Constellation Quality Health

Molina Healthcare of Mississippi

2024 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 requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate the MCOs' 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 2024 External Quality Review (EQR) conducted by Constellation Quality Health (Constellation) 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 protocols developed by the Centers for Medicare & Medicaid Services (CMS) for EQRs of Medicaid MCOs. The review includes a desk review of documents; a two-day virtual onsite visit; a compliance review, validation of performance improvement projects and performance measures, validation of network adequacy, validation of member and provider satisfaction surveys; and an Information Systems Capability Assessment 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 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'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 govern and guide health plan activities and functions. Molina follows appropriate processes for policy review. Staff can access policies on a SharePoint site and are educated about new/revised policies. A Regulatory Communications Committee is being established to examine regulatory changes that will guide policy revisions and the need for new/additional policies in the future.

Review of the Organizational Chart and onsite discussion confirmed all key positions are filled and staffing is sufficient to ensure all required activities can be conducted. The Chief Financial Officer position is currently vacant and is being filled on an interim basis by the Regional Chief Financial Officer. One Medical Director position is also vacant. Both positions are expected to be filled soon.

Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against fraud, waste, and abuse (FWA) are addressed comprehensively. The Compliance Plan and related policies address the Compliance Officer's roles and responsibilities. Molina reported that the two previous Compliance Committees have been consolidated; however, the current review revealed that documents, such as the committee charter and the committee membership list, have not been updated.

Compliance training is mandatory for new employees and Board members within 30 days of their start date/appointment and then annually. The Code of Business Conduct and Ethics communicates expectations for appropriate and ethical behavior for employees, subcontractors, vendors, and others. Molina has an array of policies and procedures that address requirements for the use, creation, collection, storage, transmission, access to, and disclosure of protected health information and other sensitive member information.

Molina is operating under the requirements of the *MSCAN SFY25 Emergency Contract*, which went into effect on July 1, 2024, and includes the requirements for the Beneficiary Health Management Program, formerly known as the Pharmacy Lock-in Program.

Molina meets and exceeds claims payment percentage requirements stated in the *CAN* and *CHIP Contracts*. Molina has systems and processes in place to ensure accurate member demographic and enrollment information. Molina provided appropriate Information Systems Capability Assessment documentation and supporting documents, and adequately demonstrated their data collection and storage capabilities, processing procedures, claim data tabulation, and processing procedures. Molina demonstrated activities for supporting quality assurance and utilization management program activities and other contractual requirements via attached flowcharts and technical layouts. Molina's Disaster Recovery Plan and Business Continuity Plan are updated and tested annually.

Provider Services

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

Appropriate processes are in place for initial and ongoing provider education. The 2024 MississippiCAN Provider Manual (CAN Provider Manual) and the 2024 Children's Health Insurance Program Provider Manual (CHIP Provider Manual) are comprehensive resources for providers to operate effectively within Molina's network; however, issues related to documentation of self-referrals, and the non-exclusivity statement were identified. Molina educates providers about the standards for medical record documentation via the Provider Manuals and monitors provider compliance with the standards through medical record review audits. A related policy incorrectly indicated audit results are considered during the recredentialing process.

Molina adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) from nationally recognized, evidence-based sources. Discrepancies were noted in the frequency of guideline review across several documents. Molina's documentation indicated that the adopted guidelines are the same for CAN and CHIP; however, discrepancies were noted in the guidelines listed on the CAN and CHIP websites. Additionally, the hyperlinks to several guidelines on the CHIP website were non-functional.

Annually, Molina conducts a provider satisfaction survey. The response rate for Molina's 2023 provider satisfaction survey was 7.7%, an increase from 5% the previous year. The overall survey rating was 76.3%, which is higher than the benchmark. An overview of the results of the 2023 survey was provided to the Member and Provider Satisfaction Committee and results were reported to the Quality Improvement and Health Equity Transformation Committee.

The methods Molina uses for assessment of network adequacy are reliable. Molina's Information Systems Capability Assessment documentation indicates personnel and systems can perform the Medicaid data processing required by DOM. Policies and procedures demonstrate that sound information security practices are followed.

Molina monitors and evaluates its provider network's geographic adequacy through quarterly Geographic Access Assessment Reports and by considering member complaints about network adequacy. Appointment access standards are documented in policy, the provider manuals, and on the website. Errors were identified in the documentation of two appointment access categories and in the documentation of the overall compliance goal for behavioral health/substance use disorder providers. Molina conducts quarterly appointment access audits and monitors member complaints and satisfaction survey results related to provider access. For Molina's Q2 2024 CAN and CHIP appointment access audits, the overall successful contact rates ranged from 20% to 46.67%.

Molina has developed the Health Equity and Cultural Competency Program to ensure culturally competent care for members. Health plan policies document processes for collecting and assessing practitioner race, ethnicity, and language (REL) information, but one policy incorrectly indicated Molina requests this information for providers through the initial credentialing process. Molina compares member and practitioner REL data and analyzes member complaint data to identify any network gaps and develops action plans to address any identified gaps.

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

Constellation conducts Telephonic Provider Access Studies twice a year for each CCO. For the most recent studies for CAN and CHIP (Q2 2024), improvement was shown in the successful contact rate for CAN from the previous study (Q4 2023). For CHIP, the successful contact rate decreased from the previous rate.

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

Molina documents member rights and responsibilities in policy, the MississippiCAN (Medicaid) Member Handbook (CAN Member Handbook), the Mississippi Children's Health Insurance

Program (CHIP) Member Handbook (CHIP Member Handbook), the Provider Manuals, in member newsletters, in various mailings throughout the year, and on the CCO's website.

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 resources for members; however, issues were noted in documentation of some benefits. The Member Handbooks provide the phone number for the Member Services Contact Center which can assist members with understanding information, scheduling transportation, finding providers, and addressing grievances or appeals. The Member Handbooks include information about the 24-Hour Nurse Advice Line and functions available through the MyMolina.com member portal.

Information about preventive health programs and resources is provided in policies, Member Handbooks, newsletters, mailings, the website, and via telephone/text alerts. Health fairs, mobile/RV units, and other community events are coordinated to enhance member education. Contact Center staff are trained to inform members about available resources or recommended services.

Member materials are provided at the appropriate reading levels and in alternate languages and formats. Interpreter and translation services are available at no cost to members. Contact Center staff are trained upon hire and then quarterly. Staff use interactive scripts, which are approved by DOM prior to use and are reviewed at least annually. Molina monitors Contact Center metrics for performance trends and addresses any identified opportunities for improvement.

Information about filing and processing verbal and written grievances is provided in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN and CHIP Member Handbooks, the Provider Manuals, and on Molina's website. Grievance terminology is defined, and the process for members and authorized representatives to file grievances is documented. Grievances 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.

Molina contracts with Press Ganey to do both the child and adult member surveys for CAN and CHIP. Constellation conducted a validation of the satisfaction surveys and found the surveys met the validation requirements. The CAN adult response rate was 13.0%, which is an improvement over the previous year's response rate of 10.8%. For year over year trending, the findings showed the highest rated items to be ease of filling out forms and how well doctors communicate; the lowest rated domain areas were rating of health plan and rating of health care. The CAN child response rate was 9.2% which is an improvement over last year's response rate of 7.7%. The top two domain measures were ease of filling out forms and how well doctors communicate. The lowest rated domain measures were rating of health care and rating of health plan. For CHIP, the

response rate was 11.2%, which is a slight decline from the previous year's rate of 11.9%. For year over year trending, the highest ratings were for how well doctors communicate and ease of filling out forms; the lowest rated domains were rating of health plan and rating of health care.

Quality Improvement

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

Molina's Quality Improvement (QI) Program is a comprehensive program that focuses on ensuring members receive equitable, culturally, and linguistically appropriate healthcare and services. The 2024 Quality Improvement Program Description covers a wide range of areas for CAN and CHIP including medical, behavioral health, chemical dependency, and substance abuse care. The QI program involves a dedicated team overseeing quality improvement activities, utilizing health information systems, and collaborating with stakeholders to meet state and federal requirements. The QI Program Description, page 39, states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022.

The QI Work Plan is developed annually after the completion of the QI Program Annual Evaluation from the previous year. The 2023 and 2024 QI Work Plans were received. Molina's work plans include the ability to trend data over five years.

The Quality Improvement and Health Equity Transformation Committee is responsible for the implementation and ongoing examination of the QI Program. Through subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes and evaluates the progress and results of all quality improvement activities, institutes needed action, and ensures follow up. This committee is co-chaired by the Chief Medical Officer and the Quality Lead, with members from various leadership roles within the health plan. This committee also includes external network physicians specializing in pediatrics, internal medicine, and psychiatry. The committee meets quarterly, with the possibility of more frequent meetings or material reviews as needed.

Molina shares provider performance data through various channels including the provider report card or gaps in care report. These are comprehensive tools designed to enhance the quality of care provided to Molina members by identifying and addressing gaps in care, supporting providers with actionable data, and promoting continuous improvement in healthcare delivery.

Molina's policies MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provide an overview of Molina's role in compliance with the EPSDT and Well-Baby and Well-Child Care services program requirements. Molina conducts outreach and education to inform eligible members and providers about the programs, emphasizing the importance of preventive care and

how to access services. Molina has a tracking system to monitor member compliance with EPSDT and Well-Baby and Well-Child Care service provision. Member target lists are generated to identify and provide outreach to those due for EPSDT and Well-Baby and Well-Child Care services. These policies indicate that members who receive an abnormal finding during their screenings are identified, and the member is contacted regarding the need for follow-up. Molina provided a copy of the tracking reports that demonstrated the follow-up conducted for any abnormal finding.

Annually, Molina assesses the quality improvement initiatives and activities conducted during the year. The 2023 Quality Improvement Program Evaluation was provided with the desk materials. This evaluation included the analysis, trends, changes in those trends, and any barriers impacting the rates. The findings are reported to the appropriate QI committees and the Board of Directors.

Validation of Performance Measures

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by Molina for the CAN and CHIP populations. Performance measure validation determines the extent to which the CCO followed the specifications established for the 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 the validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2023, through December 31, 2023.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Molina's NCQA-licensed organization. Aqurate found that Molina's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS MY2023.

All relevant HEDIS performance measures for the CAN and CHIP populations for the current review year (2023) were compared to the previous year (2022) and the changes from 2022 to 2023 are reported in the Quality Improvement section of this report. The following tables highlight the CAN and CHIP HEDIS and Core Set measures found to have substantial increases or decreases in rate from 2022 to 2023. A substantial increase or decrease is a change in rate greater than 10%.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Adult BMI Assessment (ABA)	41.31%	55.60%	14.29
Appropriate Testing for Children with Pharyngitis (CWP)			
21-24 Years	62.86%	75.05%	12.19
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Statin Adherence 80% - 21-75 years (Male)	39.18%	65.93%	26.75
Statin Adherence 80% - 40-75 years (Female)	44.26%	56.79%	12.53
Statin Adherence 80% - Total	41.14%	61.63%	20.49
Hemoglobin A1c Control for Patients with Diabetes (HBD)			
Poor HbA1c Control	58.15%	45.74%	-12.41
Adequate HbA1c Control	34.06%	47.20%	13.14
Blood Pressure Control for Patients with Diabetes (BPD)	47.45%	62.04%	14.59
Statin Therapy for Patients with Diabetes (SPD)			
Statin Adherence 80%	38.46%	60.81%	22.35
Follow-Up Care for Children Prescribed ADHD Medication (ADD) ◊			
Initiation Phase	36.56%	46.63%	10.07

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescents (IMA)			
Tdap/Td	71.53%	89.54%	18.01
Appropriate Treatment for Upper Respiratory Infection (URI)			
18-64 Years	50.52%	65.26%	14.74
Substantial Decrease in Rate (>10% decrease)			
Asthma Medication Ratio (AMR)			
5-11 Years	89.29%	75.53%	-13.76
Total	83.97%	73.91%	-10.06

Table 3: CAN CMS Core Set Measures with Substantial Changes in Rates

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Overall	44.40%	61.19%	16.79
Prescription for Buprenorphine	43.60%	56.16%	12.56
Substantial Decrease in Rate (>10% decrease)			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	55.68	41.63	-14.05
Total	55.61	41.55	-14.06
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	20.25%	8.94%	-11.31
Ages 65+	NA	NA	NA
Total	20.25%	8.80%	-11.45

Table 4: CHIP CMS Core Set Measures with Substantial Changes in Rates

CMS Core Set Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	10.36	67.53	57.17
Total	10.36	67.53	57.17
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	26.20%	38.21%	12.01

Validation of Performance Improvement Projects

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

For this review, Molina submitted six CAN PIPs. Topics for those PIPs included 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 *Table 5*. Details of each PIP's status and related interventions are included in the Quality Improvement section of this report.

Table 5: Performance Improvement Projects – CAN

Performance Improvement Project	Previous Validation Score	Current Validation Score
Asthma Medication Ratio	74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Pharmacotherapy Management of COPD Exacerbation	80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Prenatal and Postpartum Care	74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Sickle Cell Disease	74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Obesity	80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Molina submitted the same four CHIP 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 table that follows. Details of each project's status and related interventions are included in the Quality Improvement section of this report.

Table 6: Performance Improvement Projects – CHIP

Performance Improvement Project	Previous Validation Score	Current Validation Score
Asthma Medication Ratio	79/80= 99% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Obesity	80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Well Care/Well Child	85/85=100% High Confidence in Reported Results	79/80= 99% High Confidence in Reported Results

Utilization Management

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

The Utilization Management (UM) program is structured within the Healthcare Services Program . The Health Care Services Program Description and various policies describe the UM program's scope, lines of responsibility, and processes for physical and behavioral health services.

The Pharmacy Program Description provides information about the preferred drug list, the pharmacy benefit manager, timeframes for pharmacy prior authorizations, and the pharmaceutical services offered through the Molina Healthcare Pharmacy Services Department. Gainwell is the health plan's pharmacy benefit manager. The Pharmacy Services Department works to ensure that members have access to all medically necessary prescription drugs and that utilization is cost-effective and safe. This team creates, operates, and monitors the pharmacy benefit program following all federal and state laws.

The evaluation of approval and denial files reflected consistent decision-making using approved criteria according to an established hierarchy. Appropriate professionals made utilization determinations within the required timeframes. Approval notices containing the required information were sent to providers. Adverse Benefit Determination notices were written in language appropriate for a layperson to comprehend and included instructions for requesting an appeal.

Processes for filing and managing standard and expedited appeals are outlined in policies, the Member Handbooks, the Provider Manuals, and on Molina's website. An appeal is defined appropriately as a request to reconsider an adverse benefit determination. Options for filing verbally or in writing, with associated acknowledgement and resolution timeframes, are provided in provider and member materials. 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. Of the appeal sample files reviewed for the 2024 EQR, all were addressed in a timely manner. During the onsite, the number of CAN and CHIP appeal files closed due to the lack of receipt of a signed written consent form was discussed. Constellation offered a recommendation that Molina include information in the Member Handbooks about consenting for a representative to file appeals and grievances on the member's behalf.

Molina's Integrated Care Management Program offers care coordination, transitional care, and disease management programs. Members are referred for care management services through various resources and are stratified to an appropriate risk level at enrollment.

Once a member is identified as high or medium risk level, a health risk assessment is conducted, and an Individualized Care Plan is developed to address the member's identified needs. A Molina policy described the treatment plan development process that applies to both CAN and CHIP; however, it does not reference the *CHIP Contract*. Once the treatment plan is developed, care management activities are provided to address members' needs such as behavioral health care management, integrated care management, transitional care management, etc.

Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. For this review, Molina reported eight delegation agreements for CAN and CHIP.

Before delegating services, Molina conducts a pre-delegation assessment of the third-party entity's understanding, staff credentials, compliance with standards, policies, procedures, and other necessary areas to ensure they can perform the delegated services. Ongoing monitoring is conducted and reported to the appropriate committee quarterly. An annual delegation oversight audit is conducted, and findings are reviewed to determine the continuation of the delegation. If the delegated entity's performance is found below standards, a corrective action plan is issued. The Delegation Oversight team monitors the plan and reports to relevant committees. Termination of the agreement may be recommended if there is no improvement. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

Corrective Action Plans and Recommendations from Previous EQR

Constellation requires the health plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. Technical assistance is provided until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which Molina implemented the actions to address deficiencies identified during the previous EQR and found that Molina addressed and implemented appropriate corrective action for all previous EQR findings. Details regarding the 2023 CAP can be found in *Attachment 4: Assessment of Corrective Action Plans from Previous EQR*.

Conclusions

Molina met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*. *Table 7: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Molina's compliance scores relative to each of the 13 Subpart D and QAPI standards that were reviewed.

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

Category	Report Section	Total Number of CAN and CHIP 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	28	93%

Category	Report Section	Total Number of CAN and CHIP 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	24	100%
• 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	40	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	6	6	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	16	13	81%
• 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	36	95%
• 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	2	100%
• 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 preceding table, issues were found with the following:

- Several appointment access timeframes and the overall appointment access compliance goal for behavioral health/substance use disorder providers were incorrectly documented.
- The CAN and CHIP QI program description was not updated to include the centralized credentialing process implemented by DOM in 2022.
- Discrepancies were noted in the documentation of the frequency of review of clinical practice and preventive health guidelines. Also, discrepancies in the guidelines were noted between the CAN and CHIP websites. The CHIP website had non-functional hyperlinks for several guidelines.

Table 8: Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2023 review. For CAN, 183 of 189 standards received a score of "Met." Five standards were scored as "Partially Met" and one standard was scored as "Not Met."

Table 8: Scoring Overview—CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	30	1	0	0	0	31	97%
2024	31	0	0	0	0	31	100%
Provider Services							
2023	46	0	3	0	0	49	94%
2024	45	3	1	0	0	49	92%
Member Services							
2023	28	5	0	0	0	33	85%
2024	32	1	0	0	0	33	97%
Quality Improvement							
2023	15	3	1	0	0	19	79%
2024	18	1	0	0	0	19	95%
Utilization							
2023	52	2	0	0	0	54	96%
2024	54	0	0	0	0	54	100%
Delegation							
2023	1	0	1	0	0	2	50%
2024	3	0	0	0	0	3	100%
Totals							
2023	**172**	**11**	**5**	**0**	**0**	**188**	**91.5%**
2024	**183**	**5**	**1**	**0**	**0**	**189**	**96.8%**

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

Table 9: Scoring Overview—CHIP, provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2023 review. For 2024, 180 of 186 standards received a score of "Met." Six standards were scored as "Partially Met." No standards were scored as "Not Met."

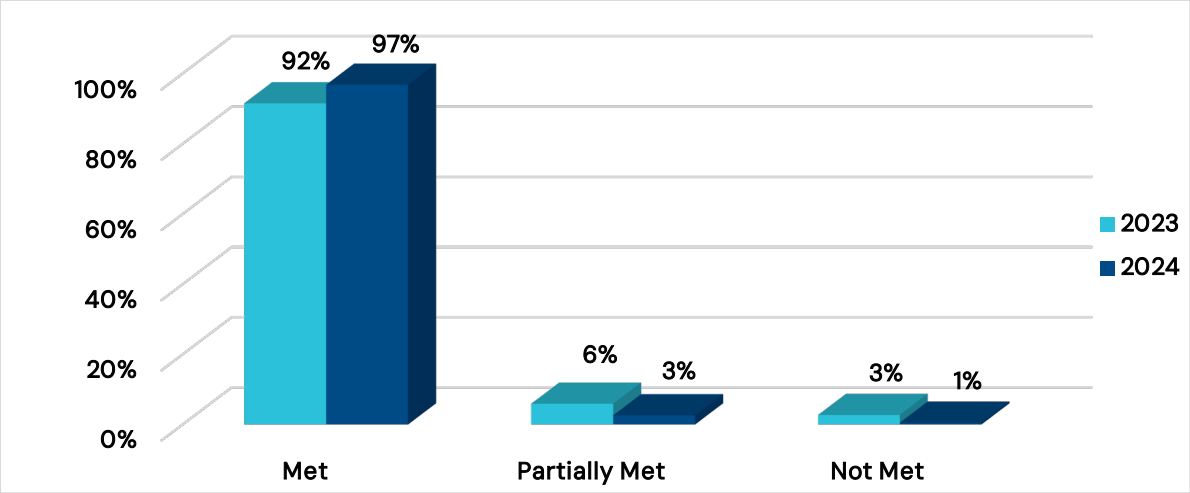
Table 9: Scoring Overview—CHIP

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	30	1	0	0	0	31	97%
2024	31	0	0	0	0	31	100%
Provider Services							
2023	44	1	2	0	0	47	94%
2024	43	4	0	0	0	47	92%
Member Services							
2023	27	5	0	0	0	32	84%
2024	31	1	0	0	0	32	97%
Quality Improvement							
2023	15	3	1	0	0	19	79%
2024	18	1	0	0	0	19	95%
Utilization							
2023	52	2	0	0	0	54	96%
2024	54	0	0	0	0	54	100%
Delegation							
2023	1	0	1	0	0	2	50%
2024	3	0	0	0	0	3	100%
Totals							
2023	**169**	**12**	**4**	**0**	**0**	**185**	**91.4%**
2024	**180**	**6**	**0**	**0**	**0**	**186**	**96.8%**

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

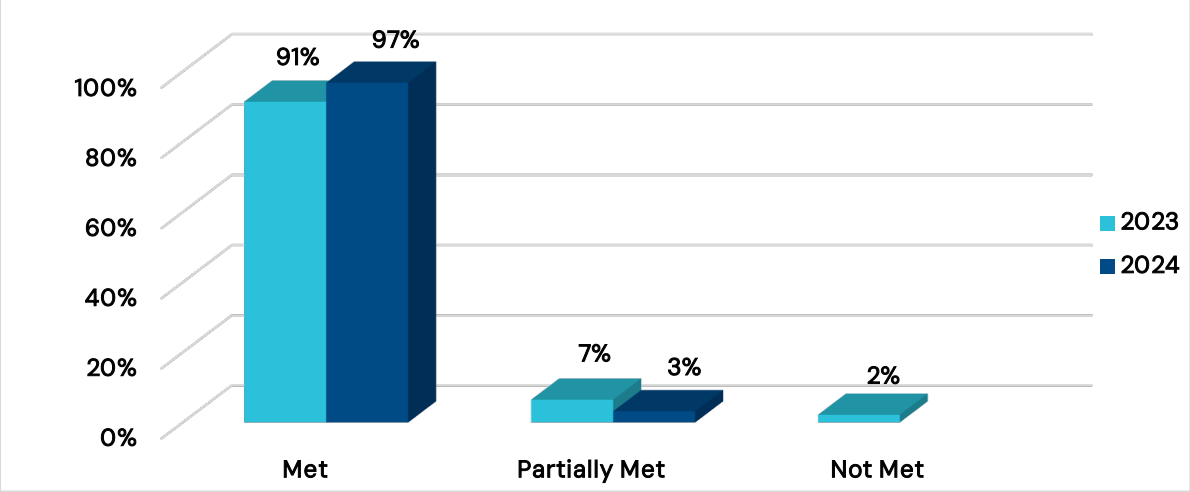
As shown in the figures that follow, the 2024 Annual EQR for CAN found that Molina achieved "Met" scores for 96.8% of the standards, "Partially Met" scores for 2.6% of the standards, and "Not Met" scores for 0.5% of the standards. For CHIP, 96.8% of the standards were scored as "Met" and 3.2% were scored as "Partially Met."

Figure 1: Annual EQR Results Comparison – CAN



Scores were rounded to the nearest whole number.

Figure 2: Annual EQR Results Comparison – 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 improvement. Specific details of strengths, weaknesses, recommendations, and corrective actions can be found in the sections that follow.

Table 10: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Molina has established processes for policy development and ongoing review. Policies are housed in a location that is readily accessible by staff.	✓		
Molina is establishing a Regulatory Communications Committee to guide policy revisions and the need for new/additional policies.	✓		
Molina has systems and processes in place to ensure accurate and complete member demographic and enrollment data.	✓		✓
Molina meets and exceeds claims payment percentage requirements stated in the *CAN* and *CHIP Contracts*.	✓		
Molina has an adequate disaster recovery and business continuity plan which is tested and reviewed annually.	✓		
Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against FWA are addressed comprehensively in the 2024 Compliance Plan, the 2024 Fraud, Waste, and Abuse Plan for Molina Healthcare of Mississippi, Inc., and related policies and procedures.	✓		
Molina has adopted a Code of Business Conduct and Ethics, which communicates expectations for appropriate and ethical behavior for employees, subcontractors, vendors, and others. The Code of Business Conduct and Ethics is given to all employees at employment and then annually, and employees must provide an attestation of their understanding of the document.	✓		
Compliance training is mandatory for new employees within 30 days of their start date and annually for all employees. The training includes the Compliance Plan, FWA, whistleblower protections, confidentiality of protected information, and reporting responsibilities.	✓		
Molina ensures effective and open communication and provides a variety of options for reporting compliance concerns or suspicions of FWA. The CCO ensures there is no retaliation for anyone who makes a report.	✓		
Provider Services			
Provider panel assignments can be viewed/downloaded from the Availity portal and there are various mechanisms in place for providers to verify member eligibility.			✓
Molina monitors the status of providers' panels to ensure there are enough providers with open panels to provide appropriate member access.			✓
Geographic access standards for all provider types are appropriately documented and routine monitoring is conducted to ensure network adequacy.			✓
Molina's website provides information about cultural competency, including information about interpreter services, provider training modules, and provider tools.	✓		✓
Molina conducts routine audits of appointment and after-hours access.			✓
Initial and ongoing provider education processes are sufficient to ensure providers have the information needed to operate within Molina's network.	✓		
Molina adopts CPGs and PHGs to provide up-to-date treatment and diagnostic information to providers, reduce inter-provider variation, and define expected standards of practice.	✓		
Molina routinely assesses provider compliance with medical record documentation and maintenance standards.	✓		
Member Services			

Strengths	Quality	Timeliness	Access to Care
The contact center service staff satisfaction rates increased to 41.1% in 2023, which is higher than the benchmark of 38.8%.	✓		
The grievance files demonstrated that grievances were acknowledged and resolved, and that members were notified of resolution, in a timely manner.		✓	
Information on preventive health programs and resources is provided to members in a variety of ways, including mailings, the website, telephone/text alerts, health fairs, mobile/RV units, and other community events to enhance member education.			✓
Quality Improvement			
Molina's QI Program covers a wide range of health care aspects, including physical, behavioral, and oral health, ensuring that members receive holistic and integrated care across the entire health care continuum.	✓		
The QI Program places a strong emphasis on health equity, addressing health and care inequalities, and ensuring culturally and linguistically appropriate services. This is crucial for reducing disparities and improving health outcomes for diverse populations.	✓		
The following CAN HEDIS and CMS Core Set measure rates (MY 2023) were strengths for Molina since their rates had a greater than 10 percentage point improvement: • Adult BMI Assessment (ABA) measure • Appropriate Testing for Children with Pharyngitis (CWP), the 21-24 Years indicator • Statin Therapy for Patients with Cardiovascular Disease (SPC) measure, the Statin adherence 80% - 21-75 years (Male) indicator, the Statin adherence 80% - 40-75 years (Female) indicator, and the Statin adherence 80% - Total indicator • Hemoglobin A1c Control for Patients with Diabetes (HBD), the Poor HbA1c Control indicator and the Adequate HbA1c Control indicator • Blood Pressure Control for Patients with Diabetes (BPD) measure • Statin Therapy for Patients with Diabetes (SPD) measure, the Statin Adherence 80% indicator • Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure, Initiation Phase	✓		
The following CHIP HEDIS and CMS Core Set measure rates (MY 2023) were strengths for Molina since their rates had a greater than 10 percentage point improvement: • Appropriate Treatment for Upper Respiratory Infection (URI) measure, the 18-64 Years indicator • Immunizations for Adolescents (IMA) measure, the Tdap/Td indicator • Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) measure, the Overall indicator, and the Prescription for Buprenorphine indicator • The Diabetes Short-term Complications Admission rate (PQI01-AD) measure, the Ages 18-64, and Total indicators • Sealant Receipt On Permanent First Molars (SFM-CH), the Numerator 1 At Least One Sealant indicator	✓		
All of the CAN and CHIP PIPs received a validation score within the High Confidence Range.	✓		
Utilization Management			
Molina's program goal of 98% for timeliness of service authorization completion was met or exceeded monthly.		✓	
According to the results of the Care Management Program Evaluation, members expressed satisfaction with both Level II and Level III Care Management. Additionally, the evaluation indicated that satisfaction increased in three out of eight identified areas for Level II Care Management.	✓		

Strengths	Quality	Timeliness	Access to Care
All the appeal sample files reviewed for the 2024 EQR were addressed in a timely manner.		✓	
Delegation			
The Delegation Oversight Program includes pre-delegation assessments, ongoing monitoring through Joint Operations Committee meetings, and comprehensive annual audits. This ensures that third-party entities consistently meet performance and compliance standards, providing a robust framework for accountability.	✓		
Molina mandates that all third-party entities enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Administration				
Inconsistencies were noted in the name of the Compliance Committee in various documents, including the Compliance Plan, the MHMS Committee Organizational Chart, and Charter C-00b, Compliance Committee Charter – Management Level. Molina reported that the two previous Compliance Committees were recently consolidated into one.	*Recommendation: Revise all applicable documents to reflect the consolidation of the two committees into one, and to reflect the correct name for the Compliance Committee.*	✓		
Charter C-00b, Compliance Committee Charter-Management Level, does not specify the frequency of Compliance Committee meetings and contains incomplete information about who serves as the committee's chairperson.	*Recommendation: Develop a new charter for the consolidated Compliance Committee and include the meeting frequency and clear documentation that the committee is co-chaired by the Compliance Officer and Assistant Vice President of Compliance.*	✓		
The Chief Medical Officer was listed as absent for Compliance Committee meetings; however, the Chief Medical Officer is not listed as a committee member on the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document for 2024.	*Recommendation: Develop a new charter for the consolidated Compliance Committee and add the Chief Medical Officer to the Compliance Committee Membership document for 2024.*	✓		
Provider Services				
Molina confirmed that there is no policy documenting the process for informing providers of their panel assignments.	*Recommendation: Create a policy, or add to an existing policy, to document the process for notifying providers of members assigned to their panels.*			✓
Page four of Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, states, "Molina requests	*Recommendation: Revise Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, to correct the process*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
practitioner race/ethnicity and language information from all contracted practitioners, on a voluntary basis, through its initial credentialing process." However, credentialing has not been a health plan responsibility for more than two years.	*by which Molina receives provider race, ethnicity, and language data.*			
Appointment access standards for CAN are documented in Policy MHMS-QI-006, Access to Care, in the CAN Provider Manual, and on the CAN website. The following issues were noted: • Policy MHMS-QI-006, Access to Care, states that post-discharge appointments with behavioral health (BH)/substance use disorder (SUD) providers are required within 7 calendar of the discharge and 30 calendar days from previous appointment. The *CAN Contract, Section 7 (B) (2) and the CHIP Contract, Section 7 (B) (2)* do not include "and 30 calendar days from previous appointment." • For routine visits with BH/SUD providers, the CAN Provider Manual, CHIP Provider Manual, and the CAN and CHIP websites indicate the timeframe is within 7 calendar days. The *CAN Contract, Section 7 (B) (2), the CHIP Contract, Section 7 (B) (2),* and Policy MHMS-QI-006 state the correct timeframe of within 21 calendar days. • For most appointment standards, Policy MHMS-QI-006 indicates Molina's goal is for 90% of appointments to be provided within the established timeframes. However, the policy states the goal for BH post-discharge appointments is for 75% of the appointments to be provided within the established timeframe. Onsite discussion revealed this is incorrect; the goal for post-discharge BH appointments is 90%.	*Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to reflect the correct timeframe for post-discharge BH/SUD provider appointments and to correct the goal for post-discharge BH/SUD provider appointments. Revise the CAN and CHIP Provider Manuals and CAN and CHIP websites to reflect the correct timeframe for routine visits with BH/SUD providers.*	✓		✓
The Q2 2024 CAN and CHIP Provider Appointment Availability Reports showed that the overall successful contact rates were low, ranging from 20% to 46.67%.	*Recommendation: Continue efforts to educate providers about the importance of being available to members by telephone.*			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The CAN and CHIP Provider Manuals state, "Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Member Contact Center…" However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services.	*Corrective Action Plan: Revise the CAN and CHIP Provider Manuals to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center.*			✓
The CAN Provider Manual does not include the required statement regarding non-exclusivity. Refer to the *CAN Contract, Section 7 (H) 2 (s).*	*Corrective Action Plan: Revise the CAN Provider Manual to include the required non-exclusivity statement.*	✓		
Discrepancies were noted in the frequency of reviewing CPGs and PHGs when comparing the following: • Per report of Molina staff during onsite discussion, the CPGs and PHGs are reviewed at least annually. • Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, states, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer." It then states, "All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly…" • The CAN Provider Manual indicates all CPGs and PHGs are reviewed at least monthly. • The CHIP Provider Manual indicates CPGs are reviewed annually. It then states a review is conducted at least monthly. For PHGs, the CHIP Provider Manual states, "All guidelines are updated with each release by USPSTF…" but does not define the frequency of review. • The QI Program Description indicates the CPGs and PHGs are reviewed at least quarterly.	*Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.*	✓	✓	
Molina submitted an explanation that the adopted clinical practice and preventive health guidelines are the same for CAN and CHIP; however, there were discrepancies noted in the guidelines listed on the CHIP website when comparing to the CAN website.	*Corrective Action Plan: Revise the CHIP website to include the same clinical practice and preventive health guidelines as those listed on the CAN website. Update all the non-functional hyperlinks to the guidelines. Revise the CHIP website to include the current*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Additionally, the hyperlinks for the following guidelines were non-functional on the CHIP website: • Coronary and Other Vascular Disease • Heart Failure • Gestational Diabetes • Synagis • Clinical Management Guideline Compendium • The CHIP website includes the guideline for "Standards in Medical Care in Diabetes – 2019" while the CAN website includes "Standards of Care in Diabetes—2023."	*"Standards of Care in Diabetes—2023" guideline.*			
Policy MHMS-QI-124, Standards of Medical Record Documentation, page nine, states, "Noncompliant providers with incomplete CAPs are submitted to the Peer Review Committee for consideration during the recredentialing process." However, the CCO does not conduct recredentialing activities.	*Recommendation: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to correctly reflect the process followed for non-compliant providers with incomplete CAPs.*	✓		
For the 2023 provider satisfaction survey, the response rate was low at 7.7%, although this is an increase from 5% last year.	*Recommendation: Continued efforts should be made to improve survey response rates to gather a better representation of the providers.*	✓		
Member Services				
Discrepancies were identified in documentation of CAN member benefits. Findings for the CAN Member Handbook and website include: • For Eye Care – Vision Services, the CAN Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the website states, "1 eye exam and 1 pair of glasses, annually." • The website states that "Genetic Testing - Inheritable disease diagnosis" is available, but this is not indicated in the CAN Member Handbook. • There is inconsistent wording regarding non-emergency transportation services. The CAN Member Handbook states that transportation is available "To medical appointments, vision exams and pharmacy visits immediately following	Corrective Action: Review and revise the CAN Member Handbook and website to ensure clear and consistent wording regarding covered benefits.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
a medical appointment." The website states that transportation is available "To medical appointments, vision exams and pharmacy."				
Discrepancies were identified in documentation of CHIP member benefits. Findings for the CHIP Member Handbook and website include: • The CHIP Member Handbook indicates that prior authorization is required for Ambulatory Surgical Center Services. However, the website does not indicate the requirement of prior authorization for this service. • The website does not match the CHIP Member Handbook regarding covered services for Substance Abuse Services Inpatient/Outpatient Care. • The CHIP Member Handbook indicates coverage of Disease Management services "as indicated by PCP." This is not referenced on the website. • The CHIP Member Handbook qualifies Emergency Ambulance services as being unlimited "based on life threatening condition present." However, the website does not match this requirement. • The CHIP Member Handbook documents that prior authorization is required for Radiology/X-rays, which is not indicated on the website.	*Corrective Action: Review and revise the CHIP Member Handbook and website to ensure clear and consistent wording regarding covered benefits.*	✓		
Quality Management				
The CAN and CHIP QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022.	*Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing program.*	✓		
The following HEDIS and CMS Core Set measure rates (MY 2023) were determined to be areas of opportunities for Molina since their rates had a greater than 10 percentage point decline: • The Asthma Medication Ratio (AMR) measure, 5-11 years indicator declined by 13.76 percentage points and the	*Recommendation: Seek opportunities to improve the HEDIS and CMS Core Measures that showed a decline in the rates.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Total indicator declined by over 10 percentage points for the CHIP population. • The Chronic Obstructive Pulmonary Disease (COPD) OR Asthma in Older Adults Admission Rate (PQI-05) measure, Ages 40-64 and Total indicators decreased by over 14 per 100,000 member months for the CAN population. • The HIV Viral Load Suppression (HVL-AD) measure, Ages 18-64 and Total indicators decreased by over 11 percentage points for the CAN population.				
One record did not pass medical record review validation for the Prenatal and Postpartum Care (PPC) – Prenatal measure. Since 100% of all hybrid numerator compliant records were reviewed during medical record review validation for the PPC – Prenatal measure, this one error did not bias the reported rate, and can be considered reportable.	*Recommendation: Improve medical record review processes to ensure accurate abstraction for hybrid measures.*	✓		
While Molina seems to have experienced improvements in rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years.	*Recommendation: Improve processes for rate validation and trending to identify measure reporting concerns.*	✓		
The explanation provided for the variance in measure rates reported for the Contraceptive Care – Postpartum Women Ages 15 To 20 (CCP-CH) measure for the CAN population for MY 2023 raises questions about the validity of rates reported for MY 2023 and MY 2022. Based on explanation provided by Molina, the rate originally provided for MY 2022 is not reportable and cannot be used to trend rates year over year.	*Recommendation: Review measure rates for CCP-AD, CCP-CH, CCW-AD and CCW-CH for the CAN and CHIP populations for accuracy in calculation and reporting for MY 2021, MY 2022, and MY 2023 and correct rates as appropriate.*	✓		
A decline in at least one indicator was identified in some of the CAN and CHIP PIPs.	*Recommendation: Assess the current interventions to determine if changes are needed. If changes are not needed, continue efforts to improve the indicator rates in the PIPs.*	✓		
Utilization Management				

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify *the CHIP Contract, Section 8 (A)* in the Source of Decision information.	*Recommendation: Include a reference to the CHIP Contract, Section 8 (A) in the Source of Decision for Policy 154.01, Individualized Care Development Procedure Addendum.*	✓		
The CAN and CHIP Member Handbooks do not address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf.	*Recommendation: Revise the CAN and CHIP Member Handbooks to address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. Consider including a hyperlink to the form for convenient member access.*	✓		

METHODOLOGY

The process Constellation Quality Health (Constellation) used for the External Quality Review (EQR) activities was based on protocols the Centers for Medicare & Medicaid Services (CMS) developed for the external quality review of a Medicaid Managed Care Organization (MCO)/Prepaid Inpatient Health Plan (PIHP). The process 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 June 3, 2024, Constellation sent notification of the initiation of the annual EQR to Molina Healthcare of Mississippi (Molina) (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the Coordinated Access Network (CAN) and Children's Health Insurance (CHIP) Coordinated Care Organizations (CCOs).

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with Constellation and the Mississippi Division of Medicaid (DOM) to provide Molina an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials Constellation requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on July 2, 2024, for review at Constellation's offices (see *Attachment 1*). The second segment was a virtual onsite review conducted on October 16, 2024, and October 17, 2024. The onsite visit focused on areas not covered in the desk review and areas 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 attend 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 Administration review includes policy management processes, health plan staffing, information management systems capabilities, compliance, program integrity, and processes to ensure confidentiality of information.

Molina develops policies to govern and guide health plan activities and functions. New and revised policies and procedures are approved by the Policy and Procedure Committee and are implemented upon approval by the committee and DOM. All policies and procedures are reviewed at least annually and are housed on a SharePoint site for staff access. Departmental leadership and/or the Compliance Department educate staff about new and revised policies and procedures. Molina reported that a new Regulatory Communications Committee is being established to examine regulatory changes that will guide policy revisions and the need for new/additional policies. The committee is expected to hold its initial meeting in Q4 2024.

Molina's Organizational Chart and onsite discussion confirmed staffing is sufficient to ensure all required activities can be conducted and all contractually required services can be provided. The Chief Financial Officer position is vacant and currently filled on an interim basis by the Regional Chief Financial Officer. The position is expected to be filled in approximately one month. Also, one Medical Director position is vacant, but a candidate has been identified and negotiations are in progress.

Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against fraud, waste, and abuse (FWA) are addressed comprehensively in Molina's 2024 Compliance Plan (Compliance Plan), the 2024 Fraud, Waste, and Abuse Plan for Molina Healthcare of Mississippi, Inc. (FWA Plan), and in related policies and procedures. The Compliance Plan addresses the Compliance Officer's roles and responsibilities related to oversight and operation of the Compliance Program. The Compliance Plan also documents the Compliance Program's reporting structure and processes for risk management, policy implementation, investigations of and responses to potential compliance matters, compliance training, monitoring, and auditing, etc.

Various documents addressed the roles and responsibilities of the Compliance Committee; however, inconsistencies in the name of the committee were noted. During onsite discussion, Molina reported that the two previous Compliance Committees (the Compliance Committee of the Board of Directors and the Management Level Compliance Committee) were recently consolidated into one Compliance Committee. Charter C-00b, Compliance Committee Charter-Management Level, does not specify the frequency of Compliance Committee meetings and includes incomplete information about who chairs the committee. Molina addressed the

corrective action from the previous EQR to correct the Compliance Committee Membership document to correctly indicate which staff member chairs the committee. However, a new issue was noted this year in that the Compliance Committee Membership document did not list the Chief Medical Officer as a voting member of the committee, but documentation of voting member attendance at the Compliance Committee reflected that the Chief Medical Officer was absent for two meetings. Review of Molina's Compliance Committee minutes for meetings from July 2023 through April 2024 reflected quarterly meetings with a quorum confirmed for each meeting.

Compliance training is mandatory for new employees and Board members within 30 days of their start date/appointment and then annually. Compliance training includes the Compliance Plan; FWA; whistleblower protections; reporting responsibilities; and the Code of Business Conduct and Ethics (Code of Conduct), which communicates expectations for appropriate and ethical behavior for employees, subcontractors, vendors, and others. Molina has an array of policies and procedures that address requirements for the use, creation, collection, storage, transmission, access to, and disclosure of protected health information and other sensitive member information.

Molina maintains an open-door policy for employees to ask questions and to discuss or report concerns. Reporting methods include options for reporting by telephone, email, online, or directly to the Compliance Officer, Compliance Committee, Human Resources, Legal Department staff, and others. The online reporting system (Alertline) allows anonymous and confidential reporting and is publicly accessible. Information about the Alertline is included in provider training materials, provider handbooks, and on Molina's website.

Addendum one of Procedure HCS 407.01, Continuity of Care and Access to Care for New and Existing Members, addresses the requirements for the Beneficiary Health Management Program, formerly known as the Pharmacy Lock-in Program. Molina informed Constellation during onsite discussion that the health plan is operating under the requirements of the *MSCAN SFY25 Emergency Contract*, which went into effect on July 1, 2024.

Health Information Systems

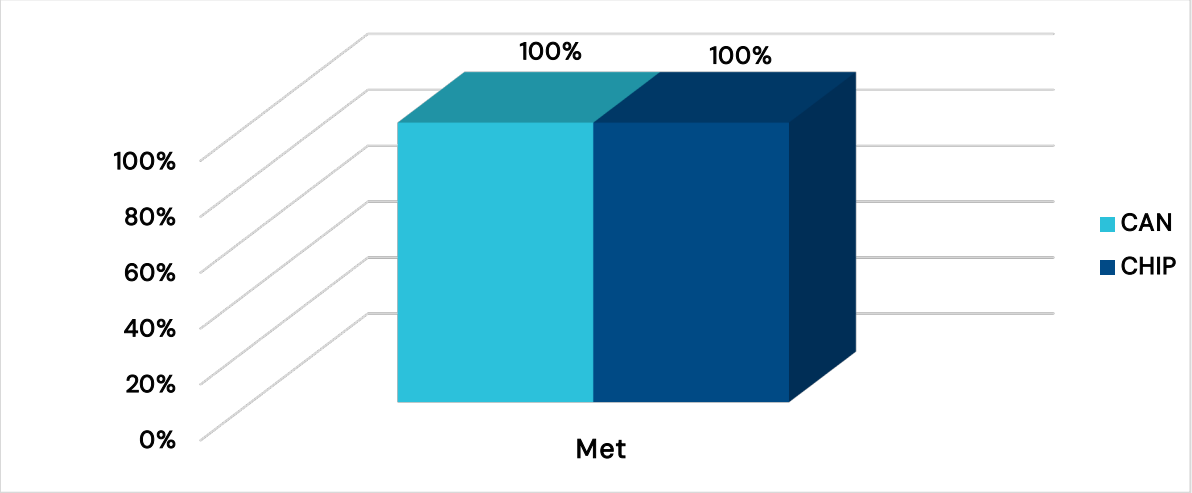
42 CFR § 438.242, 42 CFR § 457.1233 (d)

Molina provided Information Systems Capability Assessment documentation. On average, Molina pays 99% of clean claims within 30 days and 99.99% of claims within 90 days, exceeding internal goals and contractual requirements. Molina utilizes Claimsphere to perform data completeness and integrity checks to ensure accurate member demographic and enrollment information. Reports are generated during the Extract Transform Load process which keeps track of member and provider data and can be submitted to any requesting oversight agency or CMS. Molina adequately demonstrated their data collection and storage capabilities, processing procedures,

and claim data tabulation and processing processes. Support of Quality Assurance and Utilization Management Program activities and other contractual requirements were illustrated via flowcharts and technical layouts. Molina has both a Disaster Recovery Plan and a Business Continuity Plan, which are updated and tested annually, and has redundancy systems in place with documented document recovery processes.

As noted in *Figure 3: Administration Findings*, 100% of the Administration standards were scored as "Met."

Figure 3: Administration Findings



Strengths, weaknesses, and recommendations for the Administration section are included in the following tables.

Table 11: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Molina has established processes for policy development and ongoing review. Policies are housed in a location that is readily accessible by staff.	✓		
Molina is establishing a Regulatory Communications Committee to guide policy revisions and the need for new/additional policies.	✓		
Molina has systems and processes in place to ensure accurate and complete member demographic and enrollment data.	✓		✓
Molina meets and exceeds claims payment percentage requirements stated in the *CAN* and *CHIP Contracts*.	✓		
Molina has an adequate disaster recovery and business continuity plan which is tested and reviewed annually.	✓		

Strengths	Quality	Timeliness	Access to Care
Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against FWA are addressed comprehensively in the 2024 Compliance Plan, the 2024 Fraud, Waste, and Abuse Plan for Molina Healthcare of Mississippi, Inc., and related policies and procedures.	✓		
Molina has adopted a Code of Business Conduct and Ethics, which communicates expectations for appropriate and ethical behavior for employees, subcontractors, vendors, and others. The Code of Business Conduct and Ethics is given to all employees at employment and then annually, and employees must provide an attestation of their understanding of the document.	✓		
Compliance training is mandatory for new employees within 30 days of their start date and annually for all employees. The training includes the Compliance Plan, FWA, whistleblower protection, confidentiality of protected information, and reporting responsibilities.	✓		
Molina ensures effective and open communication and provides a variety of options for reporting compliance concerns or suspicions of FWA. The CCO ensures there is no retaliation for anyone who makes a report.	✓		

Table 12: Administration Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Inconsistencies were noted in the name of the Compliance Committee in various documents, including the Compliance Plan, the MHMS Committee Organizational Chart, and Charter C-00b, Compliance Committee Charter – Management Level. Molina reported that the two previous Compliance Committees were recently consolidated into one.	*Recommendation: Revise all applicable documents to reflect the consolidation of the two committees into one, and to reflect the correct name for the Compliance Committee.*	✓		
Charter C-00b, Compliance Committee Charter-Management Level, does not specify the frequency of Compliance Committee meetings and contains incomplete information about who serves as the committee's chairperson.	*Recommendation: Develop a new charter for the consolidated Compliance Committee and include the meeting frequency and clear documentation that the committee is co-chaired by the Compliance Officer and Assistant Vice President (AVP) of Compliance.*	✓		
The Chief Medical Officer was listed as absent for Compliance Committee	*Recommendation: Develop a new charter for the consolidated*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
meetings; however, the Chief Medical Officer is not listed as a committee member on the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document for 2024.	*Compliance Committee and add the Chief Medical Officer to the Compliance Committee Membership document for 2024.*			

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					Molina develops policies to govern and guide health plan activities and functions. New and revised policies and procedures are approved by the Policy and Procedure Committee and are implemented upon final approval by the committee and DOM. All policies and procedures are reviewed at least annually. Staff can access policies and procedures on a SharePoint site. Staff are educated about new/revised policies and procedures by departmental leadership and/or the Compliance Department. These processes are documented in Policy No. MHMS-GC-28, Policy and Procedure Format and Review. Molina reported that a Regulatory Communications Committee is being established to examine regulatory changes that will guide policy revisions and the need for new/additional policies. The committee will hold its initial meeting in Q4 2024.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Chief Executive Officer;	X					
1.2 *Chief Operating Officer;	X					
1.3 Chief Financial Officer;	X					The Organizational Chart indicates the Chief Financial Officer position is vacant. Onsite discussion confirmed the Regional Chief Financial Officer has assumed the duties of the Chief Financial Officer until the position is filled. The health plan has identified a candidate and expects the position to be filled within one month.
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					
1.6.1 *Provider contracting and education;	X					
1.7 *Member Services Manager;	X					
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					
1.9 Utilization Management Coordinator;	X					
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Staffing includes the Chief Medical Officer and five Medical Directors. One Medical Director position is currently vacant, but Molina staff reported that negotiations are in progress with a candidate and the position will soon be filled.
1.13 *Compliance Officer.	X					
2. Operational relationships of CCO staff are clearly delineated.	X					
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					On average, Molina pays 99% of clean claims within 30 days and 99.99% of claims within 90 days. This exceeds Molina's internal goal and contractual requirements.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina uses Claimsphere to perform data completeness and integrity checks to ensure accurate member demographic and enrollment information. Molina also uses Clinical Care Advanced, an internal case management system, in conjunction with a comprehensive needs assessment, to track member appointments. These data are further validated with audit reports generated to ensure complete data load. Reports are also generated during the Extract Transform Load process which keep track of member and provider data and can be submitted to any requesting oversight agency or CMS.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Molina included all appropriate Information Systems Capability Assessment documentation as well as supporting documents. Molina adequately demonstrated their data collection and storage capabilities, processing procedures, and claim data tabulation and processing processes. Support of Quality Assurance and Utilization Management Program activities and other contractual requirements were illustrated via flowcharts and technical layouts. The processes were reviewed and discussed during the onsite review.
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 has both a documented Disaster Recovery Plan and a Business Continuity Plan which are updated and tested annually (last updated 6/4/2024). Molina has redundancy systems in place with documented document recovery processes.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					Molina's 2024 Compliance Plan outlines the CCO's commitment to ethical behavior, compliance with laws and regulations, and prevention of fraud and abuse. The FWA Plan outlines policies and procedures for detecting, preventing, investigating, and reporting potential health care FWA. Related policies and procedures provide detailed information about these topics.
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 Compliance Plan references the Code of Conduct, which communicates expectations for appropriate and ethical behavior for employees, subcontractors, vendors, and others. The Code of Conduct is given to all employees at employment and then annually, and employees must attest to their understanding of the document. The Code of Conduct is included in the FWA Plan (Attachment B), and addresses expectations that employees act within Molina's "mission to improve health and lives, vision to be a reliable low-cost health plan, and values of integrity, accountability, teamwork, communication, and community focus."
2.2 Identification of the Compliance Officer;						The Compliance Plan addresses the Compliance Officer's roles and responsibilities related to oversight and operation of the Compliance Program. It also documents the Compliance Program's reporting structure and processes for risk management, policy implementation, investigations of and responses to potential compliance matters, compliance training, monitoring, and auditing, etc. Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, provides detailed information about the Compliance Officer's duties and reporting structure within the health plan.
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						As noted in the Compliance Plan, compliance training is mandatory for new employees within 30 days of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						their start date and annually for all employees. Board members must complete compliance training within 30 days of appointment and then annually. Compliance training includes the Code of Conduct, Compliance Plan, FWA, whistleblower protections, confidentiality of protected information, and reporting responsibilities. Compliance training is provided through a combination of live and web-based sessions. Molina maintains records of Compliance trainings that are completed, and completion of the training is considered in performance evaluations. Procedure C-01.3, Effective Training and Education, provides detailed information about requirements and processes for initial and ongoing compliance training for employees and the Board of Directors.
2.5 Lines of communication;						As noted in the Compliance Plan, Molina maintains an open-door policy for employees to ask questions and to discuss or report concerns. Reporting methods include: • direct reports to the Compliance officer (by phone, email, or online messaging) • direct reports to the Compliance Committee • direct reports to human resources, legal, any member of management, and privacy or security officials • a third-party telephonic and online reporting system (Alertline) which allows anonymous and confidential reporting (to the extent permitted by law)

Standard	Score					Comments
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						• using contact information for state or federal government agencies responsible for investigating suspected FWA The Alertline is publicly accessible and information about the Alertline is included in provider training materials, provider handbooks, and on Molina's website. Additional information about lines of communication is found in Procedure C-01.4, Effective Lines of Communication.
2.6 Enforcement and accessibility;						The Compliance Plan includes information about enforcement and accessibility, and indicates noncompliance may result in disciplinary action, up to and including termination of employment and/or referral to law enforcement entities. The Compliance and Human Resources Departments collaborate to ensure disciplinary actions are applied consistently and fairly. As noted in the Compliance Plan and Procedure C-01.5, Well-Publicized Disciplinary Standards, employees are informed of possible disciplinary action that may result from noncompliance and/or inappropriate business conduct through new employee materials, compliance training, Molina's Central Repository, the Human Resources SharePoint site, and upon request at any time.
2.7 Internal monitoring and auditing;						Molina conducts internal auditing and monitoring activities to evaluate compliance with state and federal requirements, detect process issues or deficiencies, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determine the effectiveness of any remediation efforts. Key performance indicators are routinely reported to the Compliance Committee and Board of Directors. Noncompliant key performance indicators are reviewed during monthly meetings with the Compliance Officer and health plan leadership. Monitoring and auditing activities include an annual risk assessment upon which the internal audit work plans and upcoming compliance activities are based. Additional auditing and monitoring activities include desk audits, surveys, interviews, document audits, phantom claims or inquiries, and audits of business unit methodologies. These processes are detailed in the Compliance Plan and in Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks.
2.8 Response to offenses and corrective action;						Preliminary investigations are conducted when there is a report of suspected FWA. If the preliminary investigation findings indicate suspicious activity, a detailed investigation is conducted. When the investigation confirms issues are related to coding/billing abuse, provider education is conducted to address the identified issue, and a corrective action plan (CAP) may be implemented. Confirmed FWA is reported to the Office of Program Integrity and other agencies as applicable. For credible allegations of fraud, provider payments may be suspended according to statutory requirements. This information is included in the Compliance Plan. Additional detailed information is found in Procedure C-01.7, Prompt

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Response (Investigation and Corrective Action) to Compliance Issues.
2.9 Exclusion status monitoring.						Molina conducts pre-employment background checks on all applicants to ensure they have not been found guilty of a healthcare-related crime or are not suspended, excluded, or debarred from participation in state and federal healthcare programs. All employees, board members, third-party employees, and contractors are screened monthly against exclusion lists, including: the United States Department of Health and Human Services Office of Inspector General, General Services Administration, the CMS Preclusion List, and state Medicaid agency lists. Flagged issues are reviewed and acted upon. For vendors and subcontractors, Molina conducts similar checks during the engagement process and at least monthly thereafter. These processes are described in the Compliance Plan, Policy C-03.0, Prohibited Affiliations, and Procedure C-03.1, Prohibited Affiliations. Requirements for exclusion status monitoring are also included in the Molina Healthcare of Mississippi Inc. Delegation Services Addendum.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					Review of Molina's documentation about the Compliance Committee reflects inconsistencies in the name of the committee in various documents, including the Compliance Plan, the MHMS Committee Organizational Chart, and Charter C-00b, Compliance Committee Charter – Management Level. During

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						onsite discussion of this finding, Molina reported that the two previous Compliance Committees (the Compliance Committee of the Board of Directors and the Management Level Compliance Committee) were recently consolidated into one Compliance Committee. *Recommendation: Revise all applicable documents to reflect the consolidation of the two committees into one, and to reflect the correct name for the Compliance Committee.* Charter C-00b, Compliance Committee Charter-Management Level, does not specify the frequency of the Compliance Committee meetings. The current review confirmed Molina implemented the corrective action from the previous EQR to revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee. Onsite discussion confirmed the committee continues to be co-chaired by the Compliance Officer and AVP Compliance; however, Charter C-00b, Compliance Committee Charter-Management Level states the chairperson is the Compliance Officer. *Recommendation: Develop a new charter for the consolidated Compliance Committee and include the meeting frequency and clear documentation that the committee is co-chaired by the Compliance Officer and AVP Compliance.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Compliance Committee minutes were reviewed for meetings held from July 2023 through April 2024. Meetings were held quarterly with a quorum confirmed for each meeting. The Chief Medical Officer was listed as absent for two meetings; however, the Chief Medical Officer is not listed as a committee member on the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document for 2024. *Recommendation: Develop a new charter for the consolidated Compliance Committee and add the Chief Medical Officer to the Compliance Committee Membership document for 2024.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Processes to prevent and detect potential or suspected FWA are addressed in the Compliance Plan, FWA Plan, Code of Conduct, and in various policies and procedures. Policy MHMS-MM- 001, Member Eligibility, indicates automatic member termination occurs for specific reasons, including change of residence outside of the service area and death, and that the information is provided to the health plan via the eligibility file from the State.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Processes for investigating reported incidents of FWA are documented in Policy MHI-SIU-102, Opening and Conducting Investigations, and the corresponding procedure. The Special Investigation Unit triages complaints/allegations, gathers information, conducts preliminary investigations, and proceeds to full

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						investigations as warranted. The policy and procedure describe these processes as well as possible resolutions.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy MHI-SIU-101, Administrative Actions, and the corresponding 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					Addendum one of Procedure HCS 407.01, Continuity of Care and Access to Care for New and Existing Members, addresses the requirements for the Beneficiary Health Management Program, formerly known as the Pharmacy Lock-in Program. Molina informed Constellation during onsite discussion that the health plan is operating under the requirements of the *MSCAN SFY25 Emergency Contract,* which went into effect on July 1, 2024.
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					Molina has an array of policies and procedures that address requirements for maintaining the confidentiality of protected information. Specifically, Policy and Procedure 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.

ADMINISTRATION—CHIP

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					Molina develops policies to govern and guide health plan activities and functions. New and revised policies and procedures are approved by the Policy and Procedure Committee and are implemented upon final approval by the committee and DOM. All policies and procedures are reviewed at least annually. Staff can access policies and procedures on a SharePoint site. Staff are educated about new/revised policies and procedures by departmental leadership and/or the Compliance Department. These processes are documented in Policy No. MHMS-GC-28, Policy and Procedure Format and Review. Molina reported that a Regulatory Communications Committee is being established to examine regulatory changes that will guide policy revisions and the need for new/additional policies. The committee will hold its initial meeting in Q4 2024.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Chief Executive Officer;	X					
1.2 *Chief Operating Officer;	X					
1.3 Chief Financial Officer;	X					The Organizational Chart indicates the Chief Financial Officer position is vacant. Onsite discussion confirmed the Regional Chief Financial Officer has assumed the duties of the Chief Financial Officer until the position is filled. The health plan has identified a candidate and expects the position to be filled within one month.
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					
1.6.1 *Provider contracting and education;	X					
1.7 *Member Services Manager;	X					
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					
1.9 Utilization Management Coordinator;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					
1.11 *Marketing and/or Public Relations;	X					
1.12 *Medical Director;	X					Staffing includes the Chief Medical Officer and five Medical Directors. One Medical Director position is currently vacant, but Molina staff reported that negotiations are in progress with a candidate and the position will soon be filled.
1.13 *Compliance Officer.	X					
2. Operational relationships of CCO staff are clearly delineated.	X					
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					On average, Molina pays 99% of clean claims within 30 days and 99.99% within 90 days. This exceeds Molina's internal goal and contractual requirements.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina uses Claimsphere to perform data completeness and integrity checks to ensure accurate member demographic and enrollment information. Molina also uses Clinical Care Advanced, an internal case management system, in conjunction with a comprehensive needs assessment, to track member appointments. These data are further validated with audit reports generated to ensure complete data load. Reports are also generated during the Extract

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Transform Load process which keeps track of member and provider data and can be submitted to any requesting oversight agency or CMS.
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 included all appropriate Information Systems Capability Assessment documentation as well as supporting documents. Molina adequately demonstrated their data collection and storage capabilities, processing procedures, and claim data tabulation and processing processes. Support of Quality Assurance and Utilization Management Program activities and other contractual requirements were illustrated via flowcharts and technical layouts. The processes were reviewed and discussed during the onsite review.
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 has both a documented Disaster Recovery Plan and a Business Continuity Plan which are updated and tested annually (last updated 6/4/2024). Molina has redundancy systems in place with documented document recovery processes.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					Molina's 2024 Compliance Plan outlines the CCO's commitment to ethical behavior, compliance with laws and regulations, and prevention of fraud and abuse. The FWA Plan outlines policies and procedures for detecting, preventing, investigating, and reporting potential health care FWA. Related policies and procedures provide detailed information about these topics.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Compliance Plan references the Code of Conduct, which communicates expectations for appropriate and ethical behavior for employees, subcontractors, vendors, and others. The Code of Conduct is given to all employees at employment and then annually, and employees must attest to their understanding of the document. The Code of Conduct is included in the FWA Plan (Attachment B), and addresses expectations that employees act within Molina's "mission to improve health and lives, vision to be a reliable low-cost health plan, and values of integrity, accountability, teamwork, communication, and community focus."
2.2 Identification of the Fraud and Abuse Compliance Officer;						The Compliance Plan addresses the Compliance Officer's roles and responsibilities related to oversight and operation of the Compliance Program. It also documents the Compliance Program's reporting structure and processes for risk management, policy implementation, investigations of and responses to potential compliance matters, compliance training, monitoring, and auditing, etc. Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, provides detailed information about the Compliance Officer's duties and reporting structure within the health plan.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Information about the Compliance Committee;						
2.4 Compliance training and education;						As noted in the Compliance Plan, compliance training is mandatory for new employees within 30 days of their start date and annually for all employees. Board members must complete compliance training within 30 days of appointment and then annually. Compliance training includes the Code of Conduct, Compliance Plan, FWA, whistleblower protections, confidentiality of protected information, and reporting responsibilities. Compliance training is provided through a combination of live and web-based sessions. Molina maintains records of Compliance trainings that are completed, and completion of the training is considered in performance evaluations. Procedure C-01.3, Effective Training and Education, provides detailed information about requirements and processes for initial and ongoing compliance training for employees and the Board of Directors.
2.5 Lines of communication;						As noted in the Compliance Plan, Molina maintains an open-door policy for employees to ask questions and to discuss or report concerns. Reporting methods include: • direct reports to the Compliance officer (by phone, email, or online messaging) • direct reports to the Compliance Committee • direct reports to human resources, legal, any member of management, and privacy or security officials

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• a third-party telephonic and online reporting system (Alertline) which allows anonymous and confidential reporting (to the extent permitted by law) • using contact information for state or federal government agencies responsible for investigating suspected FWA The Alertline is publicly accessible and information about the Alertline is included in provider training materials, provider handbooks, and on Molina's website. Additional information about lines of communication is found in Procedure C-01.4, Effective Lines of Communication.
2.6 Enforcement and accessibility;						The Compliance Plan includes information about enforcement and accessibility, and indicates noncompliance may result in disciplinary action, up to and including termination of employment and/or referral to law enforcement entities. The Compliance and Human Resources Departments collaborate to ensure disciplinary actions are applied consistently and fairly. As noted in the Compliance Plan and Procedure C-01.5, Well-Publicized Disciplinary Standards, employees are informed of possible disciplinary action that may result from noncompliance and/or inappropriate business conduct through new employee materials, compliance training, Molina's Central Repository, the Human Resources SharePoint site, and upon request at any time.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Internal monitoring and auditing;						Molina conducts internal auditing and monitoring activities to evaluate compliance with state and federal requirements, detect process issues or deficiencies, and determine the effectiveness of any remediation efforts. Key performance indicators are routinely reported to the Compliance Committee and Board of Directors. Noncompliant key performance indicators are reviewed during monthly meetings with the Compliance Officer and health plan leadership. Monitoring and auditing activities include an annual risk assessment upon which the internal audit work plans and upcoming compliance activities are based. Additional auditing and monitoring activities include desk audits, surveys, interviews, document audits, phantom claims or inquiries, and audits of business unit methodologies. These processes are detailed in the Compliance Plan and in Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks.
2.8 Response to offenses and corrective action;						Preliminary investigations are conducted when there is a report of suspected FWA. If the preliminary investigation findings indicate suspicious activity, a detailed investigation is conducted. When the investigation confirms issues are related to coding/billing abuse, provider education is conducted to address the identified issue, and a corrective action plan may be implemented. Confirmed FWA are reported to the Office of Program Integrity and other agencies as applicable. For credible allegations of fraud, provider payments may be suspended

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						according to statutory requirements. This information is included in the Compliance Plan. Additional detailed information is found in Procedure C-01.7, Prompt Response (Investigation and Corrective Action) to Compliance Issues.
2.9 Exclusion status monitoring.						Molina conducts pre-employment background checks on all applicants to ensure they have not been found guilty of a healthcare-related crime or are not suspended, excluded, or debarred from participation in state and federal healthcare programs. All employees, board members, third-party employees, and contractors are screened monthly against exclusion lists, including: the United States Department of Health and Human Services Office of Inspector General, General Services Administration, the CMS Preclusion List, and state Medicaid agency lists. Flagged issues are reviewed and acted upon. For vendors and subcontractors, Molina conducts similar checks during the engagement process and at least monthly thereafter. These processes are described in the Compliance Plan, Policy C-03.0, Prohibited Affiliations, and Procedure C-03.1, Prohibited Affiliations. Requirements for exclusion status monitoring are also included in the Molina Healthcare of Mississippi Inc. Delegation Services Addendum.
3. The CCO has established a committee charged with oversight of the Compliance	X					Review of Molina's documentation about the Compliance Committee reflects inconsistencies in the name of the committee in various documents,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
program, with clearly delineated responsibilities.						including the Compliance Plan, the MHMS Committee Organizational Chart, and Charter C-00b, Compliance Committee Charter – Management Level. During onsite discussion of this finding, Molina reported that the two previous Compliance Committees (the Compliance Committee of the Board of Directors and the Management Level Compliance Committee) were recently consolidated into one Compliance Committee. *Recommendation: Revise all applicable documents to reflect the consolidation of the two committees into one, and to reflect the correct name for the Compliance Committee.* Charter C-00b, Compliance Committee Charter-Management Level, does not specify the frequency of the Compliance Committee meetings. The current review confirmed Molina implemented the corrective action from the previous EQR to revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee. Onsite discussion confirmed the committee continues to be co-chaired by the Compliance Officer and AVP Compliance; however, Charter C-00b, Compliance Committee Charter-Management Level states the chairperson is the Compliance Officer. *Recommendation: Develop a new charter for the consolidated Compliance Committee and include the*

Standard	Score					Comments
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						meeting frequency and clear documentation that the committee is co-chaired by the Compliance Officer and AVP Compliance. Compliance Committee minutes were reviewed for meetings held from July 2023 through April 2024. Meetings were held quarterly with a quorum confirmed for each meeting. The Chief Medical Officer was listed as absent for two meetings; however, the Chief Medical Officer is not listed as a committee member on the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document for 2024. *Recommendation: Develop a new charter for the consolidated Compliance Committee and add the Chief Medical Officer to Compliance Committee Membership document for 2024.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Processes to prevent and detect potential or suspected FWA are addressed in the Compliance Plan, FWA Plan, Code of Conduct, and in various policies and procedures. Policy MHMS-MM- 001, Member Eligibility, indicates automatic member termination occurs for specific reasons, including change of residence outside of the service area and death, and that the information is provided to the health plan via the eligibility file from the State.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Processes for investigating reported incidents of FWA are documented in Policy MHI-SIU-102, Opening and Conducting Investigations, and the corresponding

Standard	Score					Comments
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						procedure. The Special Investigation Unit triages complaints/allegations, gathers information, conducts preliminary investigations, and proceeds to full investigations as warranted. The policy and procedure describe these processes as well as possible resolutions.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy MHI-SIU-101, Administrative Actions, and the corresponding 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					Addendum one of Procedure HCS 407.01, Continuity of Care and Access to Care for New and Existing Members, addresses the requirements for the Beneficiary Health Management Program, formerly known as the Pharmacy Lock-in Program. Molina informed Constellation during onsite discussion that the health plan is operating under the requirements of the *CHIP SFY25 Emergency Contract,* which went into effect on July 1, 2024.
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					Molina has an array of policies and procedures that address requirements for maintaining the confidentiality of protected information. Specifically, Policy and Procedure 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.

B. Provider Services

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

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

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Molina conducts provider orientation within 30 days of a provider becoming active in the network. The orientation is based on Molina's processes, state and federal regulations, and National Committee for Quality Assurance (NCQA) requirements. Ongoing provider education is provided through face-to-face visits, workshops, newsletters, etc. Molina also collaborates with DOM for provider workshops. The current review confirmed Molina addressed the previous corrective actions from the 2023 EQR related to provider orientation and ongoing education.

The 2024 MississippiCAN Provider Manual (CAN Provider Manual) and the 2024 Children's Health Insurance Program Provider Manual (CHIP Provider Manual) are comprehensive resources for providers to operate effectively within Molina's network. Issues related to documentation of self-referrals, and the non-exclusivity statement were identified.

Molina educates providers about the standards for medical record documentation via the Provider Manuals and monitors provider compliance with the standards by conducting medical record review audits. Molina reported that the health plan is moving to an annual review process rather than the current three-year review cycle. Policy MHMS-QI-124, Standards of Medical Record Documentation, page nine, states "Noncompliant providers with incomplete CAPs are submitted to the Peer Review Committee for consideration during the recredentialing process." However, credentialing and recredentialing have not been health plan responsibilities for more than two years since the implementation of centralized credentialing.

Practice Guidelines

§ 438.236, § 457.1233

Molina adopts clinical practice guidelines and preventive health guidelines from nationally recognized, evidence-based sources to define expected standards of practice, provide up-to-date treatment and diagnostic information, and reduce inter-provider variation. Discrepancies were noted in the frequency of guideline review when comparing Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, the CAN Provider Manual, the CHIP Provider Manual, the QI Program Description, and information obtained from onsite discussion.

Molina disseminates the guidelines to providers through orientation materials, provider manuals, newsletters, mailings, fax blasts, the CAN and CHIP websites, and in print upon request. Molina submitted an explanation that the adopted guidelines are the same for CAN and CHIP; however, there were discrepancies noted in the guidelines listed on the CAN and CHIP websites, and hyperlinks to several guidelines on the CHIP website were non-functional.

Provider Satisfaction Survey Validation

Molina's 2023 provider satisfaction survey was administered by Press Gainey, an NCQA-certified survey vendor. The response rate was 7.7%, which is an increase from 5% the previous year. The overall survey rating was 76.3%, which is higher than the benchmark. When asked if the provider would recommend Molina, the rating was 86.4%, which is below the benchmark. Ratings also fell below the benchmark in the Finance, Utilization Management, Networking, Pharmacy, and Provider Relations areas. The Contact Center was at the benchmark. Member and Provider Satisfaction Committee minutes from December 2023 included an overview of the 2023 provider satisfaction survey. Results were reported to Molina's Quality Improvement and Health Equity Transformation Committee during the Q1 2024 meeting. *Table 13* indicates the section of the EQR Survey Validation Worksheet that needs improvement, along with the reason and recommendation.

Table 13: 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, the response rate was 7.7%. 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.

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 conducted a validation review of Molina's provider network following the CMS protocol "*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 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. The following is an overview of the results for each activity.

The methods Molina used for assessment of network adequacy are reliable and include provider access studies and network adequacy time/distance assessments using Quest Analytics software. Molina's Information Systems Capability Assessment documentation indicates the organization's personnel and systems can perform the Medicaid data processing required by DOM. Policies and procedures demonstrate that sound information security practices are utilized.

Provider Network File Questionnaire

The Provider Network File Questionnaire revealed that Molina uses QNXT as its data management system. Daily updates are received from Gainwell, the centralized credentialing vendor. Verification is conducted through a portal update based on information from the provider. The member-facing Provider 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)

Molina notifies primary care physicians (PCPs) of member panel assignments via the Availity provider portal, but this process is not documented in a policy. Providers can verify member eligibility by calling the Member and Provider Contact Center, using the automated telephone system, and through the provider portal. Non-participating providers can verify member eligibility and enrollment by contacting the Member and Provider Contact Center.

Molina documents network geographic access standards policies and runs quarterly Geographic Access Assessment Reports to assess the geographic adequacy of the network. Member complaints about network adequacy are also considered. Molina reported that the Indian Health Care Providers in Mississippi decline to contract with the CCO, but eligible members can see these providers with no authorization required. The claims systems are set to pay Indian Health Care Providers at an in-network rate.

Appointment access standards and processes for assessing provider compliance with the standards are documented in a health plan policy, in the CAN and CHIP Provider Manuals, and

on the CAN and CHIP websites. The review confirmed that Molina corrected the issues identified in the 2023 EQR regarding the documentation of appointment access standards. However, the current review revealed issues with the documentation of the appointment timeframes for routine and post-discharge appointments with behavioral health (BH)/substance use disorder (SUD) providers. There was also an error in the documentation of the appointment access compliance rate goal for BH/SUD providers.

Molina conducts quarterly appointment access and after-hours access audits and monitors member complaints and member satisfaction survey results related to provider access. The results are reported to the Quality Improvement and Health Equity Transformation Committee. Corrective action is implemented for identified issues. The 2024 EQR confirmed Molina addressed the corrective action from the previous EQR related to adding the frequency of conducting appointment and after-hours access audits to the policy. The Q2 2024 CAN and CHIP Provider Appointment Availability Reports reflected that most providers who were successfully contacted were compliant with the established appointment access standards; however, the overall successful contact rates were low, ranging from 20% to 46.67%.

Molina has developed the Health Equity and Cultural Competency Program "to facilitate the provision and delivery of effective, equitable, understandable, respectful, and culturally competent health care and services" to members. The 2024-2025 Health Equity and Cultural Competency Program Description is included as an appendix to the 2024 Quality Improvement Program Description. Health plan policies document processes for collecting and assessing practitioner and member race, ethnicity, and language (REL) information. One policy incorrectly indicates Molina requests practitioner REL information through the initial credentialing process. Due to the implementation of centralized credentialing, the CCO has had no responsibility for provider credentialing for more than two years. Molina compares member and practitioner REL data and analyzes member complaint data to identify any network gaps and develops action plans to address any identified gaps. The CAN and CHIP Provider Manuals provide an overview of cultural competency and linguistic services. Molina's website provides information about cultural competency, including information about interpreter services, provider training modules, and provider tools.

Overall, Molina met the requirements of the Network Adequacy Validation. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

Provider Access and Availability Study

Constellation conducts Telephonic Provider Access Studies twice a year 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 Q2, 2024, improvement was shown in the successful contact rate for

CAN from the previous study that was conducted in Q4 2023. For CHIP, the successful contact rate decreased from the previous rate. See *Table 14*.

Table 14: Provider Access Study Results for Current and Previous Review Cycles

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
CAN			
Q4 2023	41 of 87	47%	.071
Q2 2024	46 of 89	52%	
CHIP			
Q4 2023	51 of 84	61%	.001
Q2 2024	29 of 85	34%	

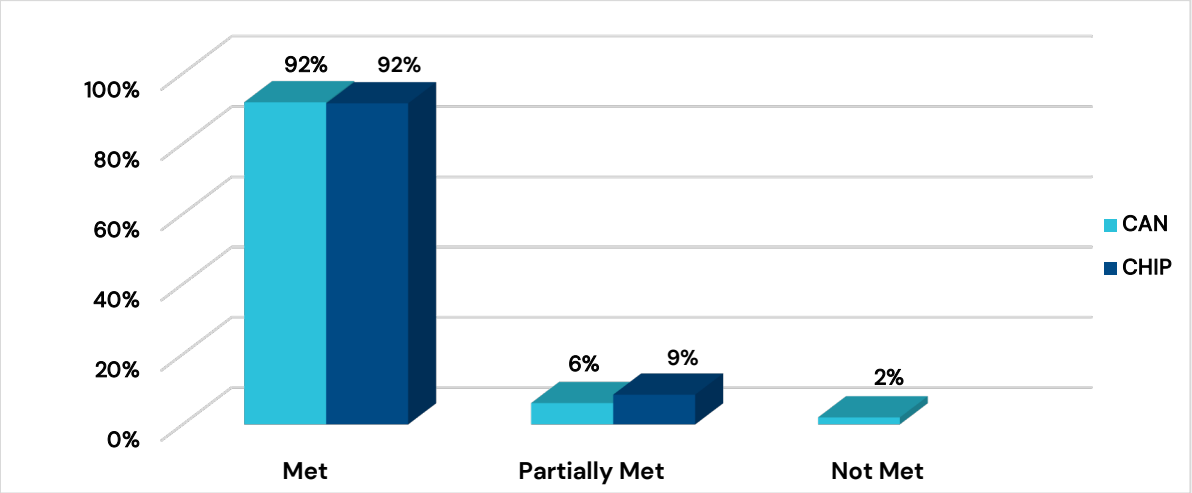
CAN: For Q2 2024, the success rate was 52%. This is a non- statistically significant improvement in the successful contact rate compared to the previous rate of 47%. The routine appointment compliance rate was 11% and the urgent appointment compliance rate was 0%. For the provider directory validation, the accuracy rate was 89%.

CHIP: For Q2 2024, the success rate was 34%. This is a decline from the successful contact rate of 61% from the previous rate. The routine appointment availability compliance rate was 68% and the urgent appointment availability compliance rate was 9%. For the provider directory validation, the accuracy rate was 62%.

The Q4 2024 call studies for CAN and CHIP are currently in progress.

As displayed in *Figure 4: Provider Services Findings*, 92% of the Provider Services standards were scored as "Met" for both CAN and CHIP.

Figure 4: Provider Services Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, recommendations, and corrective actions for the Provider Services section are found in the following tables.

Table 15: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Provider panel assignments can be viewed/downloaded from the Availity portal and there are various mechanisms in place for providers to verify member eligibility.			✓
Molina monitors the status of providers' panels to ensure there are enough providers with open panels to provide appropriate member access.			✓
Geographic access standards for all provider types are appropriately documented and routine monitoring is conducted to ensure network adequacy.			✓
Molina's website provides information about cultural competency, including information about interpreter services, provider training modules, and provider tools.	✓		✓
Molina conducts routine audits of appointment and after-hours access.			✓
Initial and ongoing provider education processes are sufficient to ensure providers have the information needed to operate within Molina's network.	✓		
Molina adopts clinical practice guidelines and preventive health guidelines to provide up-to-date treatment and diagnostic information to providers, reduce inter-provider variation, and define expected standards of practice.	✓		
Molina routinely assesses provider compliance with medical record documentation and maintenance standards.	✓		

Table 16: Provider Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Molina confirmed that there is no policy documenting the process for informing providers of their panel assignments.	*Recommendation: Create a policy, or add to an existing policy, to document the process for notifying providers of members assigned to their panels.*			✓
Page four of Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, states, "Molina requests practitioner race/ethnicity and language information from all contracted practitioners, on a voluntary basis, through its initial credentialing process." However, credentialing has not been a health plan responsibility for more than two years.	*Recommendation: Revise Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, to correct the process by which Molina receives provider race, ethnicity, and language data.*	✓		
Appointment access standards for CAN are documented in Policy MHMS-QI-006, Access to Care, in the CAN Provider Manual, and on the CAN website. The following issues were noted: • Policy MHMS-QI-006, Access to Care, states that post-discharge appointments with BH/SUD providers are required within 7 calendar days of the discharge and 30 calendar days from previous appointment. The *CAN Contract, Section 7 (B) (2) and the CHIP Contract, Section 7 (B) (2)* do not include "and 30 calendar days from previous appointment." • For routine visits with BH/SUD providers, the CAN Provider Manual, CHIP Provider Manual, and the CAN and CHIP websites indicate the timeframe is within 7 calendar days. The *CAN Contract, Section 7 (B) (2), the CHIP Contract, Section 7 (B) (2),* and Policy MHMS-QI-006 state the timeframe is within 21 calendar days. • For most appointment standards, Policy MHMS-QI-006 indicates Molina's goal is for 90% of the appointments to be provided within the established timeframes. However, the policy states the goal for BH post-discharge appointments is for 75% of the appointments to be provided within the established timeframe. Onsite discussion revealed this is incorrect; the goal for post-discharge BH appointments is 90%.	*Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to reflect the correct timeframe for post-discharge BH/SUD provider appointments and to correct the goal for post-discharge BH/SUD provider appointments. Revise the CAN and CHIP Provider Manuals and CAN and CHIP websites to reflect the correct timeframe for routine visits with BH/SUD providers.*	✓		✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The Q2 2024 CAN and CHIP Provider Appointment Availability Reports showed that the overall successful contact rates were low, ranging from 20% to 46.67%. Molina discussed the health plan's activities to educate providers about the importance of being available to members within the required parameters, including the ability for members to contact providers' offices by telephone.	*Recommendation: Continue efforts to educate providers about the importance of being available to members by telephone.*			✓
The CAN and CHIP Provider Manuals state, "Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Member Contact Center…" However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services.	*Corrective Action Plan: Revise the CAN and CHIP Provider Manuals to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center.*			✓
The CAN Provider Manual does not include the required statement regarding non-exclusivity. Refer to the *CAN Contract, Section 7 (H) 2 (s).*	*Corrective Action Plan: Revise the CAN Provider Manual to include the required non-exclusivity statement.*	✓		
Discrepancies were noted in the frequency of reviewing CPGs and PHGs when comparing the following: • Per report of Molina staff during onsite discussion, the CPGs and PHGs are reviewed at least annually. • Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, states, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer." It then states, "All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly…" • The CAN Provider Manual indicates all CPGs and PHGs are reviewed at least monthly. • The CHIP Provider Manual indicates CPGs are reviewed annually. It then states a review is conducted at least monthly. For PHGs, the CHIP Provider Manual states, "All guidelines are updated with each release by USPSTF…"	*Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.*	✓	✓	

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
but does not define the frequency of review. • The QI Program Description indicates the CPGs and PHGs are reviewed at least quarterly.				
Molina submitted an explanation that the adopted clinical practice and preventive health guidelines are the same for CAN and CHIP; however, there were discrepancies noted in the guidelines listed on the CHIP website when comparing to the CAN website. Additionally, the hyperlinks for the following guidelines were non-functional on the CHIP website: • Coronary and Other Vascular Disease • Heart Failure • Gestational Diabetes • Synagis • Clinical Management Guideline Compendium The CHIP website includes the guideline for "Standards in Medical Care in Diabetes – 2019" while the CAN website includes "Standards of Care in Diabetes—2023."	*Corrective Action Plan: Revise the CHIP website to include the same clinical practice and preventive health guidelines as those listed on the CAN website. Update all the non-functional hyperlinks to the guidelines. Revise the CHIP website to include the current "Standards of Care in Diabetes—2023" guideline.*	✓		
Policy MHMS-QI-124, Standards of Medical Record Documentation, page nine, states, "Noncompliant providers with incomplete CAPs are submitted to the Peer Review Committee for consideration during the recredentialing process." However, the CCO does not conduct recredentialing activities.	*Recommendation: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to correctly reflect the process followed for non-compliant providers with incomplete CAPs.*	✓		
For the 2023 provider satisfaction survey, the response rate was low at 7.7%, although this is an increase from 5% last year.	*Recommendation: Continued efforts should be made to improve survey response rates to gather a better representation of the providers.*	✓		

PROVIDER SERVICES—CAN

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					Providers are informed of the members assigned to their panels via the Availity provider portal. Providers are educated to consult the portal to view and download their member panel assignments. Information provided by Molina confirmed that there is no policy documenting the process for informing providers of their panel assignments; however, the CAN Provider Manual includes information that they may view panel assignments via the portal. *Recommendation: Create a policy, or add to an existing policy, to document the process for notifying providers of members assigned to their panels.*
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Member enrollment data is loaded into QNXT within five business days of receiving the Member Listing Report from DOM. Participating providers can verify member eligibility in a variety of ways, including: • Telephonically by calling the Member and Provider Contact Center • Telephonically through the automated telephone system

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Through the web/provider portal Non-participating providers can verify member eligibility and enrollment by contacting the Member and Provider Contact Center. These processes are documented in Policy MHMS-M&PCC-03, Eligibility Verification.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, states, "On a Bi-Annual basis, MHMS shall assess Provider Panel Availability through a Closed Panel Report to ensure that enough Providers are accepting new patients to meet member's needs." The Closed Panel Report provided for review was run in June 2024, as reported by Molina staff during the onsite. The report indicates 1,525 providers have closed panels. Molina reported no network gaps were identified related to these closed panels.
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					The geographic access standards for PCPs are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and are compliant with contractual requirements. As noted in this policy, Molina runs quarterly Geographic Access Assessment Reports to assess compliance with the geographic access requirements. These reports are submitted to DOM. The Q1 2024 MSCAN GeoAccess Report indicates provider access is measured by county using the correct parameters for PCP access.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						This report also confirmed that Molina contracts with Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Onsite discussion confirmed that the Indian Health Care Providers within the state of Mississippi decline to participate in the CCO's network. However, Molina allows eligible members to use these providers as if they were in network and with no requirements for authorization. Molina's claims systems are set to pay Indian Health Care Providers at an in-network rate.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					The geographic access standards for specialty and other provider types are documented in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, and are compliant with contractual requirements. These reports are submitted to DOM. The Q1 2024 MSCAN GeoAccess Report indicates provider access is measured by county using the correct parameters for specialty and other provider access.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					As noted in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, Molina runs quarterly GeoAccess reports and submits them to DOM. Molina uses these reports to identify network deficiencies and to determine any existing barriers to improvement, improvements since the previous quarter's report, and to determine if any enhancements or alterations to any internal standards are needed. Molina also considers member complaints

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						about access to determine if adjustments to the network are needed.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					Molina has developed the Health Equity and Cultural Competency Program "to facilitate the provision and delivery of effective, equitable, understandable, respectful, and culturally competent health care and services" to members. The 2024-2025 Health Equity and Cultural Competency Program Description is included as an appendix to the 2024 Quality Improvement Program Description. Page four of Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, states, "Molina requests practitioner race/ethnicity and language information from all contracted practitioners, on a voluntary basis, through its initial credentialing process." However, credentialing has not been a health plan responsibility for more than two years. Onsite discussion of this finding confirmed Molina collects provider race, ethnicity, and language data through the provider files received from the centralized credentialing entity, Gainwell. *Recommendation: Revise Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, to correct the process by which Molina receives provider race, ethnicity, and language data.* Policy MHMS-QI-009, Race/Ethnicity and Language Data Collection, details processes for collecting member race/ethnicity and language data from the QNXT system,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the U.S. Census Bureau, and/or Consumer Assessment of Healthcare Providers and Systems Survey results. Member and provider race/ethnicity and language data is compared to identify any network gaps and to develop action plans to address any identified gaps. Molina also analyzes complaint data related to member cultural and linguistic needs. Molina publishes provider demographic information and language services available through practices in the online provider directories, and members may call the Contact Center to obtain information about providers. The CAN Provider Manual provides an overview of Cultural Competency and Linguistic Services and directs the reader to Molina's website or to contact a Provider Services Representative to obtain additional information about cultural competency and linguistic services. Molina's website provides information about cultural competency, interpreter services, provider training modules, and provider tools.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. Molina uses QNXT as the data management system. There are daily updates from Gainwell, the centralized credentialing vendor. Verification is conducted

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						through a portal update based on information from the provider. The member-facing directory is updated 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					Processes for identifying, documenting, and tracking potential quality of care issues; reviewing, reporting, and resolving Serious Reportable Adverse Events and Never Events; and recognizing and preventing events that may place a member's health and well-being at risk are documented in Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events. Procedures for terminating a network provider and notifying the affected provider and others of the termination are found in Procedure MHMS-PC-09, MHMS Provider Termination Process. Policy MHMS-PC-02, MHMS Provider Contracting Criteria, states "In instances where MHMS declines to include a Provider in the network, MHMS will provide written notification of the reason for the decision to the Provider" and "MHMS will not contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act." Onsite discussion confirmed the Compliance Department is responsible for notifying DOM of all CCO contracting denials due to Program Integrity Reasons.
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable		X				Appointment access standards for CAN are documented in Policy MHMS-QI-006, Access to Care,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
access to practitioners and that are consistent with contract requirements.						in the CAN Provider Manual, and on the CAN website. The following issues were noted: • Policy MHMS-QI-006, Access to Care, states that post-discharge appointments with BH/SUD providers when the CCO is aware of the discharge are required within 7 calendar of the discharge and 30 calendar days from previous appointment. The *CAN Contract, Section 7 (B) (2)* does not include "and 30 calendar days from previous appointment." • For routine visits with BH/SUD providers, the CAN Provider Manual and the CAN website indicate the timeframe is within 7 calendar days. The *CAN Contract, Section 7 (B) (2)* and Policy MHMS-QI-006 state the correct timeframe of within 21 calendar days. • For most appointment standards, Policy MHMS-QI-006 indicates Molina's goal is for 90% of appointments to be provided within the established timeframes. However, the policy states the goal for BH post-discharge appointments is for 75% of appointments to be provided within the established timeframe. Onsite discussion revealed this is incorrect; the goal for post-discharge BH appointments is 90%. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to reflect the correct timeframe for post-discharge BH/SUD provider appointments and to*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						correct the goal for post-discharge BH/SUD provider appointments. Revise the CAN Provider Manual and CAN website to reflect the correct timeframe for routine visits with BH/SUD providers.
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, states, "Molina conducts an appointment and after-hour accessibility audit on a defined sample of primary care physicians, high volume specialists, high impact specialists, 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 "Procedure" section of the policy states Molina's Quality Department conducts quarterly appointment and after-hour accessibility audits. In addition to these audits, provider compliance with appointment access standards is assessed through assessment of member complaint data regarding appointment access and results of member satisfaction surveys. The results of the audits and evaluations are reported to the Quality Improvement Committee, and corrective action is implemented for identified issues. Review of the Q2 2024 CAN Provider Appointment Availability Report reflected all providers who were successfully contacted were compliant with the established appointment access standards except for one BH provider related to well care visits. However, the overall successful contact rates were low, ranging

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						from 20% to 46.67%. Molina discussed the health plan's activities to educate providers about the importance of being available to members within the required parameters, including the ability for members to contact providers' offices by telephone. *Recommendation: Continue efforts to educate providers about the importance of being available to members by telephone.*
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 the online directories are "kept current via a nightly scripted systemic job that pulls all records updated each day into the POD database to be displayed in the POD." It further states that each weekend, an update occurs "for all records in QNXT that meet the requirements to be pulled into the POD." Molina validates Provider Directory information by sending quarterly communications (telephonic, mail, and/or email) to providers to determine whether updates are needed for provider office location, office hours, phone, fax, email; additions or closures of office locations; addition or termination of a provider; change in tax ID or NPI number; panel changes, etc.
3. The CCO's provider network is adequate and is consistent with the requirements of the	X					DOM has established time/distance requirements for PCPs, obstetrics/gynecology (OB/GYN) providers, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
CMS protocol, "Validation of Network Adequacy."						specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments using Quest Analytics software. Molina's Information Systems Capability Assessment documentation indicates the organization's personnel and systems can perform the Medicaid data processing required by DOM. Policies and procedures demonstrate that sound information security practices are utilized.
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					Molina's Provider Services staff conduct provider orientation within 30 days of a provider becoming active in Molina's network. The orientation is based on Molina's processes, state and federal regulations, and NCQA requirements and follows the MHMS New Provider Orientation Presentation. The orientation covers an appropriate array of topics. If a provider declines to participate in an orientation session, the orientation materials are mailed to the provider. Records are maintained for all orientations. The provider orientation process is detailed in Policy and Procedure MHMS-NM-008, Provider Education and Training.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					The CAN Provider Manual includes an overview of Healthcare Services, including Utilization Management,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Integrated Care Management Program, Care Management, and Health Management.
2.2 Billing and reimbursement practices;	X					The CAN Provider Manual provides information about claims and billing procedures and requirements. It addresses coding and payment policies, telehealth claims and billing, claim submissions, coordination of benefits and third-party liability, etc.
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.
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;		X				The CAN Provider Manual addresses PCP referrals to specialists, and indicates prior authorization is not required for referrals to participating specialists, specialists acting as PCPs, etc. The CAN Provider Manual states, "Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Member Contact Center…" However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Molina staff stated that this is so that members may obtain a list of participating providers if needed. *Corrective Action Plan: Revise the CAN Provider Manual to clarify the statement that members may*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						self-refer to behavioral health care by calling the Member Contact Center.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					The CAN Provider Manual addresses the expectation that PCPs follow up with members who are not compliant with EPSDT services, 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 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 provides detailed information about pharmacy services, and addresses the Single Pharmacy Benefit Administrator that became effective 7/1/24, the requirement to use

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						DOM's Preferred Drug List, pharmacy prior authorization processes, pharmacy claims, etc.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					Providers must notify Molina in writing or through the CAQH portal of any changes in their practice information as soon as possible but at least 30 calendar days in advance. This includes opening or closing the practice to new patients and other changes in panel size. This process is communicated in the CAN Provider Manual.
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					Providers are informed in the CAN Provider Manual that they are expected to participate in Quality Programs, including access to care standards, site and medical record-keeping practice reviews, and delivery of patient care.
2.17 A description of the provider web portal;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.			X			The CAN Provider Manual does not include the required non-exclusivity statement. Refer to the *CAN Contract, Section 7 (H) 2 (s).* *Corrective Action Plan: Revise the CAN Provider Manual to include the required non-exclusivity requirements.*
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider education processes are detailed in Policy and Procedure MHMS-NM-008, Provider Education and Training. Molina's Provider Services staff conduct ongoing education for providers through face-to-face visits, workshops, newsletters, etc. Ongoing education and training are based on health plan processes and procedures, federal and state regulations, etc. Molina also collaborates with DOM for provider workshops.
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				Molina adopts CPGs and PHGs to provide up-to-date treatment and diagnostic information to providers, reduce inter-provider variation, and define expected standards of practice. The guidelines are adopted from nationally recognized, evidence-based sources, and they may also serve as the basis for health management programs, benefit interpretation, or quality measures. The National Quality Improvement Committee reviews and adopts the CPGs and PHGs and disseminates the adopted guidelines to the health plan for local review and approval by the Quality

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Improvement and Health Equity Transformation Committee. The membership of this committee includes external network practitioners. This information was noted in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. Discrepancies were noted in the frequency of reviewing CPGs and PHGs when comparing the following: • Per report of Molina staff during onsite discussion, the CPGs and PHGs are reviewed at least annually. • Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, states, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer." It then states, "All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly…" • The CAN Provider Manual indicates all CPGs and PHGs are reviewed at least monthly. • The QI Program Description indicates the CPGs and PHGs are reviewed at least quarterly. This was discussed during the onsite and Molina staff reported the CPGs and PHGs are reviewed at least annually.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.
2. The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members.	X					As noted in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina disseminates the PHGs and CPGs to appropriate providers in a variety of ways, including provider orientation materials, provider manuals, newsletters, mailings, fax blasts, etc. The guidelines are available on Molina's website and are available in print 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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II D. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Molina documents the standards for medical record documentation for records maintained by network providers in Policy MHMS-QI-124, Standards of Medical Record Documentation. The standards are also found in the Provider Manuals.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					Per Policy MHMS-QI-124, Standards of Medical Record Documentation, Molina monitors provider compliance with medical record documentation standards by conducting medical record review audits from a sample of network providers every three years. Each record reviewed for a specific provider is scored independently and the scores for all the provider's records are averaged to determine the provider's final score. Providers are expected to score at least 80%. Scores below 80% prompt additional review and a potential re-audit of the provider. These providers are notified in writing of the identified issues and a corrective action plan is implemented that must be completed within 180 days. A re-audit is then conducted to ensure the provider is compliant. Results of the medical record audits are reported to the appropriate Quality committee.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina reported that they are moving to an annual medical record review process. The policy, page 9, states, "Noncompliant providers with incomplete CAPs are submitted to the Peer Review Committee for consideration during the recredentialing process." However, the CCO does not conduct recredentialing activities. *Recommendation: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to correctly reflect the process followed for non-compliant providers with incomplete CAPs.*
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Member and Provider Satisfaction Committee minutes from December 2023 included an overview of the 2023 provider satisfaction survey. A total of 1,500 surveys were sent out via mail, phone, and internet. The response rate was 7.7%, which is an increase from 5% last year. The overall survey rating was 76.3%, which is higher than the benchmark. When asked if the provider would recommend Molina, the rating was 86.4%, which is below the benchmark. Ratings also fell below the benchmark in Finance, Utilization Management, Networking, Pharmacy, & Provider Relations. The Contact Center was at the benchmark. *Recommendation: Continued efforts should be made to improve survey response rates to gather a better representation of the providers.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Satisfaction survey results were presented to the Quality Improvement and Health Equity Transformation Committee in Q1 2024 meeting.

PROVIDER SERVICES—CHIP

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					Providers are informed of the members assigned to their panels via the Availity provider portal. Providers are educated to consult the portal to download their member panel assignments. Information provided by Molina confirmed that there is no policy documenting the process for informing providers of their panel assignments; however, the CHIP Provider Manual includes information that they may view panel assignments via the portal.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Create a policy, or add to an existing policy, to document the process for notifying providers of members assigned to their panels.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Member enrollment data is loaded into QNXT within five business days of receiving the Member Listing Report from DOM. Participating providers can verify member eligibility in a variety of ways, including: • Telephonically by calling the Member and Provider Contact Center • Telephonically through the automated telephone system • Through the web/provider portal. Non-participating providers can verify member eligibility and enrollment by contacting the Member and Provider Contact Center. These processes are documented in Policy MHMS-M&PCC-03, Eligibility Verification.
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, "On a Bi-Annual basis, MHMS shall assess Provider Panel Availability through a Closed Panel Report to ensure that enough Providers are accepting new patients to meet member's needs." The Closed Panel Report provided for review was run in June 2024, as reported by Molina staff during the onsite. The report indicates 1,525 providers have closed panels. Molina reported no network gaps were identified related to these closed panels.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The geographic access standards for PCPs are documented in Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, and are compliant with contractual requirements. As noted in the policy, Molina runs quarterly Geographic Access Assessment Reports to assess compliance with the geographic access requirements. These reports are submitted to DOM. The Q1 2024 CHIP GeoAccess Report indicates provider access is measured by county using the correct parameters for PCP access. The report also confirmed that Molina has contracts with FQHCs and RHCs. Onsite discussion confirmed that the Indian Health Care Providers within the state of Mississippi decline to participate in the CCO's network. However, Molina allows eligible members to use these providers as if they were in network and with no requirements for authorization. Molina's claims systems are set to pay Indian Health Care Providers at an in-network rate.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					The geographic access standards for specialty and other provider types are documented in Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, and are compliant with contractual requirements. These reports are submitted to DOM. The Q1 2024 CHIP GeoAccess Report indicates provider access is measured by county using the correct parameters for specialty and other provider access.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					As noted in Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, Molina runs quarterly GeoAccess reports and submits them to DOM. Molina uses these reports to identify network deficiencies and to determine any existing barriers to improvement, improvements since the previous quarter's report, and to determine if any enhancements or alterations to any internal standards are needed. Molina also considers member complaints about access to determine if adjustments to the network are needed.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					Molina has developed the Health Equity and Cultural Competency Program "to facilitate the provision and delivery of effective, equitable, understandable, respectful, and culturally competent health care and services" to members. The 2024-2025 Health Equity and Cultural Competency Program Description is included as an appendix to the 2024 Quality Improvement Program Description. Page four of Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, states, "Molina requests practitioner race/ethnicity and language information from all contracted practitioners, on a voluntary basis, through its initial credentialing process." However, credentialing has not been a health plan responsibility for more than two years. Onsite discussion of this finding confirmed Molina collects provider race, ethnicity, and language

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						data through the provider files received from the centralized credentialing entity, Gainwell. *Recommendation: Revise Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, to correct the process by which Molina receives provider race, ethnicity, and language data.* Policy MHMS-QI-009, Race/Ethnicity and Language Data Collection, details processes for collecting member race/ethnicity and language data from the QNXT system, the U.S. Census Bureau, and/or Consumer Assessment of Healthcare Providers and Systems Survey results. Member and provider race/ethnicity and language data is compared to identify any network gaps and to develop action plans to address any identified gaps. Molina also analyzes complaint data related to member cultural and linguistic needs. Molina publishes provider demographic information and language services available through practices in the online provider directories, and members may call the Contact Center to obtain information about providers. The CHIP Provider Manual provides an overview of Cultural Competency and Linguistic Services and directs the reader to Molina's website or to contact a Provider Services Representative to obtain additional information about cultural competency and linguistic services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina's website provides information about cultural competency, interpreter services, provider training modules, and provider tools.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. Molina uses QNXT as the data management system. There are daily updates from Gainwell, the centralized credentialing vendor. Verification is conducted through a portal update based on information from the provider. The member-facing directory is updated 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					Processes for identifying, documenting, and tracking potential quality of care issues; reviewing, reporting, and resolving Serious Reportable Adverse Events and Never Events; and recognizing and preventing events that may place a member's health and well-being at risk are documented in Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events. Procedures for terminating a network provider and notifying the affected provider and others of the termination are found in Procedure MHMS-PC-09, MHMS Provider Termination Process. Policy MHMS-PC-02, MHMS Provider Contracting Criteria, states "In instances where MHMS declines to include a Provider in the network, MHMS will provide written notification of the reason for the decision to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Provider" and "MHMS will not contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act." Onsite discussion confirmed the Compliance Department is responsible for notifying DOM of all CCO denials of contracting due to Program Integrity reasons.
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				Appointment access standards for CHIP are documented in Policy MHMS-QI-006, Access to Care, in the CHIP Provider Manual, and on the CHIP website. The following issues were noted: • Policy MHMS-QI-006, Access to Care, states that post-discharge appointments with BH/SUD providers when the CCO is aware of the discharge are required within 7 calendar days of the discharge and 30 calendar days from previous appointment. The *CHIP Contract, Section 7 (B) (2)* does not include "and 30 calendar days from previous appointment." • For routine visits with BH/SUD providers, the CHIP Provider Manual and the CHIP website indicate the timeframe is within 7 calendar days. The *CHIP Contract, Section 7 (B) (2)* and Policy MHMS-QI-006 state the correct timeframe of within 21 calendar days. • For most appointment standards, Policy MHMS-QI-006 indicates Molina's goal is for 90% of appointments to be provided within the established

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						timeframes. However, the policy states that the goal for BH post-discharge appointments is for 75% of appointments to be provided within the established timeframe. Onsite discussion revealed this is incorrect; the goal for post-discharge BH appointments is 90%. *Corrective Action Plan: Revise Policy MHMS-QI-006, Access to Care, to reflect the correct timeframe for post-discharge BH/SUD provider appointments and to correct the goal for post-discharge BH/SUD provider appointments. Revise the CHIP Provider Manual and CHIP website to reflect the correct timeframe for routine visits with BH/SUD providers.*
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, states, "Molina conducts an appointment and after-hour accessibility audit on a defined sample of primary care physicians, high volume specialists, high impact specialists, 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 "Procedure" section of the policy states Molina's Quality Department conducts quarterly appointment and after-hour accessibility audits. In addition to these audits, provider compliance with appointment access standards is assessed through assessment of member complaint data regarding appointment

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						access and results of member satisfaction surveys. The results of the audits and evaluations are reported to the Quality Improvement Committee, and corrective action is implemented for identified issues. Review of the Q2 2024 CHIP Provider Appointment Availability Report reflected all providers who were successfully contacted were compliant with the established appointment access standards except for one BH provider related to well care visits. However, the overall successful contact rates were low, ranging from 20% to 46.67%. Molina discussed the health plan's activities to educate providers about the importance of being available to members within the required parameters, including the ability for members to contact providers' offices by telephone. *Recommendation: Continue efforts to educate providers about the importance of being available to members by telephone.*
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 the online directories are "kept current via a nightly scripted systemic job that pulls all records updated each day into the POD database to be displayed in the POD." It further states that each weekend, an update occurs "for all records in QNXT that meet the requirements to be pulled into the POD."

Standard	Score					Comments
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						Molina validates Provider Directory information by sending quarterly communications (telephonic, mail, and/or email) to providers to determine whether updates are needed for provider office location, office hours, phone, fax, email; additions or closures of office locations; addition or termination of a provider; change in tax ID or NPI number; panel changes, etc.
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					DOM has established time/distance requirements for PCPs, OB/GYN providers, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments using Quest Analytics software. Molina's Information Systems Capability Assessment documentation indicates the organization's personnel and systems can perform the Medicaid data processing required by DOM. Policies and procedures demonstrate that sound information security practices are utilized.
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					Molina's Provider Services staff conduct provider orientation within 30 days of a provider becoming active in Molina's network. The orientation is based on Molina's processes, state and federal regulations, and NCQA requirements and follows the MHMS New Provider Orientation Presentation. The orientation covers an appropriate array of topics.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						If a provider declines to participate in an orientation session, the orientation materials are mailed to the provider. Records are maintained for all orientations. The provider orientation process is detailed in Policy and Procedure MHMS-NM-018, Provider Education and Training.
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 an overview of Healthcare Services, including Utilization Management and the Integrated Care Management Program.
2.2 Billing and reimbursement practices;	X					The CHIP Provider Manual provides information about claims and billing procedures and requirements. It addresses coding and payment policies, telehealth claims and billing, claim submissions, coordination of benefits and third-party liability, etc.
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					
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;		X				The CHIP Provider Manual addresses PCP referrals to specialists, and indicates prior authorization is not required for referrals to participating specialists, specialists acting as PCPs, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CHIP Provider Manual states, "Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling Molina's Member Contact Center…" However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Molina staff stated that this is so that members may obtain a list of participating providers if needed. *Corrective Action Plan: Revise the CHIP Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center.*
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					The CHIP Provider Manual addresses the expectation that PCPs follow up with members who are not compliant with Well-Baby and Well-Child Care services, 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.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 provides detailed information about pharmacy services, and addresses the Single Pharmacy Benefit Administrator that became effective 7/1/24, the requirement to use DOM's Preferred Drug List, pharmacy prior authorization processes, pharmacy claims, etc.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					Providers must notify Molina in writing or through the CAQH portal of any changes in their practice information as soon as possible but at least 30 calendar days in advance. This includes opening or closing the practice to new patients and other changes in panel size. This process is communicated in the CHIP Provider Manual.
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					Providers are informed in the CHIP Provider Manual that they are expected to participate in the Quality Improvement Program, including activities related to quality of care and services. The manual also indicates Molina uses provider performance data to develop quality improvement activities, public reporting to consumers, preferred status designation in the network, and/or reduced Member cost sharing.
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					The CHIP Provider Manual states, "Molina may not enter into a Provider agreement that prohibits the Provider from contracting with another Payer or that prohibits or penalizes Molina for contracting with other Providers. Molina may not require Providers who agree to participate in the CHIP Program to contract with Molina's other lines of business."
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider education processes are detailed in Policy and Procedure MHMS-NM-018, Provider Education and Training. Molina's Provider Services staff conduct ongoing education for providers through face-to-face visits, workshops, newsletters, etc. Ongoing education and training are based on health plan processes and procedures, federal and state regulations, etc. Molina also collaborates with DOM for provider workshops.
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Molina adopts CPGs and PHGs to provide up-to-date treatment and diagnostic information to providers, reduce inter-provider variation, and define expected standards of practice. The guidelines are adopted from nationally recognized, evidence-based sources, and they may also serve as the basis for health management programs, benefit interpretation, or quality measures. The National Quality Improvement Committee reviews and adopts the CPGs and PHGs and disseminates the adopted guidelines to the health plan for local review and approval. This is the responsibility of the Quality Improvement and Health Equity Transformation Committee. The membership of this committee includes external network practitioners. This information was noted in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. Discrepancies were noted in the frequency of reviewing CPGs and PHGs when comparing the following: • Per report of Molina staff during onsite discussion, the CPGs and PHGs are reviewed at least annually. • Policy MHMS QI 018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, states, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer." It then states, "All clinical practice guidelines and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						preventive health guidelines will be reviewed at least quarterly…" • The CHIP Provider Manual indicates CPGs are reviewed annually. It then states a review is conducted at least monthly. For PHGs, the CHIP Provider Manual states, "All guidelines are updated with each release by USPSTF…" but does not define the frequency of review. • The QI Program Description indicates the CPGs and PHGs are reviewed at least quarterly. This was discussed during the onsite and Molina staff reported the CPGs and PHGs are reviewed at least annually. *Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.*
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, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina disseminates the PHGs and CPGs to appropriate providers in a variety of ways, including provider orientation materials, provider manuals, newsletters, mailings, fax blasts, etc. The guidelines are available on Molina's website and are available in print upon request. Molina submitted an explanation that the adopted guidelines are the same for CAN and CHIP; however, there were discrepancies noted in the guidelines listed

Standard	Score					Comments
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						on the CHIP website when comparing to the CAN website. Additionally, the hyperlinks for the following guidelines were non-functional on the CHIP website: • Coronary and Other Vascular Disease • Heart Failure • Gestational Diabetes • Synagis • Clinical Management Guideline Compendium The CHIP website includes the guideline for "Standards in Medical Care in Diabetes – 2019" while the CAN website includes "Standards of Care in Diabetes—2023." *Corrective Action: Revise the CHIP website to include the same guidelines as those listed on the CAN website. Update all the non-functional hyperlinks to the guidelines. Revise the CHIP website to include the current "Standards of Care in Diabetes—2023" guideline.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.4 Recommendations specific to member high-risk groups;	X					
3.5 Behavioral health.	X					
II D. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Molina documents the standards for medical record documentation for records maintained by network providers in Policy MHMS-QI-124, Standards of Medical Record Documentation. The standards are also found in the Provider Manuals.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	X					Per Policy MHMS-QI-124, Standards of Medical Record Documentation, Molina monitors provider compliance with medical record documentation standards by conducting medical record review audits from a sample of network providers every three years. Each record reviewed for a specific provider is scored independently and the scores for all the provider's records are averaged to determine the provider's final score. Providers are expected to score at least 80%. Scores below 80% prompt additional review and a potential re-audit of the provider. These providers are notified in writing of the identified issues and a corrective action plan is implemented that must be completed within 180 days. A re-audit is then conducted to ensure the provider is compliant. Results of the medical record audits are reported to the appropriate Quality committee. Molina reported that they are moving to an annual medical record review process.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The policy, page 9, states, "Noncompliant providers with incomplete CAPs are submitted to the Peer Review Committee for consideration during the recredentialing process." However, the CCO does not conduct recredentialing activities. *Recommendation: Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to correctly reflect the process followed for non-compliant providers with incomplete CAPs.*
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					Member and Provider Satisfaction Committee minutes from December 2023 included an overview of the 2023 provider satisfaction survey. A total of 1,500 surveys were sent out via mail, phone, and internet. The response rate was 7.7%, which is an increase from 5% last year. The overall survey rating was 76.3%, which is higher than the benchmark. When asked if the provider would recommend Molina, the rating was 86.4%, which is below the benchmark. Ratings also fell below the benchmark in Finance, Utilization Management, Networking, Pharmacy, & Provider Relations. The Contact Center was at the benchmark. *Recommendation: Continued efforts should be made to improve survey response rates to gather a better representation of the providers.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Satisfaction survey results were presented to the Quality Improvement and Health Equity Transformation Committee in Q1 2024 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 policies, procedures, member rights and responsibilities, member education, preventive health and chronic disease management, processes for handling grievances, and member enrollment and disenrollment.

Molina documents member rights and responsibilities in Policy MHMS-ME-003, Member Rights and Responsibilities, the 2024 MississippiCAN (Medicaid) Member Handbook (CAN Member Handbook), the 2024 Mississippi Children's Health Insurance Program (CHIP) Member Handbook (CHIP Member Handbook), the CAN and CHIP Provider Manuals, in member newsletters, in various mailings throughout the year, and on the CCO's website.

Members are educated about the health plan, coverage, programs, and services via new member packets, Member Handbooks, newsletters, etc. Discrepancies were noted in documentation of CAN member benefits when comparing the CAN Member Handbook to Molina's website. Those discrepancies were related to vision services, genetic testing, and non-emergency transportation. There were also discrepancies noted when comparing the CHIP Member Handbook and Molina's website. Those discrepancies included prior authorization requirements for ambulatory surgery, covered services for substance abuse, coverage for disease management, emergency transportation services, and prior authorization for radiology services. The Member Handbooks provide the phone number for the Member Services Contact Center, which can be contacted for various needs such as understanding information, scheduling rides, finding providers, and addressing grievances or appeals. The Member Handbooks also mention the 24-Hour Nurse Advice Line as well as functions available through the MyMolina.com member portal.

The CAN and CHIP Member Handbooks instruct members about PCP selection and sources of assistance if needed during the enrollment process. Policy MHI-EA-309.1, Disenrollment Processes, details the steps taken by the Enrollment Department to manage member disenrollment requests.

Information about preventive health programs and resources is provided in policy, the Member Handbooks, newsletters, mailings, the website, and telephone/text alerts. Health fairs, mobile/RV units, and other community events are coordinated to enhance member education. Contact Center staff are trained to inform members about available resources and recommended services.

Grievances

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

Information about filing and processing verbal and written grievances is provided in Policy MHMS-MRT-01, Member Complaints and Grievances. Grievance terminology is defined and the process for members and authorized representatives to file grievances is documented.

Members are informed of their right to file a grievance if they disagree with an extension of the resolution timeframe for an appeal or grievance. All grievances are logged and categorized with trends reported quarterly to the Quality Improvement and Health Equity Transformation Committee. Constellation reviewed a sample of grievance files. The files demonstrated that grievance acknowledgement, resolution, and member notification of the resolution were timely.

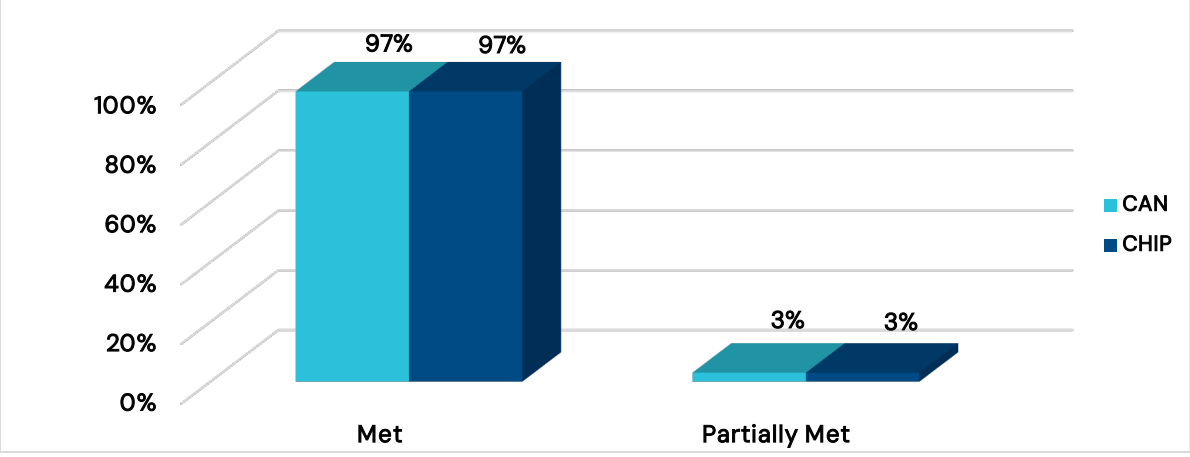
Member Satisfaction Survey Validation

Molina contracts with Press Ganey to conduct both the child and adult member surveys. The Measure Year (MY) 2022 surveys were fielded from March 2023 through May 2023. For reporting year 2023, the adult response rate was 13.0%, which is an improvement over the previous year's response rate of 10.8%. For year over year trending, the findings showed the highest rated items to be ease of filling out forms and how well doctors communicate; the lowest rated domain areas were rating of health plan and rating of health care.

The CAN child response rate was 9.2%, an improvement over last year's response rate of 7.7%. The top two domain measures were ease of filling out forms and how well doctors communicate. The lowest rated domain measures were rating of health care and rating of health plan. The CHIP response rate was 11.2%, which is a slight decline from the previous year's rate of 11.9%. For year over year trending, the highest ratings were for how well doctors communicate and ease of filling out forms; the lowest rated domains were rating of health plan and rating of health care.

As shown in *Figure 5,* 97% of the Member Services standards for CAN and CHIP were scored as "Met." Discrepancies in documentation of member benefits resulted in a "Partially Met" score.

Figure 5: Member Services Findings



Strengths, weaknesses, and corrective actions for the Member Services section are included in the following tables.

Table 17: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
The contact center service staff satisfaction rates increased to 41.1% in 2023, which is higher than the benchmark of 38.8%.	✓		
Information on preventive health programs and resources is provided to members in a variety of ways, including mailings, the website, telephone/text alerts, health fairs, mobile/RV units, and other community events to enhance member education.			✓
The grievance files demonstrated that grievances were acknowledged, resolved, and the members notified in a timely manner.		✓	

Table 18: Member Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Discrepancies were identified in documentation of CAN member benefits. Findings for the CAN Member Handbook and website include: • For Eye Care – Vision Services, the CAN Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the website states, "1 eye exam and 1 pair of glasses, annually." • The website states that "Genetic Testing - Inheritable disease diagnosis" is available, but this is not indicated in the CAN Member Handbook. • The CAN Member Handbook states transportation is available "To medical appointments, vision exams and pharmacy visits immediately following a medical appointment." The website states transportation is available "To medical appointments, vision exams and pharmacy."	*Corrective Action: Review and revise the CAN Member Handbook and website to ensure clear and consistent wording regarding covered benefits.*			✓
Discrepancies were identified in documentation of CHIP member benefits.	*Corrective Action: Review and revise the CHIP Member Handbook and website to*			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Findings for the CHIP Member Handbook and website include: • The CHIP Member Handbook indicates prior authorization is required for Ambulatory Surgical Center Services. The website does not indicate that prior authorization is required for this service. • The website does not match the CHIP Member Handbook regarding covered services for Substance Abuse Services Inpatient/Outpatient Care. • The CHIP Member Handbook indicates coverage of Disease Management services "as indicated by PCP." This is not referenced on the website. • The CHIP Member Handbook qualifies Emergency Ambulance services as being unlimited "based on life threatening condition present." However, the website does not match this requirement. • The CHIP Member Handbook documents that prior authorization is required for Radiology/X-rays, which is not indicated on the website.	*ensure clear and consistent wording regarding covered benefits.*			

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					Policy, MHMS-ME-003, Member Rights and Responsibilities, the CAN Member Handbook, Provider Manual, and the website document member rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services						

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:		X				Discrepancies were identified in documentation of CAN member benefits. Findings for the CAN Member Handbook and website include: • For Eye Care – Vision Services, the CAN Member Handbook states, "1 eye exam and 1 pair of glasses every fiscal year." However, the website states, "1 eye exam and 1 pair of glasses, annually." • The website states that "Genetic Testing - Inheritable disease diagnosis" is available, but this is not indicated in the CAN Member Handbook. • There is inconsistent wording regarding non-emergency transportation services. The CAN Member Handbook states that transportation is available "To medical appointments, vision exams and pharmacy visits immediately following a medical appointment." The website states that transportation is available "To medical appointments, vision exams and pharmacy."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Review and revise the CAN Member Handbook and website to ensure clear and consistent wording regarding covered benefits.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The CAN Member Handbook 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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 A description of EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						The CAN Member Handbook describes fraud and abuse and informs members of verbal, written, and anonymous reporting options.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						The CAN Member Handbook describes the purpose of advance directives along with member resources for additional information or assistance.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					The Member Handbook and website indicate the Contact Center's hours of operation are from 8:00 a.m. to 5:00 p.m. The Nurse Advice Line is available 24 hours per day, seven days per week.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Policy MHMS-M&PCC-04, Member Services General Operations, describes the initial and quarterly training for Contact Center staff, including the use of scripts

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and small group focused training to improve and enhance performance measures.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHI-EA-309.1, Disenrollment Processes, details the steps taken by the Enrollment Department to manage member disenrollment requests.
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 encourages members to utilize recommended services. Education is provided to members on a variety of topics, including general health education and information about preventive services and recommendations in the CAN Member Handbook, on the website, and via text/call messaging platforms.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.						
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					
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, to conduct both the adult and child surveys. Press Ganey acquired SPH analytics.
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 adult and child surveys.
3. The CCO reports results of the member satisfaction survey to providers.	X					The member satisfaction survey results were made available to providers in the Q1 2024 newsletter.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The Quality Improvement and Health Equity Transformation Committee discussed the results of the member satisfaction survey and opportunities for improvement in Q1 2024.
III G. Grievances						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Processes for the receipt and review of member grievances are described in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN Member Handbook, the CAN Provider Manual, and Molina's website.
1.1 Definition of a grievance and who may file a grievance;	X					Grievances are defined in the CAN Member Handbook and website.
1.2 The procedure for filing and handling a grievance;	X					Processes and platforms for filing a verbal or written grievance are outlined in the CAN Member Handbook.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					Timeframes for grievance acknowledgement, resolution, and extensions are clearly indicated in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN Member Handbook, CAN Provider Manual, and on Molina's website.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					Constellation reviewed a sample of CAN grievance files. The files demonstrated grievance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						acknowledgements, resolutions, and member notification of the resolutions were timely.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Grievances are appropriately evaluated for trends, which are 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 determine if the change is due to dissatisfaction.	X					DOM has approved Molina's process for evaluating member requests for disenrollment or PCP changes via the Disenrollment Survey. Monitored by the Enrollment Department, grievances are offered due to member dissatisfaction. Trending is reported quarterly to the Quality Improvement and Health Equity Transformation Committee.
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					Policy, MHMS-ME-003, Member Rights and Responsibilities, the CHIP Member Handbook, Provider Manual, and the website document member rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding 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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
of charge and be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:		X				Discrepancies were identified in documentation of CHIP member benefits. Findings for the CHIP Member Handbook and website include: • The CHIP Member Handbook indicates that prior authorization is required for Ambulatory Surgical Center Services. However, the website does not indicate the requirement of prior authorization for this service. • The website does not match the CHIP Member Handbook regarding covered services for Substance Abuse Services Inpatient/Outpatient Care. • The CHIP Member Handbook indicates coverage of Disease Management services "as indicated by PCP." This is not referenced on the website. • The CHIP Member Handbook qualifies Emergency Ambulance services as being unlimited "based on life threatening condition present." However, the website does not match this requirement.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The CHIP Member Handbook documents that prior authorization is required for Radiology/X-rays, which is not indicated on the website. *Corrective Action: Review and revise the CHIP Member Handbook and website to ensure clear and consistent wording regarding covered benefits.*
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the CCO's call center, and the member portal;						
1.13 A description of the Well-Baby and Well-Child services which include:						
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/education and referral for identified problems.						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						
1.17 Instructions on reporting suspected cases of fraud and abuse;						The CHIP Member Handbook describes fraud and abuse and informs members of verbal, written, and anonymous reporting options.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						The CHIP Member Handbook describes the purpose of advance directives along with member resources for additional information or assistance.
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					
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages.	X					
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					The Member Handbook and website indicate the Contact Center's hours of operation from 8:00 a.m. to 5:00 p.m. The Nurse Advice Line is available 24 hours per day, seven days per week.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Policy MHMS-M&PCC-04, Member Services General Operations, describes the initial and quarterly training for Contact Center staff, including the use of scripts

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and small group focused training to improve and enhance performance measures.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHI-EA-309.1, Disenrollment Processes, details the steps taken by the Enrollment Department to manage member disenrollment requests.
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 encourages members to utilize recommended services. Education is provided to members on a variety of topics, including general health education and information about preventive services and recommendations, in the CHIP Member Handbook, on the website, and via text/call messaging platforms.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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, to conduct the child surveys. Press Ganey acquired SPH analytics.
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 child member satisfaction survey.
3. The CCO reports the results of the member satisfaction survey to providers.	X					The member satisfaction survey results are made available to providers in the Q1 2024 newsletter.
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					The Quality Improvement and Health Equity Transformation Committee discussed the results of the member satisfaction survey and opportunities for improvement in Q1 2024.
III G. Grievances *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Processes for the receipt and review of member grievances are described in Policy MHMS-MRT-01, Member Complaints and Grievances, the CHIP Member Handbook, the CHIP Provider Manual, and on Molina's website.
1.1 Definition of a grievance and who may file a grievance;	X					Grievances are defined in the CHIP Member Handbook and website.
1.2 The procedure for filing and handling a grievance;	X					Processes and platforms for filing a verbal or written grievance are outlined in the CHIP Member Handbook.
1.3 Timeliness guidelines for resolution of the grievance;	X					Timeframes for grievance acknowledgements, resolutions, and extensions are clearly indicated in Policy MHMS-MRT-01, Member Complaints and Grievances, the CHIP Member Handbook, Provider Manual, and website.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					Constellation reviewed a sample of CHIP grievance files. The files demonstrated the grievances were acknowledged, resolved, and member notification of grievance resolution were timely.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are appropriately evaluated for trends, which are reported quarterly to the Quality Improvement and Health Equity Transformation 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					DOM has approved Molina's process for evaluating member requests for disenrollment or PCP changes via the Disenrollment Survey. Monitored by the Enrollment Department, grievances are offered due to member dissatisfaction. Trending is reported quarterly to the Quality Improvement and Health Equity Transformation Committee.
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 is a comprehensive program that focuses on ensuring members receive equitable, culturally, and linguistically appropriate healthcare and services. The 2024 Quality Improvement Program Description (QI Program Description) covers a wide range of areas for CAN and CHIP including medical, behavioral health, chemical dependency, and substance abuse care. Molina evaluates key aspects of healthcare and services, monitors continuity and coordination of care, assesses quality and clinical indicator performance, and addresses social needs and risks. Molina employs data-driven processes, collects and analyzes data from various sources, and implements quality improvement strategies to enhance health outcomes, patient safety, and reduce disparities. The QI Program involves a dedicated team overseeing quality improvement activities, utilizing health information systems, and collaborating with stakeholders to meet state and federal requirements.

The QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022.

Utilization data collection and analysis are integral components of Molina's QI Program. The scope of this program involves collecting and analyzing data from various sources to evaluate key aspects of healthcare and services. This data-driven approach helps in identifying disparities, improving services, enhancing health outcomes, and tailoring services to meet the unique needs of its members. Molina reviews potential over-and under-utilization data at least yearly using cross-functional teams.

The QI Work Plan is developed annually after the completion of the QI Program Annual Evaluation from the previous year. The 2023 and 2024 QI Work Plans were received. Molina's work plans include the ability to trend data over five years.

The Quality Improvement and Health Equity Transformation Committee is responsible for the implementation and ongoing examination of the QI Program. Through subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes and evaluates the progress and results of all quality improvement activities, institutes needed action, and ensures follow up. This committee is co-chaired by the Chief Medical Officer and the Quality Lead, with members from various leadership roles within the health plan. This committee also includes external network physicians specializing in pediatrics, internal medicine, and psychiatry. The committee meets quarterly, with the possibility of more frequent meetings or material reviews as needed. A quorum of at least 51% of committee members, including no less than half of network provider participants, is required to enact decisions.

Molina's participating practitioners serve on various committees and subcommittees within the organization. Participating providers may also be asked to participate with provider advisory groups that focus on critical topics. In cases where specific practitioner specialty feedback is needed, network physicians and specialists are used for assisting with the design or evaluation of specific programs. Molina shares provider performance data through various channels including the provider report card or gaps in care report. These are comprehensive tools designed to enhance the quality of care provided to Molina members by identifying and addressing gaps in care, supporting providers with actionable data, and promoting continuous improvement in healthcare delivery.

Policies MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provide an overview of Molina's role in compliance with the EPSDT, Well-Baby and Well-Child Care services program requirements. Molina conducts outreach and education to inform eligible members and providers about the program, emphasizing the importance of preventive care and how to access services. Molina has a tracking system to monitor member compliance with EPSDT and Well-Baby and Well-Child Care service provisions, including initial visits for newborns, screenings, diagnostic services, and follow-ups. Member target lists are generated to identify and provide outreach to those due for EPSDT and Well-Baby and Well-Child Care services. These policies indicate that members who receive an abnormal finding during their screenings are identified, and the member is contacted regarding the need for follow-up. Molina provided a copy of the tracking reports that demonstrated the follow-up conducted for abnormal findings.

Annually, Molina assesses the quality improvement initiatives and activities conducted during the year. The 2023 Quality Improvement Program Evaluation was provided with the desk materials. This evaluation included the analysis, trends, changes in those trends, and any barriers impacting the rates. The findings are reported to the appropriate QI committees and the Board of Directors.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

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

measures. The final PM validation results reflected the measurement period of January 1, 2023, through December 31, 2023.

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, 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 2023.

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. One record did not pass medical record review validation for the Prenatal and Postpartum Care (PPC) – Prenatal measure. Since 100% of all hybrid numerator compliant records were reviewed during medical record review validation (MRRV) for the PPC – Prenatal measure, this one error did not bias the reported rate and can be considered reportable.

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

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

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

Performance Measure Documentation — Documentation provided by Molina was used for validation of review findings. Supplementary information was provided via interviews and system demonstrations. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative

descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by Molina was acceptable.

There were variances in measure rates reported for the Contraceptive Care – Postpartum Women Ages 15 To 20 (CCP-CH) measure for the CAN population for MY 2023. The explanation provided for this variance raises questions about the validity of rates reported for MY 2023 and MY 2022. Based on the explanation provided by Molina, the rate originally provided for MY 2022 is not reportable and cannot be used to trend rates year over year.

All relevant CAN and CHIP HEDIS performance measures and CMS Core Set measures were compared for the current review year (MY 2023) to the previous year (MY 2022), and the changes from 2022 to 2023 are reported in the tables that follow. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

While Molina seems to have experienced improvements in rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years.

Table 19: CAN HEDIS Performance Measure Results

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA)	41.31%	55.60%	14.29
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	54.50%	56.69%	2.19
Counseling for Nutrition	42.09%	47.45%	5.36
Counseling for Physical Activity	40.63%	44.04%	3.41
Childhood Immunization Status (CIS)			
DTaP	73.24%	69.34%	-3.90
IPV	89.05%	85.40%	-3.65
MMR	87.83%	85.64%	-2.19
HiB	84.43%	82.97%	-1.46
Hepatitis B	90.27%	88.81%	-1.46
VZV	87.35%	85.16%	-2.19
Pneumococcal Conjugate	72.99%	71.05%	-1.94
Hepatitis A	80.05%	76.64%	-3.41
Rotavirus	73.72%	69.10%	-4.62
Influenza	25.30%	18.73%	-6.57
Combination #3	67.40%	63.75%	-3.65
Combination #7	56.69%	53.53%	-3.16

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Combination #10	20.19%	13.63%	-6.56
Immunizations for Adolescents (IMA)			
Meningococcal	50.12%	47.27%	-2.85
Tdap	76.40%	73.27%	-3.13
HPV	15.09%	13.03%	-2.06
Combination #1	49.64%	47.05%	-2.59
Combination #2	13.63%	12.19%	-1.44
Lead Screening in Children (LSC)	63.99%	64.48%	0.49
Breast Cancer Screening (BCS)	42.56%	41.10%	-1.46
Breast Cancer Screening (BCS-E)	42.45%	41.28%	-1.17
Cervical Cancer Screening (CCS)	53.04%	46.83%	-6.21
Chlamydia Screening in Women (CFL)			
16-20 Years	49.79%	49.30%	-0.49
21-24 Years	63.47%	64.33%	0.86
Total	53.71%	53.26%	-0.45
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
16-20 Years	75.14%	84.00%	8.86
21-24 Years	62.86%	75.05%	12.19
65+ Years	NA	NA	NA
Total	72.92%	82.85%	9.93
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	21.43%	25.29%	3.86
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	48.65%	58.62%	9.97
Bronchodilator	74.32%	76.72%	2.40
Asthma Medication Ratio (AMR)			
5-11 Years	80.77%	75.41%	-5.36
12-18 Years	66.67%	60.80%	-5.87
19-50 Years	57.83%	55.96%	-1.87
51-64 Years	50.00%	52.94%	2.94
Total	69.53%	64.97%	-4.56
Plan All-Cause Readmissions (PCR-AD)			
Observed Readmission Rate	11.02%	9.88%	-1.14
Expected Readmission Rate	10.00%	10.14%	0.14
Observed/Expected (O/E) Ratio	1.10%	0.97%	-0.13
Outlier Rate	69.86%	65.83%	-4.03
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	47.45%	52.07%	4.62
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	NA

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy - 21-75 years (Male)	78.23%	79.13%	0.90
Statin Adherence 80% - 21-75 years (Male)	39.18%	65.93%	26.75
Received Statin Therapy - 40-75 years (Female)	77.22%	84.38%	7.16
Statin Adherence 80% - 40-75 years (Female)	44.26%	56.79%	12.53
Received Statin Therapy - Total	77.83%	81.52%	3.69
Statin Adherence 80% - Total	41.14%	61.63%	20.49
Cardiac Rehabilitation (CRE)			
Initiation - 18-64 Years	1.75%	1.85%	0.10
Engagement1 - 18-64 Years	1.75%	3.70%	1.95
Engagement2 - 18-64 Years	1.75%	3.70%	1.95
Achievement - 18-64 Years	0.00%	3.70%	3.70
Initiation - 65+ years	NA	NA	NA
Engagement1 - 65+ Years	NA	NA	NA
Engagement2 - 65+ Years	NA	NA	NA
Achievement - 65+ Years	NA	NA	NA
Initiation – Total	1.75%	1.85%	0.10
Engagement1 – Total	1.75%	3.70%	1.95
Engagement2 - Total	1.75%	3.70%	1.95
Effectiveness of Care: Diabetes			
Hemoglobin A1c Control for Patients with Diabetes (HBD)			
Poor HbA1c Control	58.15%	45.74%	-12.41
Adequate HbA1c Control	34.06%	47.20%	13.14
Eye Exam for Patients with Diabetes (EED)◊	52.31%	55.23%	2.92
Blood Pressure Control for Patients with Diabetes (BPD)	47.45%	62.04%	14.59
Kidney Health Evaluation for Patients with Diabetes (KED)			
18-64 Years	16.92%	20.18%	3.26
65-74 Years	NA	NA	NA
75-85 Years	NA	NA	NA
Total	16.89%	20.16%	3.27
Statin Therapy for Patients with Diabetes (SPD)			
Received Statin Therapy	53.23%	53.22%	-0.01
Statin Adherence 80%	38.46%	60.81%	22.35
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	59.77%	59.23%	-0.54
Effective Continuation Phase Treatment	37.78%	39.91%	2.13
Follow-Up Care for Children Prescribed ADHD Medication (ADD)◊			
Initiation Phase	36.56%	46.63%	10.07

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Continuation and Maintenance (C&M) Phase	59.35%	54.55%	-4.80
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	61.71%	66.79%	5.08
6-17 years - 7-Day Follow-Up	39.29%	38.09%	-1.20
18-64 years - 30-Day Follow-Up	47.61%	48.23%	0.62
18-64 years - 7-Day Follow-Up	24.43%	29.16%	4.73
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	54.66%	59.39%	4.73
7-Day Follow-Up	31.86%	34.53%	2.67
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Follow-Up After Emergency Department Visit for Mental Illness – 30 days (6-17)	50.67%	55.13%	4.46
Follow-Up After Emergency Department Visit for Mental Illness – 7 days (6-17)	30.67%	35.90%	5.23
Follow-Up After Emergency Department Visit for Mental Illness – 30 days (18-64)	32.59%	37.23%	4.64
Follow-Up After Emergency Department Visit for Mental Illness – 7 days (18-64)	19.26%	25.55%	6.29
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)	39.05%	43.72%	4.67
Follow-Up After Emergency Department Visit for Mental Illness – 7 days (Total)	23.33%	29.30%	5.97
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)	41.28%	39.08%	-2.20
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (18-64)	28.44%	25.29%	-3.15
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)	40.71%	39.96%	-0.75

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (Total)	27.43%	23.91%	-3.52
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)◊			
30-Day Follow-Up: 13-17 Years	NA	NA	NA
7-Day Follow-Up: 13-17 Years	NA	NA	NA
30-Day Follow-Up: 18+ Years	24.17%	21.88%	-2.29
7-Day Follow-Up: 18+ Years	12.50%	14.38%	1.88
30-Day Follow-Up: Total	22.63%	22.75%	0.12
7-Day Follow-Up: Total	12.41%	14.29%	1.88
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	30.43%	38.83%	8.40
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	30.43%	38.83%	8.40
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	69.94%	74.48%	4.54
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	58.67%	63.64%	4.97
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	53.16%	62.19%	9.03
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose Testing (1-11)	35.20%	33.82%	-1.38
Cholesterol Testing (1-11)	23.98%	25.29%	1.31
Blood Glucose and Cholesterol Testing (1-11)	21.43%	24.12%	2.69
Blood Glucose Testing (12-17)	49.72%	52.88%	3.16
Cholesterol Testing (12-17)	29.78%	30.58%	0.80
Blood Glucose and Cholesterol Testing (12-17)	26.97%	28.57%	1.60
Blood Glucose Testing (Total)	44.57%	44.11%	-0.46
Cholesterol Testing (Total)	27.72%	28.15%	0.43
Blood Glucose and Cholesterol Testing (Total)	25.00%	26.52%	1.52
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	1.35%	1.20%	-0.15
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 Months-17 Years	75.07%	76.28%	1.21
18-64 Years	56.38%	58.91%	2.53
65+ Years	NA	NA	NA
Total	73.46%	74.87%	1.41
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
3 Months-17 Years	59.23%	58.18%	-1.05

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
18–64 Years	32.37%	32.02%	-0.35
65+ Years	NA	NA	NA
Total	56.98%	56.27%	-0.71
Use of Imaging Studies for Low Back Pain (LBP)	69.80%	64.99%	-4.81
Use of Opioids at High Dosage (HDO)	0.44%	1.51%	1.07
Use of Opioids from Multiple Providers (UOP)			
Multiple Prescribers	24.18%	20.10%	-4.08
Multiple Pharmacies	1.73%	3.65%	1.92
Multiple Prescribers and Multiple Pharmacies	0.86%	2.60%	1.74
Risk of Continued Opioid Use (COU)			
18–64 years – >=15 Days Covered	2.17%	8.66%	6.49
18–64 years – >=31 Days Covered	1.21%	4.37%	3.16
65+ years – >=15 Days Covered	NA	NA	NA
65+ years – >=31 Days Covered	NA	NA	NA
Total – >=15 Days Covered	2.17%	8.66%	6.49
Total – >=31 Days Covered	1.21%	4.37%	3.16
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20–44 Years	80.71%	80.08%	-0.63
45–64 Years	84.15%	84.90%	0.75
65+ Years	NA	NA	NA
Total	81.72%	81.50%	-0.22
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0–2)	-	18.93%	-
Oral Evaluation, Dental Services (3–5)	-	56.18%	-
Oral Evaluation, Dental Services (6–14)	-	57.21%	-
Oral Evaluation, Dental Services (15–20)	-	41.42%	-
Oral Evaluation, Dental Services (Total)	-	45.39%	-
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1–2)	-	9.20%	-
Topical Fluoride for Children (3–4)	-	18.59%	-
Topical Fluoride for Children (Total)	-	13.38%	-
Initiation and Engagement of AOD Dependence Treatment (IET)◊			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Other drug abuse or dependence: Initiation of AOD Treatment: 13–7 Years	56.00%	65.32%	9.32
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	0.00%	1.61%	1.61
Total: Initiation of AOD Treatment: 13–17 Years	55.43%	68.87%	13.44
Total: Engagement of AOD Treatment: 13–17 Years	0.00%	1.32%	1.32
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	41.09%	44.49%	3.40
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	8.91%	7.22%	-1.69
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	63.83%	65.93%	2.10
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	27.66%	26.37%	-1.29
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	45.02%	44.49%	-0.53
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.66%	5.40%	-3.26
Total: Initiation of AOD Treatment: 18+ Years	45.95%	46.88%	0.93
Total: Engagement of AOD Treatment: 18+ Years	10.93%	8.32%	-2.61
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.97%	47.16%	5.19
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	8.39%	6.74%	-1.65
Opioid abuse or dependence: Initiation of AOD Treatment: Total	63.16%	67.68%	4.52
Opioid abuse or dependence: Engagement of AOD Treatment: Total	27.37%	24.24%	-3.13
Other drug abuse or dependence: Initiation of AOD Treatment: Total	46.55%	48.89%	2.34
Other drug abuse or dependence: Engagement of AOD Treatment: Total	7.45%	4.60%	-2.85
Total: Initiation of AOD Treatment: Total	46.91%	50.31%	3.40
Total: Engagement of AOD Treatment: Total	9.82%	7.23%	-2.59
Prenatal and Postpartum Care (PPC)◊			
Timeliness of Prenatal Care Under 21 (Admin only rate)	-	85.63%	-
Postpartum Care Under 21 (Admin only rate)	-	52.79%	-
Timeliness of Prenatal Care Over 21 (Admin only rate)	-	87.42%	-
Postpartum Care Over 21 (Admin only rate)	-	51.30%	-
Timeliness of Prenatal Care (Total per IDSS)	95.38%	90.27%	-5.11
Postpartum Care (Total per IDSS)	68.13%	67.15%	-0.98
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
6–11 Years	55.46%	61.24%	5.78
12–17 Years	61.54%	56.25%	-5.29
Total	59.14%	58.37%	-0.77

HEDIS Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	57.28%	57.17%	-0.11
15 Months-30 Months	66.75%	67.98%	1.23
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	43.60%	45.05%	1.45
12-17 Years	35.86%	35.00%	-0.86
18-21 Years	18.96%	18.29%	-0.67
Total	39.51%	40.16%	0.65

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.
◊ indicates that the measure has a "Trend with Caution" guidance note from NCQA for MY 2023.

As shown in the preceding table, the following measures showed an improvement for the CAN population:

- The Adult Body Mass Index (BMI) Assessment (ABA) measure improved by over 14 percentage points.
- For the Appropriate Testing for Children with Pharyngitis (CWP) measure, the 21-24 Years indicator improved by 12.19 percentage points.
- For the Statin Therapy for Patients with Cardiovascular Disease (SPC) measure, the Statin adherence 80% - 21-75 years (Male) indicator improved by 26.75 percentage points, the Statin adherence 80% - 40-75 years (Female) indicator improved by 12.53 percentage points, and the Statin adherence 80% - Total indicator increased by 20.49 percentage points.
- For the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure, the Poor HbA1c Control indicator improved by over 12 percentage points and the Adequate HbA1c Control indicator improved by 13.14 percentage points.
- The Blood Pressure Control for Patients with Diabetes (BPD) measure improved by 14.59 percentage points.
- For the Statin Therapy for Patients with Diabetes (SPD) measure, the Statin Adherence 80% indicator improved by 22.35 percentage points.
- For the Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure, the Initiation Phase indicator improved by over 10 percentage points.

There were no measures that showed a substantial decrease in rate.

Table 20: CHIP HEDIS Performance Measure Results

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	49.88%	56.69%	6.81
Counseling for Nutrition	35.28%	41.36%	6.08
Counseling for Physical Activity	36.01%	41.85%	5.84
Childhood Immunization Status (CIS)			
DTaP	81.90%	84.44%	2.54
IPV	89.84%	93.37%	3.53
MMR	89.21%	93.95%	4.74
HiB	86.98%	92.22%	5.24
Hepatitis B	89.21%	88.47%	-0.74
VZV	88.89%	93.37%	4.48
Pneumococcal Conjugate	84.13%	82.71%	-1.42
Hepatitis A	84.13%	86.74%	2.61
Rotavirus	82.54%	82.13%	-0.41
Influenza	27.62%	23.63%	-3.99
Combination #3	78.10%	74.93%	-3.17
Combination #7	69.84%	66.28%	-3.56
Combination #10	25.08%	18.44%	-6.64
Immunizations for Adolescents (IMA)			
Meningococcal	46.47%	55.96%	9.49
Tdap/Td	71.53%	89.54%	18.01
HPV	15.09%	20.19%	5.10
Combination #1	46.23%	55.96%	9.73
Combination #2	14.60%	19.71%	5.11
Lead Screening in Children (LSC)	63.81%	65.99%	2.18
Chlamydia Screening in Women (CHL)			
16-20 Years	43.17%	38.65%	-4.52
21-24 Years	NA	NA	NA
Total	43.17%	38.65%	-4.52
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
3-17 Years	77.89%	84.21%	6.32
18-64 Years	72.97%	76.23%	3.26
65+ Years	NA	NA	NA
Total	77.73%	83.95%	6.22

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Asthma Medication Ratio (AMR)			
5-11 Years	89.29%	75.53%	-13.76
12-18 Years	77.14%	72.22%	-4.92
19-50 Years	NA	NA	NA
51-64 Years	NA	NA	NA
Total	83.97%	73.91%	-10.06
Plan All-Cause Readmissions (PCR-AD)			
Observed Readmission Rate	NA	NA	NA
Expected Readmission Rate	NA	NA	NA
Observed/Expected (O/E) Ratio	NA	NA	NA
Outlier Rate	NA	NA	NA
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	NA	NA	NA
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	NA
Effectiveness of Care: Diabetes			
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
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
Follow-up care for children prescribed ADHD Medication (ADD)◦			
Initiation Phase	43.87%	47.78%	3.91
Continuation and Maintenance (C&M) Phase	60.00%	52.44%	-7.56

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	68.42%	64.71%	-3.71
6-17 years - 7-Day Follow-Up	36.84%	34.31%	-2.53
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	68.69%	64.22%	-4.47
Total-7-day Follow-Up	35.35%	33.94%	-1.41
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
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	NA	NA	NA

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
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)	40.00%	35.56%	-4.44
Cholesterol Testing (1-11)	27.50%	24.44%	-3.06
Blood Glucose and Cholesterol Testing (1-11)	27.50%	22.22%	-5.28
Blood Glucose Testing (12-17)	57.14%	47.37%	-9.77
Cholesterol Testing (12-17)	31.75%	28.95%	-2.80
Blood Glucose and Cholesterol Testing (12-17)	31.75%	26.32%	-5.43
Blood Glucose Testing (Total)	50.49%	42.98%	-7.51
Cholesterol Testing (Total)	30.10%	27.27%	-2.83
Blood Glucose and Cholesterol Testing (Total)	30.10%	24.79%	-5.31
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.99%	1.18%	0.19
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 months-17 Years	68.85%	70.69%	1.84
18-64 Years	50.52%	65.26%	14.74
65+ Years	NA	NA	NA
Total	68.35%	70.54%	2.19
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
3 Months – 17 Years	36.92%	40.00%	3.08
18-64 Years	NA	NA	NA
65+ Years	NA	NA	NA
Total	37.01%	39.89%	2.88
Use of Imaging Studies for Low Back Pain (LBP)	NA	NA	NA
Use of Opioids at High Dosage (HDO)	NA	NA	NA

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
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			
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	-	*29.34%*	-
Oral Evaluation, Dental Services (3-5)	-	*61.01%*	-
Oral Evaluation, Dental Services (6-14)	-	*64.30%*	-
Oral Evaluation, Dental Services (15-20)	-	*49.01%*	-
Oral Evaluation, Dental Services (Total)	-	*57.60%*	-
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	-	*12.37%*	-
Topical Fluoride for Children (3-4)	-	*21.50%*	-
Topical Fluoride for Children (Total)	-	*17.91%*	-
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

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
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)	61.29%	58.82%	-2.47
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	6.45%	0.00%	-6.45
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care Under 21 (Admin only rate)	NA	NA	NA
Postpartum Care Under 21 (Admin only rate)	NA	NA	NA

HEDIS Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Timeliness of Prenatal Care (Total per IDSS)	NA	NA	NA
Postpartum Care (Total per IDSS)	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	63.89%	54.72%	-9.17
Total	58.93%	55.84%	-3.09
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	72.83%	69.03%	-3.80
15 Months–30 Months	83.51%	80.53%	-2.98
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	45.55%	44.93%	-0.62
12–17 Years	39.90%	40.84%	0.94
18–21 Years	25.41%	22.74%	-2.67
Total	41.72%	41.65%	-0.07

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.
◊ indicates that the measure has a "Trend with Caution" guidance note from NCQA for MY 2023.

There were two measures that demonstrated an improvement in the reported rate. For the Appropriate Treatment for Upper Respiratory Infection (URI) measure, the 18–64 Years indicator improved by 14.74 percentage points. For the Immunizations for Adolescents (IMA) measure, the Tdap/Td indicator improved by over 18 percentage points. For the Asthma Medication Ratio (AMR) measure, the 5–11 years indicator declined by 13.76 percentage points and the Total indicator declined by over 10 percentage points.

Table 21: CAN CMS Core Set Measure Rates

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Adult Core Set Measures			
Primary Care Access and Preventative Care			
COLORECTAL CANCER SCREENING (COL-AD)			
Ages 46 - 50	--	17.10%	--
Ages 50 - 64	26.50%		--
Ages 51- 65	--	28.19%	--
Ages 65 - 75	NA	NA	--
Ages 66 - 75	--	NA	--

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Total (Ages 46 – 75)	24.54%	25.97%	1.43
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-65	0.69%	2.89%	2.20
Ages 65+	NA	NA	NA
Total	0.69%	2.89%	2.20
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or Moderately Effective Contraception – 3 days	12.46%	13.33%	0.87
Most or Moderately Effective Contraception – 90 days	0.44%	59.46%	5.37
LARC - 3 Days	9.25%	1.22%	0.78
LARC - 90 Days Reported	12.46%	12.38%	3.13
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or Moderately Effective Contraception Rate	23.46%	24.81%	1.35
LARC Rate	2.57%	2.85%	0.28
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	24.19	24.06	-0.13
Ages 65+	0.00	0	0
Total	24.19	24.05	-0.14
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	55.68	41.63	-14.05
Ages 65+	0.00	0	0
Total	55.61	41.55	-14.06
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	48.85	48.12	-0.73
Ages 65+	0.00	0	0
Total	48.83	48.1	-0.73
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	1.30	0.63	-0.67
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	20.25%	8.94%	-11.31
Ages 65+	NA	NA	NA
Total	20.25%	8.80%	-11.45
DIABETES CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: HEMOGLOBIN A1C (HbA1c) POOR CONTROL (>9.0%) (HPCMI-AD)			
Ages 18 - 64	--	79.59%	--
Ages 65+	--	NA	--

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Total	--	79.59%	--
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	0.71%	2.62%	1.91
Ages 65+	NA	NA	NA
Total	0.71%	2.62%	1.91
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	4.16%	9.26%	5.10
Ages 65+	NA	NA	NA
Total	4.16%	9.26%	5.10
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	44.40%	61.19%	16.79
Prescription for Buprenorphine	43.60%	56.16%	12.56
Prescription for Oral Naltrexone	2.00%	3.65%	1.65
Prescription for Long-Acting, Injectable Naltrexone	0.00%	0.00%	0.00
Prescription for Methadone	0.40%	1.37%	0.97
MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	--	7.51%	--
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	--	5.94%	--
Discussed or Recommended Cessation Medications: Ages 18 to 64	--	3.44%	--
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	--	2.92%	--
Percentage of Current Smokers and Tobacco Users: Age 65 and Older	--	3.74%	--
Advising Users to Quit: Age 65 and Older	--	0.00%	--
Discussing Cessation Medications: Age 65 and Older	--	0.00%	--
Discussing Cessation Strategies: Age 65 and Older	--	0.00%	--
Percentage of Current Smokers and Tobacco Users: Total	--	7.31%	--
Advising Users to Quit: Total	--	5.63%	--
Discussing Cessation Medications: Total	--	3.26%	--
Discussing Cessation Strategies: Total	--	2.77%	--
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	3.09%	2.00%	-1.09
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	33.06%	37.47%	4.41

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Age 2 Screening	46.93%	49.84%	2.91
Age 3 Screening	45.07%	46.38%	1.31
Total Screening	39.48%	43.39%	3.91
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or Moderately Effective Contraception – 3 days	3.17%	1.16%	-2.01
Most or Moderately Effective Contraception – 90 days	47.62%	50.87%	3.25
LARC - 3 Days	0.00%	0.58%	0.58
LARC - 90 Days Reported	7.94%	16.18%	8.24
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or Moderately Effective Contraception Rate	26.01%	26.57%	0.56
LARC Rate	2.10%	2.27%	0.17
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	34.38%	42.15%	7.77
Numerator 2 All Four Molars Sealed	21.91%	28.30%	6.39
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.99%	1.03%	0.04
Ages 1-2	19.74%	21.87%	2.13
Ages 3-5	48.41%	52.34%	3.93
Ages 6-7	54.93%	57.50%	2.57
Ages 8-9	55.01%	56.74%	1.73
Ages 10-11	52.41%	54.79%	2.38
Ages 12-14	45.72%	48.45%	2.73
Ages 15-18	37.24%	39.75%	2.51
Ages 19-20	20.99%	22.82%	1.83
Total Ages <1-20	39.25%	42.01%	2.76
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	9.37%	0.13%	-9.24
Ages 3-5	21.21%	23.97%	2.76
Ages 6-7	24.22%	27.58%	3.36
Ages 8-9	25.88%	26.18%	0.30
Ages 10-11	21.75%	24.31%	2.56
Ages 12-14	18.78%	20.56%	1.78
Ages 15-18	13.26%	14.69%	1.43
Ages 19-20	5.93%	5.79%	-0.14
Total Ages 1-20	17.76%	19.85%	2.09
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			

CMS Core Set Measure/Data Element	MY 2022 CAN Rates	MY 2023 CAN Rates	Change from 2022 to 2023
Ages 1–2	4.88%	6.40%	1.52
Ages 3–5	18.91%	22.12%	3.21
Ages 6–7	23.30%	26.92%	3.62
Ages 8–9	25.07%	25.67%	0.60
Ages 10–11	21.35%	23.88%	2.53
Ages 12–14	18.25%	20.19%	1.94
Ages 15–18	12.79%	14.29%	1.50
Ages 19–20	5.71%	5.57%	-0.14
Total Ages 1–20	16.04%	18.37%	2.33
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	3.05%	2.85%	-0.20
Ages 3–5	0.54%	0.31%	-0.23
Ages 6–7	0.02%	0.02%	0.00
Ages 8–9	0.08%	0.07%	-0.01
Ages 10–11	0.00%	0.05%	0.05
Ages 12–14	0.05%	0.05%	0.00
Ages 15–18	0.06%	0.06%	0.00
Ages 19–20	0.00%	0.00%	0.00
Total Ages 1–20	0.76%	0.63%	-0.13

NA: not enough data were available for reporting.
–: New measure, no prior year or change data available for reporting.

The explanation provided for the variance in measure rates reported for the Contraceptive Care – Postpartum Women Ages 15 To 20 (CCP-CH) measure for the CAN population for MY 2023 raises questions about the validity of rates reported for MY 2023 and MY 2022. Based on the explanation provided by Molina, the rate originally provided for MY 2022 is not reportable and cannot be used to trend rates year over year.

For the Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) measure, the Overall indicator improved by 16.79 percentage points and the Prescription for Buprenorphine indicator improved by 12.56 percentage points. Two measures had a greater than 10 percentage point decline: For the Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05) measures, the Ages 40–64 and Total indicators decreased by over 14 per 100,000 member months. For the HIV Viral Load Suppression (HVL-AD) measure, the Ages 18–64 and Total indicators decreased by over 11 percentage points.

Table 22: CHIP CMS Core Set Measure Rates

CMS Core Set Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
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	0.97%	1.32%	0.35
Ages 65+	NA	NA	NA
Total	0.97%	1.32%	0.35
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	10.36	67.53	57.17
Ages 65+	NA	NA	NA
Total	10.36	67.53	57.17
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	9.65	9.65
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
DIABETES CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: HEMOGLOBIN A1C (HbA1c) POOR CONTROL (>9.0%) (HPCMI-AD)			
Ages 18 - 64	-	NA	-
Ages 65+	-	NA	-
Total	-	NA	-
Behavioral Health Care			
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)			

CMS Core Set Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Overall	NA	NA	NA
Prescription for Buprenorphine	NA	NA	NA
Prescription for Oral Naltrexone	NA	NA	NA
Prescription for Long-acting, Injectable Naltrexone	NA	NA	NA
Prescription for Methadone	NA	NA	NA
MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	-	NA	-
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	-	NA	-
Discussed or Recommended Cessation Medications: Ages 18 to 64	-	NA	-
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	-	NA	-
Child Core Set Measures			
Primary Care Access and Preventative Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	1.10%	1.71%	0.61
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	NA	NA	NA
Age 2 Screening	56.47%	56.32%	-0.15
Age 3 Screening	53.24%	53.00%	-0.24
Total Screening	54.33%	55.13%	0.80
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	26.36%	27.92%	1.56
LARC Rate	2.01%	2.43%	0.42
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	26.20%	38.21%	12.01
Numerator 2 All Four Molars Sealed	18.36%	25.71%	7.35
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	NA	NA	NA
Ages 1-2	31.95%	29.49%	-2.46
Ages 3-5	56.14%	58.81%	2.67

CMS Core Set Measure/Data Element	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change from 2022 to 2023
Ages 6–7	65.24%	63.29%	-1.95
Ages 8–9	65.75%	66.53%	0.78
Ages 10–11	62.55%	59.61%	-2.94
Ages 12–14	57.65%	58.50%	0.85
Ages 15–18	45.66%	46.66%	1.00
Ages 19–20	33.99%	32.65%	-1.34
Total Ages <1–20	54.62%	54.52%	-0.10
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1–2	18.91%	15.35%	-3.56
Ages 3–5	28.45%	29.52%	1.07
Ages 6–7	36.15%	32.36%	-3.79
Ages 8–9	36.77%	34.35%	-2.42
Ages 10–11	33.75%	28.47%	-5.28
Ages 12–14	27.65%	28.20%	0.55
Ages 15–18	19.55%	19.57%	0.02
Ages 19–20	10.00%	9.52%	-0.48
Total Ages 1–20	27.65%	26.41%	-1.24
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1–2	11.42%	10.18%	-1.24
Ages 3–5	25.45%	28.11%	2.66
Ages 6–7	34.44%	31.31%	-3.13
Ages 8–9	35.47%	33.90%	-1.57
Ages 10–11	32.67%	28.37%	-4.30
Ages 12–14	26.56%	27.51%	0.95
Ages 15–18	18.61%	18.75%	0.14
Ages 19–20	10.00%	9.52%	-0.48
Total Ages 1–20	25.92%	25.38%	-0.54
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	4.87%	3.23%	-1.64
Ages 3–5	0.38%	0.20%	-0.18
Ages 6–7	0.19%	0.16%	-0.03
Ages 8–9	0.09%	0.00%	-0.09
Ages 10–11	0.17%	0.22%	0.05
Ages 12–14	0.05%	0.27%	0.22
Ages 15–18	0.26%	0.30%	0.04
Ages 19–20	0.00%	0.00%	0.00
Total Ages 1–20	0.44%	0.38%	-0.06

NA: not enough data were available for reporting.
–: New measure, no prior year or change data available for reporting.

For the Diabetes Short-term Complications Admission rate (PQI01-AD) measure, the Ages 18-64 and Total indicators improved by 57.17 per 100,000 member months. For the Sealant Receipt On Permanent First Molars (SFM-CH) measures, the Numerator 1 At Least One Sealant indicator also improved by 12.01 percentage points. There were no measures that showed a substantial rate decrease.

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*. 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 six CAN PIPs. Topics for those PIPs included 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 the following tables. A summary of each PIP's status and interventions is also included.

Table 23: Asthma Medication Ratio CAN PIP

Asthma Medication Ratio	
The aim for the Asthma PIP is to increase the compliance rate of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The Asthma PIP focused on the AMR HEDIS rate for ages 5 to 64. Quarterly data showed an increase from 64.69% in Q4 2023 to 84.80% in Q1 2024 with a goal of 72.89%.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Asthma Medication Ratio
• Asthma education video on proper use of inhalers • Monitoring of the non-compliant members and encouraging 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 • School Visits

Table 24: 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 Q4 2023 to Q1 2024, there was an increase from 57.89% to 62.07% for the corticosteroid measure, with a goal of 53.43%; and a non-significant decline from 77.19% to 75.89% 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 that provides access to over-the-counter tobacco cessation products • Provider education tools • Quality Performance Tool Dashboard • Case management enrollment • Staff training	

Table 25: 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 reduced from 52.05% to 27.53% (the goal is 50%). The 7-day rate declined from 31.10% to 19.66% with a goal of 28.32%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Transition of Care (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 26: 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 postpartum care visits within 84 days of delivery. For prenatal visits, the rate increased from 87.03% to 89.36% and the goal is 94.92%. For postpartum visits, the rate declined from 51.11% to 35.41%, with a goal of 74.30%.	
Previous Validation Score	Current Validation Score
74/75=99% 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 an electric breast pump for the first six months of their child's life	

Table 27: Sickle Cell Disease CAN PIP

Sickle Cell Disease	
This PIP focuses on the percentage of members with Sickle Cell Disease that are enrolled in case management. The rate declined from 9.47% to 8.25% 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 emergency department visits • Provider education: Distribution of educational materials to providers. The Provider Toolkit contains information to assist providers in HEDIS measures and other preventive and maintenance health measures that affect the sickle cell population. • Collaboration with the MS Sickle Cell Foundation • Member educational materials	

Table 28: Obesity CAN PIP

Obesity	
This PIP utilizes the BMI percentile documentation, counseling for nutrition, and counseling for physical activity HEDIS measures. For BMI percentile documentation, rates declined from 27.72% to 14.01%, with a goal of 61.31%. The counseling for nutrition declined 15.69% to 7.46% with a goal of 52.31%. The counseling for physical activity measure declined 15.61% to 7.30% with a goal of 57.42%.	
Previous Validation Score	Current Validation Score

Obesity	
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Provider education • Member incentives • Member outreach and member events for awareness and education	

Constellation Quality Health provided recommendations for the four PIPs that demonstrated a decline in at least one indicator. These are displayed in *Table 29: CAN Performance Improvement Project Recommendation*.

Table 29: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Follow-up After Hospitalization for Mental Illness	Was there any documented, quantitative improvement in processes or outcomes of care?	For the 30-day follow up, the **rate reduced** from 52.05% to 27.53% (the goal is 50%). The 7-day **declined** from 31.10% to 19.66% with a goal of 28.32%.	Continue member and provider focused interventions to educate toward efforts to improve follow-up after discharge.
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The case management enrollment rate for sickle cell disease members **declined** from 9.47% to 8.25%	Continue ongoing interventions for tracking and monitoring of members and collaborative efforts to increase enrollment.
Obesity	Was there any documented, quantitative improvement in processes or outcomes of care?	For the BMI percentile, rates **declined** from 27.72% to 14.01%. Counseling for nutrition **declined** 15.69% to 7.46%. Counseling for physical activity **declined** 15.61% to 7.30%.	Continue ongoing interventions to educate providers and members toward efforts to improve percentage of members receiving counseling and improve documentation.
Prenatal and Postpartum Care	Was there any documented, quantitative improvement in processes or outcomes of care?	For prenatal visits, the rate **increased** from 87.03% to 89.36%; for postpartum visits, the rate **declined** from 51.11% to 35.41%.	Continue focusing on member education and community fairs and events to ensure appropriate engagement in postpartum care.

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 30: 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 an improvement from 75.84% in Q4 2023 to 80.70% in Q1 2024, with the goal rate being 72.89%. The rate has been above the goal rate for several measurement periods.	
Previous Validation Score	**Current Validation Score**
79/80= 99% High Confidence in Reported Results	85/85=100% High Confidence in Reported Results
Interventions	
• Asthma education for members on the proper use of an inhaler • Telephone campaigns to encourage members to get annual wellness exams • Provider education with toolkits and assistance with member outreach	

Table 31: 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 declined from 55% in Q4 2023 to 37.5% in Q1 2024. The goal is 50%. For the 7-day rate, the rate declined from 32% in Q4 2023 to 25% in Q1 2024. The goal is 28.32%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% 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 32: Obesity CHIP PIP

Obesity	
The Obesity PIP aims to increase the percentage of CHIP members who had an outpatient visit with their PCP or OB/GYN that includes weight assessment counseling. The BMI documentation rate declined from 24.49% to 11.06% with a goal of 61.31%. The nutrition counseling rate also declined from 16.23% to 6.40%, with a goal of 52.31%. Counseling for physical activity declined from 15.62% to 6.0%, with a goal of 57.42%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Provider toolkits to help facilitate tracking reports and address areas needed • Member education, community outreach, and incentives	

Table 33: 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. Rates were 69.03% in Q4 2023 and reduced to 63.16% in Q1 2024. The goal rate is 56.13% so the rate is still above the goal rate. The well child visit rate has been above the goal rate for the last several measurements.	
Previous Validation Score	**Current Validation Score**
85/85=100% High Confidence in Reported Results	79/80= 99% 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 recommendations are provided for the Well Child Visits, Obesity, and the Follow-up after Hospitalization for Mental Illness CHIP PIPs:

Table 34: CHIP Performance Improvement Project Recommendation

Project	Section	Reasoning	Recommendation
Well Child Visits	Was there any documented, quantitative improvement in	Rates were 69.03% in Q4 2023 and **declined** to 63.16% in Q1 2024. The goal rate is 56.13% so the rate is still above the goal rate.	Continue interventions focused on member education and assessment of barriers to receiving well-child visits.

Project	Section	Reasoning	Recommendation
	processes or outcomes of care?		
Obesity	Was there any documented, quantitative improvement in processes or outcomes of care?	The BMI documentation rate **declined** from 24.49% to 11.06%. The nutrition counseling rate also **declined** from 16.23% to 6.40%. Counseling for physical activity **declined** from 15.62% to 6.0%.	Continue ongoing interventions to educate providers and members toward efforts to improve percentage of members receiving counseling and improve documentation
Follow-up after Hospitalization for Mental Illness	Was there any documented, quantitative improvement in processes or outcomes of care?	The 30-day rate for 6–17-year-olds **declined** from 55% in Q4 2023 to 37.5% in Q1 2024. The 7-day rate **declined** from 32% in Q4 2023 to 25% in Q1 2024.	Continue member and provider focused interventions to educate toward efforts to improve follow-up after discharge

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*.

Following the 2023 EQR, corrective action plans were required for the following areas: Molina's QI Work Plan, monitoring provider compliance with the clinical practice guidelines, the outreach required for abnormal findings on EPSDT and Well-Baby and Well-Child Care services, and the annual QI Program Evaluation. During the current EQR, Constellation assessed the degree to which Molina implemented the actions to address these deficiencies and found Molina implemented the appropriate corrective actions for these deficiencies in the Quality Improvement section. Details regarding the 2023 CAP can be found in *Attachment 4: Assessment of Corrective Action Plans from Previous EQR*. For this EQR, Molina CAN and CHIP met 95% of the standards in the Quality Improvement section. Issues identified in the CAN and CHIP QI Program Description resulted in a "Partially Met" score.

Figure 6: Quality Improvement Findings

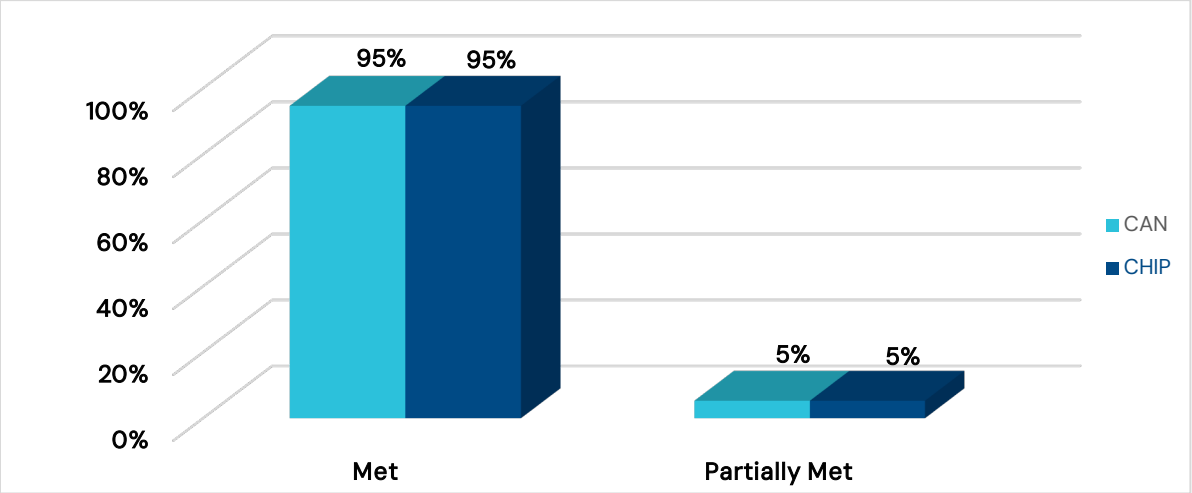


Table 35: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Molina's QI Program covers a wide range of health care aspects, including physical, behavioral, and oral health, ensuring that members receive holistic and integrated care across the entire health care continuum.	✓		
The QI Program places a strong emphasis on health equity, addressing health and care inequalities, and ensuring culturally and linguistically appropriate services. This is crucial for reducing disparities and improving health outcomes for diverse populations.	✓		
Molina was fully compliant with all information standards. Valid and reportable rates were submitted for all HEDIS measures in scope of the audit.	✓		
There were no concerns with Molina's data processing, integration, and measure production for most of the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Molina followed the measure specifications and produced reportable rates for the measures in the scope of the validation of PMs.	✓		
The following CAN HEDIS and CMS Core Set measure rates (MY 2023) were strengths for Molina since their rates had a greater than 10 percentage point improvement: • Adult BMI Assessment (ABA) measure • Appropriate Testing for Children with Pharyngitis (CWP), the 21-24 Years indicator • Statin Therapy for Patients with Cardiovascular Disease (SPC) measure, the Statin adherence 80% - 21-75 years (Male) indicator and the Statin adherence 80% - 40-75 years (Female) indicator, and the Statin adherence 80% - Total • Hemoglobin A1c Control for Patients with Diabetes (HBD), the Poor HbA1c Control indicator and the Adequate HbA1c Control indicator • Blood Pressure Control for Patients with Diabetes (BPD) measure • Statin Therapy for Patients with Diabetes (SPD) measure, the Statin Adherence 80% indicator • Follow-Up Care for Children Prescribed ADHD Medication (ADD) measure, Initiation Phase	✓		
The following CHIP HEDIS and CMS Core Set measure rates (MY 2023) were strengths for Molina since their rates had a greater than 10 percentage point improvement:	✓		

Strengths	Quality	Timeliness	Access to Care
• Appropriate Treatment for Upper Respiratory Infection (URI) measure, the 18-64 Years indicator • Immunizations for Adolescents (IMA) measure, the Tdap/Td indicator • Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) measure, the Overall indicator and the Prescription for Buprenorphine indicator • The Diabetes Short-term Complications Admission rate (PQI01-AD) measure, the Ages 18-64, and Total indicators • Sealant Receipt On Permanent First Molars (SFM-CH), the Numerator 1 At Least One Sealant indicator			
All the CAN and CHIP PIPs received a validation score within the High Confidence Range.	✓		

Table 36: Quality Improvement Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022.	*Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing program.*	✓		
The following HEDIS and CMS Core Set measure rates (MY 2023) were determined to be areas of opportunities for Molina since their rates had a greater than 10 percentage point decline: • The Asthma Medication Ratio (AMR) measure, 5-11 years indicator declined by 13.76% percentage points and the Total indicator declined by over 10 percentage points for the CHIP population. • The Chronic Obstructive Pulmonary Disease (COPD) OR Asthma in Older Adults Admission Rate (PQI-05), Ages 40-64 and Total indicators decreased by over 14 per 100,000 member months for the CAN population. • The HIV Viral Load Suppression (HVL-AD) measure, Ages 18-64 and Total indicators decreased by over 11 percentage points for the CAN population.	*Recommendation: Seek opportunities to improve the HEDIS and CMS Core Measures that showed a decline in the rates.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
One record did not pass medical record review validation for the PPC – Prenatal measure. Since 100% of all hybrid numerator compliant records were reviewed during MRRV for the PPC – Prenatal measure, this one error did not bias the reported rate, and it can be considered reportable.	*Recommendation: Improve medical record review processes to ensure accurate abstraction for hybrid measures.*	✓		
While Molina seems to have experienced improvements in measure rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years.	*Recommendation: Improve processes for rate validation and trending to identify measure reporting concerns.*	✓		
The explanation provided for the variance in measure rates reported for the Contraceptive Care – Postpartum Women Ages 15 To 20 (CCP-CH) measure for the CAN population for MY 2023 raises questions about the validity of rates reported for MY 2023 and MY 2022. Based on explanation provided by Molina, the rate originally provided for MY 2022 is not reportable and cannot be used to trend rates year over year.	*Recommendation: Review measure rates for CCP-AD, CCP-CH, CCW-AD and CCW-CH for the CAN and CHIP populations for accuracy in calculation and reporting for MY 2021, MY 2022, and MY 2023 and correct rates as appropriate.*	✓		
A decline in at least one indicator was identified in some of the CAN and CHIP PIPs.	*Recommendation: Assess the current interventions to determine if changes are needed. If changes are not needed, continue efforts to improve the indicator rates in the PIPs.*	✓		

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 QI Program is comprehensive and focuses on ensuring members receive equitable, culturally, and linguistically appropriate healthcare and services. The 2024 Quality Improvement Program Description (QI Program Description) covers a wide range of areas for CAN including medical, behavioral health, chemical dependency, and substance abuse care. Molina evaluates key aspects of healthcare and services, monitors continuity and coordination of care, assesses quality and clinical indicator performance, and addresses social needs and risks. Molina employs data-driven processes, collects and analyzes data from various sources, and implements quality improvement strategies to enhance health outcomes, patient safety, and reduce disparities. The QI program involves a dedicated team overseeing quality improvement activities, utilizing health information systems, and collaborating with stakeholders to meet state and federal requirements. The QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022. Constellation recommended this section of the QI Program

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description be updated or removed. This recommendation was not completed. *Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing 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 has developed a Health Equity and Cultural Competency Program to ensure the delivery of effective, equitable, understandable, respectful, and culturally competent and linguistically appropriate services and the provision of language access and disability-related access to all members, including limited English Proficiency persons.
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					Utilization data collection and analysis are integral components of Molina's QI Program. The scope of this program involves collecting and analyzing data from various sources to evaluate key aspects of healthcare and services. This data-driven approach helps in identifying disparities, improving services, enhancing health outcomes, and tailoring services to meet the unique needs of its members. Molina reviews potential over-and under-utilization data at least yearly using cross-functional teams.
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	X					The QI Work Plan is developed annually after the completion of the QI Program Annual Evaluation from the previous year. The 2023 and 2024 QI Work Plans were received. Molina's work plans include the ability to trend data over five years.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
completion, and the person(s) responsible for the project(s).						
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 responsible for the implementation and ongoing examination of the QI Program. Through subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes and evaluates the progress and results of all quality improvement activities, institutes needed action, and ensures 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, with members from various leadership roles within the health plan. This committee also includes external network physicians specializing in pediatrics, internal medicine, and psychiatry.
3. The QI Committee meets at regular intervals.	X					The committee meets quarterly, with the possibility of more frequent meetings or material reviews as needed. A quorum of at least 51% of committee members, including no less than half of network provider participants, is required to enact decisions.
4. Minutes are maintained that document proceedings of the QI Committee.	X					The Committee Charter indicates minutes are recorded for each meeting. The Charter specifies that the Recorder, who is a Quality Specialist, is responsible for meeting coordination, which includes drafting

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meeting minutes. Molina provided copies of the committee minutes for review.
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 a validation review of the performance measures identified by DOM to evaluate their accuracy as reported by Molina for the CAN populations. One record did not pass medical record review validation for the PPC – Prenatal measure. Since 100% of all hybrid numerator compliant records were reviewed during MRRV for the PPC – Prenatal measure, this one error did not bias the reported rate, and it can be considered reportable. While Molina seems to have experienced improvements in rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years. The explanation provided for the variance in measure rates reported for the Contraceptive Care – Postpartum Women Ages 15 To 20 (CCP-CH) measure for the CAN population for MY 2023 raises questions about the validity of rates reported for MY 2023 and MY 2022. Based on the explanation provided by Molina, the rate originally provided for MY 2022 is not reportable and cannot be used to trend rates year over year.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendations: Improve medical record review processes to ensure accurate abstraction for hybrid measures. Improve processes for rate validation and trending to identify measure reporting concerns. Review measure rates for CCP-AD, CCP-CH, CCW-AD and CCW-CH for the CAN and CHIP populations for accuracy in calculation and reporting for MY 2021, MY 2022, and MY 2023 and correct rates as appropriate.
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 six CAN PIPs. Topics for those PIPs included 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. A decline in at least one indicator was identified in some of the PIPs. *Recommendation: Assess the current interventions to determine if changes are needed. If changes are not needed, continue efforts to improve the indicator rates in the PIPs.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					Molina's participating practitioners serve on various committees and subcommittees within the organization. Participating providers may also be asked to participate with provider advisory groups

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						that focus on critical topics. In cases where specific practitioner specialty feedback is needed, network physicians and specialists are used for assisting with the design or evaluation of specific programs.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Molina shares provider performance data through various channels including the provider report card or gaps in care report. These are comprehensive tools designed to enhance the quality of care provided to Molina members by identifying and addressing gaps in care, supporting providers with actionable data, and promoting continuous improvement in healthcare delivery.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
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's policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment provides an overview of Molina's role in compliance with the EPSDT program requirements. Molina conducts outreach and education to inform eligible members and providers about the EPSDT program, emphasizing the importance of preventive care and how to access services. Molina has a tracking system to monitor member compliance with EPSDT service provisions,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						including initial visits for newborns, screenings, diagnostic services, and follow-ups. Member target lists are generated to identify and provide outreach to those due for EPSDT services. This policy indicates that members who receive an abnormal finding during their EPSDT screenings are identified, and the member is contacted regarding the need for follow-up. Molina provided a copy of the EPSDT tracking report that demonstrated the follow-up conducted for any abnormal finding.
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					Annually, Molina assesses the quality improvement initiatives and activities conducted during the year. The 2023 Quality Improvement Program Evaluation was provided with the desk materials. This evaluation included the analysis, trends, changes in those trends, and any barriers impacting the rates. The findings are reported to the appropriate QI committees and the Board of Directors.
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				Molina's QI Program is comprehensive and focuses on ensuring members receive equitable, culturally, and linguistically appropriate healthcare and services. The QI Program Description covers a wide range of areas for CHIP including medical, behavioral health, chemical dependency, and substance abuse care. Molina evaluates key aspects of healthcare and services, monitors continuity and coordination of care, assesses quality and clinical indicator performance, and addresses social needs and risks. Molina employs data-driven processes, collects and analyzes data from various sources, and implements quality improvement strategies to enhance health outcomes, patient safety, and reduce disparities. The QI program involves a dedicated team overseeing quality improvement activities, utilizing health information systems, and collaborating with stakeholders to meet state and federal requirements. The QI Program Description, page 39 states, "Molina maintains a comprehensive and detailed credentialing and recredentialing program." This description does not describe the centralized credentialing process implemented by DOM in 2022. Constellation recommended this section of the QI Program

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description be updated or removed. This recommendation was not completed. *Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing 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 has developed a Health Equity and Cultural Competency Program to ensure the delivery of effective, equitable, understandable, respectful, and culturally competent and linguistically appropriate services. Additionally, the program ensures the provision of language access and disability-related access to all members, including limited English Proficiency persons.
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					Utilization data collection and analysis are integral components of Molina's QI Program. The scope of this program involves collecting and analyzing data from various sources to evaluate key aspects of healthcare and services. This data-driven approach helps in identifying disparities, improving services, enhancing health outcomes, and tailoring services to meet the unique needs of its members. Molina reviews potential over-and under-utilization data at least yearly using cross-functional teams.
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	X					The QI Work Plan is developed annually after the completion of the QI Program Annual Evaluation from the previous year. The 2023 and 2024 QI Work Plans

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
completion, and the person(s) responsible for the project(s).						were received. Molina's work plans include the ability to trend data over five years.
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 responsible for the implementation and ongoing examination of the QI Program. Through subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes and evaluates the progress and results of all quality improvement activities, institutes needed action, and ensures 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, with members from various leadership roles within the health plan. This committee also includes external network physicians specializing in pediatrics, internal medicine, and psychiatry.
3. The QI Committee meets at regular intervals.	X					The committee meets quarterly, with the possibility of more frequent meetings or material reviews as needed. A quorum of at least 51% of committee members, including no less than half of network provider participants, is required to enact decisions.
4. Minutes are maintained that document proceedings of the QI Committee.	X					The Committee Charter indicates minutes are recorded for each meeting. The Charter specifies that the Recorder, who is a Quality Specialist, is responsible for meeting coordination, which includes drafting

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meeting minutes. Molina provided copies of the committee minutes for review.
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 a validation review of the performance measures identified by DOM to evaluate their accuracy as reported by Molina for the CHIP populations. One record did not pass medical record review validation for the PPC – Prenatal measure. Since 100% of all hybrid numerator compliant records were reviewed during MRRV for the PPC – Prenatal measure, this one error did not bias the reported rate, and it can be considered reportable. While Molina seems to have experienced improvements in rates, it was unclear whether the improvements are a result of improved performance or a reflection of data gaps or reporting errors in prior years. The explanation provided for the variance in measure rates reported for the Contraceptive Care – Postpartum Women Ages 15 To 20 (CCP-CH) measure for the CAN population for MY 2023 raises questions about the validity of rates reported for MY 2023 and MY 2022. Based on the explanation provided by Molina, the rate originally provided for MY 2022 is not reportable and cannot be used to trend rates year over year.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendations: Improve medical record review processes to ensure accurate abstraction for hybrid measures. Improve processes for rate validation and trending to identify measure reporting concerns. Review measure rates for CCP-AD, CCP-CH, CCW-AD and CCW-CH for the CAN and CHIP populations for accuracy in calculation and reporting for MY 2021, MY 2022 and MY 2023 and correct rates as appropriate.
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. A decline in at least one indicator was identified in some of the PIPs. *Recommendation: Assess the current interventions to determine if changes are needed. If changes are not needed, continue efforts to improve the indicator rates in the PIPs.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					Molina's participating practitioners serve on various committees and subcommittees within the organization. Participating providers may also be

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						asked to participate with provider advisory groups that focus on critical topics. In cases where specific practitioner specialty feedback is needed, network physicians and specialists are used for assisting with the design or evaluation of specific programs.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Molina shares provider performance data through various channels including the provider report card or gaps in care report. These are comprehensive tools designed to enhance the quality of care provided to Molina members by identifying and addressing gaps in care, supporting providers with actionable data, and promoting continuous improvement in healthcare delivery.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
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					Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, provides an overview of Molina's role in compliance with the Well-Baby and Well-Child Services program requirements. Molina conducts outreach and education to inform eligible members and providers about the Well-Baby and Well-Child program, emphasizing the importance of preventive care and how to access services. Molina has a tracking system to monitor member compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						with the Well-Baby and Well-Child Care service provisions, including initial visits for newborns, screenings, diagnostic services, and follow-ups. Member target lists are generated to identify and provide outreach to those due for Well-Baby and Well-Child Care services. This policy indicates that members who receive an abnormal finding during their Well-Baby and Well-Child Care screenings are identified, and the member is contacted regarding the need for follow-up. Molina provided a copy of the Well-Baby and Well-Child Care services tracking report that demonstrated the follow-up conducted for any abnormal finding.
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					Annually, Molina assesses the quality improvement initiatives and activities conducted during the year. The 2023 Quality Improvement Program Evaluation was provided with the desk materials. This evaluation included the analysis, trends, changes in those trends, and any barriers impacting the rates. The findings are reported to the appropriate QI committees and the Board of Directors.
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 Molina Health Care Services (HCS) Program includes Utilization Management (UM), Care Management, Transitions of Care, and other critical programs for health plan members. Constellation's review of Molina's CAN and CHIP UM Programs included the HCS and Pharmacy Program descriptions and evaluations, policies and procedures related to service authorizations and medical necessity determinations, pharmacy requirements, as well as review of the CAN and CHIP Member Handbooks and CAN and CHIP Provider Manuals.

The HCS Program ensures that UM services delivered are medically necessary and use resources appropriately, based on the level of care needed for members. The program promotes the provision of quality, cost-effective, and medically appropriate services offered across a continuum of care and integrates a range of services appropriate to meet individual needs.

The Vice President of HCS, in consultation with the Chief Medical Officer (CMO), holds significant authority and responsibility for the HCS Program development and implementation. The Molina Healthcare Board of Directors, with the ultimate authority and responsibility for the HCS Program, ensures a robust governance structure. The HCS Committee reports its activities and accomplishments directly to the Quality Improvement and Health Equity Transformation Committee and Board of Directors. The HCS Program Description is presented and approved annually by the HCS and the Quality Improvement and Health Equity Transformation Committees. A member of HCS leadership serves on each of the committees within the Quality Improvement and Health Equity Transformation Committee structure.

The Pharmacy Program Description outlines the preferred drug list, the pharmacy benefit manager, and timeframes for pharmacy prior authorizations. Molina's Pharmacy Services Department works to ensure that members have access to all medically necessary prescription drugs and that utilization is cost-effective and safe. This team creates, operates, and monitors Molina's pharmacy benefit programs following all federal and state laws.

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

Evaluation of approval and denial files reflects consistent decision-making using approved criteria according to an established hierarchy. Appropriate professionals made medical necessity determinations within the required timeframes. Approval notices containing all the necessary information were faxed to providers, and Adverse Benefit Determination notices were written in language appropriate for a layperson to understand and included instructions for requesting an appeal.

It is Molina's policy to ensure that all practitioners can discuss any medical necessity determinations with a Molina Healthcare medical director, consulting physician reviewer, Behavioral Health medical director, or Pharmacy manager, as appropriate.

Appeals

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

Processes for filing and managing standard and expedited appeals are outlined in the Medicaid Appeals and State Fair Hearing policy and procedure (MHI A&G 001), the CAN and CHIP Member Handbooks and Provider Manuals, and on Molina's website.

An appeal is defined appropriately as a request to reconsider an adverse benefit determination. Options for filing verbally or in writing, with associated acknowledgement and resolution timeframes, are provided in provider and member materials. Members are informed of their right to file a grievance if they disagree with a request to extend the appeal resolution timeframe. It was recommended that the CAN and CHIP Member Handbooks be revised to address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. Including a hyperlink to the written consent form for convenient member access was also discussed onsite.

All sample appeal files reviewed for the 2024 EQR were addressed in a timely manner. No issues were identified.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

Molina's Integrated Care Management Program offers care coordination, transitional care, and disease management programs. Members are referred to care management services through various resources such as community referrals, claims data, pharmacy claims, provider referrals, self-referrals, etc. Members are stratified at enrollment and assigned to an appropriate risk level. For members who are identified with high or medium risk level needs, a health risk assessment is completed within 30 calendar days.

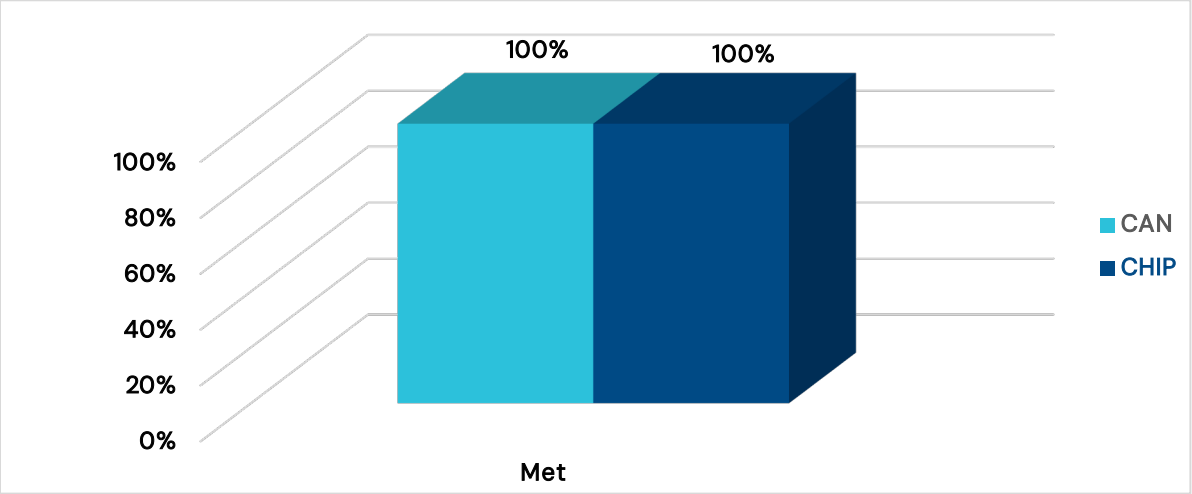
After completion of the health risk assessment, an Individualized Care Plan is developed with the member or guardian, if applicable, as outlined in various policies and Molina's Health Care Services Program Description. Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract* as a source of reference.

Molina offers comprehensive integrated care services for members, which entails assessment, referral to appropriate resources, discharge planning, and ensuring that coordinated services are offered for members with behavioral health needs. Transition of care services are also

provided to members wherein a Transition of Care Coach along with an Interdisciplinary Care Team collaborate to ensure a successful transition to the least restrictive level of care.

As shown in *Figure 7: Utilization Management Findings*, 100% of the standards for CAN and CHIP were scored as "Met."

Figure 7: Utilization Management Findings



Strengths, weaknesses, and recommendations for the Utilization Management section are included in the following tables.

Table 37: 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 monthly.		✓	
According to the results of the Care Management Program Evaluation, members expressed satisfaction with both Level II and Level III Care Management. Additionally, the evaluation indicated that satisfaction increased in three out of eight identified areas for Level II Care Management.	✓		
All the appeal sample files reviewed for the 2024 EQR were addressed in a timely manner.		✓	

Table 38: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information.	*Recommendation: Include a reference to the CHIP Contract, Section 8 (A) in the Source of Decision for Policy 154.01, Individualized Care Development Procedure Addendum.*	✓		
The CAN and CHIP Member Handbooks do not address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf.	*Recommendation: Revise the CAN and CHIP Member Handbooks to address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. Consider including a hyperlink to the form for convenient member access.*	✓		

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 and procedures describe processes to ensure UM services delivered are medically necessary and use resources appropriately based on the level of care needed for all members. The program promotes the provision of quality, cost-effective, and medically appropriate services across a continuum of care, integrating a range of services appropriate to meet individual needs.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					The Vice President of HCS, in consultation with the CMO, has authority and responsibility for HCS program development and implementation. Molina's Board of Directors has the ultimate authority and responsibility for the HCS Program. The HCS Program Description is approved annually, and evidence of most recent approval was documented in the HCS Committee meeting minutes dated 2/26/24.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Molina uses federal and state regulations, policies, and benefit guidance as well as nationally accepted evidence-based criteria guidelines for decision making. Clinical review criteria are based on sound medical evidence, updated regularly, and reviewed and approved annually by the HCS Committee.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					The HCS Program incorporates the highest level of published peer reviewed scientific evidence available to evaluate services for evolving technology and scientific advances. This includes the evaluation and treatment for medical and BH services such as outpatient, inpatient, equipment, devices, laboratory tests, and pharmaceuticals. Molina's Clinical Policy Committee and Pharmacy and Therapeutics Committee evaluate new technology and scientific advances to provide current guidelines for determining coverage criteria through evidence-based decision making.
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					Molina's compensation and conflict of interest statement indicates that Molina employees and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to members. This commitment is regularly communicated to providers, practitioners, members, and Molina staff.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The core function of the Medical Director/CMO is to provide medical oversight, clinical consultations, and ownership of medical necessity determinations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					The 2024 HCS Program Description states that clinical review and HCS criteria are reviewed, modified, and adopted by the HCS Committee at least annually.
V B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					According to the HCS Program Description, the appropriate use of criteria is incorporated into all phases of the UM decision making process by licensed staff and Medical Directors. HCS staff follow the appropriate hierarchy of decision-making according to policy and procedure.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation's review of the sample UM files found that determinations are consistent with utilizing clinical guidelines such as MCG, relevant clinical information, and evidence-based criteria as described in Policy HCS-365.01, Clinical Criteria for UM Decision Making.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy HCS-325.01, Service Authorization Procedure, references the need for reviewers to consider the individual patient needs or capabilities of the local health care delivery system. Practitioners are encouraged to identify special patient needs. Such situations do not allow approval by general guidelines, so a Medical Director, consulting physician, licensed psychiatrist, or Pharmacy professional reviews these situations, giving special consideration to patient and delivery system concerns.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Molina conducts an annual quality review, Inter-Rater Reliability, to evaluate physician and clinician comprehension and consistent application of approved criteria and medical guidelines for all whom make medical necessity decisions.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					Policy MHI PHARM 08.1, Medication Prior Authorization Processing, indicates that a formulary exception can be requested to obtain a drug that is not included on the member's drug formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug.
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 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					The HCS Program Description details the formal program of orientation and training required for all UM

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						staff. Staff are trained in the clinical concepts, components, and processes of UM, Care Management, Managed Long Term Services and Supports, transitions of care, and regulatory requirements. New staff are partnered with an experienced staff member as a mentor during their orientation period to ensure that enterprise standards as well as policies and procedures are understood and followed. This HCS training program is developed and updated annually with health plan input and adoption. Annual updates may include, but are not limited to, updates to HCS Program, policies and procedures, and criteria used for clinical decision making.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Constellation's review of sample files found that decision determinations were reached timely and communicated promptly to necessary parties. Also, in review of the Health Care Services evaluation, Molina's program goal of 98% for timeliness of service authorization completion was met or exceeded monthly.
10. Denials						
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					Constellation's review of UM denial files reflects that additional clinical information is requested appropriately prior to making an adverse benefit determination. A sufficient length of time is allowed following the request for the member/provider to supply the information.

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's review of UM denial files found that appropriate physician specialists reviewed files prior to issuing the denial 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					Files demonstrated prompt communication to necessary parties and included the basis for denial and the procedure for appeal.
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 MHI A&G 001, Medicaid Appeals and State Fair Hearing Policy, Procedure MHI A&G 001, Medicaid Appeals and State Fair Hearing Procedure, the CAN Member Handbook, and CAN Provider Manual detail steps for filing and processing 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					The appropriate definition of an appeal as a request to reconsider an adverse benefit determination is provided throughout member and provider materials.
1.2 The procedure for filing an appeal;	X					The CAN Member Handbook does not address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. *Recommendation: Revise the CAN Member Handbook to address the requirement for written consent for*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						anyone other than the member or the authorized representative to file an appeal on the member's behalf. Consider including a hyperlink to the form for convenient member access.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					The appropriate timeframes for acknowledging and resolving standard and expedited appeals, with extensions if needed, are clearly indicated in policy and throughout member and provider materials.
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					
3. Appeals are tallied, categorized, analyzed for patterns and potential quality	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
improvement opportunities, and reported to the Quality Improvement Committee.						
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR § 208, 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, transitional care, and disease management services as outlined in the Health Care Services Program Description.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Members are referred for care management services through various resources such as community referrals, claims data, pharmacy claims, provider referrals, self-referrals, etc. as outlined in the Health Care Services Program Description and Policy HCS-642.01, Coordination of Care and Referral Procedure for Behavioral Health Services.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					At enrollment, if a member's needs are assigned to medium or high risk-level, the member will have a health risk assessment completed that entails demographic information, evaluation of comorbidities, etc. within 30 calendar days as outlined in Policy HCS-161, Health Risk Assessment Policy, and Policy HCS 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					After completion of the health risk assessment, the Individualized Care Plan is developed with the member or guardian, if applicable, that entails the problem identification, barriers, interventions, etc. as outlined in various policies and the Health Care Services Program Description.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Members are stratified at enrollment and a continuous assessment of the member's risk level occurs through the predictive modeling system, claims data, and when there are any significant changes in the member's health status.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Molina offers comprehensive integrated care services for members, which entails assessment, referral to appropriate resources, discharge planning, and behavioral health care coordination for members as outlined in various policies and the health plan's Health Care Services Program Description. Annually, a population health assessment is conducted and this

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						aids in program development and refinement of the care management process to address the member's needs more effectively. Also, according to the results of the Care Management Program Evaluation, members expressed satisfaction with both Level II and Level III Care Management. Additionally, the evaluation indicated that satisfaction increased in three out of eight identified areas for Level II Care Management.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.5 Coordination of discharge planning;						As outlined in the Health Care Services Program Description, Policy HCS-368, Discharge Planning, and Policy 368.01, Discharge Planning, members have an assigned transition of care coordinator to aid in transitioning to an appropriate level of care.
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					Members assigned to the medium risk level receive specific services in addition to low risk level services. These include member health education, appointment coordination, facilitation of relapse prevention for members with substance use disorder or behavioral health issues, etc. as outlined in Molina's Health Care Services Program Description and Addendum and Policy HCS-151.01, Risk Stratification and Member Engagement Procedure.
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Molina also offers assistance for members when they disenroll from the health plan to ensure that there is no disruption in services as outlined in Policy HCS-406.01, Transition to Other Care When Benefits End Procedure.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					
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					A Transition of Care Coach along with an Interdisciplinary Care Team of nurses, physicians, community providers, etc. collaborate to provide transition of care services to ensure a successful transition to the least restrictive level of care.
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					

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					The Health Care Services Program Description and various policies and procedures describe processes to ensure UM services delivered are medically necessary and use resources appropriately, based on the level of care needed for all members. The program promotes the provision of quality, cost-effective, and medically appropriate services across a continuum of care, integrating a range of services appropriate to meet individual needs.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					The Vice President of HCS, in consultation with the CMO, has authority and responsibility for HCS program development and implementation. Molina's Board of Directors has the ultimate authority and responsibility for the HCS Program. The HCS Program Description is approved annually, and evidence of most recent

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						approval was documented in the HCS Committee meeting minutes dated 2/26/24.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Molina uses federal and state regulations, policies, and benefit guidance as well as nationally accepted evidence-based criteria guidelines for decision making. Clinical review criteria are based on sound medical evidence, updated regularly, and reviewed and approved annually by the HCS Committee.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					The HCS Program incorporates the highest level of published peer reviewed scientific evidence available to evaluate services for evolving technology and scientific advances. This includes the evaluation and treatment for medical and BH services such as outpatient, inpatient, equipment, devices, laboratory tests, and pharmaceuticals. Molina's Clinical Policy Committee and Pharmacy and Therapeutics Committee evaluate new technology and scientific advances to provide current guidelines for determining coverage criteria through evidence-based decision making.
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	X					Molina's compensation and conflict of interest statement indicates that Molina employees and its delegated contractors do not use incentive

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
or UM staff for denials of coverage or services.						arrangements to reward the restriction of medical care to members. This commitment is regularly communicated to providers, practitioners, members, and Molina staff.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The core function of the Medical Director/CMO is to provide medical oversight, clinical consultations, and ownership of medical necessity determinations.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					The 2024 HCS Program Description states that clinical review criteria are reviewed, modified, and adopted by the HCS Committee at least annually.
V B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					According to the HCS Program Description, the appropriate use of criteria is incorporated into all phases of the UM decision making process by licensed staff and Medical Directors. HCS staff follow the appropriate hierarchy of decision-making according to policy and procedure.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation's review of the UM sample files found that determinations are consistent with utilizing clinical guidelines such as MCG, relevant clinical information, and evidence-based criteria as described in Policy HCS-365.01, Clinical Criteria for UM Decision Making.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy HCS-325.01, Service Authorization Procedure, references the need for reviewers to consider the individual patient needs or capabilities of the local health care delivery system. Practitioners are encouraged to identify special patient needs. Such situations do not allow approval by general guidelines, so a Medical Director, consulting physician, licensed psychiatrist, or Pharmacy professional reviews these situations, giving special consideration to patient and delivery system concerns.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Molina conducts annual Inter-Rater Reliability testing to evaluate HCS physician and clinician comprehension and consistent application of approved criteria and medical guidelines for all whom make medical necessity decisions.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Policy MHI PHARM 08.1, Medication Prior Authorization Processing, indicates that a formulary exception can be requested to obtain a drug that is not included on the member's drug formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug.

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 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					
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Constellation's review of sample files found that decision determinations were reached timely and communicated promptly to necessary parties. Also, in review of the Health Care Services evaluation, Molina's program goal of 98% for timeliness of service authorization completion was met or exceeded monthly.
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					Constellation's review of UM denial files reflects that additional clinical information is requested appropriately prior to making an adverse benefit determination. A sufficient length of time is allowed following the request for the member/provider to supply the information.
10.2 All decisions to deny services based on medical necessity are	X					Constellation's review of UM denial files found that appropriate physician specialists reviewed files prior to issuing the denial determination.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
reviewed by an appropriate physician specialist.						
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					Files demonstrated prompt communication to necessary parties and included the basis for denial and the procedure for appeal.
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 MHI A&G 001, Medicaid Appeals and State Fair Hearing Policy, Procedure MHI A&G 001, Medicaid Appeals and State Fair Hearing Procedure, the CHIP Member Handbook, and the CHIP Provider Manual detail steps for filing and processing 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					The appropriate definition of an appeal as a request to reconsider an adverse benefit determination is provided throughout member and provider materials.
1.2 The procedure for filing an appeal;	X					The CHIP Member Handbook does not address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. *Recommendation: Revise the CHIP Member Handbook to address the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						behalf. Consider including a hyperlink to the form for convenient member access.
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					Appropriate timeframes for acknowledging and resolving standard and expedited appeals, with extensions if needed, are clearly indicated in policies and member and provider materials.
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					
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 describes Molina's Healthcare Integrated Care Management Program that offers care coordination and disease management services to 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 claims data, member assessments, self-referrals, practitioner referrals, etc. as outlined in Policy HCS-642.01, Coordination of Care and Referral Procedure for Behavioral Health Services, and in the Health Care Services Program Description.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					As outlined in Policy HCS-154.01, Individualized Care Plan Development, health risk assessments are completed by qualified staff and an Individualized Care Plan is developed within 30 days of completion of the health risk assessment. Policy HCS 154.01, Individualized Care Plan Development Procedure Addendum, applies to both CAN and CHIP; however, it does not identify the *CHIP Contract, Section 8 (A)* in the Source of Decision information. *Recommendation: Include a reference to the CHIP Contract, Section 8 (A) in the Source of Decision for Policy 154.01, Individualized Care Development Procedure Addendum.*
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Molina offers comprehensive integrated care management services for members, which entails discharge planning, health education, referral assistance, and follow up to coordinated services.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						Members have an assigned transition of care coordinator to aid in transitioning to an appropriate level of care.
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;						

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					Members assigned to the medium risk level receive specific services in addition to low risk level services. These include member health education, appointment coordination, relapse prevention for members with substance use disorder or behavioral health issues, etc. as outlined in Molina's Health Care Services Program Description and Addendum and Policy HCS-151.01, Risk Stratification and Member Engagement Procedure.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.	X					Molina offers a Disease Management program that focuses on education, member self-management, and disease prevention to ensure overall member wellness.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					As described in Policy MHMS-QI-004, Monitoring of Continuity Care, Molina collects data from various sources at least annually to monitor the continuity and coordination of care that members receive between medical care practitioners and across the health care network.
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					
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					A Transition of Care Coach along with an Interdisciplinary Care Team of nurses, physicians, behavioral health practitioners, community providers, collaborate to provide transition of care services to ensure a successful transition to the least restrictive level of care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO meets other Transition of Care Requirements.	X					
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

F. Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. For this review, Molina reported eight delegation agreements for CAN and CHIP, as shown in *Table 39: Delegated Entities and Services for CAN and CHIP*.

Table 39: 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
Infomedia Group, Inc. d/b/a Carenet Healthcare Services	Nurse Advice Line
Accordant Care Rare	Case Management

Per Procedure MHI- DO -01.1, Delegation Oversight Program, Molina ensures that all delegated entities are qualified to perform services and comply with regulations. Molina maintains accountability for all activities conducted by third-party entities.

Before delegating services, Molina conducts a pre-delegation assessment of the third-party entity's understanding, staff credentials, compliance with standards, policies, procedures, and other necessary areas to ensure they can perform the delegated services. Ongoing monitoring is conducted and reported to the appropriate committee quarterly. An annual delegation oversight audit is conducted, and findings are reviewed to determine the continuation of the delegation. If the delegated entity's performance is found to be substandard, a corrective action plan is issued. The Delegation Oversight team monitors the plan and reports to relevant committees. Termination of the agreement may be recommended if there is no improvement.

Copies of the annual delegation audits and monitoring reports were provided for all delegates. During the previous EQRs (2022 and 2023) Constellation found issues with the annual oversight monitoring for CVS/Caremark (see *Attachment 4: Assessment of Corrective Action Plans from Previous EQR* for details). For this review, the 2023 annual audit was provided. Since DOM has

transitioned to a Statewide Pharmacy Benefit Manager, the contract with CVS/Caremark was terminated before the 2024 annual audit was scheduled to be conducted.

All of the standards for CAN and CHIP in the Delegation section of this review were met as noted in the figure that follows.

Figure 8: Delegation Findings

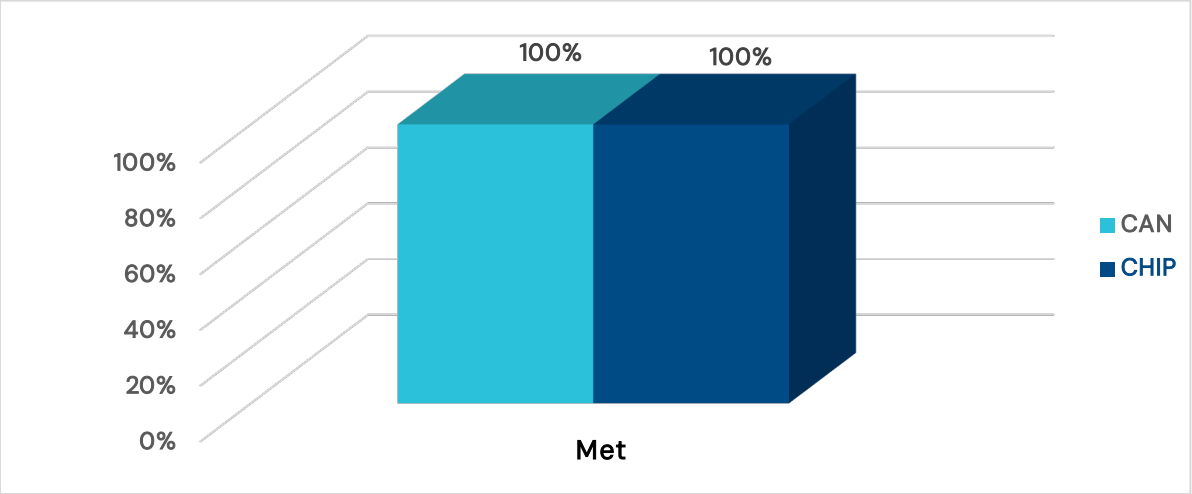


Table 40: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
The Delegation Oversight Program includes pre-delegation assessments, ongoing monitoring through Molina's Joint Operations Committee meetings, and comprehensive annual audits. This ensures that third-party entities consistently meet performance and compliance standards, providing a robust framework for accountability.	✓		
Molina mandates that all third-party entities enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights.	✓		

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 established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Policy and Procedure MHI-DO-01, Delegation Oversight Program (Procedure MHI- MHI- DO -01.1), provides an overview of Molina's delegation program and the oversight processes.
2. The CCO has written agreements with all contractors or agencies performing delegated functions that outline the responsibilities of the contractor or agency in performing those delegated functions.	X					All of Molina's subcontractors are required to enter into written agreements specifying delegated activities, reporting responsibilities, compliance with laws, and audit rights. These agreements include provisions for revocation and access by government regulators.
3. 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					Per Procedure MHI- DO -01.1, Delegation Oversight Program, Molina ensures that all delegated entities are qualified to perform services and comply with regulations. Molina maintains accountability for all activities conducted by third-party entities. Before delegating services, Molina conducts a pre-delegation assessment of the third-party entity's understanding, staff credentials, compliance with standards, policies, procedures, and other necessary areas to ensure they can perform the delegated services. Ongoing monitoring is conducted and reported to the appropriate committee quarterly. An annual delegation oversight audit is conducted, and findings are reviewed to determine the continuation of the delegation. If the delegated entity's' performance is below standard, a corrective action plan is issued.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Delegation Oversight team monitors the plan and reports to relevant committees. Termination of the agreement may be recommended if there is no improvement. For this EQR Molina reported delegation agreements with eight subcontractors. The delegated services include vision services, non-emergent transportation, care management, utilization management, dental services, nurse advice line, case management, and pharmacy services. Copies of the annual delegation audits and monitoring reports were provided for all delegates. During the previous EQRs (2022 and 2023) Constellation found issues with the annual oversight monitoring for CVS/Caremark. For this review, the 2023 annual audit was provided. Since DOM has transitioned to a Statewide Pharmacy Benefit Manager, the contract with CVS/Caremark was terminated before the 2024 annual audit was scheduled to be conducted.

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 established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Policy and Procedure MHI-DO-01, Delegation Oversight Program (Procedure MHI- MHI- DO -01.1), provides an overview of Molina's delegation program and the oversight processes.
2. The CCO has written agreements with all contractors or agencies performing delegated functions that outline the responsibilities of the contractor or agency in performing those delegated functions.	X					All of Molina's subcontractors are required to enter into written agreements specifying delegated activities, reporting responsibilities, compliance with laws, and audit rights. These agreements include provisions for revocation and access by government regulators.
3. 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					Per Procedure MHI- DO -01.1, Delegation Oversight Program, Molina ensures that all delegated entities are qualified to perform services and comply with regulations. Molina maintains accountability for all activities conducted by third-party entities. Before delegating services, Molina conducts a pre-delegation assessment of the third-party entity's understanding, staff credentials, compliance with standards, policies, procedures, and other necessary areas to ensure they can perform the delegated services. Ongoing monitoring is conducted and reported to the appropriate committee quarterly. An annual delegation oversight audit is conducted, and findings are reviewed to determine the continuation of the delegation. If the delegated entity's performance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is below standard, a corrective action plan is issued. The Delegation Oversight team monitors the plan and reports to relevant committees. Termination of the agreement may be recommended if there is no improvement. For this EQR Molina reported delegation agreements with eight subcontractors. The delegated services include vision services, non-emergent transportation, care management, utilization management, dental services, nurse advice line, case management, and pharmacy services. Copies of the annual delegation audits and monitoring reports were provided for all delegates. During the previous EQRs (2022 and 2023) Constellation found issues with the annual oversight monitoring for CVS/Caremark. For this review, the 2023 annual audit was provided. Since DOM has transitioned to a Statewide Pharmacy Benefit Manager, the contract with CVS/Caremark was terminated before the 2024 annual audit was scheduled to be conducted.

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Assessment of Corrective Action Plans from Previous EQR

Attachment 1: Initial Notice and Materials Requested for Desk Review

June 3, 2024

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 2024 External Quality Review (EQR) of Molina Healthcare of Mississippi is being initiated. The review will include the MississippiCAN (MSCAN) and Mississippi CHIP (MS CHIP) Programs and will be conducted by Constellation Quality Health, formerly The Carolinas Center for Medical Excellence.

The methodology used 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 Constellation Quality Health) and a virtual onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The virtual onsite visit will be conducted on **October 9, 2024**, and **October 10, 2024**, for the MississippiCAN and MississippiCHIP Programs.

In preparation for the desk review, the items on the enclosed Mississippi CAN Materials Request for Desk Review and Mississippi CHIP Materials Request for Desk Review lists should be provided to Constellation Quality Health no later than **July 3, 2024**.

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)

cc: DOM

Molina Healthcare of Mississippi

MississippiCAN 2024 External Quality Review

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 positions 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. Please include all of the following:
    a. A list of all contracted providers. This list should be submitted as an excel spreadsheet and include county, specialty, panel limitations, and a description of any codes used in the spreadsheet.
    b. Geographic access assessments
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios
    f. Analysis of in-network and out-of-network utilization data
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 2023 and 2024.

11. The most recent reports that summarize 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 2023 and 2024 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 2023 through June 2024. 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 2023 to June 2024. 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 2023 through June 2024.
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.
    a. Copies of the EPSDT tracking reports and follow-up activities from August 2023 through June 2024.
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 with updated data for MY 2023. *(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 2023 through June 2024.

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 2023 (MY 2023) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2023 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for all supplemental data sources that are utilized for all measures included under PMV review. If the CCO did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) CSV and Excel workbooks for MSCAN for MY 2023.
c.	HEDIS MY 2023 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 2023. NOTE: Constellation understands CCOs may not receive the FARs from the HEDIS auditors until 7/15/24. Please submit this item by 7/17/24.
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℠, 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, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health's portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. Constellation Quality Health 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	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health portal, folder 36 g) a

Folder	Requested Document	Description
	the HEDIS measures	list of the first 100 numerator compliant records and exclusions/valid data errors that are identified through medical record review. Constellation Quality Health will select a random sample to conduct the medical record review validation.
h.	Rate Reporting template populated with data for non-HEDIS measure rates	Constellation Quality Health 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 2023 through June 2024. 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 2023 through June 2024, 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 Constellation Quality Health.

These materials:

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

Molina Healthcare of Mississippi

Mississippi CHIP 2024 External Quality Review

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 positions 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. Please include all of the following:
    a. A list of all contracted providers. This list should be submitted as an excel spreadsheet and include county, specialty, panel limitations, and a description of any codes used in the spreadsheet.
    b. Geographic access assessments
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios
    f. Analysis of in-network and out-of-network utilization data
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 2023 and 2024.

11. The most recent reports that summarize 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 all committee meetings 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. Please indicate which members are voting members and include committee charters if available.
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 2023 and 2024 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 2023 through June 2024. 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 2023 to June 2024. 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 2023 through June 2024.
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.
    a. Copies of the Well-Baby Well-Child tracking reports and follow-up activities from August 2023 through June 2024.
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 with updated data for MY 2023. *(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 2023 through June 2024.

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 2023 (MY 2023) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2023 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for all supplemental data sources that are utilized for all measures included under PMV review. If the CCO did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MS CHIP	Please submit auditor locked Interactive Data Submission System (IDSS) CSV and Excel workbooks for MS CHIP for MY 2023.
c.	HEDIS MY 2023 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 2023. NOTE: Constellation understands CCOs may not receive the FARs from the HEDIS auditors until 7/15/24. Please submit this item by 7/17/24.
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, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. Constellation Quality Health 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	Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, Constellation Quality Health will send a second request with selected measures and request the CCO to upload (via Constellation Quality Health portal, folder 36.g) a list of the first 100 numerator compliant records and exclusions/valid data

Folder	Requested Document	Description
	measures	errors that are identified through medical record review. Constellation Quality Health will select a random sample to conduct the medical record review validation.
h.	Rate Reporting template populated with data for non-HEDIS measure rates	Constellation Quality Health 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 2023 through June 2024. 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 2023 through June 2024, 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 Constellation Quality Health.

These materials:

- should be organized and uploaded to the secure Constellation Quality Health EQR File Transfer site at https://eqro.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 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied
2. Health Care Services Committee (HCSC) meeting minutes
3. Updated Pharmacy Program Description
4. Any updated Pharmacy policies reflecting change in SPBA
5. A copy of the monthly quality scorecard report (for CAN and CHIP) referenced in the 2024 Primary Care Provider Pay-For-Quality Bonus Program document.
6. A copy of the monitoring conducted for provider compliance with the Clinical and Preventive Health Guidelines referenced in policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.
7. File notes for CHIP Approval File PUM2324417027
8. A copy of the 2024 Annual Delegation Audit Report for MTM, Carenet, and Progeny.
9. The most recent appointment access call study results for CAN and CHIP.
10. ABD for CHIP Denial File 24010718.

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

Attachment 3: EQR Validation Worksheets

- Member Satisfaction Survey Validation CAN
- Member Satisfaction Survey Validation CHIP
- Performance Measure Validation CAN
- Performance Measure Validation CHIP
- Performance Improvement Project Validation CAN
- Performance Improvement Project Validation CHIP
- Network Validation CAN and CHIP

EQR Survey Validation Worksheet

Plan Name	Molina CAN
Survey Validated	CAHPS MEMBER SATISFACTION – ADULT
Validation Period	2023
Review Performed	2024

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:* Press Ganey Adult CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022

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:* Press Ganey Adult CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Adult CAHPS Report MY2022

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:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022

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:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022

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,	**MET**	The quality plan is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2022.

Survey Element		Element Met / Not Met	Comments and Documentation
	procedures for missing data, and data that fails edits		
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022

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:* Press Ganey Adult CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Adult CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult CAHPS Report MY2022

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:* Press Ganey Adult CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 13.0% which is an improvement over the previous year's response rate of 10.8%. This response rate, however, is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	Molina CAN
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2023
Review Performed	2024

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:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022

Survey Element		Element Met / Not Met	Comments and Documentation
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:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022.

Survey Element		Element Met / Not Met	Comments and Documentation
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child response rate was response rate was 9.2%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.3	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.4	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:* Press Ganey Child CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	Molina CHIP
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2023
Review Performed	2024

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:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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,	**MET**	The quality plan is documented. *Documentation:* Press Ganey Child CAHPS Report MY2022.

Survey Element		Element Met / Not Met	Comments and Documentation
	procedures for missing data, and data that fails edits		
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2022

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:* Press Ganey Child CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 11.2%, which is a slight decline from the previous year's rate of 11.9%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.3	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.4	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:* Press Ganey Child CAHPS Report MY2022

EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2024**
Review Performed:	**10/16/2024**

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**	One error was found in the PPC-Prenatal chart abstraction during medical record review validation. Since 100% of the charts were reviewed, it was confirmed that there were no additional errors and the rate was reportable.

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:	**ALL ADULT AND CHILD CMS CORE MEASURES – CAN (EXCEPT HIV VIRAL LOAD SUPPRESSION (HVL- AD))**
Reporting Year:	**2024**
Review Performed:	**10/16/2024**

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	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	services outside the MCO/PIHP's network) are complete and accurate.		
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:	**2024**
Review Performed:	**10/16/2024**

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).	**Not Met**	The data submitted for the measure was incorrect. After additional research, the plan identified there was a delayed update from Claimsphere product team on the HVL-AD core set measure. Claimsphere product team confirmed that the prior provided eligible population of 10 was incorrect. The updated eligible population is 125, which is more in line with the prior year.

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**	Since the original denominator criteria that was applied was incorrect, the original numerator provided was zero. The updated numerator is still quite low compared to the prior year.
N3 Numerator Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Met**	The specifications were not followed when the original rate was submitted. The updated rate is lower by more than 11 percentage points. No explanation was

			provided for the decrease in rate.
Overall assessment		**Met**	

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**0**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**2**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**9**

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	**66**
Measure Weight Score	**75**
Validation Findings	**88%**

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:	**2024**
Review Performed:	**10/16/2024**

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**	Since the original denominator criteria that was applied was incorrect, the original numerator provided was zero. The updated numerator is still quite low compared to the prior year.
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 MS CHIP**
Name of PM:	**ALL ADULT AND CHILD CMS CORE MEASURES – CHIP**
Reporting Year:	**2024**
Review Performed:	**10/16/2024**

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 PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	AMR
Reporting Year:	2023
Review Performed:	2024

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**	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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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 processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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 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**	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**	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**	Quarterly data showed an **increase** from 64.69% in Q4 2023 to 84.80% in Q1 2024 with a goal of 72.89%.
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 by the plan.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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	NA	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:	PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)
Reporting Year:	2023
Review Performed:	2024

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**	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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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 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.

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**	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 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 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**	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**	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 Q4 2023 to Q1 2024., there was an increase from 57.89% to 62.07% for corticosteroid measure, with a goal of 53.43%; but a non-significant decline from 77.19% to 75.89% for the bronchodilators, with a goal of 81.8%.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 by the plan.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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	NA	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:	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)
Reporting Year:	2023
Review Performed:	2024

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 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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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: FUH for 7- and 30-day follow-up
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		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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 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**	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**	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**	For the 30-day follow up, the rate reduced from 52.05% to 27.53% (the goal is 50%). The 7-day declined from 31.10% to 19.66% with a goal of 28.32%. **Recommendation:** *Continue member and provider focused interventions to educate toward efforts to improve follow-up after discharge.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in	**NA**	Improvement did not occur.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
performance appear to be the result of the planned quality improvement intervention)? **(5)**		
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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:	OBESITY
Reporting Year:	2023
Review Performed:	2024

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**	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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data collection cycle.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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**	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**	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**	For BMI percentile, from Q1 to Q2 the rate of 27.72% declined to 14.01%. Counseling for nutrition declined 15.69% to 7.46%; counseling for physical activity declined 15.61% to 7.30%. **Recommendation:** *Continue ongoing interventions to educate provider and members toward efforts to improve percentage of members receiving counseling and improve documentation.*
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 did not occur.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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:	PRENATAL AND POSTPARTUM CARE
Reporting Year:	2023
Review Performed:	2024

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**	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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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.
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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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**	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**	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**	For prenatal visits, the rate increased from 87.03% to 89.36% and the goal is 94.92%. For postpartum visits, the rate declined from 51.11% to 35.41%, with a goal of 74.30%. **Recommendation:** *Continue focusing on member education and community fairs and events to ensure appropriate engagement in postpartum care*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement did not occur.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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%**

Check 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.*

Constellation Quality Health

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	SICKLE CELL DISEASE
Reporting Year:	2023
Review Performed:	2024

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**	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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data collection cycle.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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**	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**	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**	The percentage of members with SCD that are enrolled in case management declined from 9.47% to 8.25% in the most recent remeasurement with a goal of 15.9%. **Recommendation:** *Continue ongoing interventions for tracking and monitoring of members and collaborative efforts to increase enrollment.*
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 did not occur.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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%**

Check 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.*

Constellation Quality Health

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	ASTHMA AMR
Reporting Year:	2023
Review Performed:	2024

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 affects people of all ages and often starts during childhood. Mississippi (8.9%), with a rate higher than the national (7.6%), has the 13th highest prevalence in the nation among 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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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.
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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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**	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**	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**	Quarterly rates show an improvement from 75.84% in Q4 2023 to 80.70% in Q1 2024, with the goal rate being 72.89%.
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 did not occur.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	The rate has been above the goal rate for several measurement period.

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	5
9.3	1	1
9.4	NA	5

Project Score	**85**
Project Possible Score	**85**
Project Rating Score	**100%**

Check 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.*

Constellation Quality Health

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS
Reporting Year:	2023
Review Performed:	2024

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**	Healthy People 2030 objectives on mental illness include: increase treatment among adults with mental illness, people with substance, mental, marijuana, and drug use disorders
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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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.
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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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**	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**	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**	The 30-day rate for 6–17-year-olds declined from 55% in Q4 2023 to 37.5% in Q1 2024. For the 7-day rate, the rate declined from 32% in Q4 2023 to 25% in Q1 2024. **Recommendation:** *Continue member and provider focused interventions to educate toward efforts to improve follow-up after discharge.*
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 did not occur.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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%**

Check 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.*

Constellation Quality Health

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	OBESITY
Reporting Year:	2023
Review Performed:	2024

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 highest (20th) rates of WIC children aged 2 to 4 years who have obesity in the nation (MS: 14.8%, US: 15.5%).
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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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.
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.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 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**	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**	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**	The BMI documentation rate declined from 24.49% to 11.06% with a goal of 61.31%. The nutrition counseling rate also declined from 16.23% to 6.40%, with a goal of 52.31%; and Counseling for physical activity declined from 15.62% to 6.0%, with a goal of 57.42%. **Recommendation:** *Continue ongoing interventions to educate provider and members toward efforts to improve percentage of members receiving counseling and improve documentation.*

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 did not occur.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.
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%**

Check 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.*

Constellation Quality Health

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	WELL-CHILD VISITS
Reporting Year:	2023
Review Performed:	2024

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**	With 71.2%, in 2021, Mississippi ranks 49th lowest percentage of well-child visit (ages 3-17) in the nation.
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**	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)**	**N/A**	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:*	**N/A**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	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.
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 sources of the data.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	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**	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**	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**	The most recent rates were 69.03% in Q4 2023 and that reduced to 63.16% in Q1 2024. The goal rate is 56.13% so the rate is still above the goal rate. **Recommendation:** *Continue interventions focused on member education and assessment of barriers to receiving well-child visits.*
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 did not occur.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance testing is documented.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	The well child visit rate has been above the goal rate for the last several measurements.

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	5

Project Score	**79**
Project Possible Score	**80**
Project Rating Score	**99%**

Check 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.*

Constellation Quality Health

EQR Network Adequacy Validation Worksheet

Plan Name:	**Molina CAN/CHIP**
Reporting Year	**2023**
Review Performed:	**2024**

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)**	**N/A**	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		
Component / Standard (Total Points)	**Score**	**Comments**
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 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	99	99

Project Score	99
Project Possible Score	99
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 indicator. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire indicator in question. *Validation findings below 60% are classified here.*

Attachment 4: Assessment of Corrective Action Plans from Previous EQR

Constellation Quality Health

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

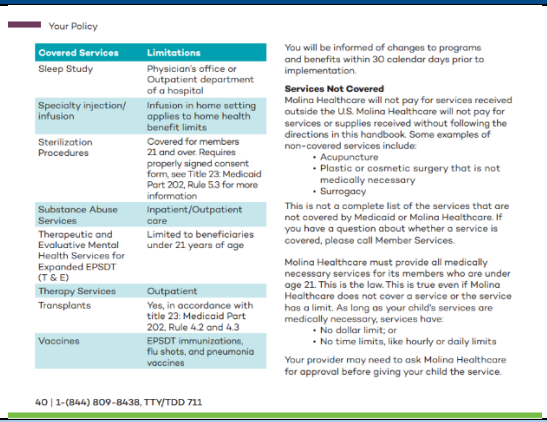
Molina Healthcare of Mississippi 2023 Corrective Action Plan – CAN

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
I A. Compliance/Program Integrity			
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.			
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. *Corrective Action Plan: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.*	Jeremy Ketchum will chair the Compliance Committee moving forward. See document: Compliance Committee Charter uploaded to the portal.	✓	
PROVIDER SERVICES			
II A. Adequacy of the Provider Network			
2. Practitioner Accessibility 2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.			
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.	Documents provided: CAP Item#2 MSCAN Provider Manual and EQR 2023 CAP No. 2-3 On pages 73-74, the following has been updated in the MSCAN Provider Manual:	✓	

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
• 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. 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 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).*	• For routine visits with Behavioral Health/Substance Use Disorder providers, Molina has revised the MSCAN provider manual to state that the standard is 7 calendar days. • Molina has included the full contractual requirement for Behavioral Health/Substance Use Disorder providers. • Molina has included the appointment access standard for Emergency Providers. Policy MHMS-QI-006, Access to Care, has been revised to indicate specialist appointment access standard as not to exceed 45 days (pg.4 of policy). Also, the language regarding the initial visit scheduling within 10 days has been removed. Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2024 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 Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP"		
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.			
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. <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.*	Documents provided: EQR 2023 CAP No. 2-3, MHMS-MM-003-Member Rights and Responsibilities 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 (pg. 7). Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2024 meeting.	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	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 Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP"		
II B. Provider Education			
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;			
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 the correct limit for the number of home health services visits.*	Molina has added "Limited to 36 visits per year" on the MSCAN member website. MSCAN Member Website: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx In addition, we have removed the Molina Healthcare Benefits at a Glance MississippiCAN Covered Services" document from the website to only reflect the benefits and services that are included in the grid.	✓	
Member Services			
III A. Member Rights and Responsibilities			
3. Member responsibilities include the responsibility: 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	Molina has updated the MSCAN member website to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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 web page listing member responsibilities to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage.*	MSCAN Member Website: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx		
III B. Member CCO Program Education			
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in coverage;			
The CAN Member Handbook 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.*	See document- CAP #6 MSCAN Member handbook. Molina has added "Limited to 36 visits per year" in the MSCAN member handbook.	✓	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.			
Molina staff confirmed there is no policy that addresses the process for informing members of changes to programs and benefits within 30 calendar days prior to implementation. *Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.*	This language will be included in the revised Member Handbook in accordance with the Policy & Procedure language **2.2.2024** Updated Response: Policy MHMS-MM-007 Enhanced and Covered Services uploaded to the portal. 2/2/2024: Molina has added this language in the MSCAN Member Handbook on page 40. Please see below screenshot for reference. MSCAN Handbook has been uploaded to portal.	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	 Your Policy **Covered Services** / **Limitations** Sleep Study — Physician's office or Outpatient department of a hospital Specialty injection/ infusion — Infusion in home setting applies to home health benefit limits. Sterilization Procedures — Covered for members 21 and over. Requires properly signed consent form, see Title 23: Medicaid Part 202, Rule 5.3 for more information Substance Abuse Services — Inpatient/Outpatient care Therapeutic and Evaluative Mental Health Services for Expanded EPSDT (T & E) — Limited to beneficiaries under 21 years of age Therapy Services — Outpatient Transplants — Yes, in accordance with title 23: Medicaid Part 202, Rule 4.2 and 4.3 Vaccines — EPSDT immunizations, flu shots, and pneumonia vaccines You will be informed of changes to programs and benefits within 30 calendar days prior to implementation. **Services Not Covered** Molina Healthcare will not pay for services received outside the U.S. Molina Healthcare will not pay for services or supplies received without following the directions in this handbook. Some examples of non-covered services include: • Acupuncture • Plastic or cosmetic surgery that is not medically necessary • Surrogacy This is not a complete list of the services that are not covered by Medicaid or Molina Healthcare. If you have a question about whether a service is covered, please call Member Services. Molina Healthcare must provide all medically necessary services for its members who are under age 21. This is the law. This is true even if Molina Healthcare does not cover a service or the service has a limit. As long as your child's services are medically necessary, services have: • No dollar limit; or • No time limits, like hourly or daily limits Your provider may need to ask Molina Healthcare for approval before giving your child the service. 40 | 1-(844) 809-8438, TTY/TDD 711		
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.			
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.*	Policy MHMS-MPCC-04 Member Service General Operations has been updated on page 2.	✓	
III G. Grievances			
2. The CCO applies the grievance policy and procedure as formulated.			
Six CAN resolution letters contained wording indicating that steps had been taken to resolve the grievance; however, no	We are working with the Division of Medicaid to establish a process to submit for extension when we are unable to complete the request	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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.*	within the timeframe allowed. Once the process has been established the team with be educated on the update by the end of Q2 2024. We will be sure the steps taken will be in the letters. **2.1.2024 Response:** The Division is working on a process to address this CAP. For now, the process would be for all extensions: Submit the request to: Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov Lucretia Causey Lucretia.Causey@medicaid.ms.gov Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov Patricia Collins Subject "Expedited Approval – 14 Day extension. All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day. All inquiries received after 12 noon will be responded by 12 noon the following day. We Have attached a workflow that speaks to this update as well as the letters. A verbiage template has been comprised for unable to contact cases that speaks to the steps we took to complete the case. This verbiage has been included in the workflow along with the template and an example. The workflow will be presented and implemented to the team on 2/5/2024.		
Quality Improvement			
IV A. Quality Improvement (QI) Program			
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).			
There were 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	See document EQR 2023_CAP No. 10 and 26_MSCAN_CHIP The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected and benchmark/goals were updated.	✓	

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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. • 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.	For easy identification, all changes in the document are in red. Corrections below: • Program Operation - Page 11. "Met" changed to "Ongoing" • Availability of Practitioners: • Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500" • Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500" • Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500" • Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles". • Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles", • Oncologists: "1:30 minutes OR 1:30 miles" • Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles", • Psychiatrists: "1:30 minutes OR 1:30 miles" • Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days • Results/Timeframe/Date the Goal: (see above):		

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Corrective Action Plan: Correct the errors identified in the 2023 QI Work Plan.	• Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type • Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available." • Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine" • Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners" • Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly. • Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10" • Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30". A revised copy of the work plan 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. 10 and 26_1-12-24_MSCAN_CHIP" **2.2.2024- Updated Response** The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business.		

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24" The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24" See document EQR 2023_CAP No. 10 and 26_MSCAN_CHIP The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected and benchmark/goals were updated. For easy identification, all changes in the document are in red. Corrections below: Program Operation - Page 11. "Met" changed to "Ongoing" Availability of Practitioners: Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500" Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500" Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500" Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles". Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles", Oncologists: "1:30 minutes OR 1:30 miles"		

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
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	Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles", Psychiatrists: "1:30 minutes OR 1:30 miles" Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days Results/Timeframe/Date the Goal: (see above): Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available." Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine" Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners" Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly. Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10" Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30".		

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
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	A revised copy of the work plan 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. 10 and 26_1-12-24_MSCAN_CHIP" **2.2.2024- Updated Response** The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24" The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24" **2.19.2024 – Updated Response** • As indicated, Work Plan has been revised and updated with terminology utilized in Policy QI-006 in slide and sections as indicated below: SLIDES 30 & 31 changes: Access to appointments for PCPs are monitored by preventive primary care, routine sick, urgent care, and after hours. Goals are set to meet regulatory requirements. Preventive primary care (PCP): 90% Not to exceed 30 days Preventive primary care (OB/GYN): 90% Not to exceed 30 days Routine Sick (PCP): 90% Not to exceed 7 days Routine Sick (OB/GYN): 90% Not to exceed 7 days After review of the policy and work plan, the language used in the policy needed clarifying. Therefore, the Policy MHMS-QI-006 has been revised with the appropriate language for Routine Sick for PCP and OB/GYN (page 3 of 7) and congruent language was used in the work plan (pages 30-31). The policy will be sent back to the QIC for approval of the changes during Q1 2024 QIC Meeting. A redline copy of the policy is provided with this response.		

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	The 2023 QI Work Plan with the aforementioned revisions is provided (pages 30-31). However, the 2024 QI Work Plan is currently unavailable at this time. It is expected by March 2024.		
IV E. Provider Participation in Quality Improvement Activities			
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.			
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 Contract, Section 10 (M) and Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.*	The monitoring of provider compliance against two aspects of the Clinical Practice Guidelines annual report will be provided by February 29, 2024. The report will focus on perinatal care and PPC HEDIS measures. Also, we have included the 2022 Performance measures Report (EQR Audit 2023_CAP No 11 and 27_MSCAN_CHIP_1-12-24.) Molina has added "Limited to 36 visits per year" in the MSCAN member handbook on page 38.	✓	
4. The CCO tracks provider compliance with EPSDT service provision requirements for: 4.2 EPSDT screenings and results;			
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.	See document: EQR 2023 CAP No. 12 and 28 EPSDT_Well Child and Tracking Report. The EPSDT/Well Child Tracker is a working, fluid document that is being updated continuously. The manual 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	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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 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. *Corrective Action 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.*	information into the EPSDT/Well Child Tracker. In columns T-AD 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. An automated system of the EPSDT/Well Child tracker is in process. 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. 12 and 28_EPSDT/Well Child Tracking Report_ **2.2.2024 Updated Response** The language from Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, page 7, regarding the creation of an automated tracking system has been removed. A redline version of the policy is included with this submission and is applicable to the MSCAN line of business. The title of the document is "CAP Item 12_Policy MHMS-QI-003_EPSDT_MSCAN_1-26-24."		
IV F. Annual Evaluation of the Quality Improvement Program			
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.			
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 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	See document: EQR Audit 2023_CAP No. 13 and 29_2022 QI Evaluation. The 2022 QI Program Evaluation has been revised to include analysis of the Geo Access Reports/Network Adequacy (pg. 33-35 and Provider Online Directory (pg. 40-42). A revised copy of the 2022 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 2023_CAP No. 13 and 29_2022 QI Evaluation_"	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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 <u>all</u> 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.*			
Utilization Management			
V B. Medical Necessity 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.			
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 with a written request from the Adverse Benefit Determination letters.*	The CAN Adverse Benefit Determination Letter has been updated to match the contractual requirements. Requirement for written request has been removed from the letter. See document attached: The CAN Adverse Benefit Determination Letter has been updated to match the contractual requirements. Requirement for written request has been removed from the letter. CAP #14 and #30 MHMS ABD Letter_Re Appeal Notification	✓	
V C. Appeals			
2. The CCO applies the appeal policies and procedures as formulated.			
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	We are working with the Division of Medicaid to establish a process to submit for an extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team will be educated on the update by the end Q2 of 2024. **2.2.2024. Updated Response**	✓	

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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 that the appropriate notification is provided to the Division when appeal extensions are needed.*	The Division is working on a process to address this CAP. For now the process would be for all extensions: Submit the request to Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov Lucretia Causey Lucretia.Causey@medicaid.ms.gov Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov Patricia Collins Subject "Expedited Approval – 14 Day extension All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day. All inquiries received after 12 noon will be responded by 12 noon the following day. We have attached a work flow that speaks to this update. The workflow will be presented and implemented to the team on 2/5/2024.		
Delegation			
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.			
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).*	See Documents for CVS uploaded to the Portal for both CAP #16 and 32. **2.2.2024 Updated Response** In response to the CAP (Corrective Action Plan) feedback regarding the oversight of CVS as a delegated subcontractor. Oversight of CVS Pharmacy Benefit Manager (PBM) oversight is primarily the responsibility of our Pharmacy Operations Team and not under the purview of the Delegation Oversight Team. PBM functions involve various tasks that differ from those overseen by the Delegation Oversight Team. The CHIP and CAN Contract, sections which states, "The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year." CVS's oversight, however, occurs more frequently due to the complex and dynamic nature of their responsibilities.	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	CVS's role as a PBM involves extensive monitoring, with monitoring reports, dashboards, and Surveillance Summaries being provided on a regular basis, including daily, monthly, and quarterly reports. This frequency of monitoring is necessitated by the robustness of the functions they perform, which go beyond the scope of an annual audit. To provide further clarification and insight into our oversight processes, I have included "MHI Pharm 14 Pharmacy Operations Surveillance Policy and Procedure." This document outlines the comprehensive procedures and guidelines we follow for monitoring and surveillance within Pharmacy Operations. It will offer you a more detailed understanding of our PBM oversight surveillance practice. MHI Pharmacy Operations Surveillance Policy and Procedure uploaded to the portal. **2/22/2024** Molina has provided documentation of the annual audits conducted for our PBM CVS. The annual internal audits entitled Molina Executive Dashboard, which monitors timelines. An external audit conducted by external PBM auditor Health Strategies is also included. **PBM oversight is under the purview of Pharmacy Operations not the Molina Delegation Oversight team.** **From a oversight perspective that relates the review of annual State Contract Review activities for CVS/CareMark as stated in this procedure.** **3/6/2024** The annual review referenced conducted by Molina Pharmacy Operations Analysts partner with regional Molina pharmacy representatives has been provided in the document attached entitled *MS MedicaidCHIP_Contract Review Summary 2023__*. **3.18.2024** This annual audit document the auditor share between Molina and CVS will be completed at the end of this year for 2023. This auditing process involves a comprehensive examination and analysis, which often requires thorough investigation and extensive communication between our teams.		

2023 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	Due to the depth of the discovery process and the necessity for meticulous back-and-forth communication, we have historically completed the audit towards the end of the year. **3.26.2024** Please see attached 2023 annual audit for CVS. The Delegation audit for 2023 has been completed. After speaking with the Pharmacy auditing team, it was determined that the team members who work on this task did not fully understand the ask because they are new to the team. The new team member was under the impression we were asking for a document performed for another audit. The miscommunication was cleared up and it was determined that the delegation audit was completed. See document attached.		

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

Molina Healthcare of Mississippi 2023 Corrective Action Plan – CHIP

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
I A. Compliance/Program Integrity			
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.			
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. *Corrective Action Plan: Revise the Molina Healthcare of Mississippi, Inc. Compliance Committee Membership document to correctly indicate which staff member chairs the Compliance Committee.*	Jeremy Ketchum will chair the Compliance Committee moving forward. See document: Compliance Committee Charter uploaded to the portal.	✓	
PROVIDER SERVICES			
II A. Adequacy of the Provider Network			
2. Practitioner Accessibility 2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.			
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>	See documents CAP #18 CHIP Provider Manual and EQR Audi 2023_CAP No 2-3 and 18-19. The following changes has been made to the CHIP Provider Manual: • Molina has included the full contractual requirement for Behavioral Health/Substance Use Disorder providers.	✓	

2023 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
• 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. 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." • 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).*	• Molina has included the appointment access standard for Emergency Providers. Policy MHMS-QI-006, Access to Care, has been revised to indicate specialist appointment access standard as not to exceed 45 days (pg.4 of policy). Also, the language regarding the initial visit scheduling within 10 days has been removed. Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2024 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 Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP"		
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.			
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. <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.*	See document EQR Audi 2023_CAP No 2-3 and 18-19. 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 (pg. 7). Next, the revised policy will be sent to Compliance and Government Contracts for review of appropriate language and contractual requirements (by February 2024). The policy will then be presented at to the Quality Improvement Committee for review and approval at Quarter 1 2024 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 Audit 2022_CAP No. 2-3 and 18-19_MHMS-QI-006-Access to Care_MSCAN_CHIP"	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
II B. Provider Education			
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;			
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.*	See document MSEQR_Molina Healthcare of MississippiCAN CHIP 2023 CAP #20 Molina has added "Limited to 36 visits per year" on the CHIP member website. CHIP member website https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx In addition, we have removed the Molina Healthcare Benefits at a Glance CHIP Covered Services" document from the website to only reflect the benefits and services that are included in the grid.	✓	
Member Services			
III A. Member Rights and Responsibilities			
3. Member responsibilities include the responsibility: 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.*	See document MSEQR_Molina Healthcare of MississppiCAN CHIP 2023 CAP # 21 Molina has updated the CHIP member website to include the responsibility to inform Molina of changes in family size, address changes, or other health care coverage. CHIP member website: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/quality/rights.aspx	✓	
III B. Member CCO Program Education			

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: 1.1 Full disclosure of benefits and services included and excluded in coverage;			
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.*	Molina has added "unlimited" under the emergency ambulance services requirement on the CHIP member website here https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Molina has added "Limited to 36 visits per year" in the CHIP member handbook. See document CAP #22 uploaded to the portal. Molina has updated the CHIP member handbook and the CHIP member website with the vision benefits being administered on a calendar year basis. **2.2.2024- Updated Response:** 1/24/2024: Molina has removed "based on life threatening condition present" from the CHIP member handbook.	✓	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.			
Molina staff confirmed there is no policy that addresses the process for informing members of changes to programs and benefits within 30 calendar days prior to implementation. *Corrective Action Plan: Develop and implement a policy that describes Molina's processes for notifying members of changes in services and benefits.*	This language will be included in the revised Member Handbook in accordance with the Policy & Procedure language on Covered Services and Enhanced Services. **2.2.2024- Updated Response** See CAP Item #23 MHMS- MM-007- Enhanced and Covered Services uploaded to the portal.	✓	
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.			
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	Policy MHMS-MPCC-04 Member Service General Operations has been updated on page 2.	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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.*			
III G. Grievances			
2. The CCO applies the grievance policy and procedure as formulated.			
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.*	We are working with the Division of Medicaid to establish a process to submit for extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team with be educated on the update by the end of Q2 2024. **2.2.2024- Updated Response** The Division is working on a process to address this CAP. For now the process would be for all extensions: Submit the request to: Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov Lucretia Causey Lucretia.Causey@medicaid.ms.gov Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov Patricia Collins Subject "Expedited Approval – 14 Day extension All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day. All inquiries received after 12 noon will be responded by 12 noon the following day.	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
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	We Have attached a work flow that speaks to this update as well as the letters. A verbiage template has been comprised for unable to contact cases that speaks to the steps we took to complete the case. This verbiage as been included in the workflow along with the template and an example. The workflow will be presented and implemented to the team on 2/5/2024.		
Quality Improvement			
IV A. Quality Improvement (QI) Program			
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).			
There were 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 and Routine (PCP) appointment as not to exceed 30 days. However, Policy	See document EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP. The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected and benchmark/goals were updated. For easy identification, all changes in the document are in red. Corrections below: • Program Operation - Page 11. "Met" changed to "Ongoing" • Availability of Practitioners: • Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500" • Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500" • Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500" • Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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.*	Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles". • Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles", Oncologists: "1:30 minutes OR 1:30 miles" • Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles", Psychiatrists: "1:30 minutes OR 1:30 miles" • Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days • Results/Timeframe/Date the Goal: (see above): • Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and added table with benchmark goals and rates corresponding to each provider type • Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available." • Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine"		

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	• Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners" • Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly. • Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10" • Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30". A revised copy of the work plan 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. 10 and 26_1-12-24_MSCAN_CHIP" **2.2.2024 Updated Response** The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24" The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24" See document EQR Audit 2022_CAP No. 10 and 26_1-12-24_MSCAN_CHIP. The 2023 QI Work Plan has been revised the errors and missing information denoted by the auditors in the comment section. Timelines have been corrected and benchmark/goals were updated.		

2023 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
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	For easy identification, all changes in the document are in red. Corrections below: Program Operation - Page 11. "Met" changed to "Ongoing" Availability of Practitioners: Pg 17: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "1:1500"; General Practice: "1:1500", Internal Medicine: "1:1500" Pg 19: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN: "1:2500", Oncology: "1:2500" Pg 21: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Psychologists: "1:2500", Psychiatrists: "1:2500" Pg 23: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for Family Practice/ Family Medicine: "2:15 miles"; General Practice: "2:15 miles", Internal Medicine: "2:15 miles". Pg 25: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for OB/GYN providers: "1:30 minutes OR 1:30 miles", Oncologists: "1:30 minutes OR 1:30 miles" Pg 27: Included Policy "No. MHMS-PC-10 (MSCAN) & MHMS-NM-016 (CHIP)" and added benchmark goals for each Psychologists: "1:30 minutes OR 1:30 miles", Psychiatrists: "1:30 minutes OR 1:30 miles" Accessibility of Services: Pg 30 – Added "Benchmarks Goals: Regular and Routine (PCP): 90% Not to exceed 30 days; Urgent Care (PCP): 90% Not to exceed 24 hours; Routine Sick (PCP): 90% Not to exceed 7 days; Regular and Routine (OB/GYN): 90% Not to exceed 30 days; Urgent Care (OB/GYN): 90% Not to exceed 24 hours; Routine Sick (OB/GYN): 90% Not to exceed 7 days Results/Timeframe/Date the Goal: (see above): Pg 18, 20, 22: Edited 1st sentence "Q1 & Q2: As per table listed below, the Action Plan (respectively) met goals for MSCAN and CHIP" and		

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	added table with benchmark goals and rates corresponding to each provider type Pg 24, 26, 28: Edited 1st sentence "Q1 & Q2: Applicable for MSCAN and CHIP", added table with benchmark goals and rates corresponding to each provider type, and added statement, "The rationale for this is that many rural counties in Mississippi will not have access to this provider type, thus we would not have achieved 100% adequacy in those areas where providers are not available." Pg 25: Substituted "OB/GYN, Oncologists" instead of "Family Practice/Family Medicine/General Practice, Pediatrics and Internal Medicine" Pg 27: Substituted "behavioral health care practitioners" instead of "primary care practitioners" Pg 31: The table for the Appointment Availability Survey rightly lists the goals for a Regular and Routine (PCP) appointment as not to exceed 30 days. No changes. Policy MHMS-QI-006 has been edited accordingly. Page 35: After reviewing documentation, confirmed that 10 was misprinted. The correct number is 21. Substituted "21" instead of "10" Continuity and Coordination of Medical Care. Pg 53: As indicated on MHMS-PC-09, MSMH rightly notifies members within 15 days of the termination of a PCP. Therefore, substituted "15" rather than "30". A revised copy of the work plan 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. 10 and 26_1-12-24_MSCAN_CHIP" **2.2.2024 Updated Response** The updated Policy MHMS-QI-006, has been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Policy_MHMS-QI-006-Access to Care_MSCAN_CHIP_1-26-24" The goal for urgent care in the action plan has been revised to reflect at 24-hour timeframe (page 35). The updated page 35 has		

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
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	been included with this response and is applicable to the MSCAN and CHIP lines of business. The title of the document is "CAP Item 10 and 26_Work plan Revision_Page 35_MSCAN_CHIP_1-26-24" **2.19.2024 – Updated Response** As indicated, Work Plan has been revised and updated with terminology utilized in Policy QI-006 in slide and sections as indicated below: SLIDES 30 & 31 changes: Access to appointments for PCPs are monitored by preventive primary care, routine sick, urgent care, and after hours. Goals are set to meet regulatory requirements. Preventive primary care (PCP): 90% Not to exceed 30 days Preventive primary care (OB/GYN): 90% Not to exceed 30 days Routine Sick (PCP): 90% Not to exceed 7 days Routine Sick (OB/GYN): 90% Not to exceed 7 days After review of the policy and work plan, the language used in the policy needed clarifying. Therefore, the Policy MHMS-QI-006 has been revised with the appropriate language for Routine Sick for PCP and OB/GYN (page 3 of 7) and congruent language was used in the work plan (pages 30-31). The policy will be sent back to the QIC for approval of the changes during Q1 2024 QIC Meeting. A redline copy of the policy is provided with this response. The 2023 QI Work Plan with the aforementioned revisions is provided (pages 30-31). However, the 2024 QI Work Plan is currently unavailable at this time. It is expected by March 2024.		
IV E. Provider Participation in Quality Improvement Activities			
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.			
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	See document uploaded: EQR Audit 2023_CAP No. 11 and 27_1-12-24_MSCAN_CHIP. The monitoring of provider compliance against two aspects of the Clinical Practice Guidelines annual report will be provided by	✓	

2023 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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.*	February 29, 2024. The report will focus on perinatal care and PPC HEDIS measures. Report (EQR Audit 2023_CAP No 11 and 27_MSCAN_CHIP_1-12-24.)		
4. The CCO tracks provider compliance with EPSDT service provision requirements for: 4.2 Well-Baby and Well-Child screenings and results;			
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	See document uploaded: EQR Audit 2023_CAP No. 12 and 28_EPSDT_Well Child Tracking Report **2.2.2024- Updated Response** The language from Policy MHMS-QI-005, Well-Baby/Well-Child Services and Immunization Services, page 7, regarding the creation of an automated tracking system has been removed. A redline version of the policy is included with this submission and is applicable to the CHIP line of business. The title of the document is "CAP Item 28_Policy MHMS-QI-005_Well Child_CHIP_1-26-24."	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
recent/previous calls made to members' parents and the results of those calls. *Corrective Action 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.*			
IV F. Annual Evaluation of the Quality Improvement Program			
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.			
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. <u>This continues to be an issue and was identified in the 2020, 2021, and 2022 EQRs</u>. *The CHIP Contract, Section 9 (D)* and *Exhibit F,* 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 <u>all</u> 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.*	See document uploaded: EQR Audit 2023_CAP No. 13 and 29_2022 QI Evaluation	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Utilization Management			
V B. Medical Necessity 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.			
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.*	The CHIP Adverse Benefit Determination Letter has been updated to match the contractual requirements. Requirement for written request has been removed from the letter. See document: Cap #14 and #30 MHMS ABD Letter_ Re Appeal Notification_	✓	
V C. Appeals			
2. The CCO applies the appeal policies and procedures as formulated.			
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.*	We are working with the Division of Medicaid to establish a process to submit for extension when we are unable to complete the request within the timeframe allowed. Once the process has been established the team with be educated on the update by the end of Q2. **2.2.2024- Updated Response** The Division is working on a process to address this CAP. For now the process would be for all extensions: Submit the request to Office of Coordinated Care MississippiCan.Plan@medicaid.ms.gov Lucretia Causey Lucretia.Causey@medicaid.ms.gov Mykala Stevenson Mykala.Stevenson@medicaid.ms.gov	✓	

2023 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	Patricia Collins Subject "Expedited Approval – 14 Day extension All inquiries received before 12 noon will be reviewed and responded by 4:30 that business day. All inquiries received after 12 noon will be responded by 12 noon the following day. We Have attached a work flow that speaks to this update. The workflow will be presented and implemented to the team on 2/5/2024.		
Delegation			
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.			
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).*	See Documents for CVS uploaded to the Portal for both CAP #16 and 32. **2.2.2024 Updated Response** In response to the CAP (Corrective Action Plan) feedback regarding the oversight of CVS as a delegated subcontractor. Oversight of CVS Pharmacy Benefit Manager (PBM) oversight is primarily the responsibility of our Pharmacy Operations Team and not under the purview of the Delegation Oversight Team. PBM functions involve various tasks that differ from those overseen by the Delegation Oversight Team. The CHIP and CAN Contract, sections which states, "The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year." CVS's oversight, however, occurs more frequently due to the complex and dynamic nature of their responsibilities. CVS's role as a PBM involves extensive monitoring, with monitoring reports, dashboards, and Surveillance Summaries being provided on a regular basis, including daily, monthly, and quarterly reports. This frequency of monitoring is necessitated by the robustness of the functions they perform, which go beyond the scope of an annual audit. To provide further clarification and insight into our oversight	✓	

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	processes, I have included "MHI Pharm 14 Pharmacy Operations Surveillance Policy and Procedure." This document outlines the comprehensive procedures and guidelines we follow for monitoring and surveillance within Pharmacy Operations. It will offer you a more detailed understanding of our PBM oversight surveillance practice. MHI Pharmacy Operations Surveillance Policy and Procedure uploaded to the portal. **2/22/2024** Molina has provided documentation of the annual audits conducted for our PBM CVS. The annual internal audits entitled Molina Executive Dashboard, which monitors timelines. An external audit conducted by external PBM auditor Health Strategies is also included. **PBM oversight is under the purview of Pharmacy Operations not the Molina Delegation Oversight team.** **3.18.2024** This annual audit document the auditor share between Molina and CVS will be completed at the end of this year for 2023. This auditing process involves a comprehensive examination and analysis, which often requires thorough investigation and extensive communication between our teams. Due to the depth of the discovery process and the necessity for meticulous back-and-forth communication, we have historically completed the audit towards the end of the year. **3.26.2024** Please see attached 2023 annual audit for CVS. The Delegation audit for 2023 has been completed. After speaking with the Pharmacy auditing team, it was determined that the team members who work on this task did not fully understand the ask because they are new to the team. The new team member was under the impression we were asking for a document performed for another audit. The miscommunication was cleared up and it was determined that the delegation audit was completed. See document attached.		