate of 5%. This is a decrease from the previous year's rate of 10.9% and fell below the internal goal of 30%. This is a very low response rate and may not reflect the population of providers, and therefore, results should be interpreted with caution.

Table 23 offers a recommendation along with the reason for this recommendation.

Table 23: Provider Satisfaction Survey Validation Results—CAN and CHIP

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Of the 1,500 providers in the random sample, 75 responded, creating a response rate of 5%. This is a decrease from last year's rate of 10.9% and below the internal goal of 30%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution.	Continued efforts should be made to gather a better representation of the providers.

The percentage of providers rating the overall satisfaction improved as did rates on finance issues and utilization management. Rates for satisfaction with clinical information received declined.

Network Adequacy Validation

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

Constellation Quality Health conducted a validation review of Molina's provider network following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the CCO is meeting network standards defined by the State. To validate Molina's network, Constellation Quality Health requested and reviewed:

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

A desk review of these documents was conducted to assess network adequacy. In addition, the results of the most recent Telephone Access Study were considered.

Overall, Molina met the requirements of the Network Adequacy Validation. The results of the Telephone Access Study conducted by Constellation Quality Health in Q1 2023 identified weaknesses regarding the provider contact information and the availability of routine and urgent appointments. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

The following is an overview of the results for each activity.

Provider Network File Questionnaire

Constellation reviewed the Provider Network File Questionnaire. Molina uses QNXT as the data management system. Verification is conducted through a portal update based on status information from the State. The State has time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. Information Systems Capabilities

Assessment evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.

Policy MHMS-PC-01, MHMS Provider Directory Requirements, states Molina Provider Data Management staff reach out to all contracted providers on a quarterly basis by telephone, mail, or email to request any updates related to:

- Office location, hours, phone, fax, or email
- Addition or closure of office location
- Addition or termination of a provider
- Change in Tax ID and/or NPI
- Change in panels status for Primary Care Providers (PCPs)

As updates or changes are received, they are reviewed and submitted to Provider Data Management for processing. The paper Provider Directory is updated at least every six months, and the online directory is updated nightly.

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

CAN and CHIP geographic access standards for PCPs, specialists, and other provider types are found in Policy MHMS-PC-10, Provider Network Geographic Access Standards and Other Availability Standards, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. The geographic access standards defined in the policies 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 by county and by rural standards. During the onsite, DOM staff confirmed that all counties in Mississippi are categorized as rural. Additional considerations in determining the adequacy of the network include member complaints, grievances, out of network requests, etc. Molina routinely monitors its network to identify gaps and takes action to address any identified gaps by attempting to recruit additional providers when available. Molina reported that it will be implementing Quest Analytics within 30 days to further aid in revealing gaps in real time.

Onsite discussion revealed that although Molina does not currently contract with Indian Health Care Providers, members may see these providers as if they were in network. No authorization is required, and claims systems are set to pay Indian Health Care Providers at an in-network rate.

Molina reported that it has implemented a process to monitor for closed panels to ensure sufficient providers have open panels to meet the needs of its membership. See *Table 24: 2022 Closed Panel Monitoring CAP Items* for the previous findings and the current status of the issue.

Table 24: 2022 Closed Panel Monitoring CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN and CHIP		
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements. 1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	During onsite discussion, Molina reported that no process has been implemented to track and monitor provider limitations on panel size to determine providers that are not accepting new patients. *Corrective Action Plan: Develop and implement a process to monitor provider panel limitations to ensure members have appropriate choice among providers.*	Policy MHMS-PC-10, Provider Network Geographic Access Standards and Other Availability Standards, states Molina runs a biannual Closed Panel Report to ensure that enough Providers are accepting new patients to meet member's needs. Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, states Molina runs a biannual Closed Panel Report to ensure that enough Providers are accepting new patients to meet member's needs. A copy of this report was provided after the onsite.
Molina's Response: 2.2.23 CAN—Molina has identified that there is no configured maximum panel size that would close a provider's panel once limitations are met. After review of the RFQ and contract in search of criteria specifying a maximum panel size, we were unable to identify a specified maximum. Molina requests direction from DOM/CCME on what maximum amount per provider is the standard and should be configured. 7.18.2023 CAN and CHIP—Health Plan will create a new report called the "Closed Panel Report" and review on a Bi-Annual basis of providers with closed panels. Health Plan will utilize this report alongside the existing Geo Access Network report to ensure an appropriate choice of providers. This report will also be reflected in our P&P upon approval. Additionally, this report will be discussed during our renewed Member & Provider Satisfaction Committee meetings to ensure all necessary departments are aware of any panel limitations. See redlined P&P – Provider Network Geographic Access Standards and Other Availability.		

Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Several issues were identified in the policy and in the CAN and CHIP Provider Manuals related to appointment access standards for specialists, routine and follow-up visits with Behavioral Health/Substance Use Disorder providers, and emergency

providers. The appointment access standards were appropriately documented in the CAN and CHIP Member Handbooks.

Policy MHMS-QI-006, Access to Care, also 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 processes, wait times, and delays. 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. This is an uncorrected deficiency from the previous EQR. Results of the audits are reported to the Quality Improvement and Health Equity Transformation Committee. Corrective actions are initiated when performance goals are not met and when provider-specific issues are identified.

The review revealed several deficiencies from the previous EQR were not corrected. See *Table 25: 2022 Availability of Services CAP Items* for additional information.

Table 25: 2022 Availability of Services CAP Items

Standard	EQR Comments	Molina's Response
CAN		
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Appointment access standards are defined in Policy MHMS-QI-006, Access to Care. Most appointment access standards listed in the policy are consistent with the contractual requirements. However, the timeframe for specialist appointments is specified as 20-30 calendar days. The *CAN Contract, Section 7 (B) 2* lists the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents:	Policy MHMS-QI-006, Access to Care, was not revised to indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. The CAN Provider Manual was not revised to include the correct timeframe for routine visits with Behavioral Health/Substance Use Disorder providers. All other issues were corrected.

Standard	EQR Comments	Molina's Response
	• For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CAN Member Handbook, page 36, lists the requirement as 21 days for adults and 14 days for children. • For PCP routine sick appointments, the policy correctly lists the timeframe as seven calendar days, but the CAN Member Handbook, page 35, lists the requirement as 14 days. • For specialist appointments, the *CAN Contract, Section 7 (B) (2)* states the timeframe is 45 calendar days, but the CAN Member Handbook, page 36, lists the timeframe as 21 days. • For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CAN Provider Manual, page 60, states the timeframe is 14 days. • The CAN Provider Manual does not include the appointment access requirements for routine and urgent dental appointments. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting appointment and after-hour accessibility audits and the department or entity that conducts the audits. Correct the timeframe for specialty appointments in Policy MHMS-QI-006, Access to Care. Revise the applicable CAN Member Handbook and/or CAN Provider Manual to reflect the correct appointment access standards for PCP well care appointments, PCP routine sick appointments, specialist appointments, and Behavioral Health/Substance Use routine appointments. Add the appointment access standards for routine and urgent dental appointments to the CAN Provider Manual.*	
Molina's Response: Policy MHMS-QI-006, Access to Care, has been revised to indicate the frequency for conducting appointment and after-hour accessibility audits and the department that conducts the audits. Also, the timeframe for specialty appointments has been revised to the standard "not to exceed 45 calendar days." The policy will then be presented to the Quality Improvement Committee for review and approval at Quarter 1 2023 meeting. A redlined copy of the revised policy is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR		

Standard	EQR Comments	Molina's Response
Audit 2022_CAP No. 4 and 14_MHMS-QI-006-Access to Care_MSCAN_CHIP." Additionally, the documents entitled MSCAN Provider Manual and MSCAN Member Handbook address the updates made to both manuals.		
CHIP		
2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Policy MHMS-QI-006, Access to Care, does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. Appointment access standards are defined in Policy MHMS-QI-006, Access to Care. Most appointment access standards listed in the policy are consistent with the contractual requirements. However, the timeframe for specialist appointments is specified as 20-30 calendar days. The *CHIP Contract, Section 7 (B) (2)* lists the timeframe for specialty appointments as "Not to exceed 45 calendar days." Additionally, there are inconsistencies in appointment access timeframes noted when comparing the policy to additional documents: • For PCP well care appointments, the policy correctly lists the timeframe as 30 calendar days, but the CHIP Member Handbook, page 37, lists the requirement as 21 days for adults and 14 days for children. • For specialist appointments, the CHIP Contract, Section 7 (B) (2) states the timeframe is 45 calendar days, but the CHIP Member Handbook, page 37, lists the timeframe as 21 days. • For Behavioral Health/Substance Use routine appointments, the policy correctly lists the timeframe as 21 calendar days, but the CHIP Provider Manual, page 76, states the timeframe is 14 days. • The CHIP Provider Manual does not include the appointment access requirements for routine and urgent dental appointments. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to include the frequency for conducting*	Policy MHMS-QI-006, Access to Care, was not revised to indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. All other issues were corrected.

Standard	EQR Comments	Molina's Response
	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.	
Molina's Response: 2.2.2023—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 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). 7.18.2023—See updated CHIP provider manual - page 40.		

As noted in Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, Molina monitors and evaluates its network's ability to meet members' cultural and linguistic needs. Molina conducts an annual evaluation of the network, considering member race/ethnicity and language information, CAHPS survey results, complaints and grievances related to member cultural and linguistic needs, etc. Member and practitioner data are compared to identify network gaps and interventions to address any identified gaps are developed and implemented. Molina's website includes provider resources about cultural competency, and information about cultural competence is also noted in the CAN and CHIP Provider Manuals.

Provider Access and Availability Study

Constellation Quality Health conducts Telephonic Provider Access Studies twice yearly for each CCO. Full details of these call studies are reported to DOM separately. For the most recent studies for CAN and CHIP conducted in Q1 2023, see *Table 26* and *Table 27*.

Table 26. CAN Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q3 2022	25 of 89	28%	<.001
Q1 2023	35 of 88	40%	

Table 27. CHIP Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q3 2022	29 of 87	33%	.655
Q1 2023	32 of 87	37%	

CAN: For Q1 2023 CAN, of the 94 PCPs contacted, six calls were answered by voicemail and thereby omitted from the denominator in the success rate formula. After accounting for the voicemail answered calls, the Phase 1 success rate was 40% (35 out of 88). This is a statistically significant improvement in successful contacts from the previous cycle's rate of 28%. The routine appointment compliance rate was 54%, and the urgent appointment compliance rate was 46%. Provider directory validation had an attempted 35 PCP verifications, and the accuracy rate was 83% (44 out of 51). There was one Corrective Action, which was to increase the number of contact points with providers to request updates and verify contact information.

CHIP: For Q1 2023 CHIP, a live respondent answered 87 calls. Of those 87 calls, a response for the four primary elements was successfully obtained for 32 PCPs (37%), yielding an unsuccessful contact rate of 63%. This is an increase in the successful contact rate from the Q3 2022 rate of 33%. The routine appointment compliance rate was 69%, and the urgent appointment compliance rate was 47%. Provider directory validation had an attempted 32 PCP verifications, and the accuracy rate was 75% (44 out of 51). There was one Corrective Action, which was to increase the number of contact points with providers to request updates and verify contact information.

The Q4 2023 call study is currently in progress.

As displayed in *Figure 4: 2023 Provider Services Findings*, 94% of the Provider Services standards were scored as "Met" for both CAN and CHIP.

Figure 4: Provider Services Findings

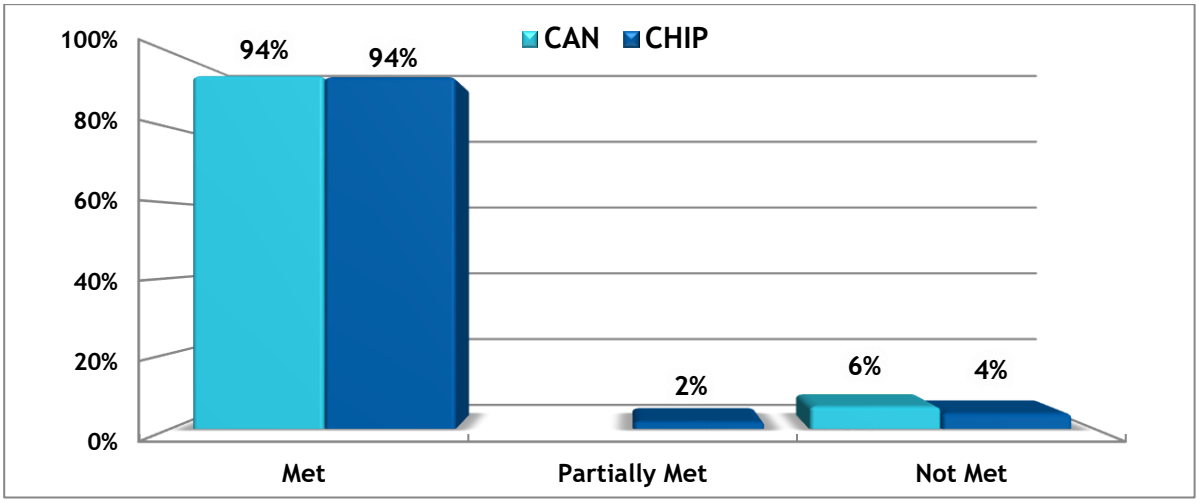


Table 28: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Molina ensures primary care providers are notified of members assigned to their panels and that all providers can verify member enrollment with the health plan.			✓
Molina tracks provider panel size limitations to ensure enough providers are accepting new patients.			✓
Health plan policies appropriately document geographic access standards for providers, and Geo Access reports demonstrate that appropriate parameters are used for measuring geographic access. Molina takes action to address any identified network geographic access gaps, and will be implementing an additional resource, Quest Analytics, to identify gaps in real time.			✓
Molina evaluates the cultural competency of its provider network and takes action to address any identified issues. Cultural competency resources are made available to providers.			✓
Molina's CAN and CHIP Provider Directories include all required elements.			✓
Initial provider orientation is conducted within 30 days of the provider's active date within the network, and ongoing education is conducted for all providers.	✓		
Molina adopts preventive health and clinical practice guidelines and disseminates them to providers.	✓		
Medical record documentation guidelines are disseminated to providers, and Molina conducts activities to assess provider compliance with the guidelines.	✓		

Table 29: Provider Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Issues noted with the policy include: • For specialists, the policy defines the appointment access standard as 20-30 calendar days. <u>This is an uncorrected deficiency from the previous EQR.</u> • For routine visits with Behavioral Health/Substance Use Disorder providers, the policy states the standard is 21 calendar days; however, it includes additional information that the initial visit must be scheduled within 10 business days.	Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care to address the identified deficiencies. Refer to the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)*.			✓
Issues were noted in the appointment access standards documented in the CAN Provider Manual and the CHIP Provider Manual. These include: • For routine visits with Behavioral Health/Substance Use Disorder providers, the CAN Provider Manual states the standard is 14 calendar days. <u>This is an uncorrected deficiency from the previous EQR.</u> • The CAN Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use Disorder providers is 7 calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge." • The CAN and CHIP Provider Manuals do not include the appointment access standard for Emergency Providers. • The CHIP Provider Manual states the follow-up appointment	Corrective Action Plan: Revise the CAN Provider Manual, and the CHIP Provider Manual to address the identified deficiencies. Refer to the *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)*.			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
standard for Behavioral Health/Substance Use Disorder providers is seven calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge."				
Policy MHMS-QI-006, Access to Care, indicates appointment and after-hour accessibility audits are conducted, but does not indicate the frequency for conducting the appointment and after-hour accessibility audits or the department or entity that conducts the audits. This is an uncorrected deficiency from the previous EQR.	Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to identify the frequency for conducting the appointment and after-hour accessibility audits and the department or entity that conducts the audits.			✓
The CAN Provider Manual refers the reader to the website to obtain benefits information. Molina's website at www.molinahealthcare.com > members > ms > en-US > mem > Medicaid > overvw > covered > benefits.aspx does not define the limit on the number of home health visits allowed, but states members under 21 can get additional visits if authorized but does not specify a limit on the number of visits. However, the Molina Healthcare Benefits at a Glance - MississippiCAN Covered Services document found by using the "view and print" link found on the same page shows a limit of 25 visits per year. This is an uncorrected deficiency from the previous EQR.	Corrective Action Plan: Revise the CAN benefits grid on the website to state the limit on the number of home health visits. Also, revise the "Molina Healthcare Benefits at a Glance MississippiCAN Covered Services" document found by using the "view and print" link at www.molinahealthcare.com/members/ms/en-US/mem/medicaid/overvw/coverd/benefits.aspx to include the correct limit for the number of home health services visits.			✓
Response rates for the provider satisfaction surveys remain low and may affect generalizability of the results.	Recommendation: Continue to seek ways to improve response rates for the provider satisfaction surveys.	✓		

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)*						
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Onsite discussion confirmed Molina notifies primary care providers (PCPs) of members assigned to their panels through the secure provider portal, which is updated nightly. Printed member lists can be provided upon request.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MHMS-M&PCC-03, Eligibility Verification, indicates out of network providers can contact the Member and Provider Services Call Center to verify member enrollment with Molina. This information is available within five business days of the date the Member Listing Report is received from DOM. Participating providers may contact the Member and Provider Services Call Center but may also obtain enrollment information through the automated phone system and the provider portal. The CAN Provider Manual informs providers of ways they can verify enrollment.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Policy MHMS-PC-10, Provider Network Geographic Access Standards and Other Availability Standards, states Molina runs a biannual Closed Panel Report to ensure that enough Providers are accepting new

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						patients to meet member's needs. A copy of this report was provided after the onsite.
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 by county and by rural standards. During the onsite, DOM staff reported that all counties in MS are classified as rural.
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.
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 compliance with geographic accessibility requirements. The submitted Geographic Access Assessment Report dated July 2023 confirms that the network is evaluated by county and by the rural standards.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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					As noted in Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, Molina monitors and evaluates its network's ability to meet members' cultural and linguistic needs. Molina conducts an annual evaluation of the network, considering member race/ethnicity and language information, CAHPS survey results, complaints and grievances related to member cultural and linguistic needs, etc. Molina compares member and practitioner data to identify network gaps and develops and implements 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, and downloadable information. Information about cultural competence is also noted in the CAN Provider Manual. Additional information related to ensuring the cultural competence of the network is found in Policy MHMS-QI-009, Race/Ethnicity and Language Data Collection, and Policy MHMS-PC-10 MHMS MSCAN, Provider

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Network Geographic Access Standards and Other Availability Standards.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Molina routinely monitors network gaps and takes action to address any identified gaps by attempting to recruit additional providers when available. Molina reported that it will be implementing Quest Analytics within 30 days to further aid in revealing gaps in real time.
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire (PNFQ) was reviewed. Molina uses QNXT as the data management system. Verification is conducted through a portal update based on status information from the State. The member facing directory is nightly.
1.10 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. 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.
2. Practitioner Accessibility						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.			X			Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Issues noted with the policy include: • For specialists, the policy defines the appointment access standard as 20-30 calendar days. This is an uncorrected deficiency from the previous EQR. • For routine visits with Behavioral Health/Substance Use Disorder providers, the policy states the standard is 21 calendar days; however, it includes additional information that the initial visit must be scheduled within 10 business days. The appointment access standards were appropriately documented in the CAN Member Handbook. Issues were noted in the appointment access standards documented in the CAN Provider Manual. These include: • For routine visits with Behavioral Health/Substance Use Disorder providers, the CAN Provider Manual states the standard is 14 calendar days. This is an uncorrected deficiency from the previous EQR. • The CAN Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use Disorder providers is seven calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						psychiatric hospital when CCO is aware of the discharge." • The CAN Provider Manual does not include the appointment access standard for Emergency Providers. *Corrective Action: Revise Policy MHMS-QI-006, Access to Care, and the CAN Provider Manual to address the identified deficiencies. Refer to the CAN Contract, Section 7 (B) (2).*
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.			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. <u>This is an uncorrected deficiency from the previous EQR.</u> Results of the audits are reported to the Quality Improvement Committee. Corrective actions are initiated when performance goals are not met and when provider-specific issues are identified.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to identify the frequency for conducting the appointment and after-hour accessibility audits and the department or entity that conducts the audits.
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Policy MHMS-PC-01, MHMS Provider Directory Requirements, states Molina Provider Data Management staff reach out to all contracted providers on a quarterly basis by telephone, mail, or email to request any updates related to: • Office location, hours, phone, fax, or email • Addition or closure of office location • Addition or termination of a provider • Change in Tax ID and/or NPI • Change in panels status for PCPs As updates or changes are received, they are reviewed and submitted to PDM for processing. Policy MHMS-PC-01, Procedure MHMS Provider Directory Requirements, states the paper Provider Directory is updated at least every six months and the online directory is updated nightly.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The state has time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. Information Systems Capabilities Assessment evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.
II B. 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.
2. Initial provider education includes:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 and Disease Management services.
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			The CAN Provider Manual refers the reader to the website to obtain benefits information. Molina's website at Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards does not define the limit on the number of home health visits allowed, but states members under 21 can get additional visits if authorized. However, the Molina Healthcare Benefits at a Glance - MississippiCAN Covered Services document (found by using the "view and print" link on the same web page) shows a limit of 25 visits per year. This is an uncorrected deficiency from the previous EQR. *Corrective Action Plan: Revise the CAN benefits grid on the website to state the limit on the number of home health visits. Also, revise the "Molina Healthcare Benefits at a Glance MississippiCAN Covered Services" document found by using the "view and print" link at Home > Members > MississippiCAN > MississippiCAN > What's Covered > Benefits and Rewards to include*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the correct limit for the number of home health services visits.
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 additional evaluation. The manual includes information that the standards and periodicity schedule follow the recommendations from the American Academy of Pediatrics/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					The CAN Provider Manual states, "Participating Providers are responsible for contacting new Members who are not compliant with EPSDT periodicity and immunization schedules for children as identified in the quarterly encounter list provided by Molina. Providers should document

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reasons for noncompliance, where possible, and document efforts to bring the Member's care into compliance with the standards."
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, such as 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.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					The CAN Provider Manual states Molina ensures access to language services such as oral interpretation, American Sign Language, and written translation. Molina also ensures access to programs, aids, and services that are congruent with cultural norms. Molina supports members with disabilities and assists members with limited English proficiency.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
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					
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, and that are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, "Molina adopts Clinical Practice Guidelines and Preventive Health Guidelines to provide up-to-date treatment and diagnostic information about important clinical and preventive health topics to Molina providers and to reduce inter-provider variation. Clinical practice guidelines and preventive health guidelines define an expected standard of practice for providers that are specific to the demographics and health care and service needs of Molina's members. The clinical practice guidelines and preventive health guidelines may serve as the basis for a health (e.g., disease) management program, benefit interpretation, or quality measures." Review of Molina's information confirmed Molina has adopted preventive health and clinical practice guidelines for an array of common diagnoses and conditions.
2. The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation	X					As noted in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, the guidelines are disseminated to practitioners through initial provider orientation

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
that they will be followed for CCO members.						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					
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 D. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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. Molina provided results of the most recent medical record documentation audit dated October 31, 2023.
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					SPH Analytics conducted the 2022 Provider Satisfaction survey. Of the 1,500 providers in the random sample, 75 responded, creating a response rate of 5%. This is a decrease from last year's rate

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of 10.9% and below the internal goal of 30%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. The percentage of providers rating the overall satisfaction improved, as did rates on finance issues and utilization management. Rates for satisfaction with clinical information received declined. *Recommendation: Continue to seek ways to improve response rates for the provider satisfaction surveys.*
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 Quality Improvement and Health Equity Transformation Committee in June 2023.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. 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), 42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Onsite discussion confirmed Molina notifies primary care providers (PCPs) of members assigned to their panels through the secure provider portal, which is updated nightly. Printed member lists can be provided upon request.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MHMS-M&PCC-03, Eligibility Verification, indicates out of network providers can contact the Member and Provider Services Call Center to verify member enrollment with Molina. This information is available within five business days of the date the Member Listing Report is received from DOM. Participating providers may contact the Member and Provider Services Call Center but may also obtain enrollment information through the automated phone system and the provider portal. The CHIP Provider Manual informs providers of ways they can verify enrollment.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, states Molina runs a biannual Closed Panel Report to ensure that enough

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Providers are accepting new patients to meet member's needs. A copy of this report was provided after the onsite.
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 Assessments Reports confirm that the network is evaluated by county and by rural standards. During the onsite, DOM staff reported that all counties in MS are classified as rural.
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 July

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						2023 confirms that the network is evaluated by county and by rural standards.
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					As noted in Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, Molina monitors and evaluates its network's ability to meet members' cultural and linguistic needs. Molina conducts an annual evaluation of the network, considering member race/ethnicity and language information, CAHPS survey results, complaints and grievances related to member cultural and linguistic needs, etc. Molina compares member and practitioner data to identify network gaps and develops and implements 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, and downloadable information. Information about cultural competence is also noted in the CHIP Provider Manual.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional information related to ensuring the cultural competence of the network is found in Policy MHMS-QI-009, Race/Ethnicity and Language Data Collection, and Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Molina routinely monitors network gaps and takes action to address any identified gaps by attempting to recruit additional providers when available. Molin reported that it will be implementing Quest Analytics within 30 days to further aid in revealing gaps in real time.
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire (PNFQ) was reviewed. Molina uses QNXT as the data management system. Verification is conducted through a portal update based on status information from the State. The member facing directory is nightly.
1.10 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. 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.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.			X			Policy MHMS-QI-006, Access to Care, defines appointment access standards for Molina's network providers. Issues noted with the policy include: • For specialists, the policy defines the appointment access standard as 20-30 calendar days. <u>This is an uncorrected deficiency from the previous EQR.</u> • For routine visits with Behavioral Health/Substance Use Disorder providers, the policy states the standard is 21 calendar days; however, it includes additional information that the initial visit must be scheduled within 10 business days. The appointment access standards were appropriately documented in the CHIP Member Handbook. Issues were noted in the appointment access standards documented in the CHIP Provider Manual. These include: • The CHIP Provider Manual states the follow-up appointment standard for Behavioral Health/Substance Use Disorder providers is seven calendar days. However, it does not include the full contractual requirement that this applies to appointments "post discharge from an acute psychiatric hospital when CCO is aware of the discharge."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The CHIP Provider Manual does not include the appointment access standard for Emergency Providers. *Corrective Action: Revise Policy MHMS-QI-006, Access to Care, and the CHIP Provider Manual to address the identified deficiencies. Refer to the CHIP Contract, Section 7 (B) (2).*
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.			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. <u>This is an uncorrected deficiency from the previous EQR.</u> Results of the audits are reported to the Quality Improvement Committee. Corrective actions are initiated when performance goals are not met and when provider-specific issues are identified.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to identify the frequency for conducting the appointment and after-hour accessibility audits and the department or entity that conducts the audits.
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Policy MHMS-PC-01, MHMS Provider Directory Requirements, states Molina Provider Data Management staff reach out to all contracted providers on a quarterly basis by telephone, mail, or email to request any updates related to: • Office location, hours, phone, fax, or email • Addition or closure of office location • Addition or termination of a provider • Change in Tax ID and/or NPI • Change in panels status for PCPs As updates or changes are received, they are reviewed and submitted to PDM for processing. Policy MHMS-PC-01, Procedure MHMS Provider Directory Requirements, states the paper Provider Directory is updated at least every six months, and the online directory is updated nightly.
3. The CCO's provider network is adequate and is consistent with the	X					The state has time/distance requirements documented for primary care, OB/GYN, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
requirements of the CMS protocol, "Validation of Network Adequacy."						specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.
II B. 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.
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 and Disease Management services.
2.2 Billing and reimbursement practices;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				The CHIP Provider Manual refers the reader to the website to obtain benefits information. Molina's website at Home > Members > CHIP > About CHIP > What's Covered > Benefits and Rewards does not define the limit on the number of home health visits allowed, but states home health services must be approved. The "Molina Healthcare Benefits at a Glance - CHIP Covered Services" document found by using the "view and print" link found on the same page correctly states the limit is 36 visits per year. *Corrective Action Plan: Revise the benefits grid on Molina's website at Home > Members > CHIP > About CHIP > What's Covered > Benefits and Rewards to list the limitation on the number of home health visits.*
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 Well Child services required for members through the end of the month in which the member turns 19 years old. Information includes

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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					The CHIP Provider Manual states, "Participating Providers are responsible for contacting new Members who are not compliant with Well Child periodicity and immunization schedules for children as identified in the quarterly encounter list provided by Molina. Providers should document reasons for noncompliance, where possible, and document efforts to bring the Member's care into compliance with the standards."
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, such as the Pharmacy and Therapeutics Committee, pharmacy network, drug formulary, submitting prior authorization requests, limitations and step therapy requirements, non-formulary medications, generic substitutions, new

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						drugs, non-covered medications, patient safety notifications, and specialty pharmaceuticals.
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					The CHIP Provider Manual states Molina ensures access to language services such as oral interpretation, American Sign Language, and written translation. Molina also ensures access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists members with limited English proficiency.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					The CHIP Provider Manual includes key contact information. Information about accessing the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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					
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, "Molina adopts Clinical Practice Guidelines and Preventive Health Guidelines to provide up-to-date treatment and diagnostic information about important clinical and preventive health topics to Molina providers and to reduce inter-provider variation. Clinical practice guidelines and preventive health guidelines define an expected standard of practice for providers that are specific to the demographics and health care and service needs of Molina's members. The clinical practice guidelines and preventive health guidelines may serve as the basis for a health (e.g., disease)

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						management program, benefit interpretation, or quality measures." Review of Molina's information confirmed Molina has adopted preventive health and clinical practice guidelines for an array of common diagnoses and conditions.
2. The CCO communicates the preventive health and clinical practice guidelines 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.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to member high-risk groups;	X					
3.5 Behavioral health.	X					
II D. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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. Molina provided results of the most recent medical record documentation audit dated October 31, 2023.
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					SPH Analytics conducted the 2022 Provider Satisfaction survey. Of the 1,500 providers in the random sample, 75 responded, creating a response rate of 5%. This is a decrease from last year's rate

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of 10.9% and below the internal goal of 30%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. The percentage of providers rating the overall satisfaction improved, as did rates on finance issues and utilization management. Rates for satisfaction with clinical information received declined. *Recommendation: Continue to seek ways to improve response rates for the provider satisfaction surveys.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Molina 2022 Provider Satisfaction Survey Report from SPH Analytics
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 QIC committee in the June 2023 meeting.

C. Member Services

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

The Member Services review includes member rights and responsibilities, member education, call center functions and monitoring, requirements for member enrollment and disenrollment, member satisfaction surveys, grievances processes and sample file review, and practitioner changes.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

Member rights and responsibilities are listed in Policy MHMS-ME-003, Member Rights and Responsibilities, in the CAN and CHIP Member Handbooks, and on the CCO's website. In addition, members are informed of their rights and responsibilities annually in member newsletters and mailings. Members may request copies of their rights and responsibilities at any time. Review of documentation of member rights and responsibilities found that Policy MHMS ME 003 and the CAN and CHIP websites do not include the member responsibility to inform the CCO of changes in family size, address, or other health care coverage.

Member CCO Program Education

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

Within 14 days of enrollment, Molina mails a welcome kit that contains a copy of the Member Handbook, the Privacy Notice, and the Notice of Non-Discrimination. A welcome letter and Member ID card are provided to new members but may be mailed separately. The CAN and CHIP Member Handbooks are comprehensive resources of information for members to understand benefits, services, programs, etc. However, review of the handbooks revealed issues with documentation of coverage for home health services in the CAN Member Handbook. This issue was previously identified in the 2022 EQR. See *Table 30: 2022 Member CCO Program Education CAP Items* for details. Issues were also noted with documentation of coverage for emergency ambulance services and eye care/vision services in the CHIP Member Handbook.

Table 30: 2022 Member CCO Program Education CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
1. Members are informed in writing, within 14 calendar	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	The CAN Member Handbook does not specify the limitation on the number of

Standard	EQR Comments	2023 EQR Findings
days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in coverage;	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.*	visits allowed for home health services.
Molina's 2022 Response: Molina has removed this reference on the number of visits in the MSCAN Member Handbook to reflect content that will only be needed for members to understand their covered benefits. See document MSCAN Member Handbook uploaded to the portal.		
CHIP		
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in their coverage;	For Radiology/X-rays, the list of covered benefits on page 40 of the CHIP Member Handbook does not include a restriction to location (as noted in benefit information on Molina's CHIP website) and states that a prior authorization is required for these services. 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.*	This issue was corrected.
Molina's 2022 Response: Molina has removed any limitations for Radiology/X-rays and added prior authorization is required only for advanced imaging services and not for routine X-rays in the CHIP Member Handbook. See updated CHIP provider manual-page 38.		

The CAN and CHIP Member Handbooks describe services available from the Member Services Call Center and the 24-Hour Nurse Advice Line. Information about accessing the MyMolina.com portal and the functions available through the portal are also included.

Appropriate processes are in place and are documented in policy for notifying affected members of a provider's termination from the network. However, onsite discussion confirmed Molina does not have an established policy addressing member notification of

changes in programs and benefits. The CAN and CHIP Member Handbooks indicate members are informed of these changes within 30 calendar days prior to implementation.

Molina produces member materials at appropriate reading levels to enhance member understanding. Member materials are available in alternate languages and formats. Interpreter and translations services are available to all members at no cost. The 24-Hour Nurse Advice Line is available around the clock to assist members with understanding and getting medical care. Relay 711 is also available for members with hearing difficulties. Information about Member Services Contact Center operations is found in Policy MHMS-M&PCC-04, Member Services General Operations. Review of the policy found that the weekend hours of operation for the Contact Center are not clearly documented and are inconsistent with the information found in the CAN and CHIP Member Handbooks.

Contact Center staff use interactive scripts for initial welcome calls, outbound calls to members, assisting with PCP selection, etc. All scripts are reviewed and approved by DOM prior to use and are reviewed at least annually for needed changes. At least quarterly, staff are provided with training that covers Medicaid, the MississippiCAN Program, general customer service, etc. Molina monitors a percentage of member calls for compliance with customer care guidelines. Also, Call Center metrics are monitored. For 2022, Molina did not meet the goals for Service Level, Average Speed to Answer, and Abandonment Rate. However, during onsite discussion, Molina reported that staffing and training were increased. As a result, Call Center goals for 2023 are currently met.

Preventive Health and Chronic Disease Management Education

Molina provides health education to members and encourages members to utilize preventive health services through the CAN and CHIP Member Handbooks, newsletters and other mailings, the website, the member portal, telephone alerts, etc. In addition, Molina provides education through local health fairs and other community events. Also, Call Center staff see system alerts about the member's past-due or needed services so that they can be reminded to get the recommended services.

Grievances

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

Descriptions for filing and processing grievances are outlined in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and on Molina's website. Grievance terminology is defined along the process for members or authorized representative to file a grievance verbally or in writing. From the previous EQR, Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN and CHIP Member Handbooks, and CAN and CHIP Provider Manuals were updated to include the member's right to file a grievance if they disagree with the request for an appeal

or grievance extension. Molina's grievance logs are maintained and categorized to evaluate trends reported quarterly to the Quality Improvement Committee (QIC).

Of the grievance files reviewed for this year's EQR, all were acknowledged and resolved in a timely manner. However, it appears that grievances are being closed rather than requesting extensions when additional information is needed. Six CAN and five CHIP grievance resolution letters contained wording indicating that steps had been taken to resolve the grievance. However, no steps were provided; instead, the members were asked to contact Molina. This was discussed onsite, and it was explained that this letter template is used when additional information is needed from the filer but that the file is closed to meet the resolution timeframe requirement.

Member Satisfaction Survey Validation

Molina contracts with Press Ganey, a certified vendor, to conduct both the child and adult member satisfaction surveys. The surveys were fielded from February through May 2022. Response rates for the member satisfaction surveys remain low and may affect the generalizability of the results.

For reporting year 2022, the adult response rate was 10.8% (216 out of 2025), which is an improvement from the previous year's response rate of 10.2%. For year over year trending, the findings showed improvement in rating of health plan, getting needed care, rating of health care, getting care quickly, coordination of care, and rating of personal doctor. The largest decline was in the rating of specialists.

The child response rate was 7.7% for 2022 (570 out of 7425), which is an improvement over the previous year's response rate of 7.3%. Improvement was shown for rating of health plan, ease of filling out forms, getting care quickly, how well doctors communicate, and coordination of care. The largest decline was in the rating of specialists.

Press Ganey summarizes and details all results from adult and child surveys. Documentation indicated the survey results were reported to the Quality Improvement and Health Equity Transformation Committee in June 2023.

As noted in *Figure 5: Member Services Findings*, 85% of the Member Services standards were scored as "Met" for CAN, and 84% were scored as "Met" for CHIP.

Figure 5: Member Services Findings

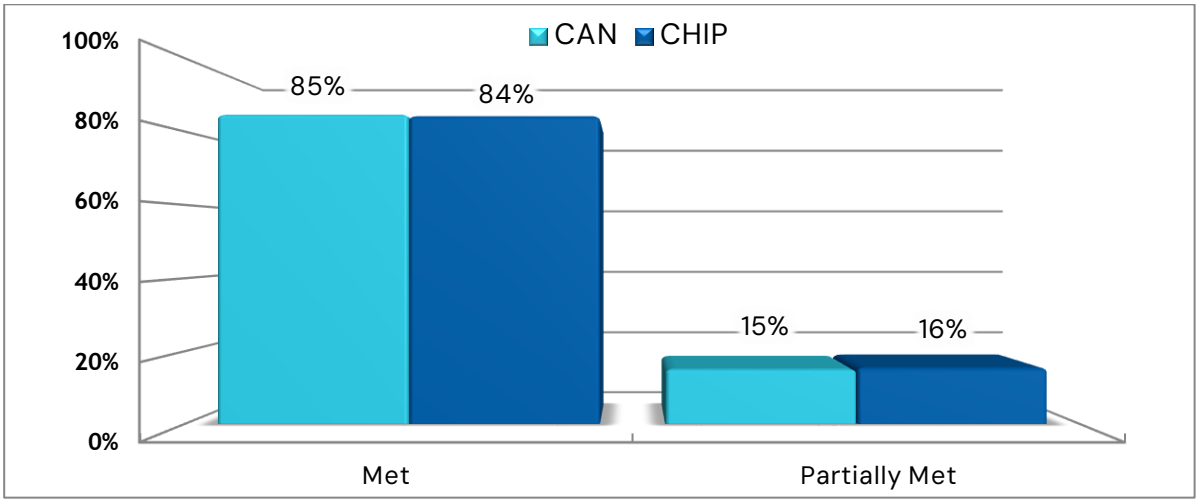


Table 31: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Member rights are consistently documented in policy, Member Handbooks, and on the CCO's website. Members are educated about their rights in various ways.	✓		
Overall, the CAN and CHIP Member Handbooks are comprehensive resources for members to understand their coverage, health plan processes, etc.			✓
Member materials are written at an appropriate reading level, available in alternate formats, and can be translated into alternate languages.			✓
Molina routinely monitors Call Center staff performance and metrics. Interventions were implemented to address unmet goals in 2021 and 2022, resulting in improvement noted in 2023.	✓		
Call Center staff use interactive scripts and talking points for member calls. The scripts are reviewed at least annually for needed changes.	✓		
Call Center staff are provided with training on a quarterly basis.	✓		
Various methods are used to educate members about recommended preventive care services, screenings, etc.			✓
Adult and child member satisfaction survey results are examined internally.	✓		
Of the grievance files sample for the 2023 EQR, all were acknowledged and resolved in a timely manner.		✓	

Table 32: Member Services Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN and CHIP web pages listing member responsibilities do not include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.	Corrective Action Plan: Revise Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN and CHIP web pages listing member responsibilities to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.	✓		
The CAN Member Handbook does not specify the limitation on the number of visits allowed for home health services.	Corrective Action Plan: Revise the CAN Member Handbook to state the limitation on the number of home health visits per year.			✓
Issues identified in benefits documentation in the CHIP Member Handbook include: • For Emergency Ambulance Services, the CHIP Member Handbook states, "Unlimited based on life threatening condition present" and this is not stated on the benefits information on the CHIP website. Molina staff were unable to explain the restriction about life threatening conditions. • The CHIP Member Handbook, page 39, does not specify the number of visits allowed for home health services. • For Eye Care – Vision Services, the CHIP Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the CHIP website states, "1 eye exam and 1 pair of glasses annually."	Corrective Action Plan: Correct the identified issues with member benefit documentation.			✓
The CAN and CHIP Member Handbooks indicate members are informed of changes to programs and benefits within 30 calendar days prior to implementation. Molina staff confirmed there is no policy that addresses this requirement.	Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.			✓
Information about operations of the Member Services Contact Center is found in Policy MHMS-M&PCC-04, Member Services General Operations. As noted in the policy, the Member Services Contact Center hours of operation are 7:30 a.m. to 8:00 p.m., Monday through Friday and one weekend a month, excluding State holidays. As written in the policy, it appears that the call center is open until 8 p.m. one weekend per month.	Corrective Action Plan: Revise Policy MHMS-M&PCC-04, Member Services General Operations, to list the correct weekend hours of operation for the call center.			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
However, onsite discussion confirmed the weekend hours are 8 a.m. to 5 p.m.				
Response rates for the member satisfaction surveys remain low and may affect generalizability of the results.	Recommendation: Continue to seek ways to improve response rates for the member satisfaction surveys.	✓		
It appears that grievances are being closed rather than requesting extensions when additional information is needed.	Corrective Action: Ensure that processes are in place to comply with Policy MHMS-MRT-01, Member Complaints and Grievances regarding the use of extensions when needed to obtain additional information needed to resolve a grievance.	✓		

MEMBER SERVICES—CAN

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					Member rights and responsibilities are documented in Policy MHMS-ME-003, Member Rights and Responsibilities. The policy lists ways that members are informed of their rights and responsibilities, including Member Handbooks, the health plan's website, annually in member newsletters and mailings, and at any time upon request. The CAN Provider Manual refers the reader to the CAN Member Handbook or to the website to view member rights and responsibilities. A link to the information on the website is provided.
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately documented in the CAN Member Handbook.
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:		X				Identified issues are documented in the standards below.
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.						Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN web page listing member responsibilities do not include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise Policy MHMS ME 003, Member Rights and Responsibilities, and the CAN web page listing member responsibilities to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:		X				Identified issues are documented in the standards below.
1.1 Full disclosure of benefits and services included and excluded in coverage;						The CAN Member Handbook does not specify the limitation on the number of visits allowed for home health services. *Corrective Action Plan: Revise the CAN Member Handbook to state the limitation on the number of home health visits per year.*
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Information about prior authorization processes and requirements is found in the CAN Member Handbook. Members are informed that they may obtain a list of services that do/do not require prior authorization by referring to the benefits grid within the CAN Member Handbook, by visiting the CCO's website, or by contacting Member Services.
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The CAN Member Handbook includes information about member notification of changes to programs and benefits within 30 calendar days prior to implementation and changes to the provider network within 15 days after Molina receives notification of a provider change.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						Throughout the CAN Member Handbook, information is included that describes services available from the Member Services Call Center and the 24-Hour Nurse Advice Line. Contact information is included. Information about accessing the MyMolina.com portal and the functions available through the portal are also addressed.
1.13 A description of EPSDT services;						Information about Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						including the components of EPSDT exams, services covered under EPSDT, and the periodicity schedule is included in the CAN Member Handbook.
1.14 Procedures for disenrolling from the CCO;						The CAN Member Handbook informs that members can request to change health plans within 90 days of enrollment and annually during open enrollment. The CAN Member Handbook also addresses involuntary disenrollment and circumstances under which a member may be involuntarily disenrolled.
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;						Members are informed about how to access the Provider Directory online and that they may contact Member Services to obtain information about providers.
1.17 Instructions for reporting suspected cases of fraud and abuse;						The CAN Member Handbook describes the terms "fraud" and "abuse," informs members that they can report fraud and abuse anonymously and provides contact information for reporting.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						The CAN Member Handbook lists conditions for which Care Management is available and indicates any member may request Care Management services. Contact information for Care Management staff is included.

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				The CAN Member Handbook indicates members are informed of changes to programs and benefits within 30 calendar days prior to implementation. Molina staff confirmed there is no policy that addresses this requirement. Procedure MHMS-PC-09, MHMS Provider Termination Process, confirms Molina provides written notification to members of provider terminations and allows members to continue an ongoing course of treatment from the provider for the greater of up to 60 days from the date of notification or up to 60 days from the effective date of the termination. When the terminating provider is a PCP, Molina sends the written member notification within 15 days to members who are treated by the PCP. *Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.*

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 as required by the contract.	X					Policy MHMS-COMM-01, Member Communication Standards, states written member materials do not exceed a sixth grade reading level as determined by the Flesch-Kincaid method. Member materials are made available in the prevalent non-English languages in Mississippi and in alternate languages upon request. Written materials use no less than a 12-point font and are available as needed in alternate formats, such as large print (no less than 18-point font).
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					As noted in the CAN Member Handbook, policies, and the website, interpreter and translations services are available to all members at no cost. The 24-Hour Nurse Advice Line is available around the clock to assist members with understanding and getting medical care. Relay 711 is also available around the clock for members with hearing difficulties.
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					Policy MHMS-ME-006, Marketing, addresses Molina's marketing processes and requirements for marketing materials.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Information about operations of the Member Services Contact Center is found in Policy MHMS-M&PCC-04, Member Services General Operations. As noted in the policy, the Member Services Contact Center hours of operation are 7:30 a.m. to 8:00 p.m., Monday through Friday and one weekend a month excluding State holidays. As written in the policy, it appears that the call center is open until 8 p.m. one weekend per month. However, onsite discussion confirmed the weekend hours are 8 a.m. to 5 p.m. The CAN Member Handbook, page 11, indicates the weekend hours are 8:00 a.m. to 5 p.m. Members may also access the Nurse Advice Line, which is available 24 hours a day, seven days a week. *Corrective Action Plan: Revise Policy MHMS-M&PCC-04, Member Services General Operations, to list the correct weekend hours of operation for the call center.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					As noted in Policy MHMS-M&PCC-04, Member Services General Operations, Molina's Call Center staff use interactive scripts for member calls, including initial welcome calls, outbound calls to members, assisting with PCP selection, etc. All

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						scripts are submitted to DOM for review and approval prior to use and are reviewed at least annually for needed changes. Call Center staff are provided with training at least quarterly. The training covers Medicaid, the MississippiCAN Program, general customer service, etc.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					As noted in Policy MHMS-M&PCC-05, Member Services Quality Assurance, Molina monitors no less than 3% of calls, which are randomly selected, for compliance with customer care guidelines. Results are reported to DOM quarterly. The Molina Healthcare of Mississippi – 2022 Quality Program Evaluation Summary, page 34, lists Call Center metrics for 2022. The documentation includes: • Service Level (goal ≥85%)—Molina's 2022 rate was 72.9%. This was an increase from the 2021 rate of 45.3%. • Average Speed to Answer (goal is ≤30 seconds—Molina's 2022 speed was 117 seconds. This was a decrease from the 2021 speed of 342 seconds. • Abandonment Rate (goal is ≤5%)—Molina's rate was 5.14%. This was a decrease from the 2021 rate of 15.61%. Review of Molina's 2022 Provider Telephone Access Standards for Medicaid showed improvement

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						across the three measures, but no measures met established goals. This was discussed with Molina staff during the onsite. Molina reported that, as result of hiring additional call center staff and increasing training for call center staff, the health plan is currently meeting all call center goals for 2023.
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					Molina members can select any participating PCP with whom they have established care or who is open to new patient assignments. Members who do not select a PCP are assigned to a PCP using the PCP Auto Assignment Process. The assignment logic takes into consideration previous member PCP information, PCPs for any family members, geographic location, age, gender, and language. Upon assignment of a PCP, an ID card is issued that lists the member's PCP. These processes are found in Policy MHMS-ME-004, PCP Assignment.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHMS-ME-001, Member Eligibility, defines populations who are eligible for the MSCAN Program. The policy states Molina will not request member disenrollment because of adverse changes in health status, age, gender identity, sexual orientation, disability, national origin, race, color,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						religion, veteran's status, political affiliation, or income. In addition, Molina does not request member disenrollment due medical service utilization, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs except when it seriously impairs the ability to furnish services to the member or other members. MHMS will only initiate member disenrollment for fraud or misuse of the member ID card or for disruptive or uncooperative behavior to the extent that it affects the ability to provide services to the member or other members. The policy includes circumstances under which a member may request disenrollment.
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					Policy MHMS-QI-125, Member Education and Prevention (ME), describes processes for providing health education to members and encouraging members to utilize recommended services. Education provided to members includes a variety of topics, including general health education and information about preventive services and recommendations. This information is communicated to members through many forums, including but not limited to, Member Handbooks, newsletters and other mailings, the website, the member portal, and telephone alerts. In addition,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina provides education through local health fairs and other community events. Molina reported that, when interacting with members, Call Center staff see system alerts about the member's past-due or needed services so that they can be reminded to get the recommended services.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, states Molina's QI Department, along with HEDIS Operations, uses a system that tracks initial visits for newborns, EPSDT screenings and reporting of screening results, and diagnostic and treatment services, including referrals. This system identifies a target list that is used to notify members about periodic well child visits through new mother education and newborn reminders. Outreach is conducted for EPSDT eligible members who are behind on EPSDT services and/or immunizations. This is conducted through written notifications of upcoming or missed appointments and telephonic

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						outreach. Transportation assistance is offered. Molina contacts the member/responsible party to inform of missed appointments and to ensure another appointment is scheduled. If the member continues to be noncompliant with recommended visits/services, additional outreach is conducted via written correspondence, telephone contacts, and face-to-face contacts to educate about the importance of the services, how to access the services, and that the services are free.
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					Molina contracts with Press Ganey, a certified vendor that acquired SPH analytics, to conduct child and adult surveys, which were fielded from February through May 2022. For reporting year 2022, the adult response rate was 10.8% (216 out of 2025), which is an improvement from the previous year's response rate of 10.2%. Response rates for the member satisfaction surveys remain low and may affect the generalizability of the results. For year-over-year trending, the findings showed improvement in rating of health plan, getting

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						needed care, rating of health care, getting care quickly, coordination of care, and rating of personal doctor. The largest decline was in the rating of specialists. The child response rate was 7.7% for 2022 (570 out of 7425), which is an improvement over the previous year's response rate of 7.3%. Improvement was shown for rating of health plan, ease of filling out forms, getting care quickly, how well doctors communicate, and coordination of care. The largest decline was in the rating of specialists. *Recommendation: Continue to seek ways to improve response rates for the member satisfaction surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from adult and child surveys.
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					Results were reported to the Quality Improvement Committee in June 2023.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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, the CAN Member Handbook, the CAN Provider Manual, and Molina's website outline processes for filing and resolving grievances.
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, the CAN Member Handbooks, and the CAN Provider Manuals indicate the member's right to file a grievance if they disagree with the request for an appeal or grievance extension.
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
for the period specified in the contract.						
2. The CCO applies the grievance policy and procedure as formulated.		X				Six CAN resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no steps were provided in the letters. Instead, the members were asked to contact the Member Services Department after the grievance was closed. Corrective Action: Ensure that processes are in place to comply with Policy MHMS-MRT-01, Member Complaints and Grievances regarding the use of extensions when needed to obtain additional information needed to resolve a grievance.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Grievance logs are evaluated for trends and reported quarterly to the Quality Improvement and Health Equity Transformation Committee.
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
determine if the change is due to dissatisfaction.						
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					

MEMBER SERVICES—CHIP

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					Member rights and responsibilities are documented in Policy MHMS-ME-003, Member Rights and Responsibilities. The policy lists ways that members are informed of their rights and responsibilities, including Member Handbooks, the health plan's website, annually in member newsletters and mailings, and at any time upon request. The CHIP Provider Manual refers the reader to the member handbook or to the website to view member rights and responsibilities. A link to the information on the website is provided.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately documented in the CHIP Member Handbook.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:		X				Identified issues are documented in the standards below.
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.						Policy MHMS ME 003, Member Rights and Responsibilities, and the CHIP web page listing member responsibilities do not include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage. *Corrective Action Plan: Revise Policy MHMS ME 003, Member Rights and Responsibilities, and the CHIP web page listing member responsibilities to include the responsibility to inform Molina 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				Identified issues are documented in the standards below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						Issues identified in benefits documentation in the CHIP Member Handbook include: • For Emergency Ambulance Services, the CHIP Member Handbook states, "Unlimited based on life

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						threatening condition present" and this is not stated on the benefits information on the CHIP website. Molina staff were unable to explain the restriction about life threatening conditions. • The CHIP Member Handbook, page 39, does not specify the number of visits allowed for home health services. • For Eye Care – Vision Services, the CHIP Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the CHIP website states, "1 eye exam and 1 pair of glasses annually." *Corrective Action Plan: Correct the identified issues with member benefit documentation.*
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Information about prior authorization processes and requirements is found in the CHIP Member Handbook. Members are informed that they may obtain a list of services that do/do not require prior authorization by referring to the benefits grid within the Member Handbook, by visiting the CCO's website, or by contacting Member Services.
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 includes information about member notification of changes to programs and benefits within 30 calendar days prior to implementation and changes to the provider network within 15 days after Molina receives notification of a provider change.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						Throughout the CHIP Member Handbook, information is included that describes services available from the Member Services Call Center and the 24-Hour Nurse Advice Line. Contact information is included. Information about accessing the MyMolina.com portal and the functions available through the portal are also addressed.
1.13 A description of the Well-Baby and Well-Child services which include:						Information about Well Child Services, including the components of Well Child exams, services covered under Well Child, and the periodicity schedule is included in the CHIP Member Handbook.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Procedures for disenrolling from the CCO;						The CHIP Member Handbook informs that members can request to change health plans within 90 days of enrollment and annually during open enrollment. The CHIP Member Handbook also addresses involuntary disenrollment and circumstances under which a member may be involuntarily disenrolled.
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;						Members are informed about how to access the Provider Directory online and that they may contact Member Services to obtain information about providers.
1.17 Instructions on reporting suspected cases of fraud and abuse;						The CHIP Member Handbook describes the terms "fraud" and "abuse," informs members that they can report fraud and abuse anonymously and provides contact information for reporting.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						The CHIP Member Handbook lists conditions for which Care Management is available and indicates any member may request Care Management services. Contact information for Care Management staff is included.
1.19 Information about advance directives;						
1.20 Additional information as required by the contract and by federal regulation.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.		X				The CHIP Member Handbook indicates members are informed of changes to programs and benefits within 30 calendar days prior to implementation. Molina staff confirmed there is no policy that addresses this requirement. Procedure MHMS-PC-09, MHMS Provider Termination Process, confirms Molina provides written notification to members of provider terminations and allows members to continue an ongoing course of treatment from the provider for the greater of up to 60 days from the date of notification or up to 60 days from the effective date of the termination. When the terminating provider is a PCP, Molina sends the written member notification within 15 days to members who are treated by the PCP. *Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.*
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					Policy MHMS-COMM-01, Member Communication Standards, states written member materials do not exceed a sixth grade reading level as determined by the Flesch-Kincaid method. Member materials are made available in the prevalent non-English languages in Mississippi and in alternate languages upon request. Written materials use no less than a

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						12-point font, and are available as needed in alternate formats, such as large print (no less than 18-point font).
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					As noted in the CHIP Member Handbook, policies, and the website, interpreter and translations services are available to all members at no cost. The 24-Hour Nurse Advice Line is available around the clock to assist members with understanding and getting medical care. Relay 711 is also available around the clock for members with hearing difficulties.
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				Information about operations of the Member Services Contact Center is found in Policy MHMS-M&PCC-04, Member Services General Operations. As noted in the policy, the Member Services Contact Center hours of operation are 7:30 a.m. to 8 p.m., Monday through Friday and one weekend a month excluding State holidays. As written in the policy, it appears that the call center is open until 8 p.m. one weekend per month. However, onsite

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussion confirmed the weekend hours are 8 a.m. to 5 p.m. The CHIP Member Handbook, page 13, indicates the weekend hours are 8:00 a.m. to 5 p.m. Members may also access the Nurse Advice Line, which is available 24 hours a day, seven days a week. *Corrective Action Plan: Revise Policy MHMS-M&PCC-04, Member Services General Operations, to list the correct weekend hours of operation for the call center.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					As noted in Policy MHMS-M&PCC-04, Member Services General Operations, Molina's Call Center staff use interactive scripts for member calls, including initial welcome calls, outbound calls to members, assisting with PCP selection, etc. All scripts are submitted to DOM for review and approval 30 days prior to use and are reviewed at least annually for needed changes. Call Center staff are provided with training at least quarterly. The training covers Medicaid, the MississippiCAN Program, general customer service, etc.
3. Performance monitoring of Call Center activity occurs as required and results	X					As noted in Policy MHMS-M&PCC-05, Member Services Quality Assurance, Molina monitors no less than 3% of calls, which are randomly selected, for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
are reported to the appropriate committee.						compliance with customer care guidelines. Results are reported to MSDOM quarterly. The Molina Healthcare of Mississippi – 2022 Quality Program Evaluation Summary, page 34, lists Call Center metrics for 2022. The documentation includes: • Service Level (goal ≥85%)—Molina's 2022 rate was 72.9%. This was an increase from the 2021 rate of 45.3%. • Average Speed to Answer (goal is ≤30 seconds—Molina's 2022 speed was 117 seconds. This was a decrease from the 2021 speed of 342 seconds. • Abandonment Rate (goal is ≤5%)—Molina's rate was 5.14%. This was a decrease from the 2021 rate of 15.61%. Review of Molina's 2022 Provider Telephone Access Standards for Medicaid showed improvement across the three measures, but no measures met established goals. This was discussed with Molina staff during the onsite. Molina reported that the health plan is currently meeting all call center goals for 2023 as a result of hiring additional call center staff and increasing training for call center staff.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Molina members can select any participating PCP with whom they have established care or who is open to new patient assignments. Members who do not select a PCP are assigned to a PCP using the PCP Auto Assignment Process. The assignment logic takes into consideration previous member PCP information, PCPs for any family members, geographic location, age, gender, and language. Upon assignment of a PCP, an ID card is issues that lists the member's PCP. These processes are found in Policy MHMS-ME-004, PCP Assignment.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHMS-ME-008, Enrollment Reports, states Molina will not request disenrollment of any member because of an adverse change in health status, age, gender identity, sexual orientation, disability, national origin, race, color, religion, veteran's status, political affiliation, or level of income. In addition, Molina does not request disenrollment of members due to medical service utilization, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs unless it seriously impairs the ability to furnish services to the member or other members. Molina will only initiate member disenrollment for fraud or misuse of the Member ID card, for disruptive or uncooperative behavior to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the extent that it affects the ability to provide services to the member or other members.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about available preventive health and chronic disease management services and encourages members to utilize these benefits.	X					Policy MHMS-QI-125, Member Education and Prevention (ME), describes processes for providing health education to members and encouraging members to utilize these services. Education provided to members includes a variety of topics, including general health education and information about preventive services and recommendations. This information is communicated to members through many forums, including but not limited to member handbooks, newsletters and other mailings, the website, the member portal, and telephone alerts. In addition, Molina provides education through local health fairs and other community events. Molina reported that, when interacting with members, Call Center staff see system alerts about the member's past-due or needed services so that they can be reminded to get the recommended services.
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
recommended care, including participation in the WIC program.						
3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, states Molina educates members about these services and immunizations. Outreach is conducted for eligible members who are behind on recommended services and/or immunizations. This is accomplished through written notifications and/or telephonic outreach about upcoming or missed appointments. Transportation assistance is offered. If the member continues to be noncompliant with recommended visits/services, additional outreach is conducted via written correspondence, telephone contacts, and face-to-face contacts to educate about the importance of the services, how to access the services, and that the services are free.
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					Molina contracts with Press Ganey, a certified vendor that acquired SPH analytics, to conduct child and adult surveys, which were fielded from February through May 2022. For reporting year

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						2022, the response rate was 11.9%, which is a slight decline from the previous year's response rate of 12%. Response rates for the member satisfaction surveys remain low and may affect the generalizability of the results. For year-over-year trending, the findings showed the top three performing measures as how well doctors communicate, getting needed care, and the rating of specialists. The bottom performing measures were customers service, coordination of care, and the rating of the health plan. *Recommendation: Continue to seek ways to improve response rates for the member satisfaction surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from the surveys.
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					Results were reported to the Quality Improvement and Health Equity Transformation Committee in June 2023.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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, the CHIP Member Handbook, the CHIP Provider Manual, and Molina's website outline processes for filing and resolving grievances.
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, the CHIP Member Handbook, and the CHIP Provider Manual indicate the member's right to file a grievance if they disagree with the request for an appeal or grievance extension.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO applies the grievance policy and procedure as formulated.		X				Five CHIP resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no steps were provided. Instead, the members were asked to contact the Member Services Department after the grievance was closed. Corrective Action: Ensure that processes are in place to comply with Policy MHMS-MRT-01, Member Complaints and Grievances, regarding the use of extensions when needed to obtain additional information needed to resolve a grievance.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievance logs are evaluated for trends and reported quarterly to the Quality Improvement Committee.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					

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

D. Quality Improvement

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

Molina's Quality Improvement (QI) Program focuses on the health care and services that CAN and CHIP members receive. The program goal is to ensure members receive accessible, appropriate, cost-effective, and high-quality health care services throughout the organization. The 2023 Quality Improvement Program Description describes the QI Program Molina has implemented to help achieve this goal. Six appendices were listed in the table of contents but were not included in the document. Also, the section titled "Implementing a Credentialing Program" indicates Molina maintains a comprehensive and detailed credentialing program. DOM has implemented a centralized credentialing process for all Medicaid providers. Therefore, the information listed in this section of the QI Program Description does not reflect Molina's responsibilities related to credentialing and recredentialing their network providers.

The Quality Improvement and Health Equity Transformation Committee is the committee responsible for the implementation and ongoing monitoring of the QI Program. During the onsite, it was noted that this committee was previously known as the Quality Improvement Committee (QIC). However, the committee meeting minutes were not updated to reflect the new name.

The Quality Improvement and Health Equity Transformation Committee is co-chaired by the Chief Medical Officer and the Quality Lead. Other members include senior management responsible for key functional areas of Molina. Participating practitioners serve as voting members on the Quality Improvement and Health Equity Transformation Committee and other clinical committees.

The QI Work Plan is developed annually after the completion of the QI Program Evaluation from the previous year. The 2022 and 2023 QI Work Plans were received and included the yearly QI activities; the individual responsible for each task, target dates, updates; and any previously identified issues. Molina's 2023 QI Work Plan includes the ability to trend data over five years, with results columns labeled as Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one. Also, there were several errors or missing information in the 2023 QI Work Plan.

Providers receive interpretation of their QI performance data and feedback. Molina provided an example of the Gaps in Care Report generated for network providers to identify members that are non-compliant or have identified gaps in care.

Molina adopts and disseminates clinical practice and preventive health guidelines that focus on key topics relevant to the health plan's members. 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. During the onsite, Constellation Quality Health questioned Molina regarding which of the "two important aspects" of the clinical practice guidelines were being measured and requested a copy of the annual report. Neither was provided.

Molina provides coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPDST) and Well Baby/Well Child services and educates members and providers about the services and resources available. 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. This was a deficiency identified during the 2020, 2021, and 2022 EQRs as noted in the table that follows.

Table 33: 2022 Provider Participation in Quality Improvement Activities CAP Items

Standard	EQR Comments	2023 EQR Findings
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, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment addresses EPSDT services, how Molina tracks services, and follow-up with members who have not received or are behind in getting services. This policy also includes the process followed for tracking follow-up treatment and referrals. Per Policy QI- 003, follow-up activities are to be documented on the EPSDT tracker. Molina provided the EPSDT tracking report. However, this report did not include documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The *CAN Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's EPSDT tracking system does not meet this contractual requirement.	Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, provides an overview of Molina's process for monitoring and reporting compliance with the EPSDT program. Per this policy, members who receive an abnormal finding during their EPSDT screening are identified, and the member is contacted regarding the need for follow-up. A copy of the EPSDT Tracker for 2023 was provided. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. This deficiency was not corrected.

Standard	EQR Comments	2023 EQR Findings
	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).	
Molina's 2022 Response: 2.2.2023—The process for EPSDT/Well Child 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, are listed. Follow-up and referrals are identified using the QNXT claims look-up tool. Quality staff reviews and documents information into the EPSDT/Well Child Tracker. In columns T-AA of the tracker contains the follow-up referral information, diagnosis, date, and/or staff contact to member. The tracker is located on the Quality SharePoint. A copy of the EPSDT/Well Child Tracker is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 7 and 17_EPSDT/Well Child Tracking Report_1-27-23"- uploaded to the portal.		
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.	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 in the Well-Baby and Well-Child tracking report. Molina provided the Well-Baby Well-Child tracking report. However, this report did not include the documentation of the follow-up activities. Molina mentioned a workgroup had been formed to create strategies for identifying abnormal findings and how follow up with members will be handled. This was an issue identified in the 2020 and 2021 EQRs. The *CHIP Contract, Section 5 (D)* requires that if a suspected problem is detected by a screening, the member must be evaluated for further diagnosis with referral, if indicated. A tracking system must be established that includes the diagnosis, treatments and/or referrals for members. Molina's Well-Baby Well-Child tracking system does not meet this contractual requirement.	Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provides an overview of Molina's process for monitoring and reporting compliance with the Well-Baby and Well-Child Services program. Per this policy, members who receive an abnormal finding during their screening are identified and the member is contacted regarding the need for follow-up. A copy of the Tracker for 2023 was provided. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. This deficiency was not corrected.

Standard	EQR Comments	2023 EQR Findings
	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).	
Molina's 2022 Response: 2.2.2023—The process for EPSDT/Well Child 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 and referrals are identified using the QNXT claims look-up tool. Quality staff reviews and documents information into the EPSDT/Well Child Tracker. In columns T-AA of the tracker contains the follow-up referral information, diagnosis, date, and/or staff contact to member. The tracker is located on the Quality SharePoint. A copy of the EPSDT/Well Child Tracker is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 7 and 17_EPSDT/Well Child Tracking Report_1-27-23		

Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provide an overview of Molina's process for monitoring and reporting compliance with the EPSDT program. These policies indicate that members who receive an abnormal finding during their EPSDT or Well Baby/Well Child screening are identified, and the member is contacted regarding the need for follow-up. A copy of the EPSDT Tracker for 2023 was provided. The tracking process listed in the document indicates "staff utilizes the Claims Lookup tool to identify all claims members received after the original EPSDT/Well Child exam to determine potential diagnosis and referral/follow-up." If no claims could be associated as a referral, the list is passed to designated staff to call the member. Also, Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, indicate work is being done to create an automated tracking dashboard for documenting recent/previous calls made to members' parents and the results of those calls. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members.

At least annually, Molina conducts a formal evaluation of the QI Program. The Quality Improvement Program 2022 Annual Evaluation was provided and did not include the results of the Geo Access reports and the Provider Directory analysis. This continues to be an issue and was identified in the 2020, 2021, and 2022 EQRs. *Table 34: 2022 Annual Evaluation of the Quality Improvement Program CAP Items* is an overview of the previous deficiency and Molina's response.

Table 34: 2022 Annual Evaluation of the Quality Improvement Program CAP Items

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

Standard	EQR Comments	2023 EQR Findings
	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.*	
Molina's 2022 Response: The 2021 QI Program Evaluation has been revised to include a more thorough account of QI activities results/analysis, opportunities for improvement and ongoing activities. Specifically, revisions have been included in the Practitioner Availability and Accessibility of Services Analysis (page 22), Appointment Access Audit completed for PCPs, specialists, and behavioral health providers (page 26-28), Geographic Access Report (page 28), Provider Online Directory (page 29-32), Credentialing (page 32-33), and Delegation Oversight (page 36-38) A revised/draft copy of the 2021 Annual Evaluation is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "CAP No. 8 and 18_2021 QI Evaluation_1-27-23." Also, the supporting Appendices A-H2 are included in the submission. These documents are uploaded to the portal.		
CHIP		
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	CCME received the 2021 QI Program Evaluation two days before the onsite. This QI Program Evaluation had been approved by the QIC in April 2022 and the Board in May 2022. There was a note on each page that indicates the document was revised in October 2022. Molina indicated there were minor revisions made to the evaluation. The Program Evaluation was incomplete and did not include the results or status of all the QI activities completed or underway in 2021. The following issues were identified with the Evaluation: •In Section VIII - Practitioner Availability and Accessibility of Services Analysis, page 21, the results of the appointment access audit completed for PCPs and behavioral health providers (reference Section 6.0 and 7.0 of the 2021 work plan) were missing. This section mentions that a root cause analysis was completed; however, not included in the QI Program Evaluation. •The Geographic Access Reports (reference Section 5.0, 2021 work plan), the Provider Directory analysis (reference Section 11, 2021 work plan), and the Credentialing activities (reference Section 19.0, 2021 work plan) were not included in the Program Evaluation. •The Delegation Oversight activities were incomplete.	This deficiency was not corrected. The QI Program 2022 Annual Evaluation did not include the results of the Geo Access reports and the Provider Directory analysis.

Standard	EQR Comments	2023 EQR Findings
	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. The *CHIP Contract, Section 9 (D) (8)* requires the QI Program Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Exhibit F (C) (6)* further defines the requirements for the QI Program Evaluation. *Corrective Action Plan: Correct the 2021 Quality Improvement Program Evaluation and include the results of all activities completed in 2021 and/or an update for the ongoing activities to meet the requirements in the CHIP Contract, Section 9, and Exhibit F.*	
Molina's 2022 Response: The 2021 QI Program Annual Evaluation has been revised to include a more thorough account of QI activities results/analysis, opportunities for improvement and ongoing activities. Specifically, revisions have been included in the Practitioner Availability and Accessibility of Services Analysis (page 22), Appointment Access Audit completed for PCPs, specialists, and behavioral health providers (page 26-28), Geographic Access Report (page 28), Provider Online Directory (page 29-32), Credentialing (page 32-33), and Delegation Oversight (page 36-38) A revised/draft copy of the 2021 Annual Evaluation is included with this submission and is applicable to the MSCAN and CHIP line of business. The title of the document is "EQR Audit 2022_CAP No. 8 and 18_2021 QI Evaluation_1-27-23." Also, the supporting Appendices A-H2 are included in the submission.		

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 National Committee for Quality Assurance (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, 2022.

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 2022.

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 were 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 performance measures were compared for the current review year (MY 2022) to the previous year (MY 2021), and the changes from 2021 to 2022 are reported in *Table 35: CAN HEDIS Performance Measure Results*. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

Table 35: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	45.34%	41.31%	-4.03%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.26%	54.50%	0.24%
Counseling for Nutrition	44.28%	42.09%	-2.19%
Counseling for Physical Activity	41.36%	40.63%	-0.73%
Childhood Immunization Status (cis)			
DTaP	69.34%	73.24%	3.90%
IPV	82.48%	89.05%	6.57%
MMR	85.64%	87.83%	2.19%
HiB	80.29%	84.43%	4.14%
Hepatitis B	80.29%	90.27%	9.98%
VZV	83.45%	87.35%	3.90%
Pneumococcal Conjugate	68.13%	72.99%	4.86%
Hepatitis A	75.18%	80.05%	4.87%
Rotavirus	69.83%	73.72%	3.89%
Influenza	27.01%	25.30%	-1.71%
Combination #3	61.07%	67.40%	6.33%
Combination #7	49.15%	56.69%	7.54%
Combination #10	20.68%	20.19%	-0.49%
Immunizations for Adolescents (ima)			
Meningococcal	47.69%	50.12%	2.43%
Tdap	63.99%	76.40%	12.41%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
HPV	11.19%	15.09%	3.90%
Combination #1	46.47%	49.64%	3.17%
Combination #2	10.95%	13.63%	2.68%
Lead Screening in Children (lsc)	71.29%	63.99%	-7.30%
Breast Cancer Screening (bcs)	33.33%	42.56%	9.23%
Cervical Cancer Screening (ccs)	52.31%	53.04%	0.73%
Chlamydia Screening in Women (chl)			
16-20 Years	47.74%	49.79%	2.05%
21-24 Years	62.11%	63.47%	1.36%
Total	52.19%	53.71%	1.52%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
16-20 Years	76.18%	75.14%	-1.04%
21-24 Years	65.23%	62.86%	-2.37%
65+ Years	NA	NA	NA
Total	74.02%	72.92%	-1.10%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	NA	21.43%	NA
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	60.48%	48.65%	-11.83%
Bronchodilator	80.65%	74.32%	-6.33%
Asthma Medication Ratio (amr)			
5-11 Years	77.07%	80.77%	3.70%
12-18 Years	65.28%	66.67%	1.39%
19-50 Years	46.03%	57.83%	11.80%
51-64 Years	NA	50.00%	NA
Total	64.75%	69.53%	4.78%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	50.12%	47.45%	-2.67%
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)	76.00%	78.23%	2.23%
Statin Adherence 80% - 21-75 years (Male)	85.96%	39.18%	-46.78%
Received Statin Therapy - 40-75 years (Female)	76.92%	77.22%	0.30%
Statin Adherence 80% - 40-75 years (Female)	85.00%	44.26%	-40.74%
Received Statin Therapy - Total	76.38%	77.83%	1.45%
Statin Adherence 80% - Total	85.57%	41.14%	-44.43%
Cardiac Rehabilitation (cre)			
Initiation - 18-64 Years	2.22%	1.75%	-0.47%
Engagement1 - 18-64 Years	4.44%	1.75%	-2.69%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Engagement2 - 18-64 Years	3.33%	1.75%	-1.58%
Achievement - 18-64 Years	1.11%	0.00%	-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	2.22%	1.75%	-0.47%
Engagement1 – Total	4.44%	1.75%	-2.69%
Engagement2 - Total	1.11%	1.75%	-1.58%
Effectiveness of Care: Diabetes			
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
Hemoglobin A1c (HbA1c) Testing	82.00%	-	NA
Poor HbA1c Control	62.53%	58.15%	-4.38%
Adequate HbA1c Control	30.17%	34.06%	3.89%
Eye Exam for Patients With Diabetes (EED)	53.28%	52.31%	-0.97%
Blood Pressure Control for Patients With Diabetes	53.77%	47.45%	-6.32%
Kidney Health Evaluation for Patients With Diabetes (KED)			
18-64 Years	17.04%	16.92%	-0.12%
65-74 Years	NA	NA	NA
75-85 Years	NA	NA	NA
Total	17.04%	16.89%	-0.15%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	51.36%	53.23%	1.87%
Statin Adherence 80%	77.06%	38.46%	-38.60%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	75.31%	59.77%	-15.54%
Effective Continuation Phase Treatment	61.18%	37.78%	-23.40%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	30.61%	36.56%	5.95%
Continuation and Maintenance (C&M) Phase	38.46%	59.35%	20.89%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	59.32%	61.71%	2.39%
6-17 years - 7-Day Follow-Up	37.08%	39.29%	2.21%
18-64 years - 30-Day Follow-Up	51.68%	47.61%	-4.07%
18-64 years - 7-Day Follow-Up	23.32%	24.43%	1.11%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	55.74%	54.66%	-1.08%
7-Day Follow-Up	30.63%	31.86%	1.23%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	59.02%	50.67%	-8.35%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	27.87%	30.67%	2.80%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	42.33%	32.59%	-9.74%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	33.13%	19.26%	-13.87%
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)	46.88%	39.05%	-7.83%
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	31.7%	23.33%	-8.37%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	31.00%	41.28%	10.28%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	14.00%	28.44%	14.44%
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)	29.52%	40.71%	11.19%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	13.33%	27.43%	14.10%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NA	NA	NC
7-Day Follow-Up: 13-17 Years	NA	NA	NC
30-Day Follow-Up: 18+ Years	6.94%	24.17%	NC
7-Day Follow-Up: 18+ Years	4.17%	12.50%	NC
30-Day Follow-Up: Total	6.29%	22.63%	NC
7-Day Follow-Up: Total	3.77%	12.41%	NC
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	49.59%	30.43%	-19.16%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	49.59%	30.43%	-19.16%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	70.60%	69.94%	-0.66%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	67.95%	58.67%	-9.28%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	51.50%	53.16%	1.66%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	37.32%	35.20%	-2.12%
Cholesterol Testing (1-11)	22.01%	23.98%	1.97%
Blood Glucose and Cholesterol Testing (1-11)	19.62%	21.43%	1.81%
Blood Glucose Testing (12-17)	43.67%	49.72%	6.05%
Cholesterol Testing (12-17)	26.68%	29.78%	3.10%
Blood Glucose and Cholesterol Testing (12-17)	23.72%	26.97%	3.25%
Blood Glucose Testing (Total)	41.38%	44.57%	3.19%
Cholesterol Testing (Total)	25.00%	27.72%	2.72%
Blood Glucose and Cholesterol Testing (Total)	22.24%	25.00%	2.76%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.30%	1.35%	0.05%
Appropriate Treatment for Children with URI (uri)			
3 Months-17 Years	75.83%	75.07%	-0.76%
18-64 Years	55.35%	56.38%	1.03%
65+ Years	NA	NA	NA
Total	73.88%	73.46%	-0.42%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 Months-17 Years	51.50%	59.23%	7.73%
18-64 Years	29.48%	32.37%	2.89%
65+ Years	NA	NA	NA
Total	48.25%	56.98%	8.73%
Use of Imaging Studies for Low Back Pain (lbp)	67.49%	69.80%	2.31%
Use of Opioids at High Dosage (hdo)	3.42%	0.44%	-2.98%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	13.39%	24.18%	10.79%
Multiple Pharmacies	1.59%	1.73%	0.14%
Multiple Prescribers and Multiple Pharmacies	0.80%	0.86%	0.06%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days Covered	9.34%	2.17%	-7.17%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
18-64 years - >=31 Days Covered	3.42%	1.21%	-2.21%
65+ years - >=15 Days Covered	NA	NA	NA
65+ years - >=31 Days Covered	NA	NA	NA
Total - >=15 Days Covered	9.34%	2.17%	-7.17%
Total - >=31 Days Covered	3.42%	1.21%	-2.21%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	82.23%	80.71%	-1.52%
45-64 Years	85.92%	84.15%	-1.77%
65+ Years	NA	NA	NA
Total	83.15%	81.72%	-1.43%
Annual Dental Visit (adv)			
2-3 Years	44.25%	53.82%	9.57%
4-6 Years	51.85%	61.19%	9.34%
7-10 Years	53.61%	62.97%	9.36%
11-14 Years	50.16%	57.85%	7.69%
15-18 Years	44.71%	50.49%	5.78%
19-20 Years	32.80%	33.24%	0.44%
Total	49.13%	57.13%	8.00%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NC
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NC
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NC
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NC
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	64.21%	56.00%	NC
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	2.11%	0.00%	NC
Total: Initiation of AOD Treatment: 13-17 Years	62.86%	55.43%	NC
Total: Engagement of AOD Treatment: 13-17 Years	4.76%	0.00%	NC
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	41.78%	41.09%	NC
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	3.29%	8.91%	NC
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	47.73%	63.83%	NC
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	23.86%	27.66%	NC
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	38.76%	45.02%	NC

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	3.72%	8.66%	NC
Total: Initiation of AOD Treatment: 18+ Years	38.71%	45.95%	NC
Total: Engagement of AOD Treatment: 18+ Years	7.03%	10.93%	NC
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	43.25%	41.97%	NC
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.29%	8.39%	NC
Opioid abuse or dependence: Initiation of AOD Treatment: Total	48.33%	63.16%	NC
Opioid abuse or dependence: Engagement of AOD Treatment: Total	23.33%	27.37%	NC
Other drug abuse or dependence: Initiation of AOD Treatment: Total	42.03%	46.55%	NC
Other drug abuse or dependence: Engagement of AOD Treatment: Total	3.51%	7.45%	NC
Total: Initiation of AOD Treatment: Total	40.99%	46.91%	NC
Total: Engagement of AOD Treatment: Total	6.82%	9.82%	NC
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	91.24%	95.38%	4.14%
Postpartum Care	63.50%	68.13%	4.63%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
6–11 Years	57.98%	55.46%	-2.52%
12–17 Years	60.30%	61.54%	1.24%
Total	59.43%	59.14%	-0.29%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	54.68%	57.28%	2.60%
15 Months–30 Months	62.67%	66.75%	4.08%
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	38.37%	43.60%	5.23%
12–17 Years	32.46%	35.86%	3.40%
18–21 Years	14.80%	18.96%	4.16%
Total	34.86%	39.51%	4.65%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR indicates that the rate was not reported.
NC: Calculation was not done due to break in trending.

The following HEDIS MY 2022 measure rates showed a substantial (>10%) improvement or decline:

- Immunizations for Adolescents (IMA)—the Tdap indicator improved by over 12 percentage points.

- Asthma Medication Ratio (AMR)—the 19-50 Years indicator improved by over 11 percentage points.
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)—the Continuation and Maintenance (C&M) Phase indicator improved by over 20 percentage points.
- Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)—rate improved over 10 percentage points for the following indicators: Age 18-64 (7 days and 30 days), 7 days total, and 30 days total.
- Pharmacotherapy Management of COPD Exacerbation (PCE)—the Systemic Corticosteroid indicator decreased by over 11 percentage points.
- Statin Therapy for Patients with Cardiovascular Disease (SPC)—the Statin Adherence 80% - 21-75 years (Male), Statin Adherence 80% - 40-75 years (Female), Statin Adherence 80% - Total indicators decreased by over 40 percentage points.
- Statin Therapy for Patients with Diabetes (SPD)—the Statin Adherence 80% indicator decreased by over 38 percentage points.
- Antidepressant Medication Management (AMM)—rate decreased for both indicators by over 15 percentage points.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)—the 7 days (18-64) indicator decreased by over 13 percentage points.
- Pharmacotherapy for Opioid Use Disorder (POD)—the Age 16-64 and Total indicators decreased by over 19 percentage points.
- Use of Opioids from Multiple Providers (UOP)—the Multiple Prescribers indicator increased by over 10 percentage points. The rate increase indicates lower performance for this measure.

All relevant CHIP HEDIS performance measures were compared for MY 2022 and the previous year (MY 2021), and the changes from 2021 to 2022 are reported in the table that follows. Rate changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 36: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	52.80%	49.88%	-2.92%

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Counseling for Nutrition	43.55%	35.28%	-8.27%
Counseling for Physical Activity	40.63%	36.01%	-4.62%
Childhood Immunization Status (cis)			
DTaP	77.34%	81.90%	4.56%
IPV	86.69%	89.84%	3.15%
MMR	92.07%	89.21%	-2.86%
HiB	84.42%	86.98%	2.56%
Hepatitis B	83.85%	89.21%	5.36%
VZV	91.22%	88.89%	-2.33%
Pneumococcal Conjugate	76.20%	84.13%	7.93%
Hepatitis A	84.99%	84.13%	-0.86%
Rotavirus	79.89%	82.54%	2.65%
Influenza	33.99%	27.62%	-6.37%
Combination #3	69.12%	78.10%	8.98%
Combination #7	58.92%	69.84%	10.92%
Combination #10	27.20%	25.08%	-2.12%
Immunizations for Adolescents (ima)			
Meningococcal	45.26%	46.47%	1.21%
Tdap/Td	62.04%	71.53%	9.49%
HPV	15.57%	15.09%	-0.48%
Combination #1	44.28%	46.23%	1.95%
Combination #2	15.09%	14.60%	-0.49%
Lead Screening in Children (lsc)	77.90%	63.81%	-14.09%
Chlamydia Screening in Women (chl)			
16-20 Years	38.94%	43.17%	4.23%
21-24 Years	NA	NA	NA
Total	38.94%	43.17%	4.23%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 Years	78.37%	77.89%	-0.48%
18-64 Years	74.65%	72.97%	-1.68%
65+ Years	NA	NA	NA
Total	78.21%	77.73%	-0.48%
Asthma Medication Ratio (amr)			
5-11 Years	87.39%	89.29%	1.90%
12-18 Years	78.64%	77.14%	-1.50%
19-50 Years	NA	N/A	N/A
51-64 Years	NA	N/A	N/A

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Total	83.18%	83.97%	0.79%
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
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
Hemoglobin A1c (HbA1c) Testing	NA	NA	NA
Poor HbA1c Control	NA	NA	NA
Adequate HbA1c Control	NA	NA	NA
Eye Exam for Patients With Diabetes (EED)	NA	NA	NA
Blood Pressure Control for Patients With Diabetes (BPD)	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)			
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

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	32.98%	43.87%	10.89%
Continuation and Maintenance (C&M) Phase	48.05%	60.00%	11.95%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	55.68%	68.42%	12.74%
6-17 years - 7-Day Follow-Up	34.09%	36.84%	2.75%
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	56.67%	68.69%	12.02%
Total-7-day Follow-Up	34.44%	35.35%	0.91%
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)			
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

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
Pharmacotherapy for Opioid Use Disorder (16-64)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	NA	NA	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	NA	NA	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NA	NA	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	30.23%	40.00%	9.77%
Cholesterol Testing (1-11)	18.60%	27.50%	8.90%
Blood Glucose and Cholesterol Testing (1-11)	18.60%	27.50%	8.90%
Blood Glucose Testing (12-17)	62.96%	57.14%	-5.82%
Cholesterol Testing (12-17)	35.19%	31.75%	-3.44%
Blood Glucose and Cholesterol Testing (12-17)	33.33%	31.75%	-1.58%
Blood Glucose Testing (Total)	48.45%	50.49%	2.04%
Cholesterol Testing (Total)	27.84%	30.10%	2.26%
Blood Glucose and Cholesterol Testing (Total)	26.80%	30.10%	3.30%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.25%	0.99%	-0.26%
Appropriate Treatment for Upper Respiratory Infection (uri)			
3 months-17 Years	65.90%	68.85%	2.95%
18-64 Years	62.32%	50.52%	-11.80%
65+ Years	NA	NA	NA
Total	65.79%	68.35%	2.56%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (aab)			
3 Months – 17 Years	31.22%	36.92%	5.70%
18-64 Years	NA	NA	NA
65+ Years	NA	NA	NA
Total	30.80%	37.01%	6.21%
Use of Imaging Studies for Low Back Pain (lbp)	NA	NA	NA

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Use of Opioids at High Dosage (hdo)	NA	NA	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days Covered	NA	NA	NA
18-64 years - >=31 Days Covered	NA	NA	NA
65+ - >=15 Days Covered	NA	NA	NA
65+ - >=31 Days Covered	NA	NA	NA
Total - >=15 Days Covered	NA	NA	NA
Total - >=31 Days Covered	NA	NA	NA
Access/Availability of Care			
Annual Dental Visit (adv)			
2-3 Years	52.63%	59.90%	7.27%
4-6 Years	64.10%	68.83%	4.73%
7-10 Years	66.57%	73.82%	7.25%
11-14 Years	63.32%	68.36%	5.04%
15-18 Years	52.35%	58.18%	5.83%
19-20 Years	40.91%	44.26%	3.35%
Total	60.47%	66.08%	5.61%
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

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
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
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)	NA	61.29%	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	NA	6.45%	NA
Prenatal and Postpartum Care (ppc)			

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
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
12–17 Years	74.36%	63.89%	-10.47%
Total	67.19%	58.93%	-8.26%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	78.38%	72.83%	-5.55%
15 Months–30 Months	74.50%	83.51%	9.01%
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	40.50%	45.55%	1.69%
12–17 Years	35.53%	39.90%	3.97%
18–21 Years	20.40%	25.41%	1.56%
Total	37.15%	41.72%	2.55%

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

The following HEDIS MY 2022 measure rates had a greater than 10% improvement or decline:

- Childhood Immunization Status (CIS)—improved by over 10 percentage points for the Combination #7 indicator.
- Follow-up care for children prescribed ADHD Medication (ADD)—rate improved by over 10 percentage points for both indicators.
- Follow-Up After Hospitalization for Mental Illness (FUH)—rate improved by over 12 percentage points for the Age 6–17 years 30 days Follow-Up and Total 30 days Follow-Up indicators.
- Lead Screening in Children (LSC)—rate decreased by over 14 percentage points.
- Appropriate Treatment for Upper Respiratory Infection (URI)—rate decreased by over 11 percentage points for 18–64 Years indicator.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—rate decreased by over 10 percentage points for Age 12–17 years indicator.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2022 and the previous year (MY 2021). The changes from 2021 to 2022 are reported in the tables that follow. Rate changes shown in

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

Table 37: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2021 Rate	MY 2022 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
COLORECTAL CANCER SCREENING (COL-AD)			
Ages 50 - 64	24.88%	26.50%	1.62%
Ages 65 - 75	NA	NA	NA
Total	24.86%	24.54%	-0.32%
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-65	0.69%	0.69%	0.00%
Ages 65+	NA	NA	NA
Total	0.69%	0.69%	0.00%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or Moderately Effective Contraception – 3 days	12.60%	12.46%	-0.14%
Most or Moderately Effective Contraception – 60 days	48.15%	-	NA
Most or Moderately Effective Contraception – 90 days	-	54.09%	NA
LARC - 3 Days	0.49%	0.44%	-0.05%
LARC - 90 Days Reported	-	9.25%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or Moderately Effective Contraception Rate	24.26%	23.46%	-0.80%
LARC Rate	3.33%	2.57%	-0.76%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	27.85	24.19	-3.66
Ages 65+	0.00	0.00	0.00
Total	27.84	24.19	-3.65
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	54.22	55.68	1.46
Ages 65+	0.00	0.00	0.00
Total	54.18	55.61	1.43
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	37.26	48.85	11.59
Ages 65+	0.00	0.00	0.00

Measure	MY 2021 Rate	MY 2022 Rate	Change
Total	37.25	48.83	11.58
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	4.52	1.30	3.22
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	13.57%	20.25%	6.68%
Ages 65+	NA	NA	NA
Total	13.38%	20.25%	6.87%
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	4.79%	0.71%	-4.08%
Ages 65+	NA	NA	NA
Total	4.79%	0.71%	-4.08%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	4.52%	4.16%	-0.36%
Ages 65+	NA	NA	NA
Total	4.52%	4.16%	-0.36%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	54.18%	44.40%	-9.78%
Prescription for Buprenorphine	53.51%	43.60%	-9.91%
Prescription for Oral Naltrexone	1.00%	2.00%	1.00%
Prescription for Long-Acting, Injectable Naltrexone	0.00%	0.00%	0.00%
Prescription for Methadone	0.00%	0.40%	0.40%
Child Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	1.10%	3.09%	1.99%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	30.00%	33.06%	3.06%
Age 2 Screening	45.53%	46.93%	1.40%
Age 3 Screening	37.75%	45.07%	7.32%
Total Screening	37.05%	39.48%	2.43%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or Moderately Effective Contraception – 3 days	1.34%	0.00%	-1.34%
Most or Moderately Effective Contraception – 60 days	46.98%	-	NA
Most or Moderately Effective Contraception – 90 days	-	7.94%	NA

Measure	MY 2021 Rate	MY 2022 Rate	Change
LARC - 3 Days	0.67%	3.17%	2.50%
LARC - 60 Days Reported	12.53%	-	NA
LARC - 90 Days Reported	-	47.62%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or Moderately Effective Contraception Rate	27.41%	26.01%	-1.40%
LARC Rate	2.91%	2.10%	-0.81%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	8.94%	34.38%	25.44%
Numerator 2 All Four Molars Sealed	4.79%	21.91%	17.12%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.10%	0.99%	0.89%
Ages 1-2	12.93%	19.74%	6.81%
Ages 3-5	30.35%	48.41%	18.06%
Ages 6-7	35.52%	54.93%	19.41%
Ages 8-9	35.82%	55.01%	19.19%
Ages 10-11	34.40%	52.41%	18.01%
Ages 12-14	30.19%	45.72%	15.53%
Ages 15-18	23.47%	37.24%	13.77%
Ages 19-20	13.24%	20.99%	7.75%
Total Ages <1-20	25.26%	39.25%	13.99%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	7.73%	9.37%	1.64%
Ages 3-5	9.64%	21.21%	11.57%
Ages 6-7	10.21%	24.22%	14.01%
Ages 8-9	10.44%	25.88%	15.44%
Ages 10-11	9.72%	21.75%	12.03%
Ages 12-14	7.57%	18.78%	11.21%
Ages 15-18	5.61%	13.26%	7.65%
Ages 19-20	2.90%	5.93%	3.03%
Total Ages 1-20	8.36%	17.76%	9.40%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	1.67%	4.88%	3.21%
Ages 3-5	5.61%	18.91%	13.30%
Ages 6-7	7.53%	23.30%	15.77%
Ages 8-9	8.06%	25.07%	17.01%
Ages 10-11	7.24%	21.35%	14.11%

Measure	MY 2021 Rate	MY 2022 Rate	Change
Ages 12–14	5.53%	18.25%	12.72%
Ages 15–18	4.19%	12.79%	8.60%
Ages 19–20	2.32%	5.71%	3.39%
Total Ages 1–20	5.10%	16.04%	10.94%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	0.00%	3.05%	3.05%
Ages 3–5	0.03%	0.54%	-2.46%
Ages 6–7	0.00%	0.02%	0.02%
Ages 8–9	0.00%	0.08%	0.08%
Ages 10–11	0.00%	0.00%	0.00%
Ages 12–14	0.00%	0.05%	0.05%
Ages 15–18	0.00%	0.06%	0.06%
Ages 19–20	0.00%	0.00%	0.00%
Total Ages 1–20	0.00%	0.76%	0.76%

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

The following non-HEDIS MY 2022 measure rates for CAN had a greater than 10% improvement:

- Heart Failure Admission Rate (PQI-08)—the Age 18-64, and Total indicators improved by over 11 percentage points.
- Sealant Receipt on Permanent First Molars (SFM-CH)—the Numerator 1 At Least One Sealant and Numerator 2 All Four Molars Sealed indicators, improved by over 17 percentage points.
- Oral Evaluation, Dental Services (OEV-CH)—improved by over 13 percentage points for all but three (Age<1, Ages 1-2, and Ages 19-20) indicators.
- Prevention: Topical Fluoride for Children (TLF-CH)—the Rate 1 indicator improved by over 11 percentage points for five indicators (Ages 3-5, Ages 6-7, Ages 8-9, Ages 10-11, and Ages 12-14). The Rate 2 indicator improved by over 10 percentage points for all but three indicators (Ages 1-2, Ages 15-18, and Ages 19-20).

Table 38: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2021 Rate	MY 2022 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	0.72%	0.97%	0.25%
Ages 65+	NA	NA	NA
Total	0.72%	0.97%	0.25%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	10.18	10.36	0.18
Ages 65+	NA	NA	NA
Total	10.18	10.36	0.18
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

Measure	MY 2021 Rate	MY 2022 Rate	Change
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	0.64%	1.10%	0.46%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	NA	NA	NA
Age 2 Screening	56.18	56.47%	0.29%
Age 3 Screening	41.65	53.24%	11.59%
Total Screening	47.42	54.33%	6.91%
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 – 90 days	NA	NA	NA
LARC - 3 Days	NA	NA	NA
LARC - 90 Days Reported	NA	NA	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or Moderately Effective Contraception Rate	25.15%	26.36%	1.21%
LARC Rate	1.42%	2.01%	0.59%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	0.00%	26.20%	26.20%
Numerator 2 All Four Molars Sealed	0.00%	18.36%	18.36%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	NA	NA	NA
Ages 1-2	20.05%	31.95%	11.90%
Ages 3-5	43.26%	56.14%	12.88%
Ages 6-7	49.83%	65.24%	15.41%
Ages 8-9	47.38%	65.75%	18.37%
Ages 10-11	48.39%	62.55%	14.16%
Ages 12-14	41.18%	57.65%	16.47%
Ages 15-18	31.51%	45.66%	14.15%
Ages 19-20	19.50%	33.99%	14.49%
Total Ages <1-20	40.01%	54.62%	14.61%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	10.29%	18.91%	8.62%

Measure	MY 2021 Rate	MY 2022 Rate	Change
Ages 3-5	13.14%	28.45%	15.31%
Ages 6-7	15.01%	36.15%	21.14%
Ages 8-9	15.97%	36.77%	20.80%
Ages 10-11	13.34%	33.75%	20.41%
Ages 12-14	12.38%	27.65%	15.27%
Ages 15-18	8.01%	19.55%	11.54%
Ages 19-20	4.21%	10.00%	5.79%
Total Ages 1-20	12.04%	27.65%	15.61%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	2.23%	11.42%	9.19%
Ages 3-5	7.92%	25.45%	17.53%
Ages 6-7	11.48%	34.44%	22.96%
Ages 8-9	11.94%	35.47%	23.53%
Ages 10-11	9.83%	32.67%	22.84%
Ages 12-14	9.20%	26.56%	17.36%
Ages 15-18	6.04%	18.61%	12.57%
Ages 19-20	4.21%	10.00%	5.79%
Total Ages 1-20	8.48%	25.92%	17.44%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	NA	4.87%	4.87%
Ages 3-5	NA	0.38%	0.38%
Ages 6-7	NA	0.19%	0.19%
Ages 8-9	NA	0.09%	0.09%
Ages 10-11	NA	0.17%	0.17%
Ages 12-14	NA	0.05%	0.05%
Ages 15-18	NA	0.26%	0.26%
Ages 19-20	NA	0.00%	0.00%
Total Ages 1-20	NA	0.44%	0.44%

The following non-HEDIS MY 2022 measure rates for CHIP had a greater than 10% improvement:

- Developmental Screening in the first 3 years of life (DEV-CH)—the Age 3 Screening indicator improved by over 11 percentage points.
- Sealant Receipt on Permanent First Molars (SFM-CH)—both indicators improved by over 18 percentage points.

- Oral Evaluation, Dental Services (OEV-CH)—improved by over 11 percentage points for all but one indicator (Age<1).
- Prevention: Topical Fluoride for Children (TLF-CH)—the Rate 1 and Rate 2 indicators improved by over 11 percentage points for all but two indicators (Ages 1-2 and Ages 19-20).

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 seven CAN PIPs for validation. Topics included, Behavioral Health Readmissions, Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 39: 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 latest report had Q1 2023 data with a readmission rate of 54.2% and increased from the Q4 2022 rate of 10.8%. Case management enrollment for the 13 readmitted members was 100%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	

Behavioral Health Readmissions
• Community connectors • Primary care initiative • Scheduling process changed • Onsite discharge planning • Transition of Care letters sent to members • Patient Outreach

Table 40: 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 Asthma PIP focused on the AMR HEDIS rate for ages 5 to 64. Quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements, with a goal of 72.89%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Asthma education video on proper use of the inhaler • Monitoring of the non-compliant members and encourage providers to contact members to close the gap in care • Telephone call campaign to encourage members to get their annual wellness exams • Provider toolkits and educational materials • Member educational materials	

Table 41: Pharmacotherapy Management of COPD Exacerbation CAN PIP

Pharmacotherapy Management of COPD Exacerbation	
The COPD PIP utilizes the systemic corticosteroid HEDIS measure and the bronchodilator HEDIS measure. For Q1 to Q2 2023, there was an increase from 48.65% to 60.94% for steroid measure, with a goal of 53.43%, and an improvement from 59.46% to 79.69% for the bronchodilators, with a goal of 81.8%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Smoking Cessation Program: This program provides access to over-the-counter tobacco cessation products. • Provider Education Tools	

Table 42: Follow-up After Hospitalization for Mental Illness CAN PIP

Follow-up After Hospitalization for Mental Illness	
This PIP assesses 7- and 30-day follow up for members hospitalized for treatment of mental illness. For the 30-day follow up, the rate improved from 34.34% to 44.73%, with a goal of 56.13%. The 7-day rate improved from 21.72% to 27.23%, with a goal of 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• TOC Coaches: Once notified of assigned admitted members, the TOC coaches follow a bundle process to outreach to members. They complete an in-patient assessment with the member. In addition, they assist with scheduling a 7- or 30-day follow-up visit with a behavioral health provider. They also address any current or foreseen barriers that may prohibit the member from keeping an aftercare follow-up plan. • Discharge planning checklist • Processes to improve efficiency of scheduling follow-up appointments • Provider Education	

Table 43: Obesity CAN PIP

Obesity	
This PIP utilizes the BMI percentile documentation, counseling for nutrition, and counseling for physical activity HEDIS measures. For BMI percentile, there was improvement from Q1 to Q2 with rates of 14.44% increasing to 18.69%, a goal of 61.31%. Counseling for nutrition improved 7.41% to 9.86%, with a goal of 52.31%. Counseling for physical activity improved 7.1% to 9.92%, with a goal of 57.42%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider Education • Member Incentives • Member outreach and member events for awareness and education	

Table 44: Prenatal and Postpartum Care CAN PIP

Prenatal and Postpartum Care
This PIP examines the rate of deliveries that received prenatal care within the first trimester and post-partum care visits within 84 days of delivery. For prenatal visits, the rate declined from 86.19% to 84.72%, with the goal of 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%.

Prenatal and Postpartum Care	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Provider Education • Member incentives-Gift cards and car seats • Member outreach events • Mother's Liquid Gold, Reduce Baby's Cold (Electric Breast Pump Pilot)-currently recruiting 100 maternity members to utilize electric breast pump for the first six months of their child's life.	

Table 45: Sickle Cell Disease CAN PIP

Sickle Cell Disease	
This focuses on the percentage of members with Sickle Cell Disease who are enrolled in case management. The rate declined from 6.25% to 4.9%, with a goal of 15.9%.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Internal monitoring and tracking for inpatient care and ED visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration with the MS Sickle Cell Foundation (MSCF). • Member educational materials	

Constellation Quality Health provided recommendations for four PIPs wherein a decline in at least one indicator was identified. These are displayed in *Table 46: CAN Performance Improvement Project Recommendation*.

Table 46: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The latest report had Q1 2023 data with a readmission rate of 54.2%, which increased from the Q4 2022 rate of 10.8%. Case management enrollment for the 13 readmitted members was 100%.	Continue to monitor BH readmission rates. Complete lessons learned report to assess key take-aways from the PIP.
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate declined from 6.25% to 4.9%, with a goal of 15.9%.	Continue ongoing interventions for tracking and monitoring of members that need to be enrolled in case management.
Asthma	Was there any documented, quantitative improvement in processes or outcomes of care?	Quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements, with a goal of 72.89%.	Continue ongoing interventions to educate provider and members toward efforts to improve medication compliance.
Prenatal and Postpartum Care	Was there any documented, quantitative improvement in processes or outcomes of care?	For prenatal visits, the rate declined from 86.19% to 84.72%, with the goal of 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%.	Continue community events and utilization of Spectra Medix value-based purchasing platform for improving patient monitoring and PPC rates.

CHIP PIP Validation Results

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

Table 47: Asthma Medication Ration CHIP PIP

Asthma Medication Ratio	
The aim for this Asthma PIP is to increase the compliance rate of Asthma medication for CHIP members. Quarterly rates show a decline from 93.02% in Q1 2023 to 76.92% in Q2 2023. The rates are above the goal rate of 71.28% (benchmark should be adjusted now that several remeasurements are above it).	
Previous Validation Score	Current Validation Score
85/85=100% High Confidence in Reported Results	79/80= 99% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of the inhaler • Telephone campaigns to encourage members to get their annual wellness exams • Provider education with toolkits and assistance with member outreach	

Table 48: Follow-up After Hospitalization for Mental Illness CHIP PIP

Follow-up After Hospitalization for Mental Illness	
The aim for this PIP is to increase the number of CHIP members who receive a follow-up after hospitalization within 7 and 30 days. The 30-day rate for 6–17-year-olds improved from 46.43% in Q1 2023 to 59.18% in Q2 2023. The goal is 56.13%. For the 7-day rate, the rate increased from 28.6% in Q1 to 34.7% in Q2. The goal is 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care collaborative on-site discharge planning • Transition of Care/Case Management post-discharge follow-up to assist with scheduling follow-up appointments and transportation • Implementation of a Discharge Planning Checklist • Behavioral Health Provider Engagement to establish processes to ensure members can be seen within 7- or 30-days post discharge	

Table 49: Obesity CHIP PIP

Obesity	
The Obesity PIP aims to increase the percentage of CHIP members who had an outpatient visit with their PCP or OBGYN that includes weight assessment counseling. The BMI documentation rate improved from 11.29% in Q1 to 15.23% in Q2, with a goal of 61.31%. The nutrition counseling rate also improved from 5.68% to 8.96%, with a goal of 52.31%. Counseling for physical activity improved from 4.73% to 8.73%, with a goal of 57.42%.	
Previous Validation Score	Current Validation Score

Obesity	
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Provider toolkits to help facilitate tracking reports and address areas needed • Member education, community outreach, and incentives	

Table 50: Well Care/Well Child CHIP PIP

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

The following recommendation is provided for the Asthma CHIP PIP

Table 51: CHIP Performance Improvement Project Recommendation

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

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

Molina met 79% of the standards in the Quality Improvement section of the EQR. A total of 16% of the standards were scored as "Partially Met" and 5% were scored as "Not Met," as shown in *Figure 6: Quality Improvement Findings*.

Figure 6: Quality Improvement Findings

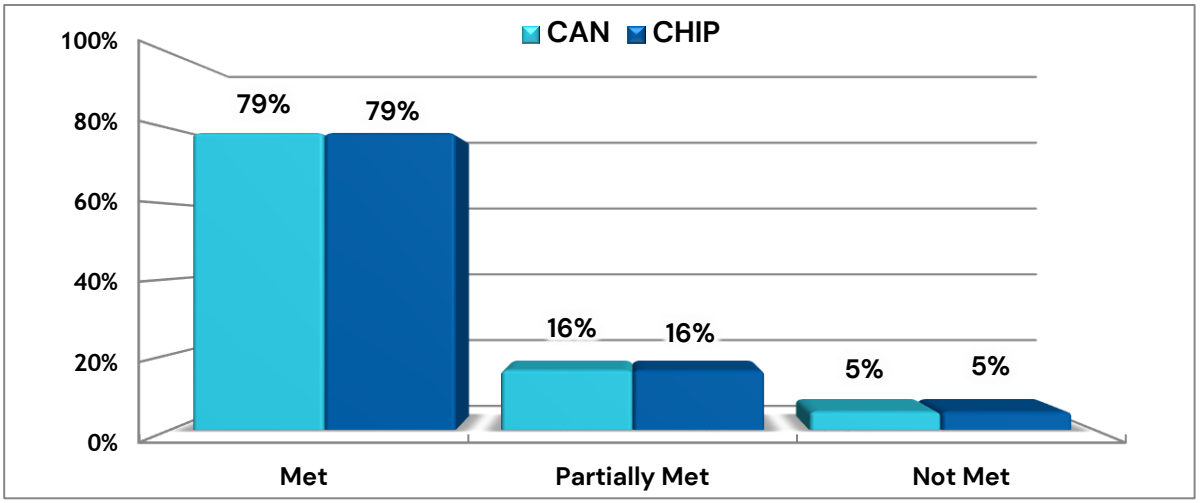


Table 52: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Molina's HEDIS auditor found that the CCO was fully compliant with all IS 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. The PM validation determined that Molina followed measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.	✓		
The following HEDIS MY 2022 measure rates were strengths for Molina's CAN population since their rates had a greater than 10 percentage point improvement: • Immunizations for Adolescents (IMA)—the Tdap indicator improved by over 12 percentage points. • Asthma Medication Ratio (AMR)—the 19-50 Years indicator improved by over 11 percentage points. • Follow-Up Care for Children Prescribed ADHD Medication (ADD)—the Continuation and Maintenance (C&M) Phase indicator improved by over 20 percentage points. • Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)—rate improved over 10 percentage points for the following indicators: Age 18-64 (7 days and 30 days), 7 days total and 30 days total. • Heart Failure Admission Rate (PQI-08)—the Age 18-64, and Total indicators improved by over 11 percentage points. • Sealant Receipt on Permanent First Molars (SFM-CH)—the Numerator 1 At Least One Sealant and Numerator 2 All Four Molars Sealed indicators, improved by over 17 percentage points.	✓		

Strengths	Quality	Timeliness	Access to Care
• Oral Evaluation, Dental Services (OEV-CH)—improved by over 13 percentage points for all but three (Age<1, Ages 1-2, and Ages 19-20) indicators. • Prevention: Topical Fluoride for Children (TLF-CH)— the Rate 1 indicator improved by over 11 percentage points for five indicators (Ages 3-5, Ages 6-7, Ages 8-9, Ages 10-11, and Ages 12-14). The Rate 2 indicator improved by over 10 percentage points for all but three indicators (Ages 1-2, Ages 15-18, and Ages 19-20).			
The following HEDIS MY 2022 measure rates were strengths for Molina's CHIP population, since their rates had a greater than 10 percentage point improvement: • Childhood Immunization Status (CIS)—improved by over 10 percentage points for the Combination #7 indicator. • Follow-up Care for Children Prescribed ADHD Medication (ADD)—rate improved by over 10 percentage points for both indicators. • Follow-Up After Hospitalization for Mental Illness (FUH)—rate improved by over 12 percentage points for the Age 6-17 years 30 days Follow-Up and Total 30 days Follow-Up indicators. • Developmental Screening in the First 3 Years of Life (DEV-CH)—the Age 3 Screening indicator improved by over 11 percentage points. • Sealant Receipt on Permanent First Molars (SFM-CH)—both indicators improved by over 18 percentage points. • Oral Evaluation, Dental Services (OEV-CH)—improved by over 11 percentage points for all but one indicator (Age<1). • Prevention: Topical Fluoride for Children (TLF-CH)— the Rate 1 and Rate 2 indicators improved by over 11 percentage points for all but two indicators (Ages 1-2 and Ages 19-20).	✓		
All of the CAN and CHIP PIPs scored in the High Confidence range	✓		

Table 53: Quality Improvement Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The appendices were not included in the 2023 QI Program Description and the section regarding Credentialing was incorrect regarding Molina's responsibilities related to credentialing and recredentialing their network providers.	Recommendation: Add the appendices to the 2023 Quality Improvement Program Description and update or remove the section that describes the credentialing program.	✓		
The Quality Improvement and Health Equity Transformation Committee was previously known as the Quality Improvement Committee. However, the committee meeting minutes were not updated to reflect the new name.	Recommendation: Update the Quality Improvement and Health Equity Transformation Committee meeting minutes to reflect the new name for this committee.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
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. During the onsite, Constellation Quality Health questioned Molina regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided.	Corrective Action Plan: On an annual basis, measure provider performance against at least two of the clinical guidelines as required by the *CAN Contract, Section 10 (M)* and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.	✓		
The results columns in the 2023 QI Work Plan are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year (Y1). Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one.	Recommendation: Label the columns for the applicable year in the 2023 QI Work Plan (example: Y1= 2023, Y2=2024 etc.).	✓		
There were several errors and/or missing information in the 2023 QI Work Plan. Those included: • In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1. • The Availability of Practitioners section (PDF pages 16–28) and the Accessibility of Services section (PDF pages 29–30) lacked benchmark goals for each activity. • The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications as to which measure those scores apply. • The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists. • The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care	Corrective Action Plan: Correct the errors identified in the 2023 QI Work Plan.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
practitioners instead of behavioral health practitioners. • The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. However, Policy MHMS-QI-006, Access to Care lists this timeframe as seven calendar days. • The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care. • In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days.				
The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for the Molina's CAN population, since their rates had a greater than 10 percentage point decline: • Pharmacotherapy Management of COPD Exacerbation (PCE)—the Systemic Corticosteroid indicator decreased by over 11 percentage points. • Statin Therapy for Patients with Cardiovascular Disease (SPC)—the Statin Adherence 80% - 21-75 years (Male), Statin Adherence 80% - 40-75 years (Female), Statin Adherence 80% - Total indicators decreased by over 40 percentage points. • Statin Therapy for Patients with Diabetes (SPD)—the Statin Adherence 80% indicator decreased by over 38 percentage points. • Antidepressant Medication Management (AMM)—rate decreased for both indicators by over 15 percentage points.	Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
• Follow-Up After Emergency Department Visit for Mental Illness (FUM)—the 7 days (18-64) indicator decreased by over 13 percentage points. • Pharmacotherapy for Opioid Use Disorder (POD)—the Age 16-64 and Total indicators decreased by over 19 percentage points. • Use of Opioids from Multiple Providers (UOP)—the Multiple Prescribers indicator increased by over 10 percentage points. The rate increase indicates lower performance for this measure.				
The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for Molina's CHIP population, since their rates had a greater than 10 percentage point decline: • Lead Screening in Children (LSC) rate decreased by over 14 percentage points. • Appropriate Treatment for Upper Respiratory Infection (URI) rate decreased by over 11 percentage points for 18-64 Years indicator. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) rate decreased by over 10 percentage points for Age 12-17 years indicator.	Recommendation: Monitor rates and implement interventions to improve the rates.	✓		
Four of seven CAN PIPs had a decline in indicator rates, and one CHIP PIP had a decrease in the indicator rates.	Recommendation: Asses the current interventions to determine if changes are needed.	✓		
At least annually, Molina conducts a formal evaluation of the QI Program. The QI Program 2022 Annual Evaluation was provided. This evaluation did not include the results of the Geo Access reports and the Provider Directory analysis. This continues to be an issue and was identified in the 2020, 2021, and 2022 EQR.	Corrective Action Plan: The results of all activities completed in 2022 and/or an update for the ongoing activities must be added to the 2022 QI Program Annual Evaluation to meet the requirements in the *CAN Contract, Section 10*, and *Exhibit G* and in the *CHIP Contract, Section 9*, and *Exhibit F*.	✓		

QUALITY IMPROVEMENT—CAN

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's Quality Improvement (QI) Program focuses on the health care and services that members receive. The goal of the program is to ensure members receive accessible, appropriate, cost-effective, and high-quality health care services throughout the organization. The 2023 Quality Improvement Program Description describes the QI Program Molina has implemented to help achieve this goal. Six appendices were listed in the table of contents. However, those appendices are not included in the document. Also, the section titled "Implementing a Credentialing Program" indicates Molina maintains a comprehensive and detailed credentialing program. DOM has implemented a centralized credentialing process for all Medicaid providers. Therefore, the information listed in this section of the QI Program Description does not reflect Molina's responsibilities related to credentialing and recredentialing their network providers. *Recommendation: Add the appendices to the 2023 QI Program Description and update or remove the section that describes the credentialing program.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Molina addresses healthcare disparities through the Health Equity and Cultural Competency Program.
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 includes measuring or monitoring over and underutilization to identify any potential problems or issues.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).		X				The QI Work Plan is developed annually after the completion of the Quality Improvement Program Annual Evaluation from the previous year. The 2022 and 2023 QI Work Plans were received, and both included the yearly quality improvement activities, the individual responsible for each task, target dates, updates, and any previously identified issues. Molina's 2023 QI Work Plan includes the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one. *Recommendation: Label the columns for the applicable year in the 2023 QI Work Plan (example: Y1= 2023, Y2=2024 etc.).*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Also, there were several errors and/or missing information in the 2023 QI Work Plan. Those included: • In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1. • The Availability of Practitioners section (PDF pages 16 – 28) and the Accessibility of Services section (PDF pages 29 – 30) lacked benchmark goals for each activity. • The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications which measure those scores apply. • The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists. • The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care practitioners instead of behavioral health practitioners. • The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Routine (PCP) appointment as not to exceed 30 days. However, Policy MHMS-QI-006, Access to Care lists this timeframe as seven calendar days. • The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care. • In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days. *Corrective Action Plan: Correct the errors identified in the 2023 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					The Quality Improvement and Health Equity Transformation Committee is the committee responsible for the implementation and ongoing monitoring of the QI Program. This committee as well as various subcommittees make recommendations for policy decisions, analyze, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						evaluate the progress and results of all QI activities, institute any needed actions, and ensure follow up.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Quality Improvement and Health Equity Transformation Committee is co-chaired by the Chief Medical Officer and the Quality Lead. Other members include senior management responsible for key functional areas of Molina. Participating practitioners serve as voting members on the Quality Improvement and Health Equity Transformation Committee and other clinical committees.
3. The QI Committee meets at regular intervals.	X					The Quality Improvement and Health Equity Transformation Committee meets quarterly. A quorum of 51 percent of voting members, with no less than half of network provider participants, is required for all committee meetings.
4. Minutes are maintained that document proceedings of the QI Committee.	X					A review of the committee minutes demonstrated the committee met the requirements for meeting frequency and for the quorum. During the onsite, it was noted that the Quality Improvement and Health Equity Transformation Committee was previously known as the Quality Improvement Committee (QIC). However, the committee meeting minutes were not updated to reflect the new name. *Recommendation: Update the Quality Improvement and Health Equity Transformation Committee*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meeting minutes to reflect the new name for this committee.
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					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the performance measure (PM) rates. There were several rates that had a greater than 10 percentage point decline. *Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.*
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, Molina submitted seven CAN Performance Improvement Projects (PIPs) for validation. Topics included, Behavioral Health Readmissions, Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Prenatal and Postpartum Care, Sickle Cell Disease, and Obesity.
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. Four of seven CAN PIPs had a decline in indicator rates.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Asses the current interventions to determine if changes are needed.
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					Molina provided an example of the Gaps in Care Report generated for network providers to identify members that are non-compliant or have identified gaps in care.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.		X				Molina adopts and disseminates clinical practice and preventive health guidelines that focus on key topics relevant to the health plan's members. 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. During the onsite, Constellation Quality Health questioned Molina regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided. *Corrective Action Plan: On an annual basis, measure provider performance against at least two of the clinical guidelines as required by the MS CAN*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Contract, Section 10 (M) and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.
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				Molina provides coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and educates members and providers regarding the services and resources available. Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, provides an overview of Molina's process for monitoring and reporting compliance with the EPSDT program. This policy indicates that members who receive an abnormal finding during their EPSDT screening are identified, and the member is contacted regarding the need for follow-up. An example of the EPSDT Tracker for 2023 was provided. The tracking process listed in the tracker indicates staff utilizes the Claims lookup tool to identify all claims members received after the original EPSDT/Well Child exam to determine potential diagnosis and referral/follow-up. If no claims could be associated as a referral, the list is

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						passed to designated staff to call. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. Also, Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, page 7, indicates work is being done to create an automated tracking dashboard for documenting recent/previous calls made to members' parents and the results of those calls. *Quality Improvement Plan: Implement a system for documenting the outreach made to members and the results of that outreach as noted in Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment.*
4.3 Diagnosis and/or treatment for children.	X					
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			At least annually, Molina conducts a formal evaluation of the QI Program. Molina uses internal Quality Specialists, external survey vendors, and analysts to collect, analyze, and report on the data using manual analysis and electronic software. Evaluation of quality activities will include a description of limitations and barriers to improvements. The QI Program 2022 Annual

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Evaluation was provided but did not include the results of the Geo Access reports referenced in Section Five and the Provider Directory analysis referenced in Section 11 of the 2022 QI Work Plan. This continues to be an issue and was identified in the 2020, 2021, and 2022 EQRs. *The CAN Contract, Section 10 (D)* and *Exhibit G*, requires the QI Program Annual Evaluation to include a description of completed and ongoing QI activities, identified issues including tracking over time, trending of measures to assess performance in quality of clinical care and quality of service to members, and an analysis of demonstrated improvements and overall effectiveness of the QI program. *Corrective Action Plan: The results of all activities completed in 2022 and/or an update for the ongoing activities must be added to the 2022 QI Program Annual Evaluation to meet the requirements in the CAN Contract, Section 10, and Exhibit G. Develop a process to review the QI Program Annual Evaluation to ensure all activities are included.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

QUALITY IMPROVEMENT—CHIP

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 2023 QI Program Description describes the QI Program Molina has implemented for the CHIP population. There were six appendices listed in the table of contents. However, those appendices are not included in the document. Also, the section titled "Implementing a Credentialing Program" indicates Molina maintains a comprehensive and detailed credentialing program. DOM has instituted a centralized credentialing process for all Medicaid providers. Therefore, the information listed in this section of the QI Program Description does not reflect Molina's responsibilities related to credentialing and recredentialing their network providers. *Recommendation: Add the appendices to the 2023 QI Program Description and update or remove the section that describes the credentialing program.*
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Molina addresses healthcare disparities through the Health Equity and Cultural Competency Program.
3. The scope of the QI program includes investigation of trends noted through	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
utilization data collection and 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, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				The QI Work Plan is developed annually after the completion of the QI Program Annual Evaluation from the previous year. The 2022 and 2023 QI Work Plans were received. Both work plans included the yearly QI activities, the individual responsible for each task, target dates, updates, and any previously identified issues. Molina's 2023 QI Work Plan includes the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. Constellation Quality Health had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted as year one. *Recommendation: Label the columns for the applicable year in the 2023 QI Work Plan (example: Y1= 2023, Y2=2024 etc.).* Also, there were several errors or missing information in the 2023 QI Work Plan. Those included:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• In the Program Operations section, the timeline for the activity related to maintaining the committee minutes is noted as "All Year." However, the goal is noted as "Met" for Y1. • The Availability of Practitioners section (PDF pages 16 – 28) and the Accessibility of Services section (PDF pages 29 – 30) lacked benchmark goals for each activity. • The Results/Timeframe/Date the Goal was Met or Not Met sections throughout this document contained scores (Met, Partially Met, Not Met) with no indications which measure those scores apply. • The Action Plan for the Objective, "Maintain an adequate number of specialists across geographic area……" (PDF page 25) incorrectly notes PCPs instead of specialists. • The Action Plan for the Objective "Maintain an adequate number of network behavioral health practitioners……" (PDF page 27) incorrectly notes primary care practitioners instead of behavioral health practitioners. • The Results table for the Appointment Availability Survey (PDF page 31) lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. However, Policy MHMS-QI-006, Access to Care lists this timeframe as seven calendar days.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The results table for the behavioral health providers (PDF page 35) lists the goals for urgent care as within 48 hours and routine care within 10 business days. Molina's Policy MHMS-QI-006, Access to Care notes those timeframes as 24 hours for urgent care and 21 days for routine care. • In the Continuity and Coordination of Medical Care section (PDF page 53) the timeframe listed for notifying members of the termination of a PCP is incorrectly listed as within 30 days of notification. Molina's Procedure MHMS-PC-09, MHMS Provider Termination Process notes this timeframe as 15 days. *Corrective Action Plan: Correct the errors identified in the 2023 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					The Quality Improvement and Health Equity Transformation Committee is the committee responsible for the implementation and ongoing monitoring of the QI Program. This committee as well as various subcommittees make recommendations for policy decisions, analyzes, and evaluates the progress and results of all QI activities, institutes any needed actions, and ensures follow up.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.	X					
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					A review of the committee minutes for the Quality Improvement and Health Equity Transformation Committee demonstrated the committee met the requirements for meeting frequency and for a quorum. During the onsite, it was noted that the Quality Improvement and Health Equity Transformation Committee was previously known as the Quality Improvement Committee. However, the committee meeting minutes were not updated to reflect the new name. *Recommendation: Update the Quality Improvement and Health Equity Transformation Committee meeting minutes to reflect the new name for this committee.*
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					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the performance measure rates. There were several

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						rates that had a greater than 10 percentage point decline. *Recommendation: Monitor rates and implement interventions to improve the rates.*
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 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. One PIP had a decrease in the indicator rates. *Recommendation: Asses the current interventions to determine if changes are needed.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.		X				Molina adopts and disseminates clinical practice and preventive health guidelines that focus on key topics relevant to the health plan's members. 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. Constellation Quality Health questioned Molina during the onsite regarding which of the "two important aspects" of the clinical practice guidelines was being measured and requested a copy of the annual report. Neither was provided. *Corrective Action Plan: On an annual basis, measure provider performance against at least two of the clinical guidelines as required by the MS CHIP Contract, Section 9 (M) and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.*
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				Molina provides coverage for all Well-Baby and Well-Child services and educates members and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers regarding the services and resources available. Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provides an overview of Molina's process for monitoring and reporting compliance with the Well-Baby/Well-Child program. This policy indicates that members who receive an abnormal finding during their Well-Baby-Well-Child screening are identified, and the member contacted regarding the need for follow-up. An example of the Well-Baby/Well-Child Tracker for 2023 was provided. The tracking process listed in the tracker indicates staff utilizes the Claims lookup tool to identify all claims members received after the original Well Child exam to determine potential diagnosis and referral/follow-up. If no claims could be associated as a referral, the list is passed to designated staff to call. The tracker demonstrated a claims analysis was conducted, but there was no documentation that calls were made or that letters were sent to the members. Also, Policy MHMS-QI-005, Well-Baby/Well-Child Services and Immunization Services, page 7, indicates work is being done to create an automated tracking dashboard for documenting recent/previous calls made to members' parents and the results of those calls.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Implement a system for documenting the outreach made to members with an abnormal finding on a Well-Baby/Well-Child exam to ensure a follow-up referral and treatment is received as required by the CHIP Contract, Section 5 (D) and Policy MHMS-QI-005, Well-Baby/Well-Child Services and Immunization Services.
4.3 Diagnosis and/or treatment for children.	X					
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			At least annually, Molina conducts a formal evaluation of the QI Program. Molina uses internal Quality Specialists, external survey vendors, and analysts to collect, analyze, and report on the data using manual analysis and electronic software. Evaluation of quality activities will include a description of limitations and barriers to improvements. The QI Program 2022 Annual Evaluation was provided but did not include the results of the Geo Access reports referenced in Section 5 and the Provider Directory analysis referenced in Section 11 of the 2022 QI Work Plan. This continues to be an issue and was identified in the 2020, 2021, and 2022 EQRs. *The CHIP Contract, Section 9 (D)* and *Exhibit F,* requires the QI Program Annual Evaluation to include a description of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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. *Corrective Action Plan: The results of all activities completed in 2022 and/or an update for the ongoing activities must be added to the 2022 QI Program Annual Evaluation 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					

E. Utilization Management

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

The Health Care Services Program Description and various policies describe Molina's CAN and CHIP Utilization Management (UM) Program scope, lines of responsibility, and processes for physical and behavioral health services. The Pharmacy Program Description outlines the Pharmacy Program that is offered through the Molina Healthcare Pharmacy Services Department.

The Health Care Services Program is structured within Molina's CAN and CHIP UM Program. The Chief Medical Officer has authority and responsibility for the Health Care Services Program's development and implementation, including conducting Level II Reviews, serving as the chair of various committees, implementing clinical practice guidelines, etc. The Behavioral Health Director provides clinical oversight of the behavioral health program and various role assignments entail providing education to network providers, reviewing quality of care issues, conducting second level reviews, etc. Lastly, the Pharmacy Director oversees the staff pharmacists and technicians and ensures effective operational execution of the Pharmacy Program.

There are several committees, such as the Quality Improvement and Health Equity Transformation Committee and Health Care Services Committee (HCSC), that provide committee oversight and the committees' responsibilities entail but are not limited to conducting yearly clinical policy reviews, reviewing trend reports, and providing recommendations based upon findings to ensure program effectiveness. Also, an annual review of the Health Care Services Program is developed and presented to the Quality Improvement and Health Equity Transformation Committee for review.

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 UM determinations are made by qualified professionals who are licensed within their respective professions. The UM reviewers use several clinical criteria/guidelines, such as Milliman Care Guidelines (MCG), State guidelines, American Society of Addiction Medicine (ASAM), Hayes Technology Assessments, etc. to make clinical determinations. Clinical guidelines are reviewed and approved annually.

Constellation Quality Health's review of a sample of CAN and CHIP UM approval files reflected that the UM determinations were consistent in use of clinical guidelines, made by appropriate licensed healthcare professionals, and communicated according to contractual requirements.

Review of the sample CAN and CHIP UM denial files indicated that Molina provided an overview of the rationale for the adverse benefit determination and the process for filing an appeal. However, the CAN and CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except when an expedited appeal is requested. This is no longer a contractual requirement. Molina acknowledged awareness and responded that they have updated the Adverse Benefit Determination letters and removed the requirement that a written appeal request must be submitted after a verbal appeal request is initiated.

Overall, the CAN and CHIP sample approval and denial files were completed in a timely manner. In review of the Health Care Services Program Annual Evaluation, Molina's program goal of 98% for timeliness of service authorization completion was met or exceeded each month.

The Health Care Services Program Description and Policy HCS-325.01, Service Authorization, indicate Molina follows state requirements for timeframes for determinations, notification, and processing extensions for service authorizations. However, in describing the extension process, neither the Health Care Services Program Description nor Policy HCS-325.01, Service Authorization, address the requirement for Molina to request an extension from DOM as required by contractual requirements.

Molina's Healthcare Pharmacy Services Department is responsible for administering and monitoring pharmacy benefit services for members. The CAN and CHIP Provider Manuals, CAN and CHIP Member Handbooks, websites, and various policies provide an overview of the Preferred Drug List (PDL), which is available in electronic and downloadable format. However, the links provided in the CHIP Provider Manual and CHIP Member Handbook to access the PDL resulted in error message indicating, "Service Unavailable-DNS Failure."

Appeals

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

Processes for filing and managing appeals are outlined in Molina's policies, the CAN and CHIP Member Handbooks, the CAN Provider Manual, and on Molina's website. Appeal terminology is defined and options for filing appeals verbally or in writing are provided. Policy MHMS-MRT-03, Expedited Member Appeals, addresses the timeframes associated with appeal acknowledgement and resolution. The process for requesting expedited resolution of an appeal is explained to members. Members are informed of their right to file a grievance if they disagree with the request to extend the timeframe for resolution of an appeal.

During the previous EQR, Constellation Quality Health identified issues with Policy MHMS-MRT-02, Standard Member Appeals, applicable to both the CAN and CHIP programs. The previous and current findings are described in *Table 54: Previous Appeals CAP Items*.

Table 54: Previous Appeals CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;	Procedures for filing an appeal are described in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Information regarding the process for filing an appeal was also found in the CAN Member Handbook, the CAN Provider Manual, and on Molina's website. These documents incorrectly indicate that a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification template. Also, Policy MHMS-MRT-02, Standard Member Appeals, documents information that must be included in appeal acknowledgement letters. However, the CAN standard appeal acknowledgement letter template does not include the statement offering a State Fair Hearing or the offering of the one-page "Grievance/Appeal Form" as mentioned in the policy. *Corrective Action: Remove the requirement that a member must follow a verbal appeal request with a written request from Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, CAN Provider Manual, the appeal request forms, and on Molina's website. Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.*	Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, CAN Provider Manual, the appeal request forms, and Molina's website correctly indicate that a verbal appeal does not need to be followed by a signed written appeal.
Molina's Response: 2.2.2023—Molina has removed 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. See documents uploaded to the portal:		

Standard	EQR Comments	2023 EQR Findings
CAP #9 MHMS-MRT-02 Standard Member Appeals Policy and Procedure CHIP and MSCAN Member Handbook Corrections – Appeals CHIP and MSCAN Provider Handbook Corrections – Appeals CAP#9- Pre-ServiceAppealRequestForm-CHIP Additionally, see Sample ABD Letter uploaded to the portal. 7.18.2023—Molina has made these corrections to the MSCAN Provider Manual. See attached MSCAN Provider Manual document. Also see attached- Standard Member appeal acknowledgement letter template.		
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: 1.2 The procedure for filing an appeal;	Procedures for filing an appeal are described in Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals. Information regarding the process for filing an appeal was also found in the CHIP Member Handbook, the CHIP Provider Manual, and on Molina's website. These documents incorrectly indicate a verbal appeal must be followed by a signed written appeal. This incorrect information is also included in several appeal request forms on the website and attached to the Adverse Benefit Notification letter. Also, Policy MHMS-MRT-02, Standard Member Appeals, includes information that must be included in appeal acknowledgement letters. However, the CHIP standard appeal acknowledgement letter template does not include the statement of offering the one-page "Grievance/Appeal Form" as mentioned in the policy. Also, this policy mentions the offering of a State Fair Hearing as being included in the acknowledgement letter. However, a State Fair Hearing is not applicable for CHIP. *Corrective Action: Remove the requirement that a member must follow-up a verbal request for an appeal with a written request from Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, CHIP Provider Manual, the appeal request forms, and on Molina's website. Correct Policy MHMS-MRT-02, Standard Member Appeals, or update the acknowledgement letter to include all the items detailed in Policy MHMS-MRT-02, Standard Member Appeals.*	Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, CAN Provider Manual, the appeal request forms, and Molina's website correctly indicate that a verbal appeal does not need to be followed by a signed written appeal.

Standard	EQR Comments	2023 EQR Findings
Molina's Response: 2.2.2023—Molina has removed 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. Additionally, see Sample ABD Letter uploaded to the portal. 7.18.2023—Molina has made these corrections to the MSCAN Provider Manual. See attached MSCAN Provider Manual document. Also see attached- Standard Member appeal acknowledgement letter template.		

In Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the "Procedure" section indicates that notification is given to the Division of the need for additional information and when the extension of an appeal is in the member's best interest. During the onsite, it was shared that this is not done for standard appeals. Molina explained that their process for contacting the appellant is to send two letters and to make two phone calls to the member or the provider when additional information is needed before closing the appeal. Seven CAN and five CHIP appeal files were extended based on the lack of receipt of a signed Authorized Representative Form and subsequently closed with no indication of notification to the Division found.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

Molina's Integrated Care Management Program offers care coordination and disease management services to Mississippi members.

There are various resources that aid in identifying potential members for the Care Management Program, such as community referrals, self-referrals, claims data, member risk assessments, and practitioner referrals. Once a member is referred for case management services, a health risk assessment is completed within 30 days. Policy HCS-161.01, Health Risk Assessment Addendum, provides an overview of the health risk assessment process and applies to both CAN and CHIP. However, the policy does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information.

Once the Health Risk Assessment is completed, the Individualized Care Plan is developed with the member based upon the member's needs and preferences. Care Management activities are provided based upon the member's identified needs and risk level stratification. Members with identified complex needs or those who have experienced a critical event receive more extensive services in addition to the services offered to members stratified into the low and medium risk levels. Specialized program services are provided for members with specific needs.

Molina also provides transition of care services for new and existing members that are transitioning from various care settings, such as inpatient treatment and long-term care settings. The Interdisciplinary Transitional Care Team ensures continuity of care and a successful transition for members within their home or community settings. During onsite discussion, Molina shared that the health plan attempts to decrease readmissions through member education, medication reconciliation, follow up, and Community Connectors that aid in addressing any social needs for the members.

As noted in *Figure 7: Utilization Management Findings*, 96% of the Utilization Management standards were scored as "Met" for CAN and CHIP.

Figure 7: Utilization Management Findings

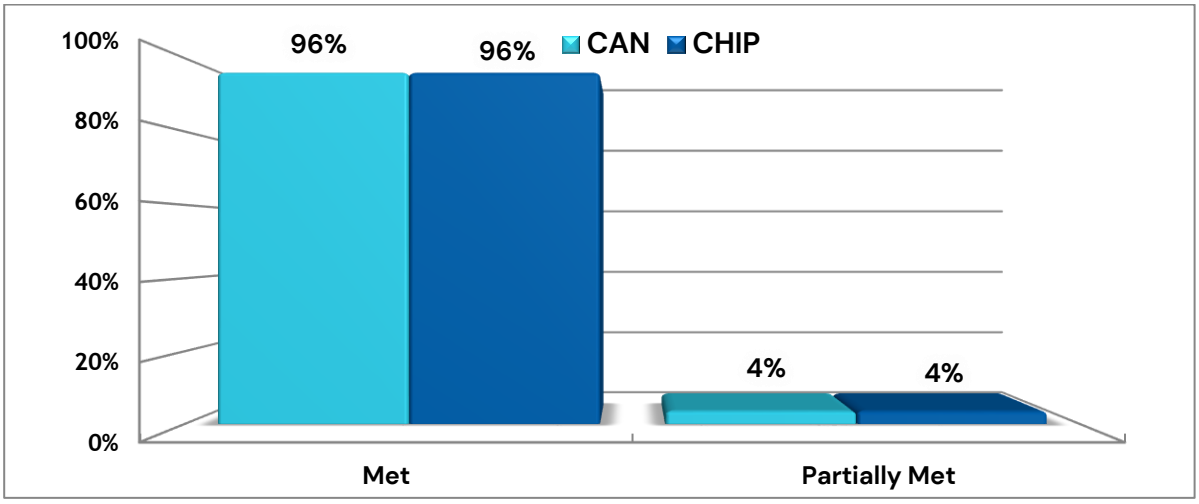


Table 55: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Molina's program goal of 98% for timeliness of service authorization completion was met or exceeded each month.		✓	
Approval files reflected that the approval decisions were communicated in a timely manner to the member and provider.		✓	
Molina's Community Connectors assist any social needs for members, such as providing transportation, appointment support, addressing housing needs, and linkage to food assistance, etc.			✓
All of the appeal files reviewed for the 2023 EQR were addressed timely.		✓	

Table 56: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The CAN and CHIP Health Care Services Program Description and Policy HCS-325.01, Service Authorization, indicate Molina follows state requirements for processing extensions for service authorizations. However, in describing the extension process, neither the Health Care Services Program Description nor the policy address the requirement for Molina to request an extension from DOM as required by contractual requirements.	Recommendation: Update the Health Care Services Program Description and Policy HCS-325.01 to indicate that for plan-requested extensions, Molina will request approval from DOM as required by the *CAN Contract, Section 5 (J) (6)* and *CHIP Contract, Section 5 (I) (1).*	✓		
The CAN and CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. This is no longer a contractual requirement.	Corrective Action: Update the CAN and CHIP Adverse Benefit Determination letters to remove the requirement that a member must follow a verbal appeal request with a written request	✓		
Links provided in the CHIP Provider Manual and CHIP Member Handbook to access the PDL result in an error message indicating, "Service Unavailable-DNS Failure."	Recommendation: Ensure the embedded links for the PDL in the CHIP Provider Manual and CHIP Member Handbook are functional.	✓		
Policy HCS-161.01, Health Risk Assessment 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 161.01 Health Risk Assessment Addendum.	✓		
In Policy MHMS–MRT–02, Standard Member Appeals, item #20 in the Procedure section indicates that notification is given to the Division of the need for additional information and when the extension of an appeal is in the Member's [best] interest. However, seven CAN and five CHIP files were extended based on the lack of the receipt of a signed Authorized Representative Form, and subsequently closed with no indication of notification to the Division.	Corrective Action: Ensure processes are in place to demonstrate compliance with Policy MHMS–MRT–02, Standard Member Appeals, and that the appropriate notification is provided to the Division when appeal extensions are needed.	✓		

UTILIZATION MANAGEMENT—CAN

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 and various policies describes Molina's Utilization Management (UM) program scope, lines of responsibility, and process for behavioral health and physical health services. The Pharmacy Program Description outlines the pharmacy program for Mississippi members that is offered through the Molina Healthcare Pharmacy Services Department.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					Molina's Chief Medical Officer has authority for the development and implementation of the Health Care Services program. There are also several committees, such as the Quality Improvement and Health Equity Transformation Committee and Health Care Services Committee, that provide committee oversight that entails but not limited to conducting yearly clinical policy reviews, reviewing trend reports, and providing recommendations based upon findings to ensure program effectiveness as outlined in the Health Care Services Program Description.

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					As described in the Health Care Services Program Description and Policy HCS-365.01, Clinical Criteria for UM Decision Making, UM reviewers use several clinical criteria and guidelines, such as Milliman Care Guidelines (MCG), State guidelines, American Society of Addiction Medicine (ASAM), Hayes Technology Assessments, etc. when making clinical determinations. The clinical guidelines are reviewed and approved annually.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					The Health Care Services Program Description and Policy HCS-325.01, Service Authorization, indicate Molina follows state requirements resolution timeframes, notification, and processing extensions for service authorizations. However, in describing the extension process, neither the Health Care Services Program Description nor the policy address the requirement that Molina request approval of extension from DOM as required by contractual regulations. *Recommendation: Update the Health Care Services Program Description and Policy HCS-325.01 to indicate that for plan-requested extensions, Molina will request approval from DOM as required by the CAN Contract, Section 5 (J) (6) and CHIP Contract, Section 5 (I) (1).*
1.5 Consideration of new technology;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					As described in the Health Care Services Program Description, the Chief Medical Officer provides oversight of the Health Care Services Program and responsibilities, including conducting Level II Reviews, serving as chair of various committees, implementing clinical practice guidelines, etc. The Behavioral Health Director provides clinical oversight of the behavioral health program and the role assignment entails providing education with network providers, reviewing quality of care issues, conducting second level reviews, etc. Lastly, the Pharmacy Director oversee the staff pharmacists and technicians and ensures effective operational execution of the pharmacy program as outlined in the Pharmacy Program Description.
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 § 4*						
1. Utilization management standards/criteria are in place for	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
determining medical necessity for all covered benefit situations.						
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation's review of a sample of UM approval files reflected that the UM determinations were consistent with using clinical guidelines, such as Milliman Care Guidelines (MCG), relevant clinical information, and individual member circumstances, 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					
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					Molina's Pharmacy Services Department is responsible for administering and monitoring pharmacy benefit services for members. Over-the-counter medications are provided at no cost to members. Additionally, the Provider Manual, Member Handbook, website, and various policies provide an overview of the Preferred Drug List,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						which are available in electronic and downloadable format.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Molina's Health Care Services Program Description and Policy HCS-325.01, Service Authorization Procedures, indicate UM decisions are conducted by licensed qualified professionals. Review of a sample of approval files reflected that licensed healthcare professionals made the UM determinations.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of a sample of approval files demonstrated that the approval decisions were communicated according to contractual requirements for standard and expedited requests. Also, in review of the Health Care Services Evaluation, Molina's goal of 98% for timeliness of service authorization completion was met or exceeded each month.
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					The review of a sample of UM denial files reflected that additional clinical information was requested appropriately 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				Review of a sample of denial decisions indicated that Molina promptly communicated and provided an overview of the rationale for the adverse benefit determination and the process for filing an appeal. However, the CAN Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except in instances of an expedited appeal request. This is no longer a contractual requirement. Molina acknowledged awareness and responded that they have updated the Adverse Benefit Determination letters and removed the requirement of a written request after a verbal appeal request is initiated. *Corrective Action Plan: Remove the requirement that a member must follow a verbal appeal request*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						with a written request from the Adverse Benefit Determination letters.
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, the CAN Member Handbook, and CAN Provider Manual describe processes for handling member appeals of Adverse Benefit Determinations.
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					Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, CAN Provider Manual, and website provide options for the verbal or written filing of an appeal.
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					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy MHMS-MRT-03, Expedited Member Appeals, includes the process followed when a member, provider, or authorized representative requests an expedited appeal.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				In Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the "Procedure" section indicates notification is given to the Division of the need for additional information and when the extension of an appeal is in the Member's [best] interest. However, seven CAN files were extended based on the lack of receipt of a signed Authorized Representative Form and subsequently closed with no indication of notification to the Division. *Corrective Action: Ensure that processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals and*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						that the appropriate notification is provided to the Division when appeal extensions are needed.
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)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Molina's Health Care Services Program Description and the Population Health Management Strategy describe Molina's Integrated Care Management Program that offers care coordination and disease management services to Mississippi members.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					There are various resources that aid in identifying potential members for the care management program, such as community referrals, self-referrals, claims data, member risk assessments, and practitioner referrals, as described in the Healthcare Services Program Description and Policy MHMS-HCS-CM-642, Coordination of Care and Referral Procedures for Behavioral Health Services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 described in Policy HCS -161.01, Health Risk Assessment Addendum and Policy HCS-154.01, Individualized Care Plan Development Addendum, the Individualized Care Plan is completed within 30 days of the Health Risk Assessment that identifies goals, barriers, personal preferences, interventions, etc. The Individualized Care Plan is developed with the member, the member's caregiver, and any additional necessary clinical and community

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						personnel based upon the member's needs and preferences.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
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;						The scheduling and referral process is addressed in Policy HCS-154.01, Individualized Care Plan Development.
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						During onsite discussion, Molina shared that the health plan receives a daily census report of members that are receiving inpatient treatment and attempt to initiate contact with the member while the member is receiving inpatient services. Once the member is discharged, contact is initiated with the member and member's provider within 48 hours to begin the coordination of care process.
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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	X					The Health Care Services Program Description and Policy HCS1-151.01, Risk Stratification and Member Management Procedure, indicate members with identified complex needs or who have experienced a critical event receive more extensive services, in addition to the services offered to members

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
by the contract including high risk perinatal and infant services.						stratified into the low and medium risk levels. There are also specialized programs offered for members with specific needs, such as the High-Risk Obstetrical Care Management Program that offers services to high-risk pregnancy members.
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					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Molina's Transition of Care program 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 described in Policy HCS-CM-168, Molina Transitions Care Procedure and the Health Care Services Program Description. An annual review is conducted of the transitional care program. During the annual review, at least four opportunities to improve the coordination of medical care are identified, as explained in Policy MHMS-QI-004, Monitoring Continuity of Care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					As described in the Health Care Services Program Description and various policies, Molina's 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. During the onsite discussion, Molina shared that the health plan attempts to decrease readmissions through member education, medication reconciliation, and follow up. Also, members are linked to Community Connectors that assist with any social needs for members, such as providing transportation, appointment support, addressing housing needs, linkage to food assistance, etc.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2023 Health Care Services Program Evaluation was approved by the Quality Improvement Committee on June 27, 2023.

UTILIZATION MANAGEMENT—CHIP

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					
1.1 Structure of the program;	X					The Health Care Services program is structured within the Utilization Management (UM) program. The Chief Medical Officer has authority and responsibility for the Health Care Services program's development and implementation, as stated in the Health Care Services Program Description.
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 use several evidenced-based clinical guidelines, such as MCG, State guidelines, etc. when making UM determinations, as described in the Health Care Services Program Description and Policy HCS-365.01, Clinical Criteria for UM Decision Making.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					The Health Care Services Program Description and Policy HCS-325.01, Service Authorization, indicate Molina follows state regulations for resolution timeframes, notification, and processing extensions of service authorizations. However, in describing the extension process, neither the Health Care Services Program Description nor the policy address the requirement for Molina to request an extension from DOM as required by contract regulations. *Recommendation: Update the Health Care Services Program Description and Policy HCS-325.01 to indicate that for plan-requested extensions, Molina will request approval from DOM as required by the CAN Contract, Section 5 (J) (6) and CHIP Contract, Section 5 (I) (1).*
1.5 Consideration of new technology;	X					
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					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					As described in Molina's Health Care Services Program Description, the Chief Medical Officer provides oversight of the Health Care Services Program. The Behavioral Health Director and Pharmacy Director have clinical oversight with their respective programs. The responsibilities of the Medical Directors include conducting Level II Reviews, reviewing clinical practice guidelines, clinical consultations, 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 § 4*						
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					Review of a sample of approval files reflected that determinations are consistent with using clinical guidelines and evidenced based clinical criteria as

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						outlined 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					
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					Molina's CHIP Provider Manual, CHIP Member Handbook, website, and various policies provide an overview of the PDL. However, the links provided in the CHIP Provider Manual and CHIP Member Handbook to access the PDL listing result in error message indicating, "Service Unavailable-DNS Failure." *Recommendation: Ensure the embedded links for the PDL list in the CHIP Provider Manual and CHIP Member Handbook are functional.*
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy MHMS-HCS-UM-384, Post Service Review Emergency Care Visits Policy and Procedure, Policy HCS-302, Post Stabilization Services, and the Member Handbook provide a detailed overview of the emergency care and post stabilization requirements.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Constellation Quality Health's review of a sample of approval files reflected that the UM determinations were made by appropriate licensed healthcare professionals, as outlined in the Health Care Services Program Description and Policy HCS-325.01, Service Authorization Procedure.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Constellation Quality Health's review of a sample of UM denial files reflected that an appropriate physician specialist made the adverse benefit determinations.
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				The review of a sample of denial decisions indicated that Molina promptly communicated and provided an overview of the rationale for the determination and process for filing an appeal. However, the CHIP Adverse Benefit Determination letters incorrectly indicated that a verbal appeal must be followed by a signed written appeal, except when an expedited appeal is requested. This is no longer a contractual requirement. Molina acknowledged awareness and responded that they have updated the Adverse Benefit Determination letters and removed the requirement for a written request after a verbal request is initiated. *Corrective Action Plan: Remove the requirement that a member must follow a verbal appeal request with a written request from the Adverse Benefit Determination letters.*
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	X					Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, and the CHIP Provider

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:						Manual, describe processes for handling member appeals of adverse benefit determinations.
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					Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, the CHIP Provider Manual, and website provide options for the verbal or written filing of an appeal.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal;	X					Policy MHMS-MRT-03, Expedited Member Appeals, includes the process followed when a member, provider, or authorized representative requests an expedited appeal.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				In Policy MHMS-MRT-02, Standard Member Appeals, item #20 in the "Procedure" section includes that notification is given to the Division of the need for additional information and when the extension of an appeal is in the Member's [best] interest. However, five CHIP files were extended based on the lack of receipt of a signed Authorized Representative Form and subsequently closed with no indication of notification to the Division. *Corrective Action: Ensure processes are in place to demonstrate compliance with Policy MHMS-MRT-02, Standard Member Appeals, and that the appropriate notification is provided to the Division when appeal extensions are needed.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Molina's Integrated Care Management Program offers care coordination and disease management services to members as described in the Health Care Services Program Description and Population Health Management Strategy Document.
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					Policy HCS-161.01, Health Risk Assessment Procedure, and Policy HCS-161.01, Health Risk Assessment Addendum, provide an overview of the health risk assessment process. However, Policy HCS-161.01, Health Risk Assessment Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information. During onsite discussion, Molina shared that stated the policy references CHIP and submitted a redlined version to reflect the CHIP reference. *Recommendation: Include a reference to the CHIP Contract, Section 8 (A) in the Source of Decision for Policy 161.01 Health Risk Assessment Addendum.*
4. The detailed health risk assessment includes all required elements:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					Policy HCS-154.01, Individualized Care Plan Development Addendum, indicates the individualized care plan is completed within 30 days of the health risk assessment that identifies goals, barriers, personal preferences, interventions, etc. The individualized care plan is developed with the member, the member's caregiver, and any additional necessary clinical and community personnel based upon the member's needs and preferences.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive,	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
coordinated care for all members through the following minimum functions:						
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;						The appointment scheduling and referral process is outlined in Policy HCS-154.01, Individualized Care Plan Development Addendum.
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;						The discharge planning process is outlined in Policy 368.01, Discharge Planning Procedures. Molina shared during onsite discussion that once the member is discharged, contact is initiated with the member and member's provider within 48 hours to begin the coordination of care process.

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.	X					The Health Care Services Program Description and Policy HCS1-151.01, Risk Stratification and Member Management Procedure, state members with identified complex needs or who have experienced a critical event receive more extensive services, in addition to the services offered to members stratified into the low and medium risk levels. There are also specialized programs offered for members with specific needs, such as the High-Risk Obstetrical Care Management Program that offers services to high-risk pregnancy members.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The Health Care Services Program Description and various policies outline Molina's Transition of Care Program approach to managing and coordinating services for members in various care settings to ensure a proper transition into their designated community-based settings. During the onsite discussion, Molina shared that the health plan receives a daily census report of members that are receiving inpatient treatment, and contact is initiated with the member while the member is receiving inpatient services. Also, once the member is discharged, contact is initiated with the member and member's provider within 48 hours to begin the coordination of care process.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs, and implements the transition of care plan, and provides oversight to the transition process.	X					
4. The CCO meets other Transition of Care Requirements.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2023 Health Care Services Program Evaluation was approved by the Quality Improvement Committee on June 27, 2023.

F. Delegation

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

Molina delegates to subcontractors and/or vendors to perform some health plan activities. Those delegated services include vision services, non-emergent transportation, care management, utilization management, dental services, and pharmacy services.

For this review, Molina reported six delegation agreements, as shown in *Table 57: Delegated Entities and Services*.

Table 57: Delegated Entities and Services

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

During this EQR period, Molina also had several entities conducting credentialing and recredentialing services. However, Molina is no longer responsible for credentialing and recredentialing since the implementation of DOM's centralized credentialing process for all Medicaid providers.

Policy DO-1.000, Delegated Oversight Program, describes processes for oversight and monitoring of delegated entities. Per policy, Molina retains the responsibility for the quality of services delivered to its members and providers and ensures the delegates comply with regulatory requirements. Pre-delegation and annual delegation oversight audits are conducted, and appropriate action is taken for deficient or non-compliant findings. Audit findings, including performance issues and corrective actions taken, are reported to the Delegation Oversight Committee, which has the authority to approve or recommend termination of the delegation.

For this review period, Healthmap was subject to a pre-delegation audit. The results of the pre-delegation audit were provided and showed the delegate received a score of 100% and met all the requirements.

Annual audits were conducted for MTM (September 2022), March Vision (September 2022), Progeny (August 2022), and Skygen (October 2022). For deficiencies that were identified during the audits, Molina requested the delegate submit a corrective action plan.

Molina's Procedure DO -1.001, Delegation Oversight, contained an overview of the pre-delegation assessment, post-implementation and ongoing monitoring conducted as part of the oversight of a delegate. This procedure indicates a comprehensive annual delegation oversight audit is conducted by the Director of Delegation Oversight and Audit. The procedure further indicates areas subject to the audit include policies, procedures, a file review, program descriptions, work plans, evaluations, trainings, HIPAA compliance etc. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation audit report was not provided. This was an issue identified during the 2022 EQR. The table that follows provides an overview of this deficiency with Molina's response.

Table 58: 2022 Delegation CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN and 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.	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. *Corrective Action: Ensure pre-delegation assessments are conducted for all potential delegates and that documentation is maintained.*	This deficiency was not corrected. The annual delegation oversight audit of CVS/Caremark was not conducted.
Molina's 2022 Response: 2.2.2023: CVS/Caremark: The initial delegation and pre-delegation assessment of CVS/Caremark was completed with the implementation of the MSCAN program on 10/1/2018. 7/18/2023: Molina's response regarding CVS: Regarding the requested documents, we would like to clarify that our health plan codes include monthly audits of CVS/Caremark. These audits encompass various aspects such as coding reports, network adequacy reporting, and claims testing. As part of the delegation assessment process, we conduct live point of sales processing and claims review. To ensure we provide		

Standard	EQR Comments	2023 EQR Findings
you with the most accurate and relevant information, we kindly request clarification regarding the specific type of assessment or operational reporting you are seeking. Are you referring to operational reporting that is conducted monthly?		

Figure 8: Delegation Findings

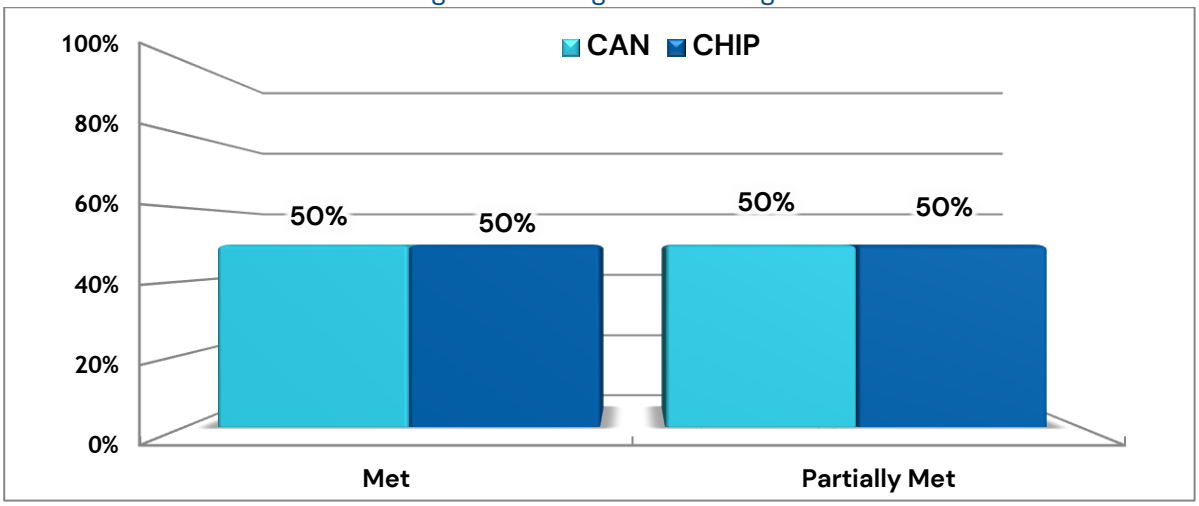


Table 59: Delegation Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The annual delegation oversight audit of CVS/Caremark was not conducted as required by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B).*	Corrective Action Plan: Conduct the annual delegation oversight audit of CVS/Caremark as required by the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B).*	✓		

DELEGATION—CAN

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					Molina delegates to subcontractors and/or vendors to perform some health plan activities. Those delegated services include vision services, non-emergent transportation, care management, utilization management, dental services, and pharmacy services. For this review, Molina reported six delegation agreements.
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			Molina's Procedure DO -1.001, Delegation Oversight, contained an overview of the pre-delegation assessment, post-implementation and ongoing monitoring conducted as part of the oversight of a delegate. This procedure indicates a comprehensive annual delegation oversight audit is conducted by the Director of Delegation Oversight and Audit. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation oversight audit report was not provided. This was an issue identified during the 2022 EQR. *Corrective Action Plan: The annual delegation oversight audit was not conducted as required by the CAN Contract, Section 15 (B).*

DELEGATION—CHIP

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					Molina delegates to subcontractors and/or vendors to perform some health plan activities. Those delegated services include vision services, non-emergent transportation, care management, utilization management, dental services, and pharmacy services. For this review, Molina reported six delegation agreements.
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			Molina's Procedure DO -1.001, Delegation Oversight contained an overview of the pre-delegation assessment, post-implementation and ongoing monitoring conducted as part of the oversight of a delegate. This procedure indicates a comprehensive annual delegation oversight audit is conducted by the Director of Delegation Oversight and Audit. Numerous monitoring reports, dashboards, and Surveillance Summaries were provided for CVS/Caremark. However, the annual delegation oversight audit report was not provided. This was an issue identified during the 2022 EQR. *Corrective Action Plan: The annual delegation oversight audit was not conducted as required by the CHIP Contract, Section 14 (B).*

Attachments

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

Attachment 1: Initial Notice and Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
3600 Glenwood Avenue, Suite 120, Raleigh, NC 27612 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

July 5, 2023

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 2023 External Quality Review (EQR) of Molina Healthcare is being initiated. The review will include the MississippiCAN Program (MSCAN) and Mississippi CHIP Program (MS CHIP) 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 November 1, 2023, through November 2, 2023, 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 August 4, 2023.

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 2023 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. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, key managers responsible for the functions, and any vacancies. For all staff required in the MSCAN Contract, Section 1 (M), indicate whether the staff are in-state, the number of FTEs, and any required credentials. For contractually required key positions, provide the percentage of time allocated to the MSCAN contract and the CHIP contract, as well as any other lines of business.

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 that support the adequacy of the provider base for the MSCAN Program, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. 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 completed Provider Network File Questionnaire

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

8. 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.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for MSCAN.

10. The Quality Improvement work plans for MSCAN for 2022 and 2023.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN Program that have been planned and completed during the previous year and any interim information available for 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.

13. 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.

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

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

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

17. Reports of medical record reviews completed in 2022 and 2023 and a copy of the tools used to complete these reviews for MSCAN providers.

18. A complete list of all MSCAN members enrolled in the Care Management Program from August 2022 through July 2023. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis that triggered the need for care management.

19. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for August 2022 to July 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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 along 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 members about the MSCAN Program.

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

24. A copy of the grievance, complaint, and appeal logs for the MSCAN Program for the months of August 2022 through July 2023.

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. Please include:
    a. Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    b. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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 specialties.

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 enrollment 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 policies 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 2022 through July 2023.

33. Provide a listing of delegates conducting activities for the MSCAN Program. 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	Delegated Functions	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management 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 2022 (MY 2022) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2022 1NCQA 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

Folder	Requested Document	Description
		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) CSV and Excel workbooks for MSCAN for MY 2022.
c.	HEDIS MY 2022 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 for MY 2022.
d.	NCQA certification for certified measure code used to generate each of the HEDIS measures	• If your CCO contracted directly with NCQA for automated source code review (ASCR) to have measure logic certified, please provide a copy of your NCQA ASCR final measure certification for the HEDIS measures reported. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each non-HEDIS measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name, and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production.
f.	Numerator positive case listings for the HEDIS and non-HEDIS measures	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. CCME will select a random sample from this list of 100 compliant records to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the site review.
g.	List of exclusions and numerator compliant records via medical record review (MRR) for the HEDIS measures	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 36 g) a list of the first 100 numerator compliant records and exclusions/valid data errors that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.

Folder	Requested Document	Description
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 MSCAN:
    a. Twenty-five medical necessity denial files for the MSCAN Program for the months of August 2022 through July 2023. Of the 25 requested files, include five behavioral health and five pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used to make the denial determination for each file.
    b. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN Program for the months of August 2022 through July 2023, including any medical information and approval criteria used to make the decision.

    Note: Appeal, Grievance, and Care Management files will be selected from the logs received with the desk materials. The CCO will then be asked 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.

Molina Healthcare of Mississippi

External Quality Review 2023 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. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, key managers responsible for the functions, and any vacancies. For all staff required in the CHIP Contract, Section 1 (L), indicate whether the staff are in-state, the number of FTEs, and any required credentials. For contractually required key positions, provide the percentage of time allocated to the CHIP contract and the MSCAN contract, as well as any other lines of business.

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 that support the adequacy of the provider base for the CHIP Program, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. 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 completed Provider Network File Questionnaire

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

8. 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.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for CHIP.

10. The Quality Improvement work plans for CHIP for 2022 and 2023.

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

12. 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 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.

13. Minutes of <u>all committee meetings</u> within the past year for committees reviewing or taking action on 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.

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

15. Any data collected for the purpose of monitoring utilization (over and under) of health care services for the CHIP Program.

16. Copies of the most recent physician profiling activities conducted to measure provider performance for the CHIP Program.

17. Reports of medical record reviews completed in 2022 and 2023 and a copy of the tools used to complete these reviews for CHIP providers.

18. A complete list of all CHIP members enrolled in the Care Management Program from August 2022 through July 2023. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis that triggered the need for care management.

19. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for August 2022 to July 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center Personnel.

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 along 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 members about the CHIP Program.

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

24. A copy of the grievance, complaint, and appeal logs for the CHIP Program for the months of August 2022 through July 2023.

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. Please include:
    a. Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    b. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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 specialties.

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 enrollment 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 policies 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 2022 through July 2023.

33. Provide a listing of delegates conducting activities for the CHIP Program. 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	Delegated Functions	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management 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 2022 (MY 2022) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2022 [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

Folder	Requested Document	Description
		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) CSV and Excel workbooks for MS CHIP for MY 2022.
c.	HEDIS MY 2022 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 for MY 2022.
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.

Folder	Requested Document	Description
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 CHIP:
    a. Twenty-five medical necessity denial files for the CHIP Program for the months of August 2022 through July 2023. Of the 25 requested files, include five behavioral health and five pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used to make the denial determination for each file.
    b. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP Program for the months of August 2022 through July 2023, including any medical information and approval criteria used to make the decision.

    Note: Appeal, Grievance, and Care Management files will be selected from the logs received with the desk materials. The CCO will then be asked 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.

Attachment 2: Materials Requested for Onsite Review

Molina Healthcare – MississippiCAN and Mississippi CHIP

External Quality Review 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copy of the annual oversight of the monitoring of CVS/Caremark.

3. Copies of the EPSDT and Well-Baby Well-Child tracking reports and follow-up activities.

4. A copy of the printed CAN Provider Directory. (The one submitted had a file size of 0 kb.)

5. A copy of any policy that addresses member notification of changes in services, benefits, etc.

6. Provider Newsletters that have been published since the desk materials were submitted

7. Provider Memo presenting CAHPS member survey results to providers for reporting year 2022/MY 2021

8. Copies of the 2023 Delegation monthly monitoring reports for the months of June, July, August, and September for the following delegates:
   - March Vision Care
   - MTM
   - Progeny
   - SKYGEN
   - CVS/ Caremark
   - HealthMap

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

Attachment 3: EQR Validation Worksheets

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

EQR Survey Validation Worksheet

Plan Name	**Molina CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION – ADULT**
Validation Period	2022
Review Performed	2023

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.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

Survey Element		Element Met / Not Met	Comments and Documentation
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

Survey Element		Element Met / Not Met	Comments and Documentation
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. Documentation: SPH Adult CAHPS Report 2022 (MY2021)
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. Documentation: SPH Adult CAHPS Report 2022 (MY2021)

Survey Element		Element Met / Not Met	Comments and Documentation
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. Documentation: SPH Adult CAHPS Report 2022 (MY2021)

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 10.8% (216 out of 2025), which is an improvement from last year's response rate of 10.2%. However, this response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Adult CAHPS Report 2022 (MY2021)

EQR Survey Validation Worksheet

Plan Name	**Molina CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2022
Review Performed	2023

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.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation: SPH Child CAHPS Report 2022 (MY2021)*

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 7.7% for 2022 (570 out of 7425), which is an improvement over the previous year's response rate of 7.3%. However, this response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
7.4	Was data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

EQR Survey Validation Worksheet

Plan Name	**Molina CHIP**
Survey Validated	**CAHPS MEMBER SATISFACTION - CHILD**
Validation Period	2022
Review Performed	2023

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.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For reporting year 2022 the response rate was 11.9%, which is a slight decline from the previous year's rate of 12.0%. This response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Child CAHPS Report 2022 (MY2021)

EQR Survey Validation Worksheet

Plan Name	**Molina CAN and CHIP**
Survey Validated	**PROVIDER SATISFACTION SURVEY**
Validation Period	2022
Review Performed	2023

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.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Of the 1,500 providers in the random sample, 75 responded, creating a response rate of 5%. This is a decrease from last year's rate of 10.9% and below the internal goal of 30%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. D*ocumentation:* SPH 2022 Provider Satisfaction Survey Report
7.4	Was data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH 2022 Provider Satisfaction Survey Report
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH 2022 Provider Satisfaction Survey Report

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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.

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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.

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Fully Compliant

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Fully Compliant

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

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:	2023
Review Performed:	11/1/2023

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.

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:	2023
Review Performed:	11/1/2023

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.

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	COLORECTAL CANCER SCREENING (COL-AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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.

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:	2023
Review Performed:	11/1/2023

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.

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	HIV VIRAL LOAD SUPPRESSION (HVL- AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	ORAL EVALUATION, DENTAL SERVICES (OEV-CH)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

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:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

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:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	HEART FAILURE ADMISSION RATE (PQI-08)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**93.33%**

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.

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare - MSCAN
Name of PM:	TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)
Reporting Year:	2023
Review Performed:	11/1/2023

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare – MSCHIP**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Not Applicable

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

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:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

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:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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.

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Not Applicable

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

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:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Not Applicable

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

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:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Not Applicable

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
Not Applicable

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCHIP**
Name of PM:	**PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2023**
Review Performed:	**11/1/2023**

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PIP Validation Worksheet

Plan Name:	Molina
Name of PIP:	BEHAVIORAL HEALTH READMISSIONS (CLINICAL)
Reporting Year:	2022
Review Performed:	2023

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Data sources are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Personnel qualifications are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for quarterly measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The latest report had Q1 2023 data with a readmission rate of 54.2% and increased from the Q4 2022 rate of 10.8%. Case management enrollment for

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		the 13 readmitted members was 100%. Recommendation: Continue to monitor BH readmission rates. Complete lessons learned report to assess key takeaways from the PIP.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	No improvement found for at least one indicator
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)
Reporting Year:	2022
Review Performed:	2023

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	MS needs to prioritize mental health patients in community settings and increase treatment.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or	MET	Indicator measures changes in health status and processes of care.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
processes of care with strong associations with improved outcomes? (1)		
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	Results showed that for the 30-day follow up, the rate improved from 34.34% to 44.73%, with a goal of 56.13%.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		The 7-day rate improved from 21.72% to 27.23% with a 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 interventions that were implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	OBESITY
Reporting Year:	2022
Review Performed:	2023

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	41.8% of school-aged children and adolescents are overweight or obese (Mississippi State Department of Health, 2018).
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measures changes in health status and processes of care.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Data sources are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Personnel qualifications are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	For BMI percentile, there was improvement from Q1 to Q2, with rates of 14.44% increasing to 18.69%, a goal of 61.31%. Counseling for nutrition improved from 7.41% to 9.86%,

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		with a goal of 52.31%. Counseling for physical activity improved from 7.1% to 9.92%, with a goal of 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 the PIP interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	Prenatal and Postpartum Care
Reporting Year:	2022
Review Performed:	2023

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	Preterm birth is the leading cause of infant death in MS
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure is clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Data sources are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported for baseline and remeasurement 1 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	Repeated measures are included in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of baseline in relation to benchmark 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 already undertaken to address barriers 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)	PARTIALLY MET	The rate of deliveries that received prenatal care within the

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		first trimester and post-partum care visits within 84 days of delivery. For prenatal visits, the rate declined from 86.19% to 84.72%, and the goal is 94.92%. For post-partum visits, the rate increased from 38.96% to 44.75%, with a goal of 74.30%. Recommendation: Continue community events and utilization of SpectraMedix value-based purchasing platform for improving patient monitoring and prenatal care rates.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Improvement was not found for both indicators. For postpartum care, the improvement appears to be related to interventions of education and programs for members for postpartum care specifically.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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	5	5
9.3	1	1
9.4	NA	NA

Project Score	74
Project Possible Score	75
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)**
Reporting Year:	2022
Review Performed:	2023

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	Mississippi is among the states with the highest COPD-related death rates in the nation.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study Aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
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	All relevant populations were included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are clearly defined and use HEDIS measures: Systemic Corticosteroid and Bronchodilators.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specified data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data was being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Personnel qualifications are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table 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 documented.
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	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
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 Q1 to Q2 2023, there was an increase from 48.65% to 60.94% for systemic corticosteroid

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		measure, with a goal of 53.43%; and an improvement from 59.46% to 79.69% for the bronchodilator measure, 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 the interventions implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	RESPIRATORY ILLNESS
Reporting Year:	2022
Review Performed:	2023

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	Asthma and lack of medication adherence to improve quality of life is a major concern in MS.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study Aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
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	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are clearly defined. Using HEDIS measures: Pharmacotherapy of COPD

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		Exacerbation and Asthma Medication Ratio.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the data sources.
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	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Personnel qualifications are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table 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 documented.
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	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	AMR for ages 5 to 64 quarterly data showed a decrease from 80.95% to 60.22% in the most recent measurements with a goal of 72.89%. Recommendation: Continue ongoing interventions to educate provider and members toward efforts to improve medication compliance.
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 not demonstrated.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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	5	5
9.3	1	1
9.4	NA	NA

Project Score	74
Project Possible Score	75
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**SICKLE CELL DISEASE**
Reporting Year:	2022
Review Performed:	2023

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	Efforts to facilitate care between settings can improve health of individuals with a chronic disease and reduce costs.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study Aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure is clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Data sources are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported 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	Repeated measures are included in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of baseline and remeasurements in relation to benchmark 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 already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The SCD member case management enrollment rate

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		declined from 6.25% to 4.9% with a goal of 15.9%. Recommendation: Continue ongoing interventions for tracking and monitoring of members that need to be enrolled in case management.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Unable to judge.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**RESPIRATORY ILLNESS – ASTHMA AMR**
Reporting Year:	2022
Review Performed:	2023

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	Childhood asthma is a major concern in MS.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
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	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are clearly defined. Using HEDIS measure: Asthma Medication Ratio.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or	MET	Indicator measures changes in health status.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
processes of care with strong associations with improved outcomes? (1)		
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the data sources.
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	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Personnel qualifications are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table 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 documented.
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	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
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	Quarterly rates showed a decline from 93.02% in Q1 2023 to 76.92% in Q2 2023. The rates are above the goal rate of 71.28%

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		Recommendation: Continue efforts to sustain case management, member education, and provider education. Consider increasing benchmark as rate declined but was still above goal rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Not applicable.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	MET	Although the indicator rate declined, the benchmark should be adjusted now that several remeasurements were above it.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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	5	5
4.2	10	10
4.3	5	5
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	79
Project Possible Score	80
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)**
Reporting Year:	2022
Review Performed:	2023

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	MS needs to prioritize mental health patients in community settings and increase treatment.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling was not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling was not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or	MET	Indicator measures changes in health status and processes of care.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
processes of care with strong associations with improved outcomes? (1)		
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	Results showed that the 30-day rate for 6–17-year-olds improved from 46.43% in Q1 2023 to 59.18% in Q2 2023. The goal is 56.13%. For the 7-day rate, the rate increased

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		from 28.6% in Q1 to 34.7% in Q2 (goal is 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 interventions that were implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	2022
Review Performed:	2023

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	MS obesity rate is 18.9% for youth and 21.9% for children, making this population at-risk for chronic issues.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study Aims are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not 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	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or	MET	Indicator measures changes in health status and processes of care.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
processes of care with strong associations with improved outcomes? (1)		
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The BMI documentation rate improved from 11.29% in Q1 to 15.23% in Q2. The goal rate is 61.31%. The nutrition counseling rate also improved from 5.68%

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		to 8.96% with a goal of 52.31%. Counseling for physical activity improved from 4.73% to 8.73% with a goal of 57.42%.
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 the PIP interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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	5	5
4.2	10	10
4.3	5	5
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	NA	NA
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**WELL-CARE/WELL-CHILD VISITS**
Reporting Year:	2022
Review Performed:	2023

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	MS has documented underutilization of preventive care for children.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Measure is administrative.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Measure is administrative.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Measure is administrative.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure is clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The 6 or more visits within the first 15 months of life). The most recent

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		rates were 59.52% in Q1 and 63.16% in Q2. The goal is 56.13%.
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 the interventions to increase preventive visits.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	MET	Above goal rate has been sustained for more than five remeasurements. The target rate should be increased based on findings.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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	NA	NA
9.3	1	1
9.4	NA	NA

Project Score	85
Project Possible Score	85
Project Rating Score	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%.*
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Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR NETWORK ADEQUACY VALIDATION WORKSHEET

Plan Name:	**Molina CAN and CHIP**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the CCO to the EQRO? **(1)**	**MET**	Data sources for appropriate timepoints were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? **(1)**	**MET**	All variables were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? **(1)**	**MET**	Missing data was addressed.
1.4 Do the CCO's data enable valid, reliable, and timely calculations of the indicators? **(1)**	**MET**	Data allowed valid and reliable calculations.
1.5 Did the CCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? **(1)**	**MET**	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the CCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? **(1)**	**MET**	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? **(1)**	**MET**	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? **(1)**	**NA**	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the CCO include appropriate calculations and sound methodology? **(5)**	**MET**	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.1 Are the methods selected by the CCO appropriate for the state? **(10)**	**MET**	Methods aligned with State standards.
2.2 Are the methods selected by the CCO appropriate to the state Medicaid and CHIP population(s)? **(10)**	**MET**	Methods aligned with populations.
2.3 Are the methods selected by the CCO adequate to generate the data needed to calculate the indicators according to the State's expectations? **(10)**	**MET**	Methods generated required data for NA assessment.

2.4 Does the CCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? **(1)**	**MET**	Provider network file questionnaire indicated appropriate provider classification.
2.5 If the CCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? **(1)**	**MET**	Sound sampling methods were applied, wherein necessary.
2.6 If the CCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? **(1)**	**MET**	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. **(1)**	**MET**	Random sampling was utilized wherein required.
2.8 Does the CCO's approach for measuring time/distance indicators match the state's expectation? **(1)**	**MET**	Approach for time/distance aligned with State requirements.
2.9 Does the CCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? **(1)**	**MET**	Ratio calculations were conducted according to State requirements.
2.10 Does the CCO's approach for determining the maximum wait time for an appointment match the state's expectation? **(1)**	**MET**	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? **(10)**	**MET**	Methods are objective and use of third-party vendors (e.g Quest Analytics) were used wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? **(10)**	**MET**	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF CCO NETWORK ADEQUACY RESULTS		
3.1 Did the CCO produce valid results? **(10)**	**MET**	Results were judged to be valid.
3.2 Did the CCO produce accurate results? **(10)**	**MET**	Results were judged to be accurate.
3.3 Did the CCO produce reliable and consistent results? **(10)**	**MET**	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the CCO accurately interpret its results? **(10)**	**MET**	Findings were interpreted and analyzed by CCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION OF AND REPORTING OF RESULTS

Step	Possible Score	Score
Step 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	NA	NA
1.9	5	5
Step 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Step 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	100	100

Project Score	99
Project Possible Score	99
Project Rating Score	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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