Constellation Quality Health

Molina Healthcare of Mississippi

2025 External Quality Review Report

Submitted: October 21, 2025

Prepared on behalf of the
Mississippi Division of Medicaid

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ACRONYMS, ABBREVIATIONS, AND INITIALISMS

Aqurate	Aqurate Health Data Management, Inc.
BH/SUD	Behavioral Health/Substance Use Disorder
CAHPS®	Consumer Assessment of Healthcare Providers and Systems, a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
CAN	Coordinated Access Network
CAP	Corrective Action Plan
CCO	Coordinated Care Organization
CFR	Code of Federal Regulation
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPG	Clinical Practice Guideline
CPT®	Current Procedural Terminology a registered trademark of the American Medical Association
Code of Conduct	Code of Business Conduct and Ethics
Compliance Plan	Molina Healthcare Compliance Plan
Constellation	Constellation Quality Health
DOM	Division of Medicaid
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FWA	Fraud, Waste, and Abuse
FWA Plan	Molina Healthcare of Mississippi, Inc. 2025 Fraud, Waste, and Abuse Plan
HCS	Healthcare Services
HEDIS®	Healthcare Effectiveness Data Informational Set, a registered trademark of NCQA
ISCA	Information Systems Capabilities Assessment
IDSS	Interactive Data Submission System
Molina	Molina Healthcare of Mississippi
MCO	Managed Care Organization
MY	Measure Year
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PDL	Preferred Drug List

PDM ..... Provider Data Management
PHG ..... Preventive Health Guideline
PHI ..... Protected Health Information
PIP ..... Performance Improvement Project
PM ..... Performance Measure
Q ..... Quarter
QA ..... Quality Assurance
QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
UM ..... Utilization Management
URL ..... Uniform Resource Locator

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 requires State Medicaid Agencies contracting with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by Molina Healthcare of Mississippi (Molina). This report contains a description of the process and the results of the 2025 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 delivered with acceptable quality.

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

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

Summary and Overall Findings

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

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Sub-contractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*
- Disenrollment *(§ 438.56)*
- Enrollee Rights *(§ 438.100)*
- Emergency and Post Stabilization Service *(§ 438.114)*

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

To assess Molina's compliance with standards set forth in *42 CFR Part 438* and *457*, Constellation's review was divided into six areas: Administration, Provider Services, Member Services, Quality Improvement, Utilization Management, and Delegation. 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

For the Administration portion of the 2025 EQR, Molina CAN and CHIP both fully met 29 and partially met 2 of 31 standards for a score of 94%. Findings for Administration include the following:

- Molina develops and maintains policies for daily operations, which are reviewed annually, approved by the Policy and Procedure Committee, and implemented after final approval by DOM.
- All key positions are fulfilled in accordance with contractual requirements and overall staffing is sufficient for conducting health plan functions and activities.
- Documentation addressing required queries of the Social Security Death Master File was not found in the Compliance Plan, Molina Healthcare of Mississippi, Inc. 2025 Fraud, Waste, and Abuse Plan (FWA Plan), or in policies and procedures.
- Molina has not developed a Compliance Committee Charter despite this being a requirement documented in a health plan procedure. Quorum, attendance, and tie-breaking procedures are also undocumented.

- Appropriate processes are in place to ensure required compliance training is completed by all staff and members of the Board of Directors. Molina's Code of Business Conduct and Ethics (Code of Conduct) reinforces expectations for ethical behavior and compliance. Staff are expected to read and attest to understanding the Code of Conduct annually.
- Molina meets all requirements for CAN and CHIP information systems capabilities, paying 99% of clean claims within 30 days and 99.99% within 90 days. Data accuracy is ensured through QNXT™ (a system developed by Cognizant) checks, auditing, and monitoring.
- Molina adequately demonstrated their data collection and storage capabilities, processing procedures, claim data tabulation and processing, and showed adequate support for Quality Assurance and Utilization Management program activities.
- The CCO maintains a documented Disaster Recovery Plan, Business Continuity Plan, and Cybersecurity Risk Management Plan, with redundancies and recovery processes in place to ensure operational resilience.

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

For the Provider Services section of the 2025 EQR, Molina CAN fully met 44 and partially met 5 of 49 standards for a score of 90%. Molina CHIP fully met 42 and partially met 5 of 47 standards for a score of 89%. Findings for Provider Services include the following:

- Molina has appropriate processes in place for initial and ongoing provider education. Internal departments and external entities, including DOM, collaborate to determine provider training topics.
- Molina educates providers about medical record documentation standards, confidentiality, storage, and retention, and conducts medical record audits every three years to monitor provider compliance. The next audit is scheduled for 2026.
- Molina also educates providers about adopted clinical practice guidelines (CPGs) and preventive health guidelines (PHGs), though the current EQR found some of the guideline links on the CAN and CHIP websites were broken, misdirected, or required membership or passwords.
- Molina used a certified vendor to conduct the provider satisfaction survey, which was consistent with federal expectations. Survey results were analyzed, shared with health plan leadership and applicable committees, and used to document and track improvement strategies.
- The Provider Network File Questionnaire revealed that Molina uses QNXT as its data management system with daily updates received from the centralized credentialing

vendor. Verification is conducted through a portal update based on information from the provider and the member-facing online Provider Directory is updated nightly.

- Molina documents CAN and CHIP geographic access standards for network providers in policies and evaluates member access to providers through quarterly Geographic Access Reports. Processes are in place to expand the network when access insufficiencies are identified. Appointment access standards are also included in policies, Provider Manuals, and the CAN and CHIP websites; however, errors were noted in the access standards for routine and urgent behavioral health/substance use disorder (BH/SUD) visits. The Q2 2025 call study indicated that Molina assessed providers against the contractually required 21 calendar-day timeframe for routine BH/SUD visits instead of the 14 calendar-day timeframe specified in policy, Provider Manuals, and on the CAN and CHIP websites.
- Molina maintains a Health Equity and Cultural Competency Program, and Provider Manuals include an overview of cultural competency and links to Molina's website for cultural competency training resources.
- The Q2 2025 Telephonic Provider Access Studies conducted by Constellation showed improvement in successful contacts for CAN and CHIP over the Q4 2024 results.
- The 2025 EQR found that several documents contained references to credentialing that are no longer applicable since centralized credentialing began in 2022.

Member Services

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

For the Member Services section of the review, Molina CAN fully met 32 and partially met 1 of 33 standards for a score of 97%. Molina CHIP fully met 31 and partially met 1 of 32 standards for a score of 97%. Findings for Member Services include the following:

- Molina communicates members' rights and responsibilities through policies, Member Handbooks, Provider Manuals, new member materials, and its website. These documents also provide information about the health plan, coverage, programs, and services.
- The MississippiCAN (Medicaid) Member Handbook (CAN Member Handbook) and the Mississippi Children's Health Insurance Program (CHIP) Member Handbook (CHIP Member Handbook) include the phone number for the Member Services Call Center, which can help members with benefits, finding providers, transportation, grievances and appeals, and more. Call Center staff are trained upon hire and then quarterly, and use interactive, DOM-approved scripts that are reviewed at least annually. Molina monitors Call Center performance metrics and reports trends to the Quality Improvement and Health Equity Transformation Committee.

- Molina's member materials are provided at the appropriate reading level and in alternate languages and formats. Interpreter and translation services are available at no cost to members.
- 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. Call Center staff are trained to inform members about available resources or recommended services.
- Processes for filing grievances are clearly described in policy, Member Handbooks, Provider Manuals, and online, with grievances categorized and monitored quarterly. However, the review of grievance files found issues such as missing resolution letters, undated extension letters, incomplete investigative notes, and cases marked closed but noted as open for investigation.
- Molina contracts with Press Ganey to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult and child member satisfaction surveys for CAN and CHIP. Using CMS's *Protocol 6: Administration or Validation of Quality of Care Surveys*, Constellation validated the satisfaction surveys and found they met the validation requirements.

Quality Improvement

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

The Quality Improvement portion of the 2025 EQR included performance measure validation and performance improvement project (PIP) validation. For this section, both Molina CAN and CHIP fully met 16 and partially met 3 of 19 standards for a score of 84%. Findings for Quality Improvement include the following:

- Molina's Quality Improvement (QI) Program Description outlines efforts to improve healthcare quality, access, and equity, focusing on members with complex needs and integrating behavioral health, chemical dependency, and substance use services. However, it incorrectly states that Molina credentials and recredentials providers, and behavioral health appointment standards in the 2024 and 2025 QI Work Plans do not align with policy. The 2024 QI Program Evaluation also noted incomplete documentation of study results and audit outcomes.
- The 2024 QI Program Evaluation noted incomplete documentation of study results and audit outcomes. Oversight is provided by the Board of Directors and the Quality Improvement and Health Equity Transformation Committee, and Molina continues efforts to enhance health equity, satisfaction, and overall program effectiveness.

Performance Measure Validation

- Aqurate Health Data Management, Inc. (Aqurate) validated the PMs identified by DOM for accuracy as reported by Molina for the CAN and CHIP populations. This 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. The final PM validation results reflected the measurement period of January 1, 2024, through December 31, 2024.
- Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by Molina's NCQA-licensed organization. Aqurate found that Molina's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2024.
- All relevant HEDIS performance measures and CMS Core Set Measures for the CAN and CHIP populations for the current review year (2024) were compared to the previous year (2023) and the changes are reported in the Quality Improvement section of this report. The following tables highlight measures found to have substantial increases or decreases in rate from 2023 to 2024. 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 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Substantial Increase in Rate (>10% improvement)			
Asthma Medication Ratio (AMR)			
12–18 Years	60.80%	79.34%	18.54%
19–50 Years	55.96%	72.46%	16.50%
51–64 Years	52.94%	64.00%	11.06%
Total	64.97%	80.37%	15.40%
Plan All-Cause Readmissions (PCR-AD) ◇◇			
Outlier Rate	65.83%	77.51%	11.68%
Substantial Decrease in Rate (>10% decrease)			
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	58.62%	47.33%	-11.29%

◇◇: *Measure has "Break in Trending" guidance from NCQA for MY 2024*

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Substantial Increase in Rate (>10% improvement)			
Asthma Medication Ratio (AMR)			
5-11 Years	75.53%	91.14%	15.61%
Total	73.91%	83.97%	10.06%
Substantial Decrease in Rate (>10% decrease)			
Initiation and Engagement of AOD Dependence Treatment (IET)			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	58.82%	39.39%	-19.43%

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

CMS Core Set Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Substantial Increase in Rate (>10% improvement)			
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	8.94%	29.10%	20.16%
Total	8.80%	29.41%	20.61%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *			
Ages 18 - 64	79.59%	66.27%	-13.32%
Total	79.59%	66.27%	-13.32%
Substantial Decrease in Rate (>10% decrease)			
HEART FAILURE ADMISSION RATE (PQI-08) *			
Ages 65+	0	625	625.00

**: Lower rate indicates better performance*

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

CMS Core Set Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2023
Substantial Increase in Rate (>10% improvement)			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *			
Ages 18 - 64	67.53	15.71	-51.82

**: Lower rate indicates better performance*

Performance Improvement Project Validation

- PIP validation was conducted in accordance with CMS's EQR *Protocol 1: Validating Performance Improvement Projects*. The protocol reviews 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 and four CHIP PIPs. All the PIPs scored in the "High Confidence in Reported Results" range. The following tables provide a summary of the validation results and project performance over time. 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	Current Validation Score	Performance Measure	Performance Measure Results	
			R3 (MY)	R4 (MY)
Asthma Medication Ratio	85/85=100% High Confidence in Reported Results	Percentage of members 5-64 years of age who were compliant for a ratio of controller medications to total asthma medications of 0.50 or greater.	84.8% ↑ (2024)	87.17% ↑ (Q2 2025)
Pharmacotherapy Management of COPD Exacerbation	80/80=100% High Confidence in Reported Results	Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications.	62.1% ↑ (2024)	48.96% ↓ (Q2 2025)
		Percentage of COPD exacerbations for MSCAN members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.	75.9% ↓ (2024)	79.17% ↑ (Q2 2025)
Follow-up After Hospitalization for Mental Illness	85/85=100% High Confidence in Reported Results	Percentage of discharges for which the MSCAN members received follow-up within 30 days of discharge.	27.5% ↓ (2024)	54.73% ↑ (Q2 2025)
		Percentage of discharges for which the MSCAN members received follow-up within 7 days of discharge.	19.66% ↓ (2024)	34.41% ↑ (Q2 2025)
Prenatal and Postpartum Care	85/85=100% High Confidence in Reported Results	Percentage of deliveries that receive a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment	89.4% ↑ (2024)	85.45% ↓ (Q2 2025)
		Percentage of deliveries that had a postpartum visit on or between 7 and 84 days of delivery.	35.4% ↓ (2024)	50.0% ↑ (Q2 2025)
Sickle Cell Disease	80/80=100% High Confidence in Reported Results	Percentage of members 6 years of age and older with sickle cell disease who receive case management services during the measurement year.	8.3% ↓ (2024)	11.0% ↑ (Q2 2025)
Obesity	85/85=100%	Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a Primary Care Provider (PCP) or OB/GYN and who had	14.0% ↓ (2024)	20.9% ↓ (Q2 2025)

Performance Improvement Project	Current Validation Score	Performance Measure	Performance Measure Results	
			R3 (MY)	R4 (MY)
	High Confidence in Reported Results	evidence of BMI percentile during the measurement year.		
		Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	7.5% ↓ (2024)	14.1% ↑ (Q2 2025)
		Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	7.3% ↓ (2024)	12.4% ↑ (Q2 2025)

Statistically significant improvement *Statistically significant decline* *No color: not statistically significant* ↑ *Improving performance* ↓ *Declining performance*

Table 6: Performance Improvement Projects - CHIP

Performance Improvement Project	Current Validation Score	Performance Measure	Performance Measure Results	
			R3 (MY)	R4 (MY)
Asthma Medication Ratio	85/85=100% High Confidence in Reported Results	Percentage of MS CHIP asthmatic members 5-19 years of age who were compliant for a ratio of controller medications to total asthma medications of 0.50 or greater (HEDIS AMR measure).	80.7% ↑ (2024)	92% ↑ (Q2 2025)
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	Percentage of discharges for which the CHIP members received follow-up within 30 days of discharge.	37.5% ↓ (2024)	56.8% ↑ (Q2 2025)
		Percentage of discharges for which the CHIP members received follow-up within 7 days of discharge.	25.0% ↓ (2024)	39.2% ↑ (Q2 2025)
Obesity	80/80=100% High Confidence in Reported Results	Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile during the measurement year.	11.1% ↓ (2024)	18.8% ↑ (Q2 2025)
		Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	6.4% ↓ (2024)	14.0% ↑ (Q2 2025)
		Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	6.0% ↓ (2024)	12.2% ↑ (Q2 2025)

Performance Improvement Project	Current Validation Score	Performance Measure	Performance Measure Results	
			R3 (MY)	R4 (MY)
Well Care/Well Child	80/80=100% High Confidence in Reported Results	The percentage of members who turn 15 months old during the measurement period who had six or more well-child visits with a PCP during their first 15 months of life.	63.1% ↓ (2024)	63.31% ↑ (Q2 2025)

Statistically significant improvement *Statistically significant decline* *No color: not statistically significant* ↑ *Improving performance* ↓ *Declining performance*

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)

For the Utilization Management of the 2025 EQR, Molina CAN and CHIP both met 53 of 54 standards for a score of 98%. Findings for Utilization Management include:

- Molina's Utilization Management (UM) program operates within the Healthcare Services (HCS) Program, which ensures that all services provided are medically necessary and ensures appropriate use of resources based on the member's level of care.
- The UM Program is defined in the Health Care Services Program Description and related policies, with the key functions organized into eligibility and oversight, resource management, and quality management. The Vice President, Health Care Services, Assistant Vice President, Health Care Services, and Chief Medical Officer share oversight of the UM program and collaborate to develop, implement, and manage clinical policies, procedures, and UM operations.
- Members can receive most services, including emergency care, without prior approval, and information regarding covered services is provided in the Member Handbooks. Benefit determination decisions are guided by established clinical criteria and standards, which are reviewed regularly and approved annually by the Health Care Services Committee. Audits confirm consistent, timely determinations by qualified professionals, with approval and denial notices meeting requirements. Adverse Benefit Determination notices are written in clear, understandable language and include appeal instructions.
- For covered medications, Molina follows the Mississippi Division of Medicaid Preferred Drug List (PDL) and provides details about covered medications in Member Handbooks and on its website.
- Appeals processes are outlined in policy and member materials. Information about filing options and associated acknowledgement and resolution timeframes is also provided in member and provider materials. Members are informed of their right to file a grievance if they disagree with a request to extend the appeal resolution timeframe. The CAN and CHIP Member Handbooks describe the requirement for written consent for anyone other than

the member or the authorized representative to file an appeal on the member's behalf. The file review found that all CAN and CHIP appeal files were processed timely with no issues.

- Molina's Health Care Services Program provides a comprehensive Integrated Care Management Program, including care coordination, transitional care, behavioral health case management, and disease management. Members are referred through various sources, assessed for risk, and assigned acuity levels to guide their care. Molina has enhanced its program by designating Mental Health Assessor positions and implementing specialized models of care to address members' individualized needs.
- The case management file review identified that CHIP members received services aligned with their acuity levels, but documentation gaps for follow-up care were identified in four CAN case management files. Transitional care management services are also provided to members who are transitioning between services or providers, but policy language on prior authorization for continuing services beyond 30 days for new members lacks clarity.

Delegation

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

For the Delegation portion of the 2025 EQR, Molina CAN and CHIP both fully met 3 of 3 standards for a score of 100%. Findings for Delegation include:

- Molina's Delegation Oversight Program ensures delegated entities meet federal, state, and contractual requirements through pre-delegation audits, annual reviews, and ongoing monitoring. Oversight is provided by the Delegation Oversight Committee and the Quality Improvement and Health Equity Transformation Committee.
- All delegation arrangements are formalized through written agreements that outline responsibilities, monitoring, and corrective actions. For this review, Molina reported eight delegation agreements. Delegated services include vision, transportation, care management, dental, nurse advice line, and utilization management. Audit results are reviewed by the Delegation Oversight Committee, which recommends and tracks corrective actions as needed.

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 and provides technical assistance 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 one deficiency remained uncorrected:

- The QI Program Description incorrectly states that Molina credentials providers—a function it does not perform.

Details regarding the 2024 CAP can be found in *Attachment 4: Assessment of Corrective Action Plans from Previous EQR*.

Conclusions

Overall, Molina met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the QAPI program requirements described in *42 CFR § 438.330*. *Table 7* 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 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	24	80%
• Coordination and Continuity of Care *(§ 438.208)*, Availability of Services *(§ 438.206, § 457.1230)*	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	36	90%
• 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	14	88%
• 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	32	84%
• 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	6	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 table above, issues were found with the following:

- Errors were noted in documentation of some appointment access standards and Molina did not use the appointment access standard defined in CCO policy. Additionally, a Molina procedure includes incorrect references to collecting provider data through initial credentialing processes and that the information is not used to make credentialing decisions.
- Issues were identified in the sample grievance files related to premature closure, lack of resolution letters, an undated notice of extension letter, and lack of documentation about internal actions to investigate/resolve the grievance. A health plan procedure inaccurately states that a verbal appeal must be followed by a signed written appeal, which conflicts with regulatory requirements.
- Hyperlinks to some guidelines on the CAN and CHIP websites were non-functional, required passwords and/or membership, or took the user to a home page rather than to the guideline.
- The QI Program Description, Work Plan, and QI Program Evaluation for the QAPI Program contained errors and incomplete information.

Table 8 provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2024 review. For CAN, 177 of 189 standards received a score of "Met." A total of 12 standards were scored as "Partially Met" and zero standards were scored as "Not Met."

Table 8: Scoring Overview—CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2024	31	0	0	0	0	31	100%
2025	29	2	0	0	0	31	94%
Provider Services							
2024	45	3	1	0	0	49	92%
2025	44	5	0	0	0	49	90%
Member Services							
2024	32	1	0	0	0	33	97%
2025	32	1	0	0	0	33	97%
Quality Improvement							
2024	18	1	0	0	0	19	95%
2025	16	3	0	0	0	19	84%
Utilization Management							
2024	54	0	0	0	0	54	100%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2025	53	1	0	0	0	54	98%
Delegation							
2024	3	0	0	0	0	3	100%
2025	3	0	0	0	0	3	100%
Totals							
2024	183	5	1	0	0	189	96.8%
2025	177	12	0	0	0	189	93.7%

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

Table 9 provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2024 review. For 2025, 174 of 186 standards received a score of "Met." A total of 12 standards were scored as "Partially Met" and zero standards were scored as "Not Met."

Table 9: Scoring Overview—CHIP

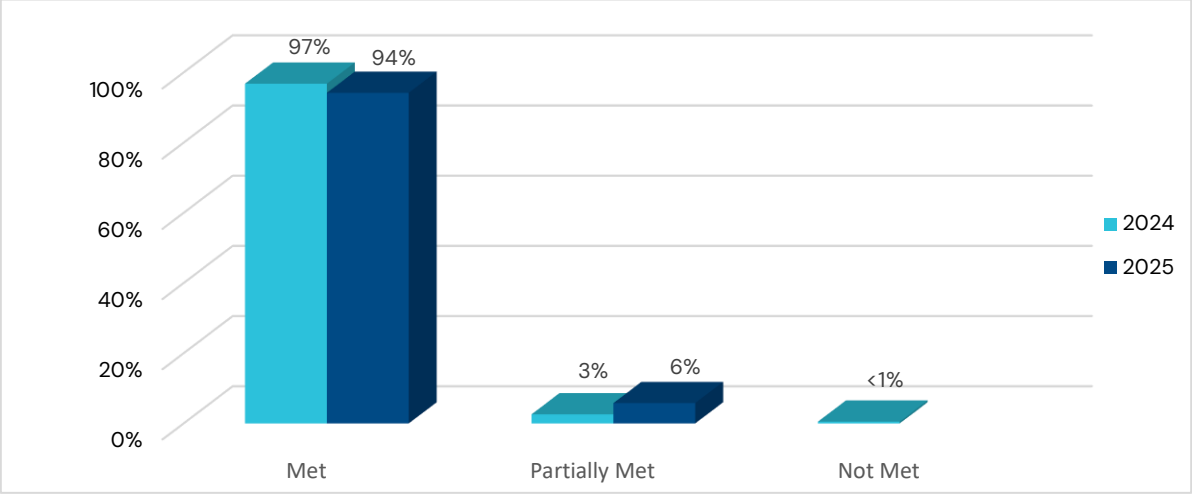
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2024	31	0	0	0	0	31	100%
2025	29	2	0	0	0	31	94%
Provider Services							
2024	43	4	0	0	0	47	92%
2025	42	5	0	0	0	47	89%
Member Services							
2024	31	1	0	0	0	32	97%
2025	31	1	0	0	0	32	97%
Quality Improvement							
2024	18	1	0	0	0	19	95%
2025	16	3	0	0	0	19	84%
Utilization Management							
2024	54	0	0	0	0	54	100%
2025	53	1	0	0	0	54	98%
Delegation							
2024	3	0	0	0	0	3	100%
2025	3	0	0	0	0	3	100%
Totals							
2024	180	6	0	0	0	186	96.8%
2025	174	12	0	0	0	186	93.5%

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

The 2025 Annual EQR for CAN shows that Molina achieved "Met" scores for 93.7% of the standards reviewed and 5.8% of the standards were scored as "Partially Met." For CHIP, 93.5% of the standards were scored as "Met" and 6.5% were scored as "Partially Met."

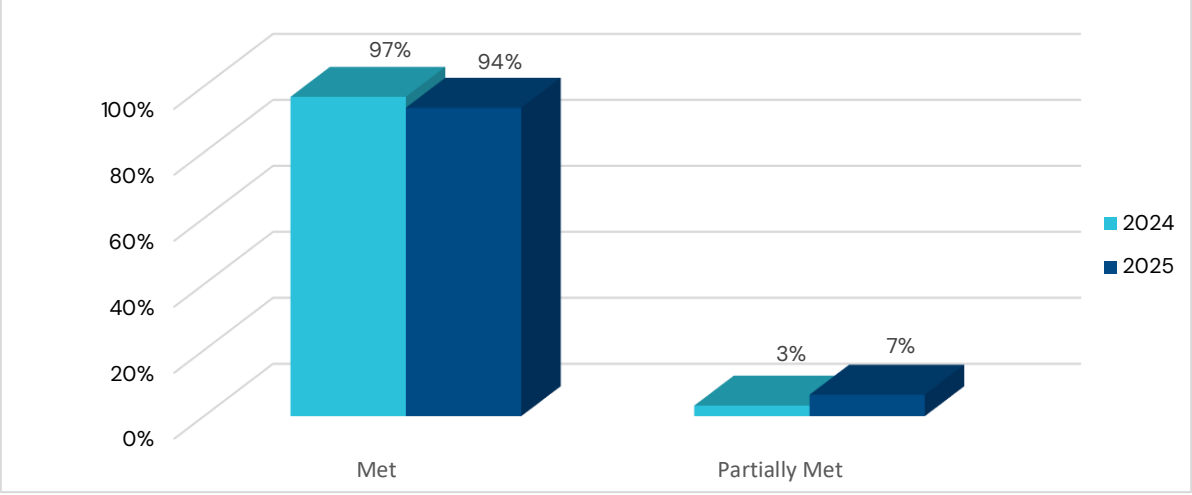
The charts that follow provide a comparison of the current review results to the 2024 review results for CAN and CHIP.

Figure 1: 2024 and 2025 Annual EQR Review Results for CAN



Scores were rounded to the nearest whole number.

Figure 2: 2024 and 2025 Annual EQR Review Results for CHIP



Scores were rounded to the nearest whole number.

Recommendations and Opportunities for Improvement

The following is a summary of key findings, recommendations, and corrective actions for the 2025 EQR. Specific details about strengths, weaknesses, recommendations, and corrective actions can be found in the sections that follow. Each item in the table below includes an indicator specifying whether it pertains to quality, timeliness, and/or access to care.

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

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for policy development and ongoing management.	✓		
Key positions are filled appropriately, and overall staffing is sufficient.	✓		
Molina requires all employees to complete initial and annual compliance training.	✓		
Molina maintains open lines of communication with multiple avenues to report compliance concerns of suspicions of FWA.	✓		
Molina educates staff about maintaining the confidentiality of protected information.	✓		
Provider Services			
Processes are in place for notifying providers of members assigned to their rosters and for providers to verify member eligibility.	✓		✓
Molina routinely monitors providers' panel status and network geographic adequacy.	✓		✓
The Health Equity and Cultural Competency Program is in place to aid in reducing healthcare disparities and ensure culturally competent, linguistically appropriate, and equitable healthcare for all members.	✓		✓
Appropriate processes are in place for initial and ongoing provider education.	✓		✓
The CAN and CHIP Provider Manuals are comprehensive resources for providers.	✓		
Molina adopts appropriate Clinical Practice and Preventive Health Guidelines.	✓		✓
Molina educates providers about medical record documentation and handling requirements and assesses provider compliance every three years.	✓		
Member Services			
Member rights and responsibilities are clearly outlined in CAN and CHIP member materials, and website.	✓		✓
Molina's marketing processes ensure that member materials are provided at the appropriate reading levels and in alternate languages and formats.	✓		✓
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 to members in a variety of ways.			✓
Quality Improvement			
The QI Program promotes health equity by integrating behavioral health and substance use services and using data on demographics and social factors to ensure culturally and linguistically appropriate care for all members.	✓		
The QI Program outlines objectives, actions, and outcomes, showcasing Molina's commitment to improving healthcare quality and removing barriers.	✓		
Molina demonstrated full compliance with information systems standards, and the audit verified that valid and reportable rates were submitted for all HEDIS measures within scope.	✓		
Molina has a comprehensive QI structure which integrates PIPs, network adequacy monitoring, and satisfaction surveys that are aligned with CMS and state requirements.	✓		

Strengths	Quality	Timeliness	Access to Care
Reliable data collection, sources, and analysis methods using statistical testing were noted during the validation review.	✓		
All QI findings were shared with stakeholders and QI committees showing oversight process.	✓		
Utilization Management			
Molina has implemented automation to improve UM processes and increase efficiency. Decision letters are autogenerated and immediately available to providers.		✓	✓
Molina reduced the volume of codes requiring prior authorization by eliminating approximately 20% of all CPT codes from the prior authorization process.		✓	✓
Molina has specialized models of care, such as Behavioral Health and Foster Care, etc. to ensure members receive tailored services based on their identified needs.	✓		✓
Molina recently designated specific Mental Health Assessor positions to ensure the appropriate and timely completion of Comprehensive Health Risk Assessments.	✓	✓	
All CAN and CHIP appeal files selected for the 2025 EQR were addressed in a timely manner and by appropriately credentialed reviewers.		✓	
Delegation			
The delegation oversight program is designed to ensure compliance with federal, state, and local laws, regulations, and contractual requirements.	✓		
Molina retains accountability for services provided by Third-Party Entities, ensuring oversight and compliance with applicable requirements.	✓		
A thorough assessment process is conducted before entering into delegation agreements, including operational capacity, accreditation, financial resources, and IT security.	✓		
Regular audits and monitoring activities ensure compliance and performance standards are met. Tools like dashboards, performance reports, and grievance tracking are used to maintain oversight.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Administration				
The Compliance Plan, FWA Plan, and related policies did not address the required queries of the Social Security Death Master File.	*Corrective Action Plan: Revise the Compliance Plan, the FWA Plan, and/or related policies to include the process and timeframe for querying the Social Security Death Master File for staff and providers.*	✓		
Procedure C-03.1, Prohibited Affiliations, page 2, item 4, inappropriately references credentialing providers.	*Corrective Action Plan: Revise Procedure C-03.1 to remove inappropriate references to credentialing providers. Alternatively, add a Mississippi-specific addendum to Procedure C-03.1.*	✓		
Molina has not developed a Compliance Committee Charter, as required by Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight.	*Corrective Action Plan: Develop a Compliance Committee Charter as required by health plan procedure. Ensure the charter defines the quorum requirement, attendance*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
	expectations for voting members, and the process to be followed if there is a tie vote.			
The 2025 Health Care Services Program Description includes outdated language for the previous Pharmacy Lock-in Program.	*Recommendation: Revise the 2025 Health Care Services Program Description to include current information about the Beneficiary Health Management Program.*	✓		
Provider Services				
Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, includes incomplete information about coverage for services from out-of-network providers.	*Recommendation: Revise Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, to clearly state Molina must pay for services from out-of-network providers when unable to identify a sufficient number of providers within a specific area or specialty.*	✓		✓
Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, and Policy MHMS-QI-124, Standards of Medical Record Documentation inappropriately reference credentialing and recredentialing processes.	*Corrective Action Plan: Revise Policy MHMS-QI-011 and Policy MHMS-QI-124 to remove the references to credentialing and/or recredentialing or add an addendum to the policies to include Mississippi-specific information.*	✓		
The CAN and CHIP Provider Manuals, the websites, and Policy MHMS-QI-006 incorrectly define the routine and/or urgent appointment access standards for BH/SUD visits.	*Corrective Action Plan: Correct the appointment access timeframe for urgent and routine visits with BH/SUD providers in Policy MHMS-QI-006, in the CAN and CHIP Provider Manuals, and on the websites.*	✓		✓
Policy MHMS-QI-006, Access to Care, indicates the timeframe for routine BH/SUD visits is within 14 calendar days. However, the call study results and the 2024 QI Program Evaluation indicate the contractually required timeframe of 21 calendar days is used to measure appointment access.	*Corrective Action Plan: When Molina's policy defines a different timeframe for appointment access than the standard defined by DOM in the contract and in the required reporting template, access must be measured and reported using both standards. Ensure call study staff/vendors are aware that both timeframes must be assessed to determine appointment access.*	✓		✓
The CAN and CHIP Provider Directories do not include provider website URLs as required by *Federal Regulation § 438.10(h)* and Policy MHMS-PC-01.	*Recommendation: Revise the CAN and CHIP Provider Directories to include provider website URLs.*	✓		✓
The CAN Provider Manual includes the required non-exclusivity statement but it references the CHIP Program rather than the CAN Program.	*Recommendation: Revise the non-exclusivity statement in the CAN Provider Manual to reference the correct program.*	✓		
Review of the CAN and CHIP websites found hyperlinks to CPGs that were non-functional, misdirected, and/or required passwords or membership.	*Corrective Action Plan: Correct the non-functional and erroneous hyperlinks to guidelines on the website. Consider creating a library of guidelines on the website rather*	✓		✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
	than using hyperlinks, particularly for guidelines that require membership or passwords to access.			
Member Services				
Issues were identified in the sample of CAN and CHIP grievance files related to premature closure, lack of resolution letters, an undated notice of extension letter, and lack of documentation about internal actions to investigate/resolve the grievance.	*Corrective Action: Ensure that steps are taken to demonstrate compliance for the management of grievance files per policy MHI-A&G-02: Core Medicaid Grievances.*		✓	
Quality Management				
The QI Program Description inaccurately indicates that Molina credentials and recredentials providers. This discrepancy was previously noted in the 2023 and 2024 EQRs and remains uncorrected.	*Corrective Action: Update the QI Program Description to eliminate any references to Molina's role in credentialing or recredentialing individual practitioners, provider organizations, facilities, and institutions.*	✓		
The behavioral health appointment standards in the 2024 and 2025 QI Work Plans are not consistent with Policy MHMS-QI-006.	*Corrective Action Plan: Update the behavioral health appointment standards in the 2024 and 2025 QI Work Plans to ensure accuracy and alignment.*	✓		
The 2024 QI Work Plan includes annual HEDIS and delegation audits, but their results were not reflected in the 2024 QI Program Evaluation, limiting assessment of program effectiveness.	*Corrective Action: Ensure the results and outcomes of all activities are fully documented and incorporated into the QI Program Evaluation, in accordance with the CAN Contract, Section 10 (D), Exhibit G, and the CHIP Contract, Section 9(D)(8) and Exhibit F.*	✓		
Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, references the planned development of a tracking dashboard, but the dashboard is already in use, indicating the policy is outdated.	*Recommendation: Revise Policy MHMS-QI-005 to remove the reference to the development of a tracking system.*	✓		
A concern was identified regarding the documentation of source code for certain CMS Core Set non-HEDIS measures.	*Recommendation: Improve monitoring of measure coding and related measure rate output for the CMS non-HEDIS core set measures*	✓		
Performance declined on pharmacy data–dependent measures, including PCE.	*Recommendation: Improve monitoring of pharmacy data and track changes potentially attributed to the pharmacy carve out to proactively track quality measure performance and impact.*	✓		
Some PIPs showed weak or non-significant improvements.	*Recommendation: Continue implementing interventions and monitoring performance.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Utilization Management				
Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), includes incorrect information regarding the appeal submission process. It inaccurately states that a verbal appeal must be followed by a signed written appeal, which conflicts with regulatory requirements.	*Corrective Action: Remove the requirement that a verbal appeal must be followed by a written appeal.*	✓		✓
Constellation's review of the UM Physician Listing identified the need for updates.	*Recommendation: Update UM Physician Listing to include current practitioners available for UM determinations.*	✓	✓	✓
Constellation's review of the CAN case management files identified gaps in the documentation of follow-up care.	*Recommendation: Ensure that all service notes accurately reflect referrals, follow-up care, and care management activities provided for members.*	✓		
Molina's policies do not clearly define prior authorization requirements beyond the initial 30 calendar days for new members transitioning into the health plan.	*Recommendation: Clarify in a policy or program description whether prior authorization for continuation of services is required beyond the initial 30 calendar days for new members, as outlined in the CAN Contract, Section 8 (B)* and *CHIP Contract, Section 8 (B).*	✓		

METHODOLOGY

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

On July 3, 2025, Constellation sent notification of the initiation of the annual EQR to Molina (refer to *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN and CHIP Programs.

Further, Molina was invited to participate in a pre-onsite conference call with Constellation and DOM where the health plan could 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 August 4, 2025, for review at Constellation's offices (refer to *Attachment 1*).

The second segment was a virtual onsite review conducted on September 10 and 11, 2025. The onsite visit focused on areas not covered in the desk review or that needed clarification. Refer to *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Molina's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the QAPI 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 "Met" (meeting the standard), "Partially Met" (acceptable but needing improvement), "Not Met" (failing the standard), "Not Applicable," or "Not Evaluated." These designations are recorded on the tabular spreadsheets included in each of the following sections.

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 guide staff in conducting daily operations. Business Owners are responsible for creating, maintaining, and ensuring policy accuracy and relevance by reviewing each policy at least annually. All new and revised policies are submitted to the Policy and Procedure Committee for approval. Policies and procedures are implemented only after final approval by DOM. Staff can access policies on a SharePoint site, and departmental leaders ensure staff are educated about new and/or revised policies. A Regulatory Communications Committee was established to examine regulatory changes to guide policy revisions and the need for new/additional policies.

Molina's Organizational Chart and onsite discussion confirmed all key positions are filled in accordance with contractual requirements and overall staffing is sufficient for conducting health plan functions and activities.

Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against and respond to FWA are detailed in the Compliance Plan, the FWA Plan, and in related policies and procedures. No issues were identified in the required Compliance Plan documentation except for documentation related to exclusion status monitoring. For this topic, documentation did not address required queries of the Social Security Death Master File. This information was also not found in the FWA Plan or in policies and procedures.

Various documents addressed the roles and responsibilities of the Compliance Committee; however, it was found that Molina has not developed a Compliance Committee Charter as required by Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, page 2, item B (2). Onsite discussion revealed that, because there are only two

voting members of the committee, the quorum is established with the presence of both. Discussion also revealed that members are expected to attend 100% of the meetings. However, neither the quorum requirement nor the attendance expectations were documented. Additionally, Molina was unable to verbalize the process to be followed if there is a tie vote for committee decisions.

The review confirmed that appropriate processes are in place to ensure required compliance training is completed by all staff and members of the Board of Directors. In addition to training, Molina provides staff with the Code of Conduct, which reinforces expectations for ethical behavior and compliance. A multidisciplinary team reviews the Code of Conduct annually, and updates are made as necessary to align with compliance priorities, legal requirements, emerging risks, best practices, etc. Staff are expected to read and attest to understanding the Code of Conduct annually.

Addendum 1 of Procedure HCS 107.01, Integration, Coordination and Access to Care, addresses the requirements for the Beneficiary Health Management Program, which was implemented to replace the former Pharmacy Lock-in Program. However, the 2025 Molina Healthcare Health Care Services Program Description (page 70) includes information that corresponds to the previous Pharmacy Lock-in Program. It appears the language in this document has not been updated to correspond to the new Beneficiary Health Management Program.

Health plan policies, procedures, program descriptions, the Code of Conduct outline Molina's processes for ensuring compliance with applicable laws related to the privacy and confidentiality of protected health information.

Health Information Systems

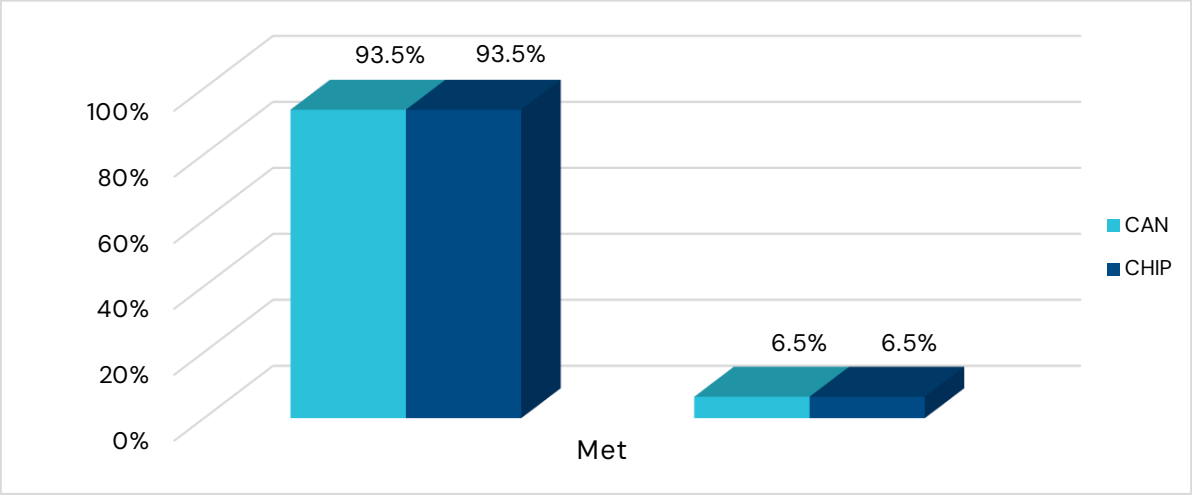
42 CFR § 438.242, 42 CFR § 457.1233 (d)

On average, Molina pays 99% of clean claims within 30 days and 99.99% of clean claims within 90 days. This exceeds the metric set internally by Molina and complies with *Miss. Code Ann. § 83-9-5*. Molina utilizes Claimsphere to perform data completeness and integrity checks on the data processed through QNXT to ensure accurate member demographic and enrollment information. Molina utilizes Current Procedural Terminology (CPT®) codes to track appointments and cross reference provider scheduling records, both which are received from providers. Molina also uses Clinical Care Advanced, an internal case management system, in conjunction with a comprehensive needs assessment, to capture member appointments. Molina adequately demonstrated their data collection and storage capabilities, processing procedures, and claim data tabulation and processing, and showed adequate support for Quality Assurance (QA) and Utilization Management program activities. Molina has a documented Disaster Recovery Plan, Business Continuity plan, and Cyber Security Risk

Management plan and has redundancy systems in place with a documented recovery process.

As noted in *Figure 3*, 93.5% of the Administration standards were scored as "Met" for CAN and 93.5% were scored as "Met" for CHIP.

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
Appropriate processes are in place for initial policy development and ongoing review and management.	✓		
All key positions are filled according to contractual requirements and overall staffing is sufficient.	✓		
Molina requires all employees to complete initial and annual compliance training to ensure awareness of compliance expectations, responsibilities, and policies.	✓		
Molina maintains open lines of communication and there are multiple avenues available to report compliance concerns of suspicions of FWA.	✓		
Molina educates staff about maintaining the confidentiality of protected information.	✓		

Table 12: Administration Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
There was no information regarding the required queries of the Social Security Death Master File identified in the Compliance Plan, the FWA Plan, Policy C-03.0, Prohibited Affiliations, or Procedure C-03.1, Prohibited Affiliations .	*Corrective Action Plan: Revise the Compliance Plan, the FWA Plan, and/or related policies to include the process and timeframe for querying the Social Security Death Master File for staff and providers.*	✓		
Procedure C-03.1, Prohibited Affiliations, page 2, item 4, inappropriately references credentialing providers. Molina has not held credentialing responsibilities since the implementation of Centralized Credentialing in 2022.	*Corrective Action Plan: Revise Procedure C-03.1 to remove the statement that credentialing applications are not advanced for providers who have been found on state or federal exclusion lists or debarred from participation or contract status with federal programs. Alternatively, add a Mississippi-specific addendum to Procedure C-03.1.*	✓		
Molina has not developed a Compliance Committee Charter, as required by Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, page 2, item B (2).	*Corrective Action Plan: Develop a Compliance Committee Charter as required by Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight. Ensure the charter defines the quorum requirement, attendance expectations for voting members, and the process to be followed if there is a tie vote.*	✓		
The 2025 Molina Healthcare Health Care Services Program Description (page 70) includes an overview of the previous Pharmacy Lock-in Program. It appears the language in this document has not been updated to correspond to the new Beneficiary Health Management Program.	*Recommendation: Revise the 2025 Molina Healthcare Health Care Services Program Description to include information about the Beneficiary Health Management Program and remove the previous Pharmacy Lock-in Program information.*	✓		

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's overall approach to policy development and management is documented in Policy MHMS-GC-28, Policy and Procedure Format and Review. Policies are reviewed annually. Business Owners are responsible for creating, maintaining, and ensuring policy accuracy and relevance. New and revised policies are submitted to the Policy and Procedure Committee for review and approval. Other committees, as applicable to the department or functional area, may review policies prior to review by the Policy and Procedure Committee. Molina confirmed that all policies are submitted to DOM for approval prior to implementation. Staff can access policies on a SharePoint site, and departmental leaders ensure staff are educated about new and/or revised policies. Molina reported that the Regulatory Communications Committee was established in 2024 to examine regulatory changes to guide policy revisions and the need for new/additional policies.
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						Overall staffing is sufficient for conducting health plan functions and activities. See notes in the standards below.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					The Chief Executive Officer position has been filled in accordance with requirements.
1.2 *Chief Operating Officer;	X					The Chief Operating Officer position is appropriately staffed.
1.3 Chief Financial Officer;	X					Staffing for the Chief Financial Officer position is appropriate.
1.4 Chief Information Officer;	X					The Chief Information Officer position is appropriately staffed.
1.4.1 *Information Systems personnel;	X					Onsite discussion confirmed there are designated Information Systems Personnel located in Mississippi. Staffing appears to be sufficient.
1.5 Claims Administrator;	X					The Claims Administrator position is appropriately filled.
1.6 *Provider Services Manager;	X					Staffing for the Provider Services Manager position meets requirements.
1.6.1 *Provider contracting and education;	X					No issues were identified for provider contracting and education staffing.
1.7 *Member Services Manager;	X					The Member Services Manager position is filled appropriately.
1.7.1 Member services and education;	X					No issues were identified for member services and education staffing.
1.8 Complaint/Grievance Coordinator;	X					The Complaint/Grievance Coordinator position is filled appropriately.
1.9 Utilization Management Coordinator;	X					The Utilization Management Coordinator position is filled appropriately.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9.1 *Medical/Care Management Staff;	X					No issues were identified for Medical Management and Care Management staffing.
1.10 Quality Management Director;	X					Staffing for the Quality Management Director position meets requirements.
1.11 *Marketing, member communication, and/or public relations staff;	X					No issues were identified for marketing, member communication, and/or public relations staffing.
1.12 *Medical Director;	X					The Chief Medical Officer position is appropriately filled, and Molina has six additional Medical Directors on staff.
1.13 *Compliance Officer.	X					Staffing for the Compliance Officer position meets requirements.
2. Operational relationships of CCO staff are clearly delineated.	X					The Organizational Chart provided by Molina displays staffing and reporting relationships for individual areas within the organization.
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 clean claims within 90 days. This exceeds the metric set both internally by Molina and complies with *Miss. Code Ann. § 83-9-5*, both which define timeliness as 90% of claims paid in 30 days and 99% of claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina utilizes Claimsphere to perform data completeness and integrity checks on the data processed through QNXT to ensure accurate member demographic and enrollment information. Molina utilizes CPT codes to track appointments, as well as

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						cross-referencing provider scheduling records, both which are received from providers. Molina also uses Clinical Care Advanced, an internal case management system, in conjunction with a comprehensive needs assessment tool, to capture member appointments. The data are further validated with audit reports generated to ensure complete data load. Reports are also generated during the Extract Transform Load process from QNXT to track of member and provider data and can be submitted to any requesting oversight agency of DOM 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 ISCA documentation as well as supporting documents. Molina adequately demonstrated their data collection and storage capability, processing procedures, claim data tabulation and processing, as well as showed adequate support of QA and UM program activities and other contractual requirements via attached flowcharts and technical layouts. The processes were reviewed and discussed during the onsite.
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 a documented Disaster Recovery Plan, Business Continuity plan, and Cyber Security Risk Management plan, all updated and tested on an annual basis. Molina has redundancy systems in place with a documented document recovery process.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The written Compliance Plan outlines Molina's commitment to ethical behavior, regulatory adherence, and the structure of its compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						program to prevent fraud and ensure operational integrity. The 2025 FWA Plan details policies, procedures, and responsibilities for detecting, preventing, and investigating healthcare fraud. Related policies and procedures provide detailed information about these topics.
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				See comments in individual standards below.
2.1 Standards of conduct;						The Compliance Plan addresses Molina's Code of Conduct. Information about the Code of Conduct is also included in the FWA Plan, with the full Code of Conduct included as Attachment B of the FWA Plan. The Code of Conduct serves as a guide for ethical behavior and compliance, is provided to all employees upon hire and annually, and is accessible on Molina's intranet (The Hub) and public website. A multidisciplinary team reviews the Code of Conduct annually, and updates are made as necessary to align with compliance priorities, legal requirements, emerging risks, best practices, etc. Staff are expected to read and attest to understanding the Code of Conduct annually.
2.2 Identification of the Compliance Officer;						Molina has a designated Compliance Officer whose roles and responsibilities are included in Molina's Compliance Plan and in Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Information about the Compliance Committee;						The Compliance Plan gives an overview of the Compliance Committee, which oversees the Compliance Program and supports the Compliance Officer in implementing the Compliance Plan, reviewing compliance activities, addressing risks, and ensuring adherence to federal and state requirements.
2.4 Compliance training and education;						As noted in the Compliance Plan, compliance training is mandatory for all employees to ensure awareness of compliance expectations, responsibilities, and policies. New employees receive the Code of Conduct on their first day, must attest to understanding it, and complete the required compliance training within 30 days of hire. Board members are required to complete compliance training within 30 days of appointment. Annual compliance training is required for all employees and board members. Compliance training content is reviewed and updated annually as needed. Detailed information about compliance training requirements is found in Procedure C-01.3, Effective Training and Education.
2.5 Lines of communication;						The Compliance Plan addresses lines of communication and emphasizes the importance of establishing and maintaining effective lines of communication to promptly report and address compliance issues and FWA. The Compliance Plan addresses:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Employee responsibility to report compliance issues, unethical behavior, privacy, or security violations, and FWA • Available reporting methods • Expectations that leaders maintain an open-door policy for reporting, questions, and discussing concerns • Confidentiality of reports to the extent permitted by law Procedure C-01.4, Effective Lines of Communication, applies to all employees and includes detailed information about communication channels between the Compliance Officer/Department and employees. The procedure addresses: • The Molina Healthcare AlertLine • Escalation protocols • Whistleblower protection and confidentiality of reporting as required by law • Identification of compliance violations/concerns • Implementation of corrective action plans
2.6 Enforcement and accessibility;						The Compliance Plan and Procedure C-01.5, Well-Publicized Disciplinary Standards, address enforcement and accessibility. Topics covered include consequences of non-compliance, disciplinary standards, and that some actions must be reported to regulatory or law enforcement agencies. As noted in Procedure C-01.5, Molina offers employee incentives to "encourage participation in the compliance program."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Internal monitoring and auditing;						The Compliance Plan gives an overview of auditing and monitoring activities Molina conducts to assess compliance with state and federal requirements, detect deficiencies, and validate the effectiveness of any measures taken to address deficiencies or noncompliance. Activities include desk audits, surveys, interviews, document audits, phantom claims/inquiries, and key performance indicator reviews. Additionally, annual compliance risk assessments are conducted to evaluate risks in functional and operational areas. Results inform internal audit work plans and compliance activities for the year. Noncompliance findings are addressed through corrective action plans. Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks, details compliance risk assessment and auditing procedures to ensure adherence to regulations.
2.8 Response to offenses and corrective action;						The Compliance Plan outlines Molina's policy for addressing compliance matters, including methods of identifying compliance issues, processes for investigations, actions taken to remediate issues, and monitoring of corrective actions. Procedure C-01.7, Prompt Response (Investigation and Corrective Action) to Compliance Issues, details the investigation process for potential violations, the Compliance Officer's role in the investigations, and implementation and follow-up of corrective action plans.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Exclusion status monitoring.						The Compliance Plan addresses exclusion status monitoring, which includes pre-employment background checks on all applicants and screening against exclusion lists maintained by the U.S. Department of Health and Human Services Office of Inspector General, General Services Administration, and state Medicaid agencies. These screenings are conducted monthly, thereafter. Similar screenings are conducted for providers, vendors, etc. during the onboarding process and then at least monthly. If any individual or entity is found to be ineligible, appropriate actions, such as termination or suspension, are taken. The FWA Plan also addresses exclusion status monitoring and specifies that Molina conducts monthly checks of providers and employees against various exclusion lists. Additional, detailed information about these processes is documented in Policy C-03.0, Prohibited Affiliations, and Procedure C-03.1, Prohibited Affiliations: None of the documents above mention that Molina queries the Social Security Death Master File. Molina staff reported that the Social Security Death Master File is queried for providers at contracting and for staff at the time of hire. Additionally, Procedure C-03.1, Prohibited Affiliations, page 2, item 4, references credentialing providers and states, Molina does not advance the credentialing application of any provider who has been found to be

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						present on state or federal exclusion lists or debarred from participation or contract status with federal programs. Molina has not held credentialing responsibilities since the implementation of Centralized Credentialing in 2022. *Corrective Action Plan: Revise the Compliance Plan, the FWA Plan, and/or related policies to include the process and timeframe for querying the Social Security Death Master File for staff and providers. Revise Procedure C-03.1 to remove the statement that credentialing applications are not advanced for providers who have been found on state or federal exclusion lists or debarred from participation or contract status with federal programs. Alternatively, add a Mississippi-specific addendum to Procedure C-03.1.*
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				Per the Compliance Plan, Molina's Regulatory Compliance Committee is responsible for oversight of the compliance program and compliance with federal and state requirements. It includes members of senior leadership and meets at least quarterly. The Regulatory Compliance Committee Membership document lists committee members, states the committee meets no less than quarterly, and states there are only two voting members. Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, page 2, item B (2) states, "Molina shall maintain a charter that outlines the responsibilities of the Regulatory Compliance Committee,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						including membership, meeting frequency, and reporting." When a copy of the Compliance Committee Charter was requested for review, Molina provided a copy of Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight. The procedure specifies that the Regulatory Compliance Committee is required to meet at least on a quarterly basis or more frequently as necessary to enable reasonable oversight of the compliance program. However, it does not specify, the quorum for the Compliance Committee, voting responsibilities/members, who breaks a tie vote, or attendance requirement for members. Onsite discussion revealed the quorum is established with the presence of 100% of the voting members and that members are expected to attend all meetings. However, Molina could not define the process followed to break a tie vote. *Corrective Action Plan: Develop a Compliance Committee Charter as required by Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight. Ensure the charter defines the quorum requirement, attendance expectations for voting members, and the process to be followed if there is a tie vote.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The FWA Plan and an array of policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse. Topics covered include but are not limited to use of claims edits, data validation though retrospective claims payment reviews,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						protocols to safeguard against unnecessary or inappropriate use of Medicaid services, use of data mining and data analytics tools, processes for conducting onsite audits by the Special Investigations Unit, payment suspensions/recoveries, verification of services, and referrals to the Medicaid Fraud Control Unit, the Office of Program Integrity, and law enforcement and regulatory agencies.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Two Special Investigations Unit investigators are in Mississippi. Multiple policies and procedures, as well as the FWA Plan and Compliance Plan describe processes for investigating suspected FWA.
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. Information about these topics is included in the FWA Plan.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					As noted in the Quality Improvement and Health Equity Transformation Work Plan, the Beneficiary Health Management Program, formerly the Pharmacy Lock-in Program, went live on August 1, 2024. There are two dedicated case managers for the program. Rounds are held weekly. Onsite discussion revealed this is a collaborative program between the CCO and DOM, and that Molina follows program requirements in Mississippi Code and reports all activities to DOM. A detailed description of the program is included in Procedure HCS 107.01, Integration, Coordination and Access to Care, Addendum 1.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2025 Molina Healthcare Health Care Services Program Description (page 70) includes an overview of the previous Pharmacy Lock-in Program. It appears the language in this document has not been updated to correspond to the new Beneficiary Health Management Program. *Recommendation: Revise the 2025 Molina Healthcare Health Care Services Program Description to include information about the Beneficiary Health Management Program and remove the previous Pharmacy Lock-in Program information.*
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy and Procedure HP-03, Privacy and Confidentiality of Protected Health Information (PHI), outlines Molina's processes for ensuring compliance with applicable laws related to the privacy and confidentiality of PHI, including but not limited to the Health Insurance Portability and Accountability Act. This policy and procedure guide employees on "the use, creation, storage, transmission, access, and disclosure of PHI, including medical records and sensitive member information." Topics covered include: • Protection of privacy in compliance with state and federal laws. • Designation of both a Privacy Official and Security Official and the responsibilities of each.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Requirements for confidentiality agreements for employees and statements of understanding of the responsibility to preserve confidentiality for Board and other committee members. • Allowed and prohibited uses and/or disclosures of PHI. • Members' rights to receive Molina's Privacy Practices and to access, amend, and request restrictions on their PHI. • Processes for providing required notifications for a breach. • Employee training related to privacy, security, and breach notification policies. • The Privacy and Security Compliance Committee.

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's overall approach to policy development and management is documented in Policy MHMS-GC-28, Policy and Procedure Format and Review. Policies are reviewed annually. Business Owners are responsible for creating, maintaining, and ensuring policy accuracy and relevance. New and revised policies are submitted

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to the Policy and Procedure Committee for review and approval. Other committees, as applicable to the department or functional area, may review policies prior to review by the Policy and Procedure Committee. Molina confirmed that all policies are submitted to DOM for approval prior to implementation. Staff can access policies on a SharePoint site, and departmental leaders ensure staff are educated about new and/or revised policies. Molina reported that the Regulatory Communications Committee was established in 2024 to examine regulatory changes to guide policy revisions and the need for new/additional policies.
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:						Overall staffing is sufficient for conducting health plan functions and activities. See notes in the standards below.
1.1 *Chief Executive Officer;	X					The Chief Executive Officer position has been filled in accordance with requirements.
1.2 *Chief Operating Officer;	X					The Chief Operating Officer position is appropriately staffed.
1.3 Chief Financial Officer;	X					Staffing for the Chief Financial Officer position is appropriate.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Chief Information Officer;	X					The Chief Information Officer position is appropriately staffed.
1.4.1 *Information Systems personnel;	X					Onsite discussion confirmed there are designated Information Systems Personnel located in Mississippi. Staffing appears to be sufficient.
1.5 Claims Administrator;	X					The Claims Administrator position is appropriately filled.
1.6 *Provider Services Manager;	X					Staffing for the Provider Services Manager position meets requirements.
1.6.1 *Provider contracting and education;	X					No issues were identified for provider contracting and education staffing.
1.7 *Member Services Manager;	X					The Member Services Manager position is filled appropriately.
1.7.1 Member services and education;	X					No issues were identified for member services and education staffing.
1.8 Grievance and Appeals Coordinator;	X					The Grievance and Appeals Coordinator position is filled appropriately.
1.9 Utilization Management Coordinator;	X					The Utilization Management Coordinator position is filled appropriately.
1.9.1 *Medical/Care Management Staff;	X					No issues were identified for Medical Management and Care Management staffing.
1.10 Quality Management Director;	X					Staffing for the Quality Management Director position meets requirements.
1.11 *Marketing and/or Public Relations;	X					No issues were identified for marketing and/or public relations staffing.

Standard	Score					Comments
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1.12 *Medical Director;	X					The Chief Medical Officer position is appropriately filled, and Molina has six additional Medical Directors on staff.
1.13 *Compliance Officer.	X					Staffing for the Compliance Officer position meets requirements.
2. Operational relationships of CCO staff are clearly delineated.	X					The Organizational Chart provided by Molina displays staffing and reporting relationships for individual areas within the organization.
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 clean claims within 90 days. This exceeds the metric set both internally by Molina and complies with *Miss. Code Ann. § 83-9-5*, both which define timeliness as 90% of claims paid in 30 days and 99% of claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina utilizes Claimsphere to perform data completeness and integrity checks on the data processed through QNXT to ensure accurate member demographic and enrollment information. Molina utilizes CPT codes to track appointments, as well as cross-referencing provider scheduling records, both which are received from providers. Molina also utilizes Clinical Care Advanced, their internal case management system, in conjunction with a comprehensive needs assessment tool, to capture member appointments. The data are further validated with audit reports generated to ensure complete data load. Reports are also generated during the Extract

Standard	Score					Comments
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						Transform Load process from QNXT to track of member and provider data and can be submitted to any requesting oversight agency of the DOM 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 ISCA documentation as well as supporting documents. Molina adequately demonstrated their data collection and storage capability, processing procedures, claim data tabulation and processing, as well as showed adequate support of QA and UM program activities and other contractual requirements via attached flowcharts and technical layouts. The processes were reviewed and discussed during the onsite.
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 the following: A documented Disaster Recovery Plan, Business Continuity plan, and Cyber Security Risk Management plan, all updated and tested on an annual basis. Molina has redundancy systems in place with a documented document recovery process.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					The written Compliance Plan outlines Molina's commitment to ethical behavior, regulatory adherence, and the structure of its compliance program to prevent fraud and ensure operational integrity. The 2025 FWA Plan details policies, procedures, and responsibilities for detecting, preventing, and investigating healthcare fraud. 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				See comments in individual standards below.
2.1 Standards of conduct;						The Compliance Plan addresses Molina's Code of Conduct. Information about the Code of Conduct is also included in the FWA Plan, with the full Code of Conduct included as Attachment B of the FWA Plan. The Code of Conduct serves as a guide for ethical behavior and compliance, is provided to all employees upon hire and annually, and is accessible on Molina's intranet (The Hub) and public website. A multidisciplinary team reviews the Code of Conduct annually, and updates are made as necessary to align with compliance priorities, legal requirements, emerging risks, best practices, etc. Staff are expected to read and attest to understanding the Code of Conduct annually.
2.2 Identification of the Fraud and Abuse Compliance Officer;						Molina has designated a Compliance Officer whose roles and responsibilities are included in Molina's Compliance Plan and in Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight.
2.3 Information about the Compliance Committee;						The Compliance Plan gives an overview of the Compliance Committee, which oversees the Compliance Program and supports the Compliance Officer in implementing the Compliance Plan, reviewing compliance activities, addressing risks, and ensuring adherence to federal and state requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Compliance training and education;						As noted in the Compliance Plan, compliance training is mandatory for all employees to ensure awareness of compliance expectations, responsibilities, and policies. New employees receive the Code of Conduct on their first day, must attest to understanding it, and complete the required compliance training within 30 days of hire. Board members are required to complete compliance training within 30 days of appointment. Annual compliance training is required for all employees and board members. Compliance training content is reviewed and updated annually as needed. Detailed information about compliance training requirements is found in Procedure C-01.3, Effective Training and Education.
2.5 Lines of communication;						The Compliance Plan addresses lines of communication and emphasizes the importance of establishing and maintaining effective lines of communication to promptly report and address compliance issues and FWA. The Compliance Plan addresses: • Employee responsibility to report compliance issues, unethical behavior, privacy, or security violations, and FWA • Available reporting methods • Expectations that leaders maintain an open-door policy for reporting, questions, and discussing concerns

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						• Confidentiality of reports to the extent permitted by law Procedure C-01.4, Effective Lines of Communication, applies to all employees and includes detailed information about communication channels between the Compliance Officer/Department and employees. The procedure addresses: • The Molina Healthcare AlertLine • Escalation protocols • Whistleblower protection and confidentiality of reporting as required by law • Identification of compliance violations/concerns • Implementation of corrective action plans
2.6 Enforcement and accessibility;						The Compliance Plan and Procedure C-01.5, Well-Publicized Disciplinary Standards, address enforcement and accessibility. Topics covered include consequences of non-compliance, disciplinary standards, and that some actions must be reported to regulatory or law enforcement agencies. As noted in Procedure C-01.5, Molina offers employee incentives to "encourage participation in the compliance program."
2.7 Internal monitoring and auditing;						The Compliance Plan gives an overview of auditing and monitoring activities Molina conducts to assess compliance with state and federal requirements, detect deficiencies, and validate the effectiveness of any measures taken to address deficiencies or noncompliance. Activities include desk audits, surveys, interviews, document audits, phantom

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						claims/inquiries, and key performance indicator reviews. Additionally, annual compliance risk assessments are conducted to evaluate risks in functional and operational areas. Results inform internal audit work plans and compliance activities for the year. Noncompliance findings are addressed through corrective action plans. Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks, details compliance risk assessment and auditing procedures to ensure adherence to regulations.
2.8 Response to offenses and corrective action;						The Compliance Plan outlines Molina's policy for addressing compliance matters, including methods of identifying compliance issues, processes for investigations, actions taken to remediate issues, monitoring of corrective actions, etc. Procedure C-01.7, Prompt Response (Investigation and Corrective Action) to Compliance Issues, details the investigation process for potential violations reported through various channels, the Compliance Officer's role in the investigations, and implementation and follow-up of corrective action plans.
2.9 Exclusion status monitoring.						The Compliance Plan addresses exclusion status monitoring, which includes pre-employment background checks on all applicants and screening against exclusion lists maintained by the U.S. Department of Health and Human Services Office of Inspector General, General Services Administration,

Standard	Score					Comments
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						and state Medicaid agencies. These screenings are conducted monthly, thereafter. Similar screenings are conducted for providers, vendors, etc. during the onboarding process and then at least monthly. If any individual or entity is found to be ineligible, appropriate actions, such as termination or suspension, are taken. The FWA Plan also addresses exclusion status monitoring and specifies that Molina conducts monthly checks of providers and employees against various exclusion lists. Additional, detailed information about these processes is documented in Policy C-03.0, Prohibited Affiliations, and Procedure C-03.1, Prohibited Affiliations: None of the documents above mention that Molina queries the Social Security Death Master File. Molina staff reported that the Social Security Death Master File is queried for providers at contracting and for staff at the time of hire. Additionally, Procedure C-03.1, Prohibited Affiliations, page 2, item 4, references credentialing providers and states, Molina does not advance the credentialing application of any provider who has been found to be present on state or federal exclusion lists or debarred from participation or contract status with federal programs. Molina has not held credentialing responsibilities since the implementation of Centralized Credentialing in 2022.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Review the Compliance Plan, the FWA Plan, and/or related policies to include the process and timeframe for querying the Social Security Death Master File for staff and providers. Review Procedure C-03.1 to remove the statement that credentialing applications are not advanced for providers who have been found on state or federal exclusion lists or debarred from participation or contract status with federal programs. Alternatively, add a Mississippi-specific addendum to Procedure C-03.1.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				Per the Compliance Plan, Molina's Regulatory Compliance Committee is responsible for oversight of the compliance program and compliance with federal and state requirements. It includes members of senior leadership and meets at least quarterly. The Regulatory Compliance Committee Membership document lists committee members, states the committee meets no less than quarterly, and states there are only two voting members. Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, page 2, item B (2) states, "Molina shall maintain a charter that outlines the responsibilities of the Regulatory Compliance Committee, including membership, meeting frequency, and reporting." When a copy of the Compliance Committee Charter was requested for review, Molina provided a copy of Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight. The procedure document

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specifies that the Regulatory Compliance Committee is required to meet at least on a quarterly basis or more frequently as necessary to enable reasonable oversight of the compliance program. However, it does not specify, the quorum for the Compliance Committee, voting responsibilities/members, who breaks a tie vote, or attendance requirement for members. Onsite discussion revealed the quorum is established with the presence of 100% of the voting members and that members are expected to attend all meetings. However, Molina could not define the process followed to break a tie vote. *Corrective Action Plan: Develop a Compliance Committee Charter as required by Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight. Ensure the charter defines the quorum requirement, attendance expectations for voting members, and the process to be followed if there is a tie vote.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The FWA Plan and an array of policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse. Topics covered include but are not limited to use of claims edits, data validation though retrospective claims payment reviews, protocols to safeguard against unnecessary or inappropriate use of Medicaid services, use of data mining and data analytics tools, processes for conducting onsite audits by the Special Investigations Unit, payment suspensions/recoveries, verification of services, and referrals to the Medicaid Fraud Control Unit,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Office of Program Integrity, and law enforcement and regulatory agencies.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Two Special Investigations Unit investigators are in Mississippi. Multiple policies and procedures, as well as the FWA Plan and Compliance Plan describe processes for investigating suspected FWA.
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. Information about these topics is included in the FWA Plan.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					As noted in the Quality Improvement and Health Equity Transformation Work Plan, the Beneficiary Health Management Program, formerly the Pharmacy Lock-in Program, went live on August 1, 2024. There are two dedicated case managers for the program. Rounds are held weekly. Onsite discussion revealed this is a collaborative program between the CCO and DOM, and that Molina follows program requirements in Mississippi Code and reports all activities to DOM. A detailed description of the program is included in Procedure HCS 107.01, Integration, Coordination and Access to Care, Addendum 1. The 2025 Molina Healthcare Health Care Services Program Description (page 70) includes an overview of the previous Pharmacy Lock-in Program. It appears the language in this document has not been updated

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to correspond to the new Beneficiary Health Management Program. *Recommendation: Revise the 2025 Molina Healthcare Health Care Services Program Description to include information about the Beneficiary Health Management Program and remove the previous Pharmacy Lock-in Program information.*
I E. Confidentiality *42 CFR § 438.224*						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy and Procedure HP-03, Privacy and Confidentiality of Protected Health Information (PHI), outlines Molina's processes for ensuring compliance with applicable laws related to the privacy and confidentiality of PHI, including but not limited to the Health Insurance Portability and Accountability Act. This policy and procedure guide employees on "the use, creation, storage, transmission, access, and disclosure of PHI, including medical records and sensitive member information." Topics covered include: • Protection of privacy in compliance with state and federal laws. • Designation of both a Privacy Official and Security Official and responsibilities of each. • Requirements for confidentiality agreements for employees and statements of understanding of the responsibility to preserve confidentiality for Board and other committee members.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Allowed and prohibited uses and/or disclosures of PHI. • Members' rights to receive Molina's Privacy Practices and to access, amend, and request restrictions on their PHI. • Processes for providing required notifications for a breach. • Employee training related to privacy, security, and breach notification policies. • The Privacy and Security Compliance Committee.

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 assesses provider education about health plan processes and requirements, provider medical record documentation standards and medical record audits, the development of and education about CPGs and PHGs, the provider satisfaction survey, and provider network adequacy.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Provider Services staff collaborate with internal departments and external entities, including DOM, to determine provider training topics and are responsible for developing, conducting, and evaluating ongoing provider education and training programs. Initial provider orientation is conducted within 30 days after a provider becomes active in Molina's network. Molina uses a written New Provider Orientation document for all orientations and maintains records of all orientations conducted. Provider orientation covers topics including but not limited to Utilization/Care Management systems and protocols, billing and reimbursement, member benefits, referrals, access standards, standards of care, medical record handling and documentation standards, member and provider grievances and appeals, and PCP responsibilities. Ongoing provider training is conducted at least annually through face-to-face/onsite visits, regional workshops, provider bulletins, newsletters, e-communications, webinars, mailings, website postings, and/or Provider Manual updates. The CCO provides DOM with quarterly reports of training topics covered, training planned for the next quarter, etc.

The 2025 MississippiCAN Provider Manual (CAN Provider Manual) and the 2025 Children's Health Insurance Program Provider Manual (CHIP Provider Manual) are comprehensive resources for providers to operate effectively within Molina's network. Review of the Provider Manuals confirmed Molina addressed an issue from the previous EQR regarding inclusion of a non-exclusivity statement in the CAN Provider Manual.

The CAN and CHIP Provider Manuals include information about medical record documentation standards and medical record confidentiality, storage, and retention. To monitor provider compliance with the standards, Molina conducts medical record audits every three years. The next audit is scheduled for 2026. Policy MHMS-QI-124, Standards of Medical Record Documentation, describes the medical record review process. The policy erroneously states that providers who are noncompliant with corrective actions related to identified medical record documentation deficiencies are referred to the Peer Review Committee for consideration during recredentialing. However, due to the implementation of centralized credentialing in 2022, Molina does not conduct credentialing or make credentialing decisions. A recommendation was given during the 2024 EQR to revise this language in the policy.

Practice Guidelines

§ 438.236, § 457.1233

Molina adopts CPGs and PHGs to reduce care variation and enhance preventive health services. The guidelines serve as a standard of practice for providers and can be used to educate members on condition-specific care recommendations. Molina's National Quality Improvement Committee oversees the selection and approval of CPGs. All CPGs and PHGs are updated at least annually and as needed for new scientific evidence and when new/revised national guidelines are published. Molina disseminates the adopted guidelines to providers through orientation materials, provider manuals, newsletters, mailings, fax blasts, the CAN and CHIP websites, and in print upon request. The review confirmed that Molina corrected the deficiency from the previous EQR regarding inconsistencies in the guidelines listed when comparing the CAN and CHIP websites. Issues were noted on the websites, however, including URLs that were non-functional or directed users to home pages rather than guidelines and requirements for membership or passwords to access guidelines.

Provider Satisfaction Survey Validation

Molina used a certified vendor to conduct the provider satisfaction survey. The survey methods, sampling, and administration were consistent with federal expectations. Survey results were analyzed to identify provider concerns and areas needing improvement including communication, administrative burden, and provider directory accuracy. The findings of the surveys were shared with the CCO's oversight committees and leadership. Molina performed root cause analysis and documented improvement strategies and committee level discussions to ensure that survey-identified quality concerns are addressed and tracked.

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 *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.

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 has processes documented in policy for notifying PCPs of member panel assignments and for ensuring all providers can verify member eligibility through several avenues. Policies also describe Molina's processes for monitoring providers' panel status to ensure there is a sufficient number of providers willing to accept new patients.

Molina evaluates member access to providers through quarterly Geographic Access Reports. Molina also considers member complaints/grievances about network access. Review confirmed the CAN and CHIP Geographic Access Reports for Q2 2025 include statewide adequacy maps and county-by-county breakdown by provider type, access parameters used to assess member access, and the percentages of members with and without access. Processes are in place to expand the network when access insufficiencies are identified.

The standards for appointment access are documented in Policy MHMS-QI-006, Access to Care, the CAN and CHIP Provider Manuals, and on the CAN and CHIP websites. Errors were noted in the timeframes for urgent BH/SUD visits in the CAN Provider Manual (page 80) and the CHIP Provider Manual (page 69). Additionally, the timeframe for routine visits with BH/SUD providers stated in Policy MHMS-QI-006, the CAN and CHIP Provider Manuals, and the CAN and CHIP websites are not in compliance with the requirements stated in the *CAN Contract, Section 7 (B) (2)*, and *CHIP Contract, Section 7 (B) (2)*.

Molina conducts routine appointment and after-hour accessibility audits on a sample of network providers and takes action to address provider noncompliance. Molina also considers member complaints related to appointment accessibility, scheduling, wait times and delays as well as member satisfaction survey results. Review of results of the most recent call studies conducted by Molina (Q2 2025) showed that Molina assessed providers against the contractually required 21 calendar-day timeframe for routine BH/SUD visits instead of the 14 calendar-day timeframe specified in policy, Provider Manuals, and on the CAN and CHIP websites.

The methods Molina used to assess network adequacy are reliable and include provider access studies and network adequacy time/distance assessments using Quest Analytics software. Molina's ISCA 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.

Molina maintains a Health Equity and Cultural Competency Program to reduce healthcare disparities and ensure culturally competent, linguistically appropriate, and equitable healthcare for all members. The CAN and CHIP Provider Manuals include an overview of cultural competency and direct the reader to Molina's website and Provider Services representatives to obtain additional information. Cultural competency training resources are found on the CAN and CHIP provider websites. Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, outlines procedures for ensuring cultural responsiveness in Molina's practitioner network; however, the policy references requesting practitioner race, ethnicity, and language information through the initial credentialing process and states this information is not used to make credentialing decisions. Due to the implementation of centralized credentialing in 2022, Molina does not conduct credentialing activities or make credentialing decisions.

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 2025, improvement was shown in successful contacts for CAN and CHIP from the previous study that was conducted in Q4 2024 (see *Table 13)*.

Table 13: Provider Access Study Results for Current and Previous Review Cycles

Review Cycle	Successful Contacts	Answer Rate
CAN		
Q4 2024	69%	27%
Q2 2025	96%	27%
CHIP		
Q4 2024	35%	24%
Q2 2025	83%	15%

CAN: For Q2 2025, the success rate was 96%. This is a non-statistically significant improvement in the successful contact rate compared to the previous rate of 69%. The routine appointment compliance rate was 83% and the urgent appointment compliance rate was 63%. For the provider directory validation, the accuracy rate was 29%.

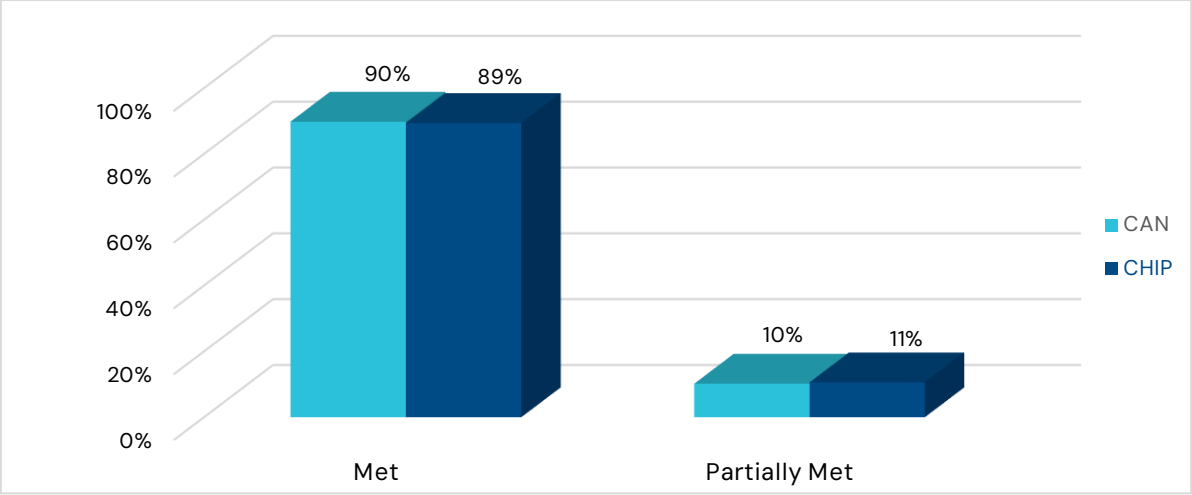
CHIP: For Q2 2025, the success rate was 83%. This is an improvement from the successful contact rate of 35% from the previous rate. The routine appointment availability compliance rate was 62% and the urgent appointment availability compliance rate was 15%. For the provider directory validation, the accuracy rate was 20%.

The next call CAN and CHIP call studies will be conducted in Q4 2025.

Overall, Molina met the requirements of the Network Adequacy Validation. Details of the Network Adequacy Validation can be found in *Attachment 3*.

As displayed in *Figure 4*, 90% of the CAN standards and 89% of the CHIP standards for Provider Services were scored as "Met."

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 tables below.

Table 14: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Processes are in place for notifying providers of members assigned to their rosters and for providers to verify member eligibility.	✓		✓
Molina routinely monitors providers' panel status and the geographic adequacy of the network.	✓		✓
The Health Equity and Cultural Competency Program is in place to aid in reducing healthcare disparities and ensure culturally competent, linguistically appropriate, and equitable healthcare for all members.	✓		✓
Appropriate processes are in place for initial and ongoing provider education.	✓		✓

Strengths	Quality	Timeliness	Access to Care
The CAN and CHIP Provider Manuals are comprehensive resources for providers.	✓		
Molina adopts appropriate CPGs and PHGs to reduce care variation, enhance preventive health services, serve as standards of practice, and educate members on condition-specific care recommendations	✓		✓
Molina educates providers about medical record documentation and handling requirements and assesses provider compliance every three years.	✓		

Table 15: Provider Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, does not clearly state that Molina must pay for services from out-of-network providers when unable to identify a sufficient number of providers within a specific area or specialty to meet the geographic access standards.	*Recommendation: Revise Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, to clearly state Molina must pay for services from out-of-network providers when unable to identify a sufficient number of providers within a specific area or specialty to meet the geographic access standards. Refer to the CHIP Contract, Section 7 (B).*	✓		✓
Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, outlines procedures for ensuring cultural responsiveness in its practitioner network. Page 4, item A references requesting practitioner race, ethnicity, and language information through the initial credentialing process. It further states this information is not used to make credentialing decisions. Due to the implementation of centralized credentialing in 2022, Molina does not credential providers or make credentialing decisions.	*Corrective Action Plan: Revise Policy MHMS-QI-011 to remove the incorrect language regarding credentialing providers or add an addendum to the policy to include Mississippi-specific information.*	✓		
The CAN Provider Manual, page 80, and the CAN website incorrectly define the appointment access standard for urgent BH/SUD visits. Refer to the *CAN Contract, Section 7 (B) 2*, Table 7 and Policy MHMS-QI-006, Access to Care. Additionally, Policy MHMS-QI-006, the CAN Provider Manual, and the CAN website incorrectly define the timeframe for routine visits with BH/SUD providers as within 14 calendar days. However, the contractual requirement is within 21 calendar days.	*Corrective Action Plan: Correct the appointment access timeframe for urgent and routine visits with BH/SUD providers in Policy MHMS-QI-006, in the CAN Provider Manual, and on the CAN website.*	✓		✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The CHIP Provider Manual, page 69, incorrectly defines the appointment access standard for urgent BH/SUD visits. Refer to the *CHIP Contract, Section 7 (B) (2)* and Policy MHMS-QI-006. Additionally, Policy MHMS-QI-006, the CHIP Provider Manual, and the CHIP website incorrectly define the timeframe for routine visits with BH/SUD providers as within 14 calendar days. However, the contractual requirement is within 21 calendar days.	*Corrective Action Plan: Correct the appointment access timeframe for urgent and routine visits with BH/SUD providers in Policy MHMS-QI-006, in the CHIP Provider Manual, and on the CHIP website.*	✓		✓
Policy MHMS-QI-006, Access to Care, indicates the timeframe for routine BH/SUD visits is within 14 calendar days. However, the call study results and the 2024 QI Program Evaluation indicate the contractually required timeframe of 21 calendar days is used to measure appointment access.	*Corrective Action Plan: When Molina's policy defines a different timeframe for appointment access than the standard defined by DOM in the contract and in the required reporting template, access must be measured and reported using both standards. Ensure call study staff/vendors are aware that both timeframes must be assessed to determine appointment access.*	✓		✓
Policy MHMS-PC-01, MHMS Provider Directory Requirements, states that for all physicians, specialists, hospitals, behavioral health providers, and other provider types, the Provider Directory shall include the web site URL, as appropriate. The print versions of the CAN and CHIP Provider Directories included all requirements except provider website URLs.	*Recommendation: Revise the print version of the CAN and CHIP Provider Directories to include provider website URLs, as required by Federal Regulation § 438.10(h).*	✓		✓
The CAN Provider Manual, page 19, includes the required non-exclusivity statement. It 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."	*Recommendation: Revise the non-exclusivity statement in the CAN Provider Manual to indicate Molina may not require Providers who agree to participate in the CAN Program to contract with Molina's other lines of business.*	✓		
Information about and links to the adopted CPGs and PHGs are included on the CAN and CHIP provider websites. However, the following issues were noted: • Non-functional hyperlinks were noted for two guidelines.	*Corrective Action Plan: Correct the non-functional and erroneous hyperlinks to guidelines on the website. Consider creating a library of guidelines on the website rather than using hyperlinks, particularly for guidelines that require membership/passwords to access.*	✓		✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
• Passwords and/or membership was required for two guidelines. • The URL for one guideline takes user to main home page of the source's website rather than to the guideline.				
Page 9 of Policy MHMS-QI-124 states providers who are noncompliant with corrective actions are referred to the Peer Review Committee for consideration during recredentialing. However, due to the implementation of centralized credentialing in 2022, Molina does not credential providers or make credentialing decisions.	*Corrective Action Plan: Revise Policy MHMS-QI-124 to remove the incorrect language regarding credentialing providers or add an addendum to the policy to include Mississippi-specific information.*	✓		

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					Procedure MHMS-NM-017, CHIP PCP Roles and Responsibilities, states it applies to both the CAN and CHIP lines of business. The procedure outlines the process for PCPs to manage their Member Roster through Molina's secure Provider Web Portal. As noted, PCPs are responsible for reviewing their Member Roster to identify new and current members. Molina sends monthly written notifications to PCPs with newly assigned members, including instructions to access the Member Roster via the secure portal. Information about PCP notification of panel assignments is also found in the CAN Provider Manual. The manual also states providers can contact Provider Services to verify panel assignments.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					As noted in Policy MHMS-M&PCC-03, Eligibility Verification, member enrollment data is loaded into QNXT, a system which houses member enrollment and eligibility data, within five business days of receiving the Member Listing Report from DOM. Call center agents can verify enrollment within five business days of the date the Member Listing Report is received from DOM. Nonparticipating providers can verify member enrollment by calling the Member and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Contact Center. Providers may also verify enrollment through the automated phone system and/or web/portal.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Per Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, Molina assesses provider panel availability biannually thought a Closed Panel Report. Molina provided a copy of a Closed Panel Report for CAN. The report indicates the number of PCPs with closed panels by county. Of the 82 counties listed, 21 (>25%) have closed panels. Molina reported that members in these counties have access to providers in neighboring counties. Molina also reported that the CCO attempts to recruit non-participating providers into the network.
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					Geographic access standards for PCPs are defined in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards. Members must have access to at least two PCPs within the required geographic access standards. Molina runs a quarterly Provider Network Geographic Access Report to assess compliance with established geographic access standards. Deficiencies are documented as well as barriers to improvement and/or successes since previous quarterly report. Molina also considers member complaints/grievances about network access. The quarterly report is submitted to DOM. Molina submitted the most recent quarterly geographic access report (Q2 2025) for CAN. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						report includes statewide adequacy maps for PCPs, county-by-county breakdown by provider type, access parameters used to assess member access, and the percentages of members with and without access. Policy MHMS-PC-10 states Molina will ensure the provider network meets the cultural and ethnic needs of the population through ongoing reviews of member-to-provider ratios related to ethnicity and spoken languages. This includes a review of Indian Tribe, Tribal Organizations, and Urban Indian Organizational providers.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Geographic access standards for non-PCP providers are defined in Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards. Per Policy MHMS-PC-10, Molina runs a quarterly Provider Network Geographic Access Report to assess compliance with established geographic access standards. Deficiencies are documented as well as barriers to improvement and/or successes since previous quarterly report. Molina also considers member complaints/grievances about network access. The quarterly report is submitted to DOM. The most recent quarterly geographic access report (Q2 2025) for CAN includes statewide adequacy maps for non-PCP providers, county-by-county breakdown by provider type, access parameters used to assess member access, and the percentages of members with and without access.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHMS-PC-10 states Molina must pay for services from out-of-network providers when Molina is unable to identify a sufficient number of providers within a specific area or specialty to meet the geographic access standards.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Per Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, Molina runs a quarterly Provider Network Geographic Access Report to assess compliance with established geographic access standards. Deficiencies are documented as well as barriers to improvement and/or successes since previous quarterly report. Molina also considers member complaints/grievances about network access.
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				Policy MHMS-QI-009, Race/Ethnicity and Language Data Collection, details Molina's processes for collecting member and practitioner race, ethnicity, and language data, as well as assessing the network's ability to meet member needs. Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, outlines procedures for ensuring cultural responsiveness in its practitioner network. In the Procedure section of the document, page 4, item A states, "Molina requests practitioner race/ethnicity and language information from all contracted practitioners, on a voluntary basis, through its initial credentialing process in accordance with Molina national policy MHI-QUAL-011 Practitioner Network Cultural Responsiveness. Molina does not use the information about practitioner race/ethnicity and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						language in contracting or credentialing decisions or for any other discriminatory purpose." However, due to the implementation of centralized credentialing in 2022, Molina does not conduct credentialing activities or make credentialing decisions. A recommendation was given during the 2024 EQR to revise this language in the policy. *Corrective Action Plan: Revise Policy MHMS-QI-009 to remove the incorrect language regarding credentialing providers or add an addendum to the policy to include Mississippi-specific information.* The CAN Provider Manual includes information about Cultural Competency and Linguistic Services, addressing relevant laws, provider and community training, related quality improvement activities, information about access to language services, etc. The manuals direct the reader to Molina's website or to contact their Provider Services representative to obtain additional information. The Molina website includes training resources and hyperlinks to additional information regarding culturally competent patient care.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Policy MHMS-PC-10, MHMS MSCAN Provider Network Geographic Access Standards and Other Availability Standards, covers actions taken to address network deficiencies. The policy specifies that: • Molina must submit documentation to DOM when there are deficiencies in meeting geographic access standards or provider availability.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The Vice Presidents of Network Management and Operations review quarterly geographic access reports, documents findings, reports deficiencies, barriers, and successes to the Executive Quality Improvement Committee, coordinates needed network improvements with Provider Contracting, and submits a copy of the report to DOM at the end of each quarter. As noted in the 2024 QI Program Evaluation, Molina identified opportunities for improvement to address the gaps in its network adequacy, particularly in urban areas. Key interventions included developing targeted recruitment initiatives, expanding telehealth services, and enhancing provider participation through value-based contracts.
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The CCO maintains provider and beneficiary data within QNXT and related systems, updated regularly. The data sets allow for ongoing monitoring.
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					Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events, describes processes for identifying, documenting, tracking, and resolving potential quality of care issues. As noted in the policy, Molina investigates potential quality of care issues, documents the results of the investigation, initiates a Quality Improvement Plan as indicated, tracks case resolution, and reports individual cases and noted trends to the appropriate quality committee. Onsite discussion confirmed cases

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and trends are reported to the Potential Quality of Care Committee. Membership of this committee includes physicians with a variety of specialties and a physician assistant. Procedure MHMS-PC-09, MHMS Provider Termination Process, outlines the process followed when a provider is terminated for cause, including quality of care. As noted, Molina notifies the affected provider in writing of the reason(s) for the termination. The notification also includes contact information for questions, appeal/review rights, the effective date, and information about continuation of care for the member. Molina notifies DOM of the termination within 48 hours.
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Appointment access standards are defined in Policy MHMS-QI-006, Access to Care, the CAN Provider Manual, and on Molina's CAN website. The CAN Provider Manual, page 80, defines the appointment access standard for urgent BH/SUD visits as "Not to exceed twenty-four (24) calendar days." The CAN website defines the appointment access standard for urgent BH/SUD visits as "Not to exceed fourteen (24) calendar days." However, the contractual standard (*CAN Contract, Section 7 (B) 2*, Table 7) and the standard stated in Policy MHMS-QI-006 is within 24 hours. Additionally, Policy MHMS-QI-006, the CAN Provider Manual, and the CAN website define the timeframe for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						routine visits with BH/SUD providers as within 14 calendar days. However, the contractual requirement is within 21 calendar days. *Corrective Action Plan: Correct the appointment access timeframe for urgent and routine visits with BH/SUD providers in Policy MHMS-QI-006, in the CAN Provider Manual, and on the CAN website.*
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." Procedure MHMS-QI-006, Access to Care, states provider network adherence to access standards is monitored through provider access studies, member complaint data, and member satisfaction survey results. The Quality Improvement Department conducts quarterly appointment and after-hours accessibility audits. Provider network adherence to access standards is monitored through provider access studies, member complaint data, and member satisfaction survey results. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHMS-QI-006, Access to Care, indicates the timeframe for routine BH/SUD visits is within 14 calendar days. However, the call study results indicate a timeframe of 21 calendar days is being used to measure appointment access. This was confirmed by documentation in the 2024 QI Program Evaluation. During onsite discussion, the reviewer requested the health plan to clarify whether the timeframe used for the call study was 14 or 21 calendar days. Molina did not provide the requested clarification. *Corrective Action Plan: When Molina's policy defines a different timeframe for appointment access than the standard defined by DOM in the contract and in the required reporting template, this must be measured and reported using both standards. Ensure call study staff/vendors are aware that both timeframes must be assessed to determine appointment access.*
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					Policy MHMS-PC-01, MHMS Provider Directory Requirements, states "Molina will develop, regularly maintain, and make available a Provider Directory specific to each of the covered populations: MississippiCAN and CHIP." This policy defines the elements that must be included in the provider directories. All required elements are included in the policy. Policy MHMS-PC-01 states the Provider Directory shall include "the following information for all physicians, specialists, hospitals, behavioral health providers, and any other provider types covered under this Contract:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						4. Web site URL, as appropriate." Review of the web-based CAN Provider Directory confirmed all required elements are included. The print version of the CAN Provider Directory included all requirements except provider website URLs. Refer to *Federal Regulation § 438.10(h).* *Recommendation: Revise the print version of the CAN Provider Directory to include provider website URLs, as required by Federal Regulation § 438.10(h).*
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Molina's processes for validating Provider Directory information are documented in Procedure MHMS-PC-01, MHMS Provider Directory Requirement. As noted, • Provider Directory reports are generated for all contracted providers, and outreach is conducted to each provider to determine of updates are needed. Provider Data Management (PDM) processes received updates. • PDM monitors the online provider directory daily to ensure updates from the previous day are noted, the search function works as expected and returns accurate information, and the displayed data is consistent with the data in QNXT. • PDM conducts monthly audits of all provider data for compliance with requirements. • Quarterly reviews of Provider Configuration Management guidelines are conducted to ensure the information needed for the online directory is entered into QNXT in a manner or format that will

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						push over to the online directory and meet requirements.
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					Provider access analysis, including panel capacity and time-distance studies demonstrate alignment with CMS network adequacy validation requirements.
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					The processes for initial provider orientation and ongoing education are documented in Policy MHMS-NM-008, Provider Education and Training. Provider Services staff are responsible for developing, conducting, and evaluating ongoing provider education and training programs. Provider Services collaborates with internal departments and external entities, including DOM, to determine training topics.
2. Initial provider education includes:						Policy MHMS-NM-008, Provider Education and Training, states initial provider orientation is conducted within 30 days after a provider becomes active in Molina's network. If a provider declines to participate in orientation, representatives document the information in a visit log on a Molina SharePoint site and mail the orientation materials and health plan contact information to the provider. Molina uses the New Provider Orientation Presentation for all orientations and maintains records of all orientations conducted.
2.1 A description of the Care Management system and protocols;	X					The CAN New Provider Orientation PowerPoint document includes an overview of Healthcare

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services, including utilization management, care management, central programs, and member and provider appeals. The CAN Provider Manual, Section 7, covers Healthcare Services, including Utilization Management and the Integrated Care Management Program, which includes Care Management and Health Management.
2.2 Billing and reimbursement practices;	X					The CAN New Provider Orientation PowerPoint and the CAN Provider Manual provide information about billing and reimbursement practices and requirements.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					The CAN New Provider Orientation PowerPoint addresses covered services for CAN members. The CAN Provider Manual, Section 6, details benefits and covered services.
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					The CAN New Provider Orientation PowerPoint and CAN Provider Manual address processes for specialist referrals. Review of the CAN Provider Manual confirmed Molina appropriately addressed the corrective action plan from the previous EQR related to self-referral for behavioral health services.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					The CAN New Provider Orientation PowerPoint addresses appointment access standards. The CAN Provider Manual addresses appointment access standards and states providers are responsible for establishing a process to document missed appointments. The process should include noting missed appointments in the member's medical record, assessing whether a visit is indicated, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documenting efforts to contact the member in the medical record.
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					The CAN Provider Manual addresses recommended standards of care, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening requirements and services. It includes information about preventive care services and related provider responsibilities.
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					The CAN Provider Manual addresses the provider's responsibility to follow up with Members who are non-compliant with EPSDT screenings and services. It states that providers are expected to make reasonable efforts to ensure that Members receive the required EPSDT screenings and services.
2.8 Medical record handling, availability, retention, and confidentiality;	X					The CAN Provider Manual addresses medical record handling, availability, retention, and confidentiality requirements.
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					The CAN New Provider Orientation PowerPoint and the CAN Provider Manual address provider and member complaint, grievance, and appeal procedures as well as provider disputes.
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 discusses pharmacy policies and procedures necessary for making informed prescription choices and the availability of a 3-day emergency supply of medication until authorization is complete. It includes information about provider adherence to DOM's PDL, the Single Pharmacy Benefit

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Administrator (Gainwell), and Physician-Administered Drugs.
2.11 Prior authorization requirements including the definition of medically necessary;	X					The CAN New Provider Orientation PowerPoint and the CAN Provider Manual address prior authorization requirements, including the definition of medical necessity, general requirements, options for submission of prior authorization requests, information needed to review requests, review timeframes, etc.
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					The CAN Provider Manual addresses the roles of a PCP and reassignment of members to another PCP.
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					The CAN Provider Manual includes the process for communicating a provider's limitations on panel size to the CCO.
2.14 Medical record documentation requirements;	X					The CAN Provider Manual covers required components of medical record documentation and states providers will be monitored for compliance with the standards.
2.15 Information regarding available translation services and how to access those services;	X					The CAN New Provider Orientation PowerPoint addresses available translation services, how to access the services, and the use of 711 Relay services. Additionally, it includes a description of additional resources offered by Molina, such as low-literacy materials, documentation translations, alternate formats such as Braille, audio, or large font. The CAN Provider Manual also covers translation services and access to those services.
2.16 Provider performance expectations including quality and	X					The CAN Provider Manual informs that Molina collects and evaluates data related to provider performance for QI activities and states providers are required to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
utilization management criteria and processes;						actively participate in Quality Programs to ensure delivery of high-quality care.
2.17 A description of the provider web portal;	X					The CAN New Provider Orientation PowerPoint provides information about the provider web portal and indicates the portal is available 24/7. A hyperlink to the portal is included. The document includes functions available through the portal. Detailed information about the web portal is found in the CAN Provider Manual.
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					The CAN Provider Manual, page 19, includes the required non-exclusivity statement. It 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." This confirms that Molina appropriately addressed the corrective action plan from the previous EQR. Onsite discussion confirmed the word "CHIP" in the statement above is incorrect. *Recommendation: Revise the non-exclusivity statement in the CAN Provider Manual to indicate Molina may not require Providers who agree to participate in the CAN Program to contract with Molina's other lines of business.*
3. The CCO provides ongoing education to providers regarding changes and/or	X					Processes and requirements for ongoing provider education are detailed in Policy MHMS-NM-008,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
additions to its programs, practices, member benefits, standards, policies, and procedures.						Provider Education and Training. Ongoing training is provided annually, quarterly, or as needed, and is tracked on a SharePoint site. The CCO provides DOM with quarterly reports of training topics covered, training planned for the next quarter, etc. Training is provided through face-to-face/onsite visits, regional workshops, provider bulletins, newsletters, e-communications, webinars, mailings, website postings, and/or Provider Manual updates. Ten workshops are conducted in collaboration with DOM annually.
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 reduce care variation and to enhance preventive health services. The guidelines serve as a standard of practice for providers and can be used to educate members on condition-specific care recommendations. Molina's National Quality Improvement Committee oversees the selection and approval of clinical practice guidelines. Membership of the NQIC includes physicians and other health professionals. The guidelines are selected "based on scientific evidence and recommendations made by national clinically based organizations." CPGs are adopted based on relevance to the member population or to high risk, high cost, and problem prone members. PHGs focus on age/condition-specific recommendations relevant to the CCO's membership. Guidelines adopted by the NQIC are reported to the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCO's Quality Improvement Committee(s) for adoption by the health plan. All CPGs and PHGs are updated at least annually and as needed for new scientific evidence and/or when new/revised national guidelines are published. These processes are detailed in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.
2. The CCO communicates to providers the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members.		X				As noted in Policy and Procedure MHMS-QI-018, Molina disseminates CPGs and PHGs to providers through: • Inclusion in new provider orientation materials with discussion during orientation visits. • Provider Manuals and/or Provider Manual inserts • Provider newsletters and special/targeted mailings • Fax blasts followed by mailings to providers without fax numbers • Online distribution with written notifications (fax, email, or mail) sent to inform providers of online availability. • Paper copies upon request. The CAN Provider Manual includes an overview of CPGs and PHGs and directs providers to the website to obtain the guidelines. Review confirmed that information about and links to the adopted CPGs and PHGs are included on the provider website. However, the following issues were noted:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Non-functional hyperlinks were noted for the following for two guidelines (Acute Stress and Post-Traumatic Stress Disorder and Anxiety/Panic Disorder). • Passwords and/or membership was required for the Perinatal Care guideline from the American College of Obstetricians and Gynecologists and Detoxification and Substance Abuse Treatment from SAMHSA. Onsite discussion revealed that Molina can provide printed copies of these guidelines to providers upon request. • The Fostering Resilience and Recovery: A Change Package for Advancing Trauma-Informed Primary Care hyperlink takes user to The National Council for Mental Wellbeing's main website rather than to the guideline. *Corrective Action Plan: Correct the non-functional and erroneous hyperlinks to guidelines on the website. Consider creating a library of guidelines on the website rather than using hyperlinks, particularly for guidelines that require membership/passwords to access.*
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	X					Adopted guidelines include: • Preventive Pediatric Health Care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Screening, Diagnosis and Treatment (EPSDT) services;						• Pediatric/Adolescent Preventive Services Recommendations • Pediatric Vision Screening • Dental Health
3.2 Recommended childhood immunizations;	X					Adopted guidelines include: • Recommended Child and Adolescent Immunization Schedule
3.3 Pregnancy care;	X					Adopted guidelines include: • Perinatal Care • Routine Prenatal and Postnatal Care
3.4 Adult screening recommendations at specified intervals;	X					Adopted guidelines include: • Adult Preventive Services Recommendations • Adult Vision Screening • Dental Health • Adult Immunization Schedule
3.5 Elderly screening recommendations at specified intervals;	X					Adopted guidelines include: • Adult Preventive Services Recommendations • Adult Vision Screening • Dental Health • Adult Immunization Schedule
3.6 Recommendations specific to member high-risk groups;	X					Adopted guidelines include: • Promoting Health for Children and Youth with Special Health Care Needs • Assessment and Management of Patients at Risk for Suicide

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Adapting Your General Recommendations for the Care of Homeless Patients
3.7 Behavioral health.	X					Adopted guidelines include: • Acute Stress and Post-Traumatic Stress Disorder • Anxiety/Panic Disorder • Diagnosis, Evaluation, and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents • Identification, Evaluation, and Management of Children With Autism Spectrum Disorder • Bipolar Disorder • Treatment of Patients with Major Depressive Disorder • Use of Medications in the Treatment of Addiction Involving Opioids • CDC Guideline for Prescribing Opioids for Chronic Pain • Schizophrenia • Detoxification and Substance Abuse Treatment • Fostering Resilience and Recovery: A Change Package for Advancing Trauma-Informed Primary Care
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					Policy and Procedure MHMS-QI-124, Standards of Medical Record Documentation, outlines the standards for medical record documentation. Required documentation elements are also included in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the CAN Provider Manual. The information is consistent across the policy and the Provider Manual.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.		X				Policy MHMS-QI-124, Standards of Medical Record Documentation, states Molina conducts medical record audits every three years. Molina had reported during the previous EQR that the CCO was planning to move to an annual review cycle; however, during onsite discussion for the current EQR, staff reported that it was decided to stay on a three-year cadence. Policy MHMS-QI-124 describes the medical record review process, including: • Molina reviews a minimum of 10 records per provider, with a representative sample of network providers included. • Passing scores are 80% or higher. Scores below 80% require over-read. If the score for the over-read is <80%, a reaudit is required before issuing a corrective action plan. • Applicable providers receive written notification of deficiencies requiring corrective action within 30 days. Providers must respond within 30 days and implement corrective actions within 180 days. • Molina conducts a reaudit after 180 days to determine the effectiveness of corrective action. • Audit results are reported to the Quality Improvement Committee. Molina staff confirmed the next audit will be conducted in 2026.

Standard	Score					Comments
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						Page 9 of Policy MHMS-QI-124 states providers who are noncompliant with corrective actions are referred to the Peer Review Committee for consideration during recredentialing. However, due to the implementation of centralized credentialing in 2022, Molina does not conduct credentialing activities or make credentialing decisions. A recommendation was given during the 2024 EQR to revise this language in the policy. *Corrective Action Plan: Revise Policy MHMS-QI-124 to remove the incorrect language regarding credentialing providers or add an addendum to the policy to include Mississippi-specific information.*
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Provider survey was conducted by a certified vendor. Survey methods, sampling, and administration were consistent with federal expectations.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Survey results were analyzed to identify provider concerns and areas needing improvement including communication, administrative burden, and provider directory accuracy.
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					Survey findings were shared with the CCO's oversight committees and leadership. The CCO performed root cause analysis, documented improvement strategies, and committee level discussions to ensure that survey-identified quality concerns are addressed and tracked.

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					Procedure MHMS-NM-017, CHIP PCP Roles and Responsibilities, outlines the process for PCPs to manage their Member Roster through Molina's secure Provider Web Portal. As noted, PCPs are responsible for frequently reviewing their Member Roster to identify new and current members. Molina sends monthly written notifications to PCPs with newly assigned members, including instructions to access the Member Roster via the secure portal. Information about PCP notification of panel assignments is also found in the CHIP Provider Manual. The manual also states providers can contact Provider Services to verify panel assignments.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					As noted in Policy MHMS-M&PCC-03, Eligibility Verification, member enrollment data is loaded into QNXT, a system which houses member enrollment and eligibility data, within five business days of receiving the Member Listing Report from DOM. Call center agents can verify enrollment within five business days of the date the Member Listing Report is received from DOM. Nonparticipating providers can verify member enrollment by calling the Member and Provider Contact Center. Providers may also verify

Standard	Score					Comments
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						enrollment through the automated phone system and/or web/portal.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Per Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, Molina assesses provider panel availability biannually thought a Closed Panel Report. Molina provided a copy of a Closed Panel Report for CHIP. The report indicates the number of PCPs with closed panels by county. Of the 82 counties listed, 23 (28%) have closed panels. Molina reported that members in these counties have access to providers in neighboring counties. Molina also reported that the CCO attempts to recruit non-participating providers into the network.
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					Geographic access standards for PCPs are defined in Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. Members must have access to at least two PCPs within the required geographic access standards. Molina runs a quarterly Provider Network Geographic Access Report to assess compliance with established geographic access standards. Deficiencies are documented as well as barriers to improvement and/or successes since previous quarterly report. Molina also considers member complaints/grievances about network access. The quarterly report is submitted to DOM. Molina submitted the most recent quarterly geographic access report (Q2 2025) for CHIP. The report includes statewide adequacy maps for PCPs

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						county-by-county breakdown by provider type, access parameters used to assess member access, and the percentages of members with and without access. Policy MHMS-NM-016 states Molina must demonstrate its network includes sufficient Indian Health Care Providers to ensure timely access to services for Indian members who are eligible to receive services from these providers.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					Geographic access standards for non-PCP providers are defined in Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards. Per Policy MHMS-NM-016, Molina runs a quarterly Provider Network Geographic Access Report to assess compliance with established geographic access standards. Deficiencies are documented as well as barriers to improvement and/or successes since previous quarterly report. Molina also considers member complaints/grievances about network access. The quarterly report is submitted to DOM. The most recent quarterly geographic access report (Q2 2025) for CHIP includes statewide adequacy maps for non-PCP providers, county-by-county breakdown by provider type, access parameters used to assess member access, and the percentages of members with and without access. Policy MHMS-NM-016 addresses circumstances under which Molina is financially responsible for services from out-of-network providers. However, there was

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						no clear statement in the policy that Molina must pay for services from out-of-network providers when unable to identify a sufficient number of providers within a specific area or specialty to meet the geographic access standards. *Recommendation: Revise Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, to clearly state Molina must pay for services from out-of-network providers when unable to identify a sufficient number of providers within a specific area or specialty to meet the geographic access standards. Refer to the CHIP Contract, Section 7 (B).*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Per Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, Molina runs a quarterly Provider Network Geographic Access Report to assess compliance with established geographic access standards. Deficiencies are documented as well as barriers to improvement and/or successes since previous quarterly report. Molina also considers member complaints/grievances about network access.
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				Policy MHMS-QI-009, Race/Ethnicity and Language Data Collection, details Molina's processes for collecting member and practitioner race, ethnicity, and language data, as well as assessing the network's ability to meet member needs. Policy MHMS-QI-011, Practitioner Network Cultural Responsiveness, outlines procedures for ensuring cultural responsiveness in its practitioner network. In the Procedure section of the

Standard	Score					Comments
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						document, page 4, item A states, "Molina requests practitioner race/ethnicity and language information from all contracted practitioners, on a voluntary basis, through its initial credentialing process in accordance with Molina national policy MHI-QUAL-011 Practitioner Network Cultural Responsiveness. Molina does not use the information about practitioner race/ethnicity and language in contracting or credentialing decisions or for any other discriminatory purpose." However, due to the implementation of centralized credentialing in 2022, Molina does not credential providers or make credentialing decisions. A recommendation was given during the 2024 EQR to revise this language in the policy. *Corrective Action Plan: Revise Policy MHMS-QI-009 to remove the incorrect language regarding credentialing providers or add an addendum to the policy to include Mississippi-specific information.* The CHIP Provider Manual includes information about Cultural Competency and Linguistic Services, addressing relevant laws, provider and community training, related quality improvement activities, information about access to language services, etc. The manuals direct the reader to Molina's website or to contact their Provider Services representative to obtain additional information. The Molina website includes training resources and hyperlinks to additional information regarding culturally competent patient care.

Standard	Score					Comments
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1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Policy MHMS-NM-016, CHIP Provider Network Geographic Access Standards and Other Availability Standards, covers actions taken to address network deficiencies. The policy specifies that: • Molina must submit documentation to DOM when there are deficiencies in meeting geographic access standards or provider availability. • The Vice Presidents of Network Management and Operations review quarterly geographic access reports, documents findings, reports deficiencies, barriers, and successes to the Executive Quality Improvement Committee, coordinates needed network improvements with Provider Contracting, and submits a copy of the report to DOM at the end of each quarter. As noted in the 2024 QI Program Evaluation, Molina identified opportunities for improvement to address the gaps in its network adequacy, particularly in urban areas. Key interventions included developing targeted recruitment initiatives, expanding telehealth services, and enhancing provider participation through value-based contracts.
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The CCO maintains provider and beneficiary data within QNXT and related systems, updated regularly. The data sets allow for ongoing monitoring.
1.10 The CCO formulates and acts within written policies and procedures for suspending or terminating a	X					Policy MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events, describes processes for identifying, documenting,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
practitioner's affiliation with the CCO for serious quality of care or service issues.						tracking, and resolving potential quality of care issues. As noted in the policy, Molina investigates potential quality of care issues, documents the results of the investigation, initiates a Quality Improvement Plan as indicated, tracks case resolution, and reports individual cases and noted trends to the appropriate quality committee. Onsite discussion confirmed cases and trends are reported to the Potential Quality of Care Committee. Membership of this committee includes physicians with a variety of specialties and a physician assistant. Procedure MHMS-PC-09, MHMS Provider Termination Process, outlines the process followed when a provider is terminated for cause, including quality of care. As noted, Molina notifies the affected provider in writing of the reason(s) for the termination. The notification also includes contact information for questions, appeal/review rights, the effective date, and information about continuation of care for the member. Molina notifies DOM of the termination within 48 hours.
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 are defined in Policy MHMS-QI-006, Access to Care, the CHIP Provider Manual, and on Molina's CHIP website. The CHIP Provider Manual, page 69, defines the appointment access standard for urgent BH/SUD visits as "Not to exceed twenty-four (24) calendar days." However, the contractual standard (*CHIP Contract,*

Standard	Score					Comments
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						Section 7 (B) 2) and the standard stated in Policy MHMS-QI-006 is within 24 hours. Additionally, Policy MHMS-QI-006, the CHIP Provider Manual, and the CHIP website define the timeframe for routine visits with BH/SUD providers as within 14 calendar days. However, the contractual requirement is within 21 calendar days. *Corrective Action Plan: Correct the appointment access timeframe for urgent and routine visits with BH/SUD providers in Policy MHMS-QI-006, in the CHIP Provider Manual, and on the CHIP website.*
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." Procedure MHMS-QI-006, Access to Care, states provider network adherence to access standards is monitored through provider access studies, member complaint data, and member satisfaction survey results. The Quality Improvement Department conducts quarterly appointment and after hours accessibility audits. Provider network adherence to access standards is monitored through provider access studies, member complaint data, and member

Standard	Score					Comments
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						satisfaction survey results. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends. Policy MHMS-QI-006, Access to Care, indicates the timeframe for routine BH/SUD visits is within 14 calendar days. However, the call study results indicate a timeframe of 21 calendar days is being used to measure appointment access. This was confirmed by documentation in the 2024 QI Program Evaluation. During onsite discussion, the reviewer requested the health plan to clarify whether the timeframe used for the call study was 14 or 21 calendar days. Molina did not provide the requested clarification. *Corrective Action Plan: When Molina's policy defines a different timeframe for appointment access than the standard defined by DOM in the contract and in the required reporting template, this must be measured and reported using both standards. Ensure call study staff/vendors are aware that both timeframes must be assessed to determine appointment access.*
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					Policy MHMS-PC-01, MHMS Provider Directory Requirements, states "Molina will develop, regularly maintain, and make available a Provider Directory specific to each of the covered populations: MississippiCAN and CHIP." This policy defines the elements that must be included in the provider directories. All required elements are included in the policy. Policy MHMS-PC-01 states the Provider Directory shall include "the following information for all physicians,

Standard	Score					Comments
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						specialists, hospitals, behavioral health providers, and any other provider types covered under this Contract: 4. Web site URL, as appropriate." Review of the web-based CHIP Provider Directory confirmed all required elements are included. The print version of the CHIP Provider Directory included all requirements except provider website URLs. Refer to *Federal Regulation § 438.10(h).* *Recommendation: Revise the print version of the CHIP Provider Directory to include provider website URLs, as required by Federal Regulation § 438.10(h).*
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Molina's processes for validating Provider Directory information are documented in Procedure MHMS-PC-01, MHMS Provider Directory Requirement. As noted, • Provider Directory reports are generated for all contracted providers, and outreach is conducted to each provider to determine of updates are needed. PDM processes received updates. • PDM monitors the online provider directory daily to ensure updates from the previous day are noted, the search function works as expected and returns accurate information, and the displayed data is consistent with the data in QNXT. • PDM conducts monthly audits of all provider data for compliance with requirements. • Quarterly reviews of Provider Configuration Management guidelines are conducted to ensure the information needed for the online directory is entered into QNXT in a manner or format that will

Standard	Score					Comments
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						push over to the online directory and meet requirements.
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					Provider access analysis, including panel capacity and time-distance studies demonstrate alignment with CMS network adequacy validation requirements.
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					The processes for initial provider orientation and ongoing education are documented in Policy MHMS-NM-018, Provider Education and Training. Provider Services staff are responsible for developing, conducting, and evaluating ongoing provider education and training programs. Provider Services collaborates with internal departments and external entities, including DOM, to determine training topics.
2. Initial provider education includes:						Policy MHMS-NM-018, Provider Education and Training, states initial provider orientation is conducted within 30 days after a provider becomes active in Molina's network. If a provider declines to participate in orientation, representatives document the information in a visit log on a Molina SharePoint site and mail the orientation materials and health plan contact information to the provider. Molina uses the New Provider Orientation Presentation for all orientations and maintains records of all orientations conducted.
2.1 A description of the Care Management system and protocols,	X					The CHIP New Provider Orientation PowerPoint document includes an overview of the Care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
including transitional care management;						Management Program, including staffing, Transition of Care functions, referrals to Care Management, inpatient management, emergency services, discharge planning, and related contact information. The CHIP Provider Manual, Section 7, covers Healthcare Services, including Utilization Management, Care Management, and Health Management.
2.2 Billing and reimbursement practices;	X					The CHIP New Provider Orientation PowerPoint and the CHIP Provider Manual provide information about billing and reimbursement practices and requirements.
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	X					The CHIP New Provider Orientation PowerPoint gives an overview of member benefits and refers the reader to the website for complete information. The CHIP Provider Manual, Section 6, details benefits and covered services.
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					The CHIP New Provider Orientation PowerPoint and CHIP Provider Manual addresses processes for specialist referrals. Review of the CHIP Provider Manual confirmed Molina appropriately addressed the corrective action plan from the previous EQR related to self-referral for behavioral health services.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					The CHIP New Provider Orientation PowerPoint addresses appointment access standards. The CHIP Provider Manual addresses appointment access standards and states providers are responsible for establishing a process to document missed appointments. The process should include noting

Standard	Score					Comments
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						missed appointments in the member's medical record, assessing whether a visit is indicated, and documenting efforts to contact the member in the medical record.
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					The CHIP Provider Manual addresses recommended standards of care, including Well-Baby and Well-Child screening requirements and services. It includes information about preventive services and related provider responsibilities.
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 provider's responsibility to follow up with Members who are non-compliant with Well-Baby and Well-Child screenings and services. It states that providers are expected to make reasonable efforts to ensure that Members receive the required Well-Baby and Well-Child screenings and services.
2.8 Medical record handling, availability, retention, and confidentiality;	X					The CHIP Provider Manual addresses medical record handling, availability, retention, and confidentiality requirements.
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					The CHIP New Provider Orientation PowerPoint and the CHIP Provider Manual address provider and member complaint, grievance, and appeal procedures, including provider disputes.
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 discusses pharmacy policies and procedures necessary for making informed prescription choices and the availability of a 3-day emergency supply of medication until authorization is complete. It includes information about provider adherence to DOM's PDL, the Single Pharmacy Benefit

Standard	Score					Comments
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						Administrator (Gainwell), and Physician-Administered Drugs.
2.11 Prior authorization requirements including the definition of medically necessary;	X					The CHIP New Provider Orientation PowerPoint and the CHIP Provider Manual address prior authorization requirements, including the definition of medical necessity, general requirements, options for submission of prior authorization requests, information needed to review requests, review timeframes, etc.
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					The CHIP Provider Manual the roles of a PCP and reassignment of members to another PCP.
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					The CHIP Provider Manual includes the process for communicating a provider's limitations on panel size to the CCO.
2.14 Medical record documentation requirements;	X					The CHIP Provider Manual covers required components of medical record documentation and states providers will be monitored for compliance with the standards.
2.15 Information regarding available translation services and how to access those services;	X					The CHIP New Provider Orientation PowerPoint addresses available translation services, how to access the services, and the use of 711 Relay services. Additionally, it includes a description of additional resources offered by Molina, such as low-literacy materials, documentation translations, alternate formats such as Braille, audio, or large font. The CHIP Provider Manual includes information about translation services and how to access these services.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					The CHIP Provider Manual informs that providers are expected to participate in Quality Programs.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.17 A description of the provider web portal;	X					The CHIP New Provider Orientation PowerPoint provides information about the provider web portal and indicates the portal is available 24/7. A hyperlink to the portal is included. The document includes functions available through the portal. Detailed information about the web portal is found in the CHIP Provider Manual.
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					The CHIP Provider Manual includes the required non-exclusivity statement.
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Processes and requirements for ongoing provider education are detailed in Policy MHMS-NM-018, Provider Education and Training. Ongoing training is provided annually, quarterly, or as needed, and is tracked on a SharePoint site. Training is provided through face-to-face/onsite visits, regional workshops, provider bulletins, newsletters, e-communications, webinars, mailings, website postings, and/or Provider Manual updates. Ten workshops are conducted in collaboration with DOM annually.
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are	X					Molina adopts CPGs and PHGs to reduce care variation and to enhance preventive health services. The guidelines serve as a standard of practice for providers and can be used to educate members on condition-specific care recommendations. Molina's National Quality Improvement Committee oversees the selection and approval of clinical practice

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
developed in conjunction with pertinent network specialists.						guidelines. Membership of the NQIC includes physicians and other health professionals. The guidelines are selected "based on scientific evidence and recommendations made by national clinically based organizations." CPGs are adopted based on relevance to the member population or to high risk, high cost, and problem prone members. PHGs focus on age/condition-specific recommendations relevant to the CCO's membership. Guidelines adopted by the NQIC are reported to the CCO's Quality Improvement Committee(s) for adoption by the health plan. All CPGs and PHGs are updated at least annually and as needed for new scientific evidence and/or when new/revised national guidelines are published. These processes are detailed in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.
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 and Procedure MHMS-QI-018, Molina disseminates CPGs and PHGs to providers through: • Inclusion in new provider orientation materials with discussion during orientation visits. • Provider Manuals and/or Provider Manual inserts • Provider newsletters and special/targeted mailings • Fax blasts followed by mailings to providers without fax numbers.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	• Online distribution with written notifications (fax, email, or mail) sent to inform providers of online availability. • Paper copies upon request. The CHIP Provider Manual includes an overview of CPGs and PHGs and directs providers to the website to obtain the guidelines. Review confirmed that information about and links to the adopted CPGs and PHGs are included on the CHIP provider website. However, the following issues were noted: • Non-functional hyperlinks were noted for the following for two guidelines (Acute Stress and Post-Traumatic Stress Disorder and Anxiety/Panic Disorder). <u>During the previous EQR, non-functional links were to guidelines were found on the CHIP website. This was not corrected.</u> • Passwords and/or membership was required for the Perinatal Care guideline from the American College of Obstetricians and Gynecologists and Detoxification and Substance Abuse Treatment from SAMHSA. Onsite discussion revealed that Molina can provide printed copies of these guidelines to providers upon request. • The Fostering Resilience and Recovery: A Change Package for Advancing Trauma-Informed Primary Care hyperlink takes user to The National Council for Mental Wellbeing's main website rather than to the guideline.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Correct the non-functional and erroneous hyperlinks to guidelines on the website. Consider creating a library of guidelines on the website rather than using hyperlinks, particularly for guidelines that require membership/passwords to access. The review found the guidelines are consistent when comparing the CAN and CHIP websites. This confirms that Molina implemented the corrective action plan from the previous EQR to "Revise the CHIP website to include the same guidelines as those listed on the CAN website."
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Well-Baby and Well-Child services;	X					Adopted guidelines include: • Preventive Pediatric Health Care • Pediatric/Adolescent Preventive Services Recommendations • Pediatric Vision Screening • Dental Health
3.2 Recommended childhood immunizations;	X					Adopted guidelines include: • Recommended Child and Adolescent Immunization Schedule
3.3 Pregnancy care;	X					Adopted guidelines include: • Perinatal Care • Routine Prenatal and Postnatal Care
3.4 Recommendations specific to member high-risk groups;	X					Adopted guidelines include: • Promoting Health for Children and Youth with Special Health Care Needs

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Assessment and Management of Patients at Risk for Suicide • Adapting Your General Recommendations for the Care of Homeless Patients
3.5 Behavioral health.	X					Adopted guidelines include: • Acute Stress and Post-Traumatic Stress Disorder • Anxiety/Panic Disorder • Diagnosis, Evaluation, and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents • Identification, Evaluation, and Management of Children With Autism Spectrum Disorder • Bipolar Disorder • Treatment of Patients with Major Depressive Disorder • Use of Medications in the Treatment of Addiction Involving Opioids • CDC Guideline for Prescribing Opioids for Chronic Pain • Schizophrenia • Detoxification and Substance Abuse Treatment • Fostering Resilience and Recovery: A Change Package for Advancing Trauma-Informed Primary Care
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					Policy and Procedure MHMS-QI-124, Standards of Medical Record Documentation, outlines the standards for medical record documentation. Required documentation elements are also included in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the CHIP Provider Manual. The information is consistent across the policy and the Provider Manual.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.		X				Policy MHMS-QI-124, Standards of Medical Record Documentation, states Molina conducts medical record audits every three years. Molina had reported during the previous EQR that the CCO was planning to move to an annual review cycle; however, during onsite discussion for the current EQR, staff reported that it was decided to stay on a three-year cadence. Policy MHMS-QI-124 describes the medical record review process, including: • Molina reviews a minimum of 10 records per provider, with a representative sample of network providers included. • Passing scores are 80% or higher. Scores below 80% require over-read. If the score for the over-read is <80%, a reaudit is required before issuing a corrective action plan. • Applicable providers receive written notification of deficiencies requiring corrective action within 30 days. Providers must respond within 30 days and implement corrective actions within 180 days. • Molina conducts a reaudit after 180 days to determine the effectiveness of corrective action. • Audit results are reported to the Quality Improvement Committee. Molina staff confirmed the next audit will be conducted in 2026.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Page 9 of Policy MHMS-QI-124 states providers who are noncompliant with corrective actions are referred to the Peer Review Committee for consideration during recredentialing. However, due to the implementation of centralized credentialing in 2022, Molina does not conduct credentialing activities or make credentialing decisions. A recommendation was given during the 2024 EQR to revise this language in the policy. *Corrective Action Plan: Revise Policy MHMS-QI-124 to remove the incorrect language regarding credentialing providers or add an addendum to the policy to include Mississippi-specific information.*
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					Provider survey was conducted by a certified vendor. Survey methods, sampling, and administration were consistent with federal expectations.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Survey results were analyzed to identify provider concerns and areas needing improvement including communication, administrative burden, and provider directory accuracy.
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					Survey findings were shared with the CCO's oversight committees and leadership. The CCO performed root cause analysis, documented improvement strategies, and committee level discussions to ensure that survey-identified quality concerns are addressed and tracked.

Member Services

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

The Member Services Review includes member rights and responsibilities, member education, call center processes, enrollment and disenrollment, member satisfaction survey validation, grievance processes, and processes for practitioner changes.

Member rights and responsibilities are outlined in policy, the CAN and CHIP Member Handbooks, the Provider Manuals, in new member materials, and on Molina's website.

Information about the health plan, coverage, programs, and services via new member materials, the CAN and CHIP Member Handbooks, the Guide to Getting Quality Health Care, etc. The Member Handbooks provide the phone number for the Member Services Call Center, which can assist members with 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.

Molina's marketing processes ensure that member materials are provided at the appropriate reading level 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 Call Center metrics for performance trends, which are reported to the Quality Improvement and Health Equity Transformation Committee, to address identified opportunities for improvement.

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. Call Center staff are trained to inform members about available resources or recommended services.

Grievances

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

Processes for filing verbal and written grievances are described in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN and CHIP Member Handbooks, the Provider Manuals, and on Molina's website. Definitions and timeframes associated with the acknowledgement and resolution of grievances are also included. Grievances are categorized and monitored each quarter for trends by the Quality Improvement and Health Equity Transformation Committee.

The sample of grievance files reviewed revealed several issues. Several CAN and CHIP grievance files showed documentation gaps, including missing or undated resolution and extension letters,

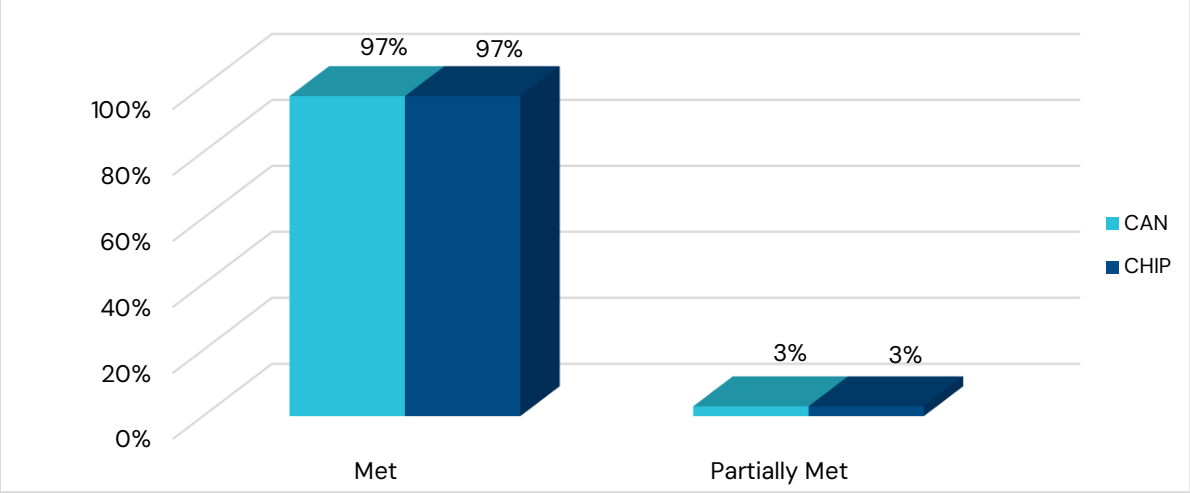
incomplete investigative notes, and lack of documentation on internal follow-up for issues. Some CAN grievances were also closed with notes indicating they would remain open for further investigation.

Member Satisfaction Survey Validation

As contractually required, Molina conducted the adult and child CAHPS surveys. Molina contracts with Press Ganey to do both the child and adult member surveys for CAN and CHIP. Using *Protocol 6: Administration or Validation of Quality of Care Surveys* developed by CMS, Constellation conducted a validation of the satisfaction surveys and found the surveys met the validation requirements. Refer to the survey worksheets in *Attachment 3*.

For the 2025 EQR, 97% of the Member Services standards for both CAN and CHIP were scored as "Met" (*Figure 5*).

Figure 5: Member Services Findings



Strengths, weaknesses, and corrective actions for the Member Services section are included in the table below.

Table 16: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Member rights and responsibilities are clearly outlined in CAN and CHIP member materials, and website.	✓		✓
Molina's marketing processes ensure that member materials are provided at the appropriate reading level and in alternate languages and formats.	✓		✓
Member Handbooks include information about the 24-Hour Nurse Advice Line and functions available through the MyMolina.com member portal.			✓

Strengths	Quality	Timeliness	Access to Care
Information about preventive health programs and resources is provided to members in a variety of ways, including telephone/text alerts, mobile/RV units, the Guide to Getting Quality Health Care, the website, and community events, to enhance member education.			✓

Table 17: Member Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
A sample of grievance files were selected for the 2025 EQR and found the following issues. • Two CAN grievances were closed with notes indicating that the file would remain open for further investigation. • One CAN file did not include a resolution letter to the member. • One CAN grievance extension letter was undated. • One CHIP grievance file did not include a resolution letter. • Some CAN and CHIP grievance files did not include investigative notes about internal follow-up reporting for identified issues such as HIPAA breaches, FWA, credentialing, etc.	*Corrective Action: Ensure that steps are taken to demonstrate compliance for the management of grievance files per policy MHI-A&G-02: Core Medicaid Grievances.*	✓		

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, the CAN Provider Manual, and the website document member rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					Policy, MHMS-ME-003, Member Rights and Responsibilities, the CAN Member Handbook, the CAN Provider Manual, and the website clearly document member rights.
2.1 To be treated with respect and dignity;						The CAN Member Handbook includes the right to be treated with dignity and respect.
2.2 To privacy and confidentiality, both in their person and in their medical information;						Members are informed of their right to privacy and confidential care in the CAN Member Handbook.
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;						The member's right to receive information about available options based on treatment needs is included in the CAN Member Handbook and on the website.
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						Members are made aware of their right to refuse any treatment, except as otherwise provided by law, in the CAN Member Handbook.
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;						Information about the right to request and receive a copy of medical records, and request that they be amended or corrected is included in the CAN Member Handbook.
2.6 To receive information in accordance with 42 CFR §438.10 which						Members have the right to receive information in a manner and format that may be easily understood.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						Translated services are explained to members in new member materials and in the CAN Member Handbook.
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;						The right to receive services free from any form of restraint or seclusion are assured in the CAN Member Handbook.
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;						The assurance of the right to freely exercise member rights without adversely affecting care is clearly indicated in the CAN Member Handbook.
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						The right to take part in health care services and to make decisions about services is indicated in the CAN Member Handbook.
3. Member responsibilities include the responsibility:	X					Policy, MHMS-ME-003, Member Rights and Responsibilities, the CAN Member Handbook, the CAN Provider Manual, and the website clearly document member responsibilities.
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;						Members are informed of their responsibility to pay for unauthorized health care services obtained from non-participating providers and their right to obtain authorization for such services.
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						The responsibility to provide health care information essential to the rendition of optimal care is outlined clearly in the CAN Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						Members are responsible for following instructions and guidelines for care that they have agreed upon with those providing health care services.
3.4 To show courtesy and respect to providers and staff;						The demonstration of courtesy and respect for providers and staff is included in the list of member responsibilities in the CAN Member Handbook.
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						It is the responsibility of members to notify Molina of any changes in family size, address changes, or other health care coverage, as described in the CAN Member Handbook.
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					The Guide to Getting Quality Health Care is provided in new member materials, along with the CAN Member Handbook and website, which contains information about benefits, limits or coverage, prior authorization requirements, and 24-hour access to care.
1.1 Full disclosure of benefits and services included and excluded in coverage;						Molina outlines benefits in detail in the CAN Member Handbook, new member materials, and website.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						The CAN Member Handbook provides information about preventive health services from a women's health provider without prior authorization or PCP referral.
1.1.2 Benefits include access to 2nd opinions at no cost including use of						If a member disagrees with a provider's plan of care, they have the right to get a second opinion, including an out-of-network provider at no cost.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						The benefits grid outlines available services, services at no cost, limits of coverage, and maximum allowable services.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Members are educated about requirements for prior approval of medical care.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						If a Molina provider is unable to provide necessary and covered services, the process for obtaining coverage from an out-of-network provider is described in the CAN Member Handbook.
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Information about the Nurse Advise Line is clearly indicated the CAN Member Handbook, website, and is provided on member ID cards.
1.6 Policies and procedures for accessing specialty/referral care;						Members are educated about procedures and requirements for accessing specialty/referral care;
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						Members are provided with information about policies and procedures for obtaining prescription medications and medical equipment.
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;						Members will be informed of changes to programs and benefits within 30 calendar days prior to implementation.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 A description of the member's identification card and how to use the card;						The Guide to Getting Quality Health Care and the Member Handbook describe the information contained on and uses of the Member ID 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;						Information about the functions of and steps to select a PCP is clearly outlined in the CAN Member Handbook.
1.11 Procedure for making appointments and information regarding provider access standards;						New members are informed to contact their PCP right away to schedule, cancel, or reschedule an appointment. Members are also instructed to call Molina for assistance making an appointment, finding a provider, or finding information about a PCP.
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						Contact information and roles of the Molina's Member Services call center are described in detail in new member materials and the CAN Member Handbook.
1.13 A description of EPSDT services;						All members under the age of 21 are eligible to receive EPSDT services. These services are provided without limitation.
1.14 Procedures for disenrolling from the CCO;						Policy MHMS-ME-10, Disenrollment Survey, the CAN Member Handbook, and member materials describe process for assisting with member disenrollment.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						Steps for filing verbal and written grievances and appeals are found in the CAN Member Handbook, new member materials, and website.
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						Members may use the Provider Directory of contact Member Services to obtain information about providers and alternate languages spoken by a provider's office.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						Information is available to members about the purpose and steps to access Care Management services in the CAN Member Handbook.
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					Members are informed of changes to programs and benefits within 30 calendar days prior to implementation.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy MHMS-COMM-01, Member Communication Standards, describes Molina's approach to ensuring that member materials are written at the appropriate reading level, meet accessibility requirements, and are provided in alternate languages if needed.
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					Members are informed that they can call the 24-hour Nurse Advice Line in the CAN Member Handbook, Member ID Card, The Guide to Getting Quality Health Care, and website.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					The CAN Member Handbook, the CAN Provider Manual, The Guide to Getting Quality Health Care, and Molina's website describe processes addressing member grievances, denials, and appeals.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					Policy MHMS-COMM-01, Member Communication Standards, indicates that member materials are marketed to meet state and federal requirements.
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					Member materials clearly provide the Call Center hours as Monday to Friday 7:30 a.m. - 8:00 p.m. (CST) and the 2nd Saturday and Sunday of the Month from 8:00 a.m. - 5:00 p.m. (CST).
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 new hire and quarterly training for Call Center staff, including the use of scripts 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					Call Center performance measures are reported to the Member and Provider Satisfaction Committee and the Quality Improvement and Health Equity Transformation Committee each quarter. Data points monitored include percentage call abandoned rates and average queue wait time.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Information on steps to select a Primary Care Provider is clearly outlined in the CAN and Member Handbook. Members may select a PCP from the Provider Directory.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHMS-ME-10, Disenrollment Survey, the CAN Member Handbook, and member materials describe process for assisting with member disenrollment. Members may change their plan selection within the first 90 days of Enrollment and thereafter during open enrollment periods.
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), the CAN Member Handbook, and website describe processes for providing health education to members and encourages members to utilize recommended services.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					The CAN Member Handbook instructs members to notify their PCP who will assist with scheduling with an OB/GYN. Benefits for pregnant members are described on Molina's website.
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					The CAN Member Handbook and website indicate that all children and adolescents under the age of 21 who are Molina members are eligible to receive EPSDT Services. These services are provided without limitation.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					The CAN Member Handbook informs members about free programs to help manage weight, stop smoking, or help with chronic diseases. Members receive learning materials and care tips.
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					Molina reports the member satisfaction survey results to providers via newsletters.
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 2025.
III G. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MHI-A&G-02, Core Medicaid Grievances Policy, the CAN Member Handbook, the CAN Provider Manual, and Molina's website describe processes for handling member grievances.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					A grievance is defined in member and provider materials and on the website as a complaint about Molina or a health care provider.
1.2 The procedure for filing and handling a grievance;	X					Processes and options for filing a verbal or written grievance are outlined in the CAN Member Handbook and on the website.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					Timeframes for grievance resolutions are clearly indicated in the CAN Member Handbook and on the 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					Procedure MHI-A&G-02.1, Core Medicaid Grievances, indicates that all oral grievances are converted to a written record in the appeals and grievances application and logged accordingly to track resolution.
2. The CCO applies the grievance policy and procedure as formulated.		X				A sample of grievance files were selected for the 2025 EQR and found the following issues. • Two CAN grievances were closed with notes indicating that the file would remain open for further investigation. • One CAN file did not include a resolution letter to the member. • One CAN grievance extension letter was undated. • Some CAN grievance files did not include investigative notes about internal follow-up

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reporting for identified issues such as HIPAA breaches, FWA, credentialing, etc. *Corrective Action: Ensure that steps are taken to demonstrate compliance for the management of grievance files per policy MHI-A&G-02: Core Medicaid Grievances.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					The Quality Improvement and Health Equity Transformation Committee Meeting minutes detail patterns of CAN grievances along with identified opportunities for improvement and achieved goals.
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					Policy HP-03, Privacy and Confidentiality of Protected Health Information (PHI), describes Molina's approach to the use, creation, collection, storage, transmission, access to and disclosure of PHI.
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					The Standard Operating Procedures document entitled Disenrollment Requests Medicaid MS states that members who have voluntarily disenrolled may still file a grievance with Molina for incidents that occurred when they were covered.
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					Grievances, including requests to change PCPs due to dissatisfaction, are evaluated for trends, which are reported quarterly to the Quality Improvement and Health Equity Transformation Committee.

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, the CHIP Provider Manual, and the website document member rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					Policy, MHMS-ME-003, Member Rights and Responsibilities, the CHIP Member Handbook, the CHIP Provider Manual, and the website clearly document member rights.
2.1 To be treated with respect and dignity;						The CHIP Member Handbook includes the right to be treated with dignity and respect.
2.2 To privacy and confidentiality, both in their person and in their medical information;						Members are informed of their right to privacy and confidential care in the CHIP Member Handbook.
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;						The member's right to receive information about available options based on treatment needs is included in the CHIP Member Handbook and on the website.
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						Members are made aware of their right to refuse any treatment, except as otherwise provided by law, in the CHIP Member Handbook.
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;						Information about the right to request and receive a copy of medical records, and request that they be amended or corrected is provided in the CHIP Member Handbook.
2.6 To receive information in accordance with 42 CFR §438.10 which						Members have the right to receive information in a manner and format that may be easily understood.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						Translated services are explained to members in new member materials and in the CHIP Member Handbook.
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;						The right to receive services free from any form of restraint or seclusion are assured in the CHIP Member Handbook.
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;						The assurance of the right to freely exercise member rights without adversely affecting care is clearly indicated in the CHIP Member Handbook.
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						The right to take part in health care services and to make decisions about services is indicated in the CHIP Member Handbook.
3. Member responsibilities include the responsibility:	X					Policy, MHMS-ME-003, Member Rights and Responsibilities, the CHIP Member Handbook, the CHIP Provider Manual, and the website clearly document member responsibilities.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						Members are informed of their responsibility for paying for unauthorized healthcare services obtained from non-participating providers and their right to obtain authorizations for such services.
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						The responsibility to provide health care information essential to the rendition of optimal care is outlined clearly in the CHIP Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						Members are responsible for following instructions and guidelines for care that they have agreed upon with those providing health care services.
3.4 To show courtesy and respect to providers and staff;						The demonstration of courtesy and respect for providers and staff is included in the list of member responsibilities in the CHIP Member Handbook.
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						It is the responsibility of members to notify Molina of any changes in family size, address changes, or other health care coverage, as described in the CHIP Member Handbook.
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					The Guide to Getting Quality Health Care is provided in new member materials, along with the CHIP Member Handbook and website, which contains information about benefits, limits or coverage, prior authorization requirements, and 24-hour access to care.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						Molina outlines benefits in detail in the CHIP Member Handbook, new member materials, and website.
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						The CHIP Member Handbook provides information about preventive health services from a women's health provider without prior authorization or PCP referral.
1.1.2 Benefits include access to 2nd opinions at no cost including use of						If a member does not agree with a provider's plan of care, the right to a second opinion is available for an out-of-network provider at no cost.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						The benefits grid outlines available services, services at no cost, limits of coverage, and maximum allowable services.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Members are educated about requirements for prior approval of medical care.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						If a Molina provider is unable to provide necessary and covered services, the process for obtaining coverage through an out-of-network provider is described in the CHIP Member Handbook.
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Information about the Nurse Advise Line is clearly indicated the CHIP Member Handbook, website, and is provided on member ID cards.
1.6 Policies and procedures for accessing specialty/referral care;						Members are educated about procedures and requirements for accessing specialty/referral care;
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						Members are provided with information about policies and procedures for obtaining prescription medications and medical equipment.
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;						Members will be informed of changes to programs and benefits within 30 calendar days prior to implementation.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 A description of the member's identification card and how to use the card;						The Guide to Getting Quality Health Care and the Member Handbook describe the information contained on and uses of the Member ID 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;						Information about the functions of and steps to select a PCP is clearly outlined in the CHIP Member Handbook.
1.11 Procedure for making appointments and information regarding provider access standards;						New members are informed to contact their PCP right away to schedule, cancel, or reschedule an appointment. Members are also instructed to call Molina for assistance making an appointment, finding a provider, or finding information about a PCP.
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						Contact information and roles of Molina's Member Services call center are described in detail in new member materials and the CHIP Member Handbook.
1.13 A description of the Well-Baby and Well-Child services which include:						All members under the age of 21 are eligible to receive Well-Baby and Well-Child services. These services are provided without limitation.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						The CHIP Member Handbook describes Well Child Services that include the comprehensive beneficiary and family/medical history.
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						Pediatric health screenings are outlined in the CHIP Member Handbook to include, but not limited to length/ height, weight, head circumference, body mass index, and blood pressure measurements.
1.13.3 Comprehensive unclothed physical exam;						Well Child Services include the comprehensive unclothed physical exam among pediatric health screenings.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13.4 Immunizations appropriate to age and health history;						Recommended immunization schedule provided by the Advisory Committee on Immunization Practices. Well Child Services also include examinations for vision, dental, hearing and all medically necessary services.
1.13.5 Assessment of nutritional status;						The CHIP Member Handbook describes the Supplemental Nutrition Assistance and Women, Infants and Children Programs, as well as the nutritional assessment.
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						The CHIP Member Handbook includes tuberculin testing and lead screening and testing as components of periodic health screenings.
1.13.7 Vision screening;						The CHIP Member Handbook includes vision screening components of periodic health screenings.
1.13.8 Hearing screening;						The CHIP Member Handbook includes hearing screening components of periodic health screenings.
1.13.9 Dental and oral health assessment;						Well Child Services include dental assessment and counseling.
1.13.10 Developmental and behavioral assessment;						The CHIP Member Handbook list of pediatric health screenings includes developmental and behavioral health assessments.
1.13.11 Health education and anticipatory guidance; and						The CHIP Member Handbook anticipatory guidance in the list of components of periodic health screenings.
1.13.12 Counseling/education and referral for identified problems.						Options for member education are described in new member materials, CHIP Member Handbook, and website.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Procedures for disenrolling from the CCO;						Policy MHMS-ME-10, Disenrollment Survey, the CHIP Member Handbook and member materials describe process for assisting with member disenrollment.
1.15 Procedures for filing complaints/grievances and appeals;						Steps for filing verbal and written grievances and appeals are found in the CHIP Member Handbook, new member materials, and website.
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						Members may use the Provider Directory of contact Member Services to obtain information about providers and alternate languages spoken by a 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;						Information is available to members about the purpose and steps to access Care Management services in the CHIP Member Handbook.
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.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Members are informed of changes to programs and benefits within 30 calendar days prior to implementation.
3. Member program education materials are written in a clear and understandable	X					Policy MHMS-COMM-01, Member Communication Standards, describes Molina's approach to ensuring

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
manner, including reading level and availability of alternate language translation for prevalent non-English languages.						that member materials are written at the appropriate reading level, meet accessibility requirements, and are provided in alternate languages if needed.
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					Members are informed that they can call the 24-hour Nurse Advice Line in the CHIP Member Handbook, Member ID Card, The Guide to Getting Quality Health Care, and website.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					The CHIP Member Handbook, the CHIP Provider Manual, The Guide to Getting Quality Health Care, and Molina's website describe processes addressing member grievances, denials, and appeals.
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					Member materials clearly provide the Call Center hours as Monday to Friday 7:30 a.m. - 8:00 p.m. (CST) and the 2nd Saturday and Sunday of the Month from 8:00 a.m. - 5:00 p.m. (CST).
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 new hire and quarterly training for Call Center staff, including the use of scripts 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					Call Center performance measures are reported to the Member and Provider Satisfaction Committee and the Quality Improvement and Health Equity Transformation Committee each quarter. Data points

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitored include percentage call abandoned rates and average queue wait time.
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					Information on steps to select a Primary Care Provider is clearly outlined in the CHIP Member Handbook. Members may select a PCP from the Provider Directory.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHMS-ME-10, Disenrollment Survey, the CHIP Member Handbook and member materials describe process for assisting with member disenrollment. Members may change their plan selection within the first 90 days of Enrollment and thereafter during open enrollment periods.
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), the CHIP Member Handbook, and website describe processes for providing health education to members and encourages members to utilize recommended services.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					The CHIP Member Handbook instructs members to notify their PCP who will assist with scheduling with an OB/GYN. Benefits for pregnant members are described on Molina's website.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					The CHIP Member Handbook and website indicate that All children and adolescents under the age of 21 who are Molina members are eligible to receive EPSDT Services. These services are provided without limitation.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					The CHIP Member Handbook informs members about free programs to help manage weight, stop smoking, or help with chronic diseases. Members receive learning materials and care tips.
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 the results of the member satisfaction survey to providers.	X					Molina reports the member satisfaction survey results to providers via newsletters.
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 2025.
III G. Grievances *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MHI-A&G-02, Core Medicaid Grievances Policy, the CHIP Member Handbook, the CHIP Provider Manual, and Molina's website describe processes for handling member grievances.
1.1 Definition of a grievance and who may file a grievance;	X					A grievance is defined in member and provider materials and on the website as a complaint about Molina or a health care provider.
1.2 The procedure for filing and handling a grievance;	X					Processes and options for filing a verbal or written grievance are outlined in the CHIP Member Handbook and on the website.
1.3 Timeliness guidelines for resolution of the grievance;	X					Timeframes for grievance resolutions are clearly indicated in the CHIP Member Handbook and on the 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					Procedure MHI-A&G-02.1, Core Medicaid Grievances, indicates that all oral grievances are converted to a written record in the appeals and grievances application and logged accordingly to track resolution.
2. The CCO applies the grievance policy and procedure as formulated.		X				A sample of grievance files were selected for the 2025 EQR and found the following issues. • One CHIP grievance file did not include a resolution letter. • Some CHIP grievance files did not include investigative notes about internal follow-up

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reporting for identified issues such as HIPAA breaches, FWA, credentialing, etc. *Corrective Action: Ensure that steps are taken to demonstrate compliance for the management of grievance files per policy MHI-A&G-02: Core Medicaid Grievances.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Quality Improvement and Health Equity Transformation Committee Meeting minutes detail patterns of CHIP grievances along with identified opportunities for improvement and achieved goals.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					Policy HP-03, Privacy and Confidentiality of Protected Health Information (PHI), describes Molina's approach to the use, creation, collection, storage, transmission, access to and disclosure of PHI.
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					The Standard Operating Procedures document entitled Disenrollment Requests Medicaid MS states that members who have voluntarily disenrolled may still file a grievance with Molina for incidents that occurred when they were covered.
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					Grievances, including requests to change PCPs due to dissatisfaction, are evaluated for trends, which are reported quarterly to the Quality Improvement and Health Equity Transformation Committee.

Quality Improvement

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

For the 2025 EQR, Molina submitted its Quality Improvement Program Description. This document provides a comprehensive framework to advance healthcare quality, accessibility, and equity for members. The program is structured around defined processes and strategies that emphasize continuous improvement. It prioritizes the unique needs of members, particularly those with complex health conditions, through personalized care, effective case management, and culturally responsive services. In addition, it integrates behavioral health, chemical dependency, and substance use services while promoting health equity and reducing disparities. The Quality Improvement and Health Equity Transformation Committee approved the program description on March 26, 2025. On page four of the QI Program Description, under "Program Component 2," it states: "Molina contracts with, credentials, and recredentials individual practitioners, provider organizations, facilities, and institutions to deliver health care and services to members, particularly individuals with complex health issues." However, Molina does not perform provider credentialing or recredentialing. This discrepancy was noted in both the 2023 and 2024 EQRs and has not been corrected.

Molina monitors services provided to members with special needs by collecting and analyzing data on race, ethnicity, language, sexual orientation, gender identity, social determinants of health, and geography to identify disparities within the member population. These efforts are part of Molina's Health Equity and Cultural Competency Program, which is designed to ensure equitable, culturally responsive, and linguistically appropriate care throughout the healthcare continuum.

The Quality Improvement/Healthcare Services Work Plan outlines timelines to help Molina achieve its goals and objectives. It provides an analysis and evaluation of the Quality Improvement and Utilization Management programs for 2024 and 2025, detailing objectives, timelines, action plans, and results. Key areas addressed include program descriptions, committee structures, policies, interrater reliability, delegation oversight, credentialing, pharmacy, appeals, and performance improvement projects. The document demonstrates Molina's ongoing commitment to meeting regulatory requirements, improving healthcare quality, and addressing barriers through proactive strategies and continuous monitoring. However, the appointment access standards for behavioral health providers listed on pages 36 and 179 do not align with Policy MHMS-QI-006, Access to Care.

The Molina Board of Directors holds ultimate authority and accountability for the quality of care and services provided by Molina and oversees the direction of the Quality Improvement Program. Responsibility for the program is delegated to the Quality Improvement and Health Equity Transformation Committee, which is co-chaired by the Chief Medical Officer and the

Quality Lead. Voting members include external network physicians and practitioners, as outlined in the committee charter. These members may include primary care physicians, medical specialists, behavioral health practitioners, and non-physician providers such as pharmacists and psychologists. Currently, the committee includes three provider participants: two specializing in pediatrics and one in internal medicine.

Providers receive regular performance updates, including adherence to clinical practice guidelines, utilization data, and other key metrics. Molina engages contracted medical and behavioral health practitioners in the planning and implementation of clinical initiatives, such as Performance Improvement Projects and quality improvement activities.

Molina evaluates the effectiveness of its QI Program at least annually. The 2024 QI Program Evaluation offered a comprehensive review of the program's effectiveness, incorporating the results of QI activities completed or in progress during 2024. The evaluation concluded with recommendations for restructuring the program in 2025, with an emphasis on advancing health equity, improving member and provider satisfaction, and addressing barriers to enhance healthcare quality and outcomes. The 2024 QI Program Evaluation was approved by the Quality Improvement and Health Equity Transformation Committee in June 2025 and subsequently reported to the Board of Directors. The 2024 QI Work Plan (pages 63 and 65) references an annual review of HEDIS medical records and delegation oversight activities; however, the results of these audits were not included in the 2024 QI Program Evaluation.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation contracts with Aqurate to conduct a validation review of the HEDIS®, CMS Adult, and CMS Child Core Set PMs identified by DOM to evaluate their accuracy as reported by the CCO for the CAN and CHIP populations. Aqurate conducted the validation of the PM rates following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. Aqurate applies the three activities to support the auditing process per *42 CFR §438.330 (c)* and *§457.1240 (b)*. PM validation determines the extent to which the CCO followed the specifications established for the NCQA HEDIS measures and the CMS Adult and Child Core Set measures when calculating the PM rates. The final PM validation results reflected the measurement period of January 1, 2024, through December 31, 2024.

Performance Measure Validation Documentation Requested

Per the contract between Molina and DOM, Molina was required to submit HEDIS data to NCQA. To ensure the HEDIS rates were accurate and reliable, DOM required Molina to undergo an NCQA HEDIS Compliance Audit. Molina contracted with an NCQA-licensed organization to conduct the

HEDIS Compliance Audit. Molina was required to submit the Completed NCQA Record of Administration, Data Management, and Processes from the MY 2024 HEDIS Compliance Audit, associated supplemental documentation, NCQA and Interactive Data Submission System files, the 2024 HEDIS Compliance Audit Final Audit Reports, and the Adult and Child Core Set measure rates reported using only administrative data.

Aqurate also requested the NCQA certification for the certified measure code used to generate each of the HEDIS measures, source code review-related documents for measures not produced using NCQA certified code, the numerator positive case listings for the HEDIS and non-HEDIS measures, and the list of numerator compliant records and exclusions identified via medical record review. Additional follow-up items were requested based on the findings from the desk review and the virtual audit review.

Performance Measure Validation Process

The following activities were conducted for the PM validation for Molina.

Review of data management processes, including:

- The health plan's measurement policies and procedures.
- The table and field definitions to ensure the correct data were being used to calculate the selected measures.
- The health plan’s standard code mapping used in the calculation of measures.
- The health plan’s policies and procedures for safeguarding confidential information.
- Compliance with HEDIS technical specifications for calculating and reporting PMs per certified auditor report.

Algorithmic compliance evaluation, including:

- Complete source code and programming logic review that detailed the calculation of the numerator and denominator for the measure, including all intermediate data merges and data staging that were used to calculate the measure.
- Verification that all the correct clinical codes defined in the measure specification were used appropriately to calculate the measure.
- Verification that age groups and other measure stratification groups were correctly programmed as defined by the measure specification.

Aqurate reviewed Molina’s final audit reports, information systems compliance tools, and Interactive Data Submission System (IDSS) files approved by the NCQA-licensed organizations. 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. The main steps in the validation process included:

- 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 processes for the CCO was acceptable.
- Data Control — The CCO's organizational infrastructure must support all necessary information systems and quality assurance practices, and backup procedures need to ensure timely and accurate processing of data and provide data protection in the event of a disaster. Aqurate validated the CCO's data control processes and determined that the data control processes in place were acceptable.
- Performance Measure Documentation — Documentation provided by the CCO was used for validation of review findings. Supplementary information was provided via interviews and system demonstrations. Aqurate reviewed all related documentation, such as the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation.

A scoring worksheet was used to evaluate and validate the HEDIS measures in accordance with CMS's *EQR Protocol 2: Validation of Performance Measures*. This ensured the CCO accurately calculated and reported performance measures as outlined in the HEDIS Volume 2 Technical Specifications.

The validation process included multiple components, such as general measure elements, denominator and numerator elements, sampling methods, and reporting standards, using a structured set of audit elements. Each audit element was assigned a weighted point value based on its importance to overall data validity. Higher-weighted elements (e.g., data source accuracy, documentation, and programming adherence) were worth 10 points, while supporting or supplementary elements (e.g., sampling methodology or hybrid integration techniques) were assigned five points. Scoring was determined based on the following criteria:

Table 18: Audit Element Scoring

Audit Element Scoring	
MET (Fully Met)	Full point value awarded.
PARTIALLY MET	Partial credit awarded—5 points for 10-point elements and 3 points for 5-point elements.
NOT MET	Zero points awarded.

The overall validation score was calculated as a percentage, using the formula: (Total Points Earned ÷ Total Possible Points) × 100. This percentage score determines the Audit Designation. *Table 19* offers an overview of the audit categories and corresponding percentage ranges.

Table 19: Audit Designations based on Performance Measure Validation Results

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.

This scoring framework offers a consistent, transparent, and quantitative method for assessing the accuracy and reliability of reported HEDIS performance measures.

HEDIS Performance Measure Validation – CAN Program

All relevant HEDIS PMs for the current measure year (MY 2024) and the change from the current to previous year are reported in *Table 20*. Rates shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%).

Table 20: CAN HEDIS Performance Measure Results

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA)	55.60%	62.57%	6.97%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	56.69%	65.21%	8.52%
Counseling for Nutrition	47.45%	54.01%	6.56%
Counseling for Physical Activity	44.04%	50.61%	6.57%
Childhood Immunization Status (CIS)			
DTaP	69.34%	74.21%	4.87%
IPV	85.40%	89.29%	3.89%
MMR	85.64%	87.59%	1.95%

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
HiB	82.97%	87.59%	4.62%
Hepatitis B	88.81%	92.21%	3.40%
VZV	85.16%	86.86%	1.70%
Pneumococcal Conjugate	71.05%	73.48%	2.43%
Hepatitis A	76.64%	79.08%	2.44%
Rotavirus	69.10%	73.48%	4.38%
Influenza	18.73%	22.63%	3.90%
Combination #3	63.75%	69.10%	5.35%
Combination #7	53.53%	57.18%	3.65%
Combination #10	13.63%	19.46%	5.83%
Immunizations for Adolescents (IMA)			
Meningococcal	47.27%	52.31%	5.04%
Tdap	73.27%	78.35%	5.08%
HPV	13.03%	16.55%	3.52%
Combination #1	47.05%	51.58%	4.53%
Combination #2	12.19%	15.57%	3.38%
Lead Screening in Children (LSC)	64.48%	70.80%	6.32%
Cervical Cancer Screening (CCS)	46.83%	51.09%	4.26%
Chlamydia Screening in Women (CHL)			
16-20 Years	49.30%	50.19%	0.89%
21-24 Years	64.33%	55.59%	-8.74%
Total	53.26%	52.08%	-1.18%
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	18.93%	20.44%	1.51%
Oral Evaluation, Dental Services (3-5)	56.18%	58.55%	2.37%
Oral Evaluation, Dental Services (6-14)	57.21%	57.78%	0.57%
Oral Evaluation, Dental Services (15-20)	41.42%	41.49%	0.07%
Oral Evaluation, Dental Services (Total)	45.39%	48.20%	2.81%
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	9.20%	9.70%	0.50%
Topical Fluoride for Children (3-4)	18.59%	20.06%	1.47%
Topical Fluoride for Children (Total)	13.38%	14.74%	1.36%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
3-17 Years	84.00%	87.54%	3.54%
18-64 Years	75.05%	83.04%	7.99%
65+ Years	NA	NA	NA
Total	82.85%	86.90%	4.05%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	58.62%	47.33%	-11.29%

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Bronchodilator	76.72%	74.05%	-2.67%
Asthma Medication Ratio (AMR)			
5-11 Years	75.41%	85.32%	9.91%
12-18 Years	60.80%	79.34%	18.54%
19-50 Years	55.96%	72.46%	16.50%
51-64 Years	52.94%	64.00%	11.06%
Total	64.97%	80.37%	15.40%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	52.07%	61.31%	9.24%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	NA
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy - 21-75 years (Male)	79.13%	75.45%	-3.68%
Statin Adherence 80% - 21-75 years (Male)	65.93%	59.04%	-6.89%
Received Statin Therapy - 40-75 years (Female)	84.38%	75.00%	-9.38%
Statin Adherence 80% - 40-75 years (Female)	56.79%	61.67%	4.88%
Received Statin Therapy - Total	81.52%	75.26%	-6.26%
Statin Adherence 80% - Total	61.63%	60.14%	-1.49%
Cardiac Rehabilitation (CRE)			
Initiation - 18-64 Years	1.85%	2.00%	0.15%
Engagement1 - 18-64 Years	3.70%	2.00%	-1.70%
Engagement2 - 18-64 Years	3.70%	2.00%	-1.70%
Achievement - 18-64 Years	3.70%	0.00%	-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	1.85%	2.00%	0.15%
Engagement1 – Total	3.70%	2.00%	-1.70%
Engagement2 - Total	3.70%	2.00%	-1.70%
Achievement - Total	3.70%	0.00%	-3.70%
Effectiveness of Care: Diabetes			
Glycemic Status Assessment for Patients With Diabetes (GSD) ◇			
Glycemic Status <8.0%	47.20%	52.31%	5.11%
*Glycemic Status >9.0% **	45.74%	39.17%	-6.57%
Eye Exam for Patients With Diabetes (EED) ◇	55.23%	60.10%	4.87%
Blood Pressure Control for Patients With Diabetes (BPD) ◇	62.04%	65.94%	3.90%
Kidney Health Evaluation for Patients With Diabetes (KED) ◇			
18-64 Years	20.18%	29.01%	8.83%
65-74 Years	NA	NA	NA

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
75–85 Years	NA	NA	NA
Total	20.16%	28.92%	8.76%
Statin Therapy for Patients with Diabetes (SPD) ◇			
Received Statin Therapy	53.22%	57.53%	4.31%
Statin Adherence 80%	60.81%	53.40%	-7.41%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (DMH)			
1–17	23.78%	26.78%	3.00%
18–64	36.20%	36.36%	0.16%
65+	NA	NA	NA
Total	26.70%	29.22%	2.52%
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	59.23%	62.26%	3.03%
Effective Continuation Phase Treatment	39.91%	41.59%	1.68%
Follow-Up After Hospitalization for Mental Illness (FUH)			
6–17 years – 30-Day Follow-Up	66.79%	62.77%	-4.02%
6–17 years – 7-Day Follow-Up	38.09%	37.59%	-0.50%
18–64 years – 30-Day Follow-Up	48.23%	49.15%	0.92%
18–64 years – 7-Day Follow-Up	29.16%	27.40%	-1.76%
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	59.39%	57.52%	-1.87%
7-Day Follow-Up	34.53%	33.66%	-0.87%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
6–17 years – 30-Day Follow-Up	55.13%	49.37%	-5.76%
6–17 years – 7-Day Follow-Up	35.90%	35.44%	-0.46%
18–64 years – 30-Day Follow-Up	37.23%	46.56%	9.33%
18–64 years – 7-Day Follow-Up	25.55%	27.48%	1.93%
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	43.72%	49.37%	-5.76%
7-Day Follow-Up	29.30%	35.44%	-0.46%
Diagnosed Substance Use Disorders (DSU)			
Alcohol (Total)	1.47%	1.30%	-0.17%
Opioid (Total)	1.12%	1.02%	-0.11%
Other (Total)	3.24%	2.87%	-0.38%
Any (Total)	4.78%	4.31%	-0.48%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
13–17 years – 30-Day Follow-Up	NA	NA	NA
13–17 years – 7-Day Follow-Up	NA	NA	NA

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
18–64 years - 30-Day Follow-Up	39.08%	35.96%	-3.12%
18–64 years - 7-Day Follow-Up	25.29%	26.97%	1.68%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	39.96%	34.41%	-5.55%
7-Day Follow-Up	23.91%	25.81%	1.90%
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	21.88%	25.53%	3.65%
7-Day Follow-Up: 18+ Years	14.38%	18.44%	4.06%
30-Day Follow-Up: Total	22.75%	23.93%	1.18%
7-Day Follow-Up: Total	14.29%	16.56%	2.27%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16–64)	38.83%	32.69%	-6.14%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	38.83%	32.69%	-6.14%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD) ◇	74.48%	77.16%	2.68%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) ◇	63.64%	72.62%	8.98%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) ◇	62.19%	58.31%	-3.88%
Effectiveness of Care: Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 Months–17 Years	76.28%	74.54%	-1.74%
18–64 Years	58.91%	58.48%	-0.43%
65+ Years	NA	NA	NA
Total	74.87%	72.97%	-1.90%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
3 Months–17 Years	58.18%	60.16%	1.98%
18–64 Years	32.02%	30.94%	-1.08%
65+ Years	NA	NA	NA
Total	56.27%	57.39%	1.12%
Use of Imaging Studies for Low Back Pain (LBP) ◇	64.99%	67.85%	2.86%
Use of Opioids at High Dosage (HDO) *	1.51%	1.27%	-0.24%
Use of Opioids from Multiple Providers (UOP) *			
Multiple Prescribers	20.10%	16.69%	-3.41%
Multiple Pharmacies	3.65%	1.54%	-2.11%

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Multiple Prescribers and Multiple Pharmacies	2.60%	0.95%	-1.65%
Risk of Continued Opioid Use (COU) *			
18-64 years - >=15 Days Covered	8.66%	6.41%	-2.25%
18-64 years - >=31 Days Covered	4.37%	2.83%	-1.54%
65+ years - >=15 Days Covered	NA	NA	NA
65+ years - >=31 Days Covered	NA	NA	NA
Total - >=15 Days Covered	8.66%	6.41%	-2.25%
Total - >=31 Days Covered	4.37%	2.83%	-1.54%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20-44 Years	80.08%	84.90%	4.82%
45-64 Years	84.90%	84.49%	-0.41%
65+ Years	NA	NA	NA
Total	81.50%	84.76%	3.26%
Initiation and Engagement of AOD Dependence Treatment (IET)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	65.32%	68.37%	3.05%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	1.61%	5.10%	3.49%
Total: Initiation of AOD Treatment: 13-17 Years	68.87%	71.30%	2.43%
Total: Engagement of AOD Treatment: 13-17 Years	1.32%	5.22%	3.90%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	44.49%	43.81%	-0.68%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	7.22%	10.62%	3.40%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	65.93%	63.54%	-2.39%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	26.37%	29.17%	2.80%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	44.49%	41.63%	-2.86%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.40%	8.59%	3.19%
Total: Initiation of AOD Treatment: 18+ Years	46.88%	44.97%	-1.91%
Total: Engagement of AOD Treatment: 18+ Years	8.32%	11.73%	3.41%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	47.16%	46.47%	-0.69%

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.74%	10.37%	3.63%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	67.68%	64.29%	-3.39%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	24.24%	28.57%	4.33%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	48.89%	46.38%	-2.51%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.60%	7.97%	3.37%
Total: Initiation of AOD Treatment: Total	50.31%	48.37%	-1.94%
Total: Engagement of AOD Treatment: Total	7.23%	10.89%	3.66%
Prenatal and Postpartum Care (PPC) ◇			
Timeliness of Prenatal Care Under 21 (Admin only rate)	85.63%	87.71%	2.08%
Postpartum Care Under 21 (Admin only rate)	52.79%	58.55%	5.77%
Timeliness of Prenatal Care Over 21 (Admin only rate)	87.42%	89.22%	1.80%
Postpartum Care Over 21 (Admin only rate)	51.30%	57.21%	5.91%
Timeliness of Prenatal Care (Total per IDSS)	90.27%	91.97%	1.70%
Postpartum Care (Total per IDSS)	67.15%	66.91%	-0.24%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) ◇			
1-11 Years	61.24%	59.81%	-1.43%
12-17 Years	56.25%	65.96%	9.71%
Total	58.37%	63.06%	4.69%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	57.17%	59.47%	2.30%
15 Months-30 Months	67.98%	69.77%	1.79%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	45.05%	47.18%	2.13%
12-17 Years	35.00%	38.45%	3.45%
18-21 Years	18.29%	20.56%	2.27%
Total	40.16%	42.72%	2.56%
Antibiotic Utilization for Respiratory Conditions (AXR)			
3m-17	41.88%	44.78%	2.90%
18-64	35.95%	41.63%	5.68%
65+	NA	NA	NA
Total	41.10%	44.35%	3.25%
Plan All-Cause Readmissions (PCR-AD) ◇◇			
Observed Readmission Rate	9.88%	11.85%	1.97%
Expected Readmission Rate	10.14%	8.54%	-1.60%
*Observed/Expected (O/E) Ratio **	0.97%	1.39%	0.41%

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Outlier Rate	65.83%	77.51%	11.68%
ECDS Measures			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)			
The percentage of children and adolescents on antipsychotics who received blood glucose testing.	44.11%	45.13%	1.02%
The percentage of children and adolescents on antipsychotics who received cholesterol testing.	28.15%	29.69%	1.54%
The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	26.52%	27.91%	1.39%
Colorectal Cancer Screening (COL-E)			
46-50	18.15%	23.94%	5.79%
51-75	28.42%	31.03%	2.61%
Total	25.97%	29.45%	3.48%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)			
Initiation	46.63%	39.30%	-7.33%
Continuation	54.55%	48.94%	-5.61%
Breast Cancer Screening (BCS-E)	41.28%	42.29%	1.01%
Adult Immunization Status (AIS-E)			
Influenza 19-65	9.34%	7.72%	-1.62%
Influenza 66+	NA	NA	NA
Influenza Total	9.35%	7.72%	-1.63%
TdTdap 19-65	22.59%	26.25%	3.66%
TdTdap 66+	NA	NA	NA
TdTdap Total	22.57%	26.23%	3.66%
Zoster 50-65	3.27%	4.07%	0.81%
Zoster 66+	NA	NA	NA
Zoster Total	3.30%	4.10%	0.81%
Pneumococcal 66+	NA	NA	NA
Postpartum Depression Screening and Follow-Up (PDS-E)			
Screening: Under 21	NA	NA	NA
Follow-up: Under 21	NA	NA	NA
Screening: Over 21	NA	NA	NA
Follow-up: Over 21	NA	NA	NA
Screening: As reported in IDSS	0.59%	1.12%	0.52%
Follow-up: As reported in IDSS	NA	NA	NA
Prenatal Immunization Status (PRS-E)			
Influenza: Under 21	NA	NA	NA
Tdap: Under 21	NA	NA	NA
Combination: Under 21	NA	NA	NA
Influenza: Over 21	NA	NA	NA

HEDIS Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Tdap: Over 21	NA	NA	NA
Combination: Over 21	NA	NA	NA
Influenza: As reported in IDSS	9.74%	6.38%	-3.36%
Tdap: As reported in IDSS	29.30%	26.96%	-2.34%
Combination: As reported in IDSS	5.59%	4.02%	-1.57%

NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not required;
BR: Biased rate
**: Lower rate indicates better performance*
◇: Measure has "Trend with Caution" guidance from NCQA for MY 2024
◇◇: Measure has "Break in Trending" guidance from NCQA for MY 2024
∞: Change in rate not able to be calculated as prior rate for health plan was not reported

As shown in the table, the following measures showed a substantial improvement for the CAN population:

- Asthma Medication Ratio (AMR) Age 12-18, Age 19-50, Age 51-64 and Total indicators.
- Plan All-Cause Readmissions (PCR-AD) Outlier rate indicator. However, this measure has a Break in Trending guidance from NCQA for MY 2024.

One CAN measure showed a substantial decrease in the rate:

- Pharmacotherapy Management of COPD Exacerbation (PCE): Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid indicator.

Molina clarified that this can be attributed to the pharmacy carve-out that went into effect in July 2024.

HEDIS Performance Measure Validation - CHIP Program

All relevant HEDIS PMs for the MY 2024 and the change from the current to previous year are reported in *Table 21*. Rates shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%).

Table 21: CHIP HEDIS Performance Measure Results

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	56.69%	59.61%	2.92%
Counseling for Nutrition	41.36%	50.61%	9.25%
Counseling for Physical Activity	41.85%	49.15%	7.30%
Childhood Immunization Status (CIS)			
DTaP	84.44%	81.27%	-3.17%
IPV	93.37%	92.70%	-0.67%
MMR	93.95%	90.51%	-3.44%

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
HiB	92.22%	91.00%	-1.22%
Hepatitis B	88.47%	92.94%	4.47%
VZV	93.37%	89.54%	-3.83%
Pneumococcal Conjugate	82.71%	81.75%	-0.96%
Hepatitis A	86.74%	82.24%	-4.50%
Rotavirus	82.13%	81.51%	-0.62%
Influenza	23.63%	19.95%	-3.68%
Combination #3	74.93%	76.64%	1.71%
Combination #7	66.28%	64.96%	-1.32%
Combination #10	18.44%	15.57%	-2.87%
Immunizations for Adolescents (IMA)			
Meningococcal	55.96%	54.99%	-0.97%
Tdap/Td	89.54%	86.86%	-2.68%
HPV	20.19%	21.41%	1.22%
Combination #1	55.96%	54.74%	-1.22%
Combination #2	19.71%	20.44%	0.73%
Lead Screening in Children (LSC)	65.99%	57.42%	-8.57%
Chlamydia Screening in Women (CHL)			
16–20 Years	38.65%	38.82%	0.17%
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0–2)	29.34%	32.34%	3.00%
Oral Evaluation, Dental Services (3–5)	61.01%	61.96%	0.95%
Oral Evaluation, Dental Services (6–14)	64.30%	63.85%	-0.45%
Oral Evaluation, Dental Services (15–20)	49.01%	48.70%	-0.31%
Oral Evaluation, Dental Services (Total)	57.60%	57.33%	-0.27%
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1–2)	12.37%	14.11%	1.74%
Topical Fluoride for Children (3–4)	21.50%	25.92%	4.42%
Topical Fluoride for Children (Total)	17.91%	20.77%	2.86%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
3–17 Years	84.21%	88.00%	3.79%
18–64 Years	76.23%	83.87%	7.64%
Total	83.95%	87.88%	3.93%
Asthma Medication Ratio (AMR)			
5–11 Years	75.53%	91.14%	15.61%
12–18 Years	72.22%	76.62%	4.40%
19–50 Years	NA	NA	NA
51–64 Years	NA	NA	NA
Total	73.91%	83.97%	10.06%

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
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
Cardiac Rehabilitation (CRE)			
Initiation - 18-64 Years	NA	NA	NA
Engagement1 - 18-64 Years	NA	NA	NA
Engagement2 - 18-64 Years	NA	NA	NA
Achievement - 18-64 Years	NA	NA	NA
Effectiveness of Care: Diabetes			
Glycemic Status Assessment for Patients With Diabetes (GSD) ◇			
Glycemic Status <8.0%	NA	NA	NA
*Glycemic Status >9.0% **	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
Effectiveness of Care: Behavioral			
Diagnosed Mental Health Disorders (DMH)			
1-17	23.62%	26.20%	2.58%
18-64	20.79%	22.12%	1.33%
Total	23.42%	25.92%	2.51%
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	NA	NA	NA
Effective Continuation Phase Treatment	NA	NA	NA
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	64.71%	64.00%	-0.71%
6-17 years - 7-Day Follow-Up	34.31%	35.20%	0.89%
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	64.22%	63.36%	-0.86%
Total-7-day Follow-Up	33.94%	34.35%	0.41%
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
Total-30-day Follow-Up	NA	NA	NA
Total-7-day Follow-Up	NA	NA	NA
Diagnosed Substance Use Disorders (DSU)			

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Alcohol (Total)	0.11%	0.05%	-0.06%
Opioid (Total)	0.04%	0.00%	-0.04%
Other (Total)	0.56%	0.69%	0.13%
Any (Total)	0.60%	0.72%	0.12%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
30 days (13-17)	NA	NA	NA
7 Days (13-17)	NA	NA	NA
30 days (18-64)	NA	NA	NA
7 Days (18-64)	NA	NA	NA
30 days (65+)	NA	NA	NA
7 Days (65+)	NA	NA	NA
30 days (Total)	NA	NA	NA
7 Days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
30 days (13-17)	NA	NA	NA
7 days (13-17)	NA	NA	NA
30 days (18+)	NA	NA	NA
7 days (18+)	NA	NA	NA
30 days (Total)	NA	NA	NA
7 days (Total)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	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
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) ◇	NA	NA	NA
Effectiveness of Care: Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 months-17 Years	70.69%	68.92%	-1.77%
18-64 Years	65.26%	69.05%	3.79%
65+ Years	NA	NA	NA
Total	70.54%	68.92%	-1.62%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
3 Months – 17 Years	40.00%	42.12%	2.12%
18-64 Years	NA	NA	NA
65+ Years	NA	NA	NA
Total	39.89%	41.74%	1.85%

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Use of Imaging Studies for Low Back Pain (LBP) ◇	NA	NA	NA
Use of Opioids at High Dosage (HDO) *	NA	NA	NA
Use of Opioids From Multiple Providers (UOP) *			
Multiple Prescribers	NA	NA	NA
Multiple Pharmacies	NA	NA	NA
Multiple Prescribers and Multiple Pharmacies	NA	NA	NA
Risk of Continued Opioid Use (COU) *			
18–64 years – >=15 Days Covered	NA	NA	NA
18–64 years – >=31 Days Covered	NA	NA	NA
Access/Availability of Care			
Initiation and Engagement of AOD Dependence Treatment (IET)			
Initiation of AOD – Alcohol Abuse or Dependence (13–17)	NA	NA	NA
Engagement of AOD – Alcohol Abuse or Dependence (13–17)	NA	NA	NA
Initiation of AOD – Opioid Abuse or Dependence (13–17)	NA	NA	NA
Engagement of AOD – Opioid Abuse or Dependence (13–17)	NA	NA	NA
Initiation of AOD – Other Drug Abuse or Dependence (13–17)	NA	NA	NA
Engagement of AOD – Other Drug Abuse or Dependence (13–17)	NA	NA	NA
Initiation of AOD – Total (13–17)	NA	NA	NA
Engagement of AOD – Total (13–17)	NA	NA	NA
Initiation of AOD – Alcohol Abuse or Dependence (18+)	NA	NA	NA
Engagement of AOD – Alcohol Abuse or Dependence (18+)	NA	NA	NA
Initiation of AOD – Opioid Abuse or Dependence (18+)	NA	NA	NA
Engagement of AOD – Opioid Abuse or Dependence (18+)	NA	NA	NA
Initiation of AOD – Other Drug Abuse or Dependence (18+)	NA	NA	NA
Engagement of AOD – Other Drug Abuse or Dependence (18+)	NA	NA	NA
Initiation of AOD – Total (18+)	NA	NA	NA
Engagement of AOD – Total (18+)	NA	NA	NA
Initiation of AOD – Alcohol Abuse or Dependence (Total)	NA	NA	NA
Engagement of AOD – Alcohol Abuse or Dependence (Total)	NA	NA	NA
Initiation of AOD – Opioid Abuse or Dependence (Total)	NA	NA	NA
Engagement of AOD – Opioid Abuse or Dependence (Total)	NA	NA	NA

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Initiation of AOD – Other Drug Abuse or Dependence (Total)	NA	NA	NA
Engagement of AOD – Other Drug Abuse or Dependence (Total)	NA	NA	NA
Initiation of AOD – Total (Total)	58.82%	39.39%	-19.43%
Engagement of AOD – Total (Total)	0.00%	0.00%	0.00%
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
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	54.72%	60.00%	5.28%
Total	55.84%	54.05%	-1.79%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	69.03%	70.26%	1.23%
15 Months–30 Months	80.53%	79.04%	-1.49%
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	44.93%	47.66%	2.73%
12–17 Years	40.84%	40.78%	-0.06%
18–21 Years	22.74%	24.85%	2.11%
Total	41.65%	43.28%	1.63%
Antibiotic Utilization for Respiratory Conditions (AXR)			
3m–17	43.48%	46.47%	2.99%
18–64	39.27%	42.86%	3.59%
65+	NA	NA	NA
Total	43.35%	46.36%	3.01%
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
ECDS Measures			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)			
The percentage of children and adolescents on antipsychotics who received blood glucose testing	42.98%	47.62%	4.64%
The percentage of children and adolescents on antipsychotics who received cholesterol testing	27.27%	28.57%	1.30%

HEDIS Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	24.79%	26.19%	1.40%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)			
Initiation	47.78%	44.36%	-3.42%
Continuation	52.44%	47.95%	-4.49%
Adult Immunization Status (AIS-E)			
Influenza 19-65	NA	NA	NA
TdTdap 19-65	NA	NA	NA
Zoster 19-65	NA	NA	NA
Pneumococcal 19-65	NA	NA	NA
Postpartum Depression Screening and Follow-Up (PDS-E)			
Screening: Under 21	NA	NA	NA
Follow-up: Under 21	NA	NA	NA
Screening: As reported in IDSS	NA	NA	NA
Follow-up: As reported in IDSS	NA	NA	NA
Prenatal Immunization Status (PRS-E)			
Influenza: Under 21	NA	NA	NA
Tdap: Under 21	NA	NA	NA
Combination: Under 21	NA	NA	NA
Influenza: As reported in IDSS	NA	NA	NA
Tdap: As reported in IDSS	NA	NA	NA
Combination: As reported in IDSS	NA	NA	NA

NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not required
BR: Biased rate
**: Lower rate indicates better performance*
◇: Measure has "Trend with Caution" guidance from NCQA for MY 2024
◇◇: Measure has "Break in Trending" guidance from NCQA for MY 2024
∞: Change in rate not able to be calculated as prior rate for health plan was not reported

One CHIP measure demonstrated an improvement in the reported rate.

- The Asthma Medication Ratio (AMR) Age 5-11 and Total indicators.

One CHIP measure demonstrated a decrease in the reported rate.

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total), however this is mostly driven by a small eligible population which was 33 members for MY 2024.

CMS Core Set Measure Validation

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2024 and the previous year, MY 2023. The change from 2023 to 2024 is reported in the following table. Rate changes shown in green

indicate a substantial (>10 percentage point) improvement, and rates shown in red indicate a substantial (>10 percentage point) decline.

Table 22: CAN CMS Core Set Measure Rates

CMS Core Set Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Adult Core Set Measures			
Dental and Oral Health Services			
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD) *			
Ages 18 - 64	-	251.50	-
Ages 65 +	-	0.00	-
Total	-	251.35	-
Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD)	-	1.53%	-
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or Moderately Effective Contraception – 3 days	13.33%	12.61%	-0.72%
Most or Moderately Effective Contraception – 90 days	59.46%	53.76%	-5.70%
LARC - 3 Days	1.22%	1.05%	-0.17%
LARC - 90 Days Reported	12.38%	12.06%	-0.32%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or Moderately Effective Contraception Rate	24.81%	32.27%	7.46%
LARC Rate	2.85%	4.66%	1.81%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *			
Ages 18 - 64	24.06	18.70	-5.36
Ages 65+	0	0	0.00
Total	24.05	18.69	-5.36
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05) *			
Ages 40 - 64	41.63	41.96	0.33
Ages 65+	0	0	0.00
Total	41.55	41.86	0.31
HEART FAILURE ADMISSION RATE (PQI-08) *			
Ages 18 - 64	48.12	44.73	-3.39
Ages 65+	0	625	625.00
Total	48.1	45.07	-3.03
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) *			
Ages 18 - 39	0.63	2.95	2.32
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	8.94%	29.10%	20.16%
Ages 65+	NA	NA	NA
Total	8.80%	29.41%	20.61%

CMS Core Set Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD) *			
Ages 18 - 64	2.62%	1.25%	-1.37%
Ages 65+	NA	NA	NA
Total	2.62%	1.25%	-1.37%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD) *			
Ages 18 - 64	9.26%	7.11%	-2.15%
Ages 65+	NA	NA	NA
Total	9.26%	7.11%	-2.15%
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-64	2.89%	5.58%	2.69%
Ages 65+	NA	NA	NA
Total	2.89%	5.58%	2.69%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *			
Ages 18 - 64	79.59%	66.27%	-13.32%
Ages 65+	NA	NA	NA
Total	79.59%	66.27%	-13.32%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	61.19%	61.27%	0.08%
Prescription for Buprenorphine	56.16%	59.31%	3.15%
Prescription for Oral Naltrexone	3.65%	0.98%	-2.67%
Prescription for Long-Acting, Injectable Naltrexone	0.00%	0.00%	0.00%
Prescription for Methadone	1.37%	1.96%	0.59%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	7.51%	2.57%	-4.94%
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	5.94%	1.63%	-4.31%
Discussed or Recommended Cessation Medications: Ages 18 to 64	3.44%	1.14%	-2.30%
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	2.92%	1.14%	-1.78%
Percentage of Current Smokers and Tobacco Users: Age 65 and Older	3.74%	NA	NA
Advising Users to Quit: Age 65 and Older	0.00%	NA	NA
Discussing Cessation Medications: Age 65 and Older	0.00%	NA	NA
Discussing Cessation Strategies: Age 65 and Older	0.00%	NA	NA
Percentage of Current Smokers and Tobacco Users: Total	7.31%	2.57%	-4.74%
Advising Users to Quit: Total	5.63%	1.63%	-4.00%
Discussing Cessation Medications: Total	3.26%	1.14%	-2.12%
Discussing Cessation Strategies: Total	2.77%	1.14%	-1.63%

CMS Core Set Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Child Core Set Measures			
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	2.00%	2.59%	0.59%
Primary Care Access and Preventative Care			
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	37.47%	39.21%	1.74%
Age 2 Screening	49.84%	50.19%	0.35%
Age 3 Screening	46.38%	48.53%	2.15%
Total Screening	43.39%	44.49%	1.10%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or Moderately Effective Contraception – 3 days	1.16%	2.07%	0.91%
Most or Moderately Effective Contraception – 90 days	50.87%	59.09%	8.22%
LARC - 3 Days	0.58%	0.41%	-0.17%
LARC - 90 Days Reported	16.18%	14.05%	-2.13%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or Moderately Effective Contraception Rate	26.57%	28.32%	1.75%
LARC Rate	2.27%	2.87%	0.60%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	42.15%	44.58%	2.43%
Numerator 2 All Four Molars Sealed	28.30%	29.47%	1.17%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	1.03%	1.68%	0.65%
Ages 1-2	21.87%	24.15%	2.28%
Ages 3-5	52.34%	56.64%	4.30%
Ages 6-7	57.50%	59.90%	2.40%
Ages 8-9	56.74%	59.53%	2.79%
Ages 10-11	54.79%	56.10%	1.31%
Ages 12-14	48.45%	50.61%	2.16%
Ages 15-18	39.75%	41.31%	1.56%
Ages 19-20	22.82%	23.32%	0.50%
Total Ages <1-20	42.01%	46.10%	4.09%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	10.79%	11.06%	0.27%
Ages 3-5	23.97%	26.59%	2.62%
Ages 6-7	27.58%	27.71%	0.13%
Ages 8-9	26.18%	27.70%	1.52%
Ages 10-11	24.31%	24.92%	0.61%

CMS Core Set Measure/Data Element	MY 2023 CAN Rates	MY 2024 CAN Rates	Change from 2023 to 2024
Ages 12-14	20.56%	21.50%	0.94%
Ages 15-18	14.69%	14.84%	0.15%
Ages 19-20	5.79%	6.83%	1.04%
Total Ages 1-20	19.85%	21.31%	1.46%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	6.40%	6.47%	0.07%
Ages 3-5	22.12%	25.11%	2.99%
Ages 6-7	26.92%	27.01%	0.09%
Ages 8-9	25.67%	27.59%	1.92%
Ages 10-11	23.88%	24.92%	1.04%
Ages 12-14	20.19%	21.50%	1.31%
Ages 15-18	14.29%	14.84%	0.55%
Ages 19-20	5.57%	6.83%	1.26%
Total Ages 1-20	18.37%	20.20%	1.83%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	2.85%	3.12%	0.27%
Ages 3-5	0.31%	0.41%	0.10%
Ages 6-7	0.02%	0.07%	0.05%
Ages 8-9	0.07%	0.00%	-0.07%
Ages 10-11	0.05%	0.07%	0.02%
Ages 12-14	0.05%	0.05%	0.00%
Ages 15-18	0.06%	0.01%	-0.05%
Ages 19-20	0.00%	0.20%	0.20%
Total Ages 1-20	0.63%	0.59%	-0.04%
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	-	29.66%	-

NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not required
BR: Biased rate
**: Lower rate indicates better performance*
∞: Change in rate not able to be calculated as prior rate for health plan was not reported
-: New measure, no prior year or change data available for reporting.

Two CAN Core Set measures demonstrated an improvement in the reported rate.

- HIV Viral Load Suppression (HVL - AD) Ages 18 – 64 and Total.
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD). This is an inverse measure where lower rate shows better performance.

One CAN Core Set measure demonstrated a decrease in the reported rate.

- Heart Failure Admission Rate (PQI-08) Ages 65+. This is an inverse measure where lower rate shows better performance. However, the numerator was 0 for MY 2023 and 1 for MY 2024 and the rate change should be reviewed with caution.

Table 23: CHIP CMS Core Set Measure Rates

CMS Core Set Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Adult Core Set Measures			
Dental and Oral Health Services			
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD) *			
Ages 18 - 64	-	62.84	-
Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD)	-	NA	-
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD) *			
Ages 18 - 64	67.53	15.71	-51.82
HEART FAILURE ADMISSION RATE (PQI-08) *			
Ages 18 - 64	0.00	0.00	NA
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD) *			
Ages 18 - 39	9.65	0.00	-9.65
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	NA	NA	NA
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NA	NA	NA
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NA	NA	NA
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18-64	1.32%	1.64%	0.32%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) *			
Ages 18 - 64	NA	NA	NA
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	NA	NA	NA
Prescription for Buprenorphine	NA	NA	NA
Prescription for Oral Naltrexone	NA	NA	NA
Prescription for Long-acting, Injectable Naltrexone	NA	NA	NA
Prescription for Methadone	NA	NA	NA
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	NA	NA	NA
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	NA	NA	NA
Discussed or Recommended Cessation Medications: Ages 18 to 64	NA	NA	NA
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	NA	NA	NA
Child Core Set Measures			

CMS Core Set Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Behavioral Health Care			
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)			
Ages 12 - 17	1.71%	1.97%	0.26%
Primary Care Access and Preventative Care			
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	NA	NA	NA
Age 2 Screening	56.32%	50.83%	-5.49%
Age 3 Screening	53.00%	54.64%	1.64%
Total Screening	55.13%	52.74%	-2.39%
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	27.92%	24.67%	-3.25%
LARC Rate	2.43%	1.95%	-0.48%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	38.21%	43.60%	5.39%
Numerator 2 All Four Molars Sealed	25.71%	29.29%	3.58%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	NA	NA	NA
Ages 1-2	29.49%	32.75%	3.26%
Ages 3-5	58.81%	59.75%	0.94%
Ages 6-7	63.29%	65.03%	1.74%
Ages 8-9	66.53%	67.36%	0.83%
Ages 10-11	59.61%	62.98%	3.37%
Ages 12-14	58.50%	56.61%	-1.89%
Ages 15-18	46.66%	46.89%	0.23%
Ages 19-20	32.65%	33.47%	0.82%
Total Ages <1-20	54.52%	55.24%	0.72%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	15.35%	15.99%	0.64%
Ages 3-5	29.52%	32.69%	3.17%
Ages 6-7	32.36%	36.26%	3.90%
Ages 8-9	34.35%	36.68%	2.33%
Ages 10-11	28.47%	33.38%	4.91%

CMS Core Set Measure/Data Element	MY 2023 CHIP Rates	MY 2024 CHIP Rates	Change from 2023 to 2024
Ages 12–14	28.20%	27.28%	-0.92%
Ages 15–18	19.57%	20.60%	1.03%
Ages 19–20	9.52%	13.13%	3.61%
Total Ages 1–20	26.41%	28.21%	1.80%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1–2	10.18%	10.14%	-0.04%
Ages 3–5	28.11%	31.03%	2.92%
Ages 6–7	31.31%	35.90%	4.59%
Ages 8–9	33.90%	36.53%	2.63%
Ages 10–11	28.37%	33.38%	5.01%
Ages 12–14	27.51%	27.28%	-0.23%
Ages 15–18	18.75%	20.60%	1.85%
Ages 19–20	9.52%	13.13%	3.61%
Total Ages 1–20	25.38%	27.50%	2.12%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	3.23%	4.55%	1.32%
Ages 3–5	0.20%	0.38%	0.18%
Ages 6–7	0.16%	0.09%	-0.07%
Ages 8–9	0.00%	0.00%	0.00%
Ages 10–11	0.22%	0.08%	-0.14%
Ages 12–14	0.27%	0.00%	-0.27%
Ages 15–18	0.30%	0.04%	-0.26%
Ages 19–20	0.00%	0.00%	0.00%
Total Ages 1–20	0.38%	0.40%	0.02%
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	-	NA	-

NA: The plan followed the specifications, but the denominator was too small (<30) to report a valid rate
NQ: Not Required; BR: Biased Rate
**: Lower rate indicates better performance*
∞: Change in rate not able to be calculated as prior rate for health plan was not reported
-: New measure, no prior year or change data available for reporting.

One CHIP Core Set measure demonstrated an improvement in the reported rate.

- Diabetes Short-Term Complications Admission Rate (PQI01-AD). This is an inverse measure where lower rate shows better performance.

No CHIP Core Set measures demonstrated a decrease in the reported rate.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

Each CCO is required to submit the PIPs they have conducted during the preceding 12 months to Constellation for validation. For the 2025 EQR, Molina submitted the following PIPs:

Table 24: CAN Performance Improvement Projects Submitted for Validation

CCO	Performance Improvement Project	Performance Improvement Project Aim
Molina - CAN	Asthma	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.
	Chronic Obstructive Pulmonary Disease	Increase the rate of Medicaid members with pulmonary issues be dispensed a systemic corticosteroid within 14 days or a bronchodilator within 30 days of inpatient discharge or emergency department visit for a COPD related event.
	Follow Up after Hospitalization for Mental Illness	Increase the number of MSCAN members who receive follow-up within 7 and 30 days of discharge for selected mental illness.
	Prenatal and Postpartum Care	Increase the number of members who receive a prenatal care visit in the first trimester, on the enrollment date or within 42 days of enrollment. Increase the number of members who receive a postpartum care visit on or between 21 and 56 days of delivery.
	Sickle Cell Disease	Increase the percentage of members with sickle cell disease, who are enrolled and /or receive case management or follow-up services after hospitalization during the measurement year.
	Obesity	To increase the percentage of members who had an outpatient visit with a PCP or OB/GYN that includes a weight assessment counseling for nutrition, physical activity, and body mass index.

Table 25: CHIP Performance Improvement Projects Submitted for Validation

CCO	Performance Improvement Project	Performance Improvement Project Aim
Molina - CHIP	Asthma	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.
	Follow Up after Hospitalization	Increase the number of CHIP members who receive follow-up within 7 and 30 days of discharge for selected mental illness.
	Obesity	To increase the percentage of CHIP members who had an outpatient visit with a PCP or OB/GYN that includes weight assessment counseling for nutrition, physical activity, and body mass index.
	Well Care- Well Child	Increase the number of CHIP members who receive at least 6 or more well care/well child visits during the first 0 to 15 months of life and who turned 15 months old during the measurement year.

Technical Methods for Data Collection and Validation

PIP validation was conducted in accordance with CMS's *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

Constellation validates and scores the submitted PIPs using the CMS-designed protocol and proprietary worksheets to evaluate the validity and confidence in the results of each project. The proprietary worksheets were developed based on the requirements included in *Protocol 1*, which include the two activities displayed in *Table 26*.

Table 26: Constellation's PIP Validation Activities per CMS Protocol

Activity One: Assess the PIP Methodology		
Step	Description	Step Questions
1	Review the Selected PIP Topic(s)	Are the selected PIP topic(s) appropriate?
2	Review the PIP Aim Statement	How appropriate and adequate is the aim statement?
3	Review the Identified PIP Population	Did the Plan clearly identify the population for the PIP in relation to the PIP aim statement?
4	Review Sampling Methods	Are the sampling methods appropriate and will they produce valid and reliable results?
5	Review the Selected PIP Variables and Performance Measures	Do the selected variables identify the Plan's performance on the PIP questions objectively and reliably and use clearly defined indicators of performance?
6	Review Data Collection Procedures	Are the procedures the Plan used to collect the data that inform the PIP measurement valid and reliable?
7	Review Data Analysis and Interpretation of PIP Results	Were appropriate techniques used, and were the analysis and interpretation of PIP results accurate?
8	Assess Improvement Strategies	Did the Plan apply appropriate interventions for achieving improvement?
9	Assess the Likelihood that Significant and Sustained Improvement Occurred	What is the likelihood that significant and sustained improvement occurred as a result of the PIP?
Activity Two: Perform Overall Validation and Reporting of PIP Results		
1	Perform Validation	Using the worksheet, score steps in Activity 1 to answer: Were the steps considered met, partially met, or not met? Which category does the overall PIP validation

Activity One: Assess the PIP Methodology		
Step	Description	Step Questions
		score fall into: High Confidence, Confidence, Low Confidence, or Not Credible?
2	Report Results	Are recommendations and/or corrective actions documented in the PIP validation worksheet and the CCO's annual report?

The PIP validation process follows a structured, nine-step methodology designed to ensure accuracy, reliability, and meaningful healthcare improvements. Each PIP is systematically reviewed to assess topic selection, aim statement clarity, population identification, sampling methods, PMs, data collection, analysis, intervention strategies, and sustainability of improvement. This comprehensive approach evaluates the methodological soundness of each project, ensuring that findings are free from bias and capable of supporting data-driven decision-making.

A weighted scoring system is applied to each step, prioritizing critical areas that have the most significant impact on the validity of results. Higher weights are assigned to essential components, such as selecting appropriate PMs, using valid sampling techniques, and implementing meaningful improvement strategies. Other elements, including population documentation, data sources, and analysis procedures, are evaluated with proportionate weight to ensure a balanced and rigorous assessment. Each component is scored as "Met," "Not Met," or "Not Applicable" to provide a standardized and objective evaluation. Failure to meet key elements can significantly affect the overall credibility of the results.

The final validation score determines the level of confidence in the reported findings (refer to *Table 27*). Projects scoring 90 to 100% are classified as High Confidence, indicating strong methodological integrity with minimal documentation concerns. A Confidence rating between 70 and 89% suggests minor issues that introduce slight bias but do not compromise overall results. A Low Confidence rating between 60 to 69% signals major deviations from established methods that may impact data integrity, while projects scoring below 60% are deemed Not Credible, indicating significant flaws that prevent validation of the reported outcomes.

Table 27: Constellation's PIP Audit Designation Categories

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.*

Overview of PIP Validation Results

The following tables provide a summary of the validation results, project performance over time, and interventions for each of the PIPs. An arrow pointing up (↑) indicates that project's performance on the measure is improving. The down arrows (↓) indicate the project's performance on the measure is declining. Cells highlighted in green indicate a statistically significant improvement in performance; yellow-highlighted cells indicate a statistically significant decline in performance; and cells without highlighting indicate the change was not statistically significant.

Molina CAN submitted six CAN PIPs for validation, as shown in *Table 28*.

Table 28: Molina CAN PIP Performance Findings

PIP Topic	2025 Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
Asthma Medication Ratio	85/85=100% High Confidence in Reported Results	Percentage of members 5-64 years of age who were compliant for a ratio of controller medications to total asthma medications of 0.50 or greater.	66.0% (2021)	72.9%	68.2% ↑ (2022)	64.7% ↓ (2023)	84.8% ↑ (2024)*	87.17% ↑ (Q2 2025)
Pharmacotherapy Management of COPD Exacerbation	80/80=100% High Confidence in Reported Results	Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications.	40.0% (2021)	53.4%	47.1% ↑ (2022)	57.9% ↑ (2023)	62.1% ↑ (2024)*	48.9% ↓ (Q2 2025)
		Percentage of COPD exacerbations for MSCAN members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.	80.0% (2021)	81.8%	74.2% ↓ (2022)	77.2% ↑ (2023)	75.9% ↓ (2024)*	79.1% ↑ (Q2 2025)
Follow-up After Hospitalization for Mental Illness	85/85=100% High Confidence in Reported Results	Percentage of discharges for which the MSCAN members received follow-up within 30 days of discharge.	16.9% (2021)	50.0%	49.2% ↑ (2022)	52.1% ↑ (2023)	27.5% ↓ (2024)*	54.73% ↑ (Q2 2025)
		Percentage of discharges for which the MSCAN members received follow-up within 7 days of discharge.	8.1% (2021)	28.3%	30.3% ↑ (2022)	31.1% ↑ (2023)	19.66% ↓ (2024)*	34.41% ↑ (Q2 2025)
Prenatal and Postpartum Care	85/85=100% High Confidence in Reported Results	Percentage of deliveries that receive a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment	89.7% (2021)	93.6%	88.7% ↓ (2022)	87.0% ↓ (2023)	89.4% ↑ (2024)*	85.4% ↓ (Q2 2025)
		Percentage of deliveries that had a postpartum visit on or between 7 and 84 days of delivery.	30.8% (2021)	74.3%	48.4% ↑ (2022)	51.1% ↑ (2023)	35.4% ↓ (2024)*	50.0% ↑ (Q2 2025)

PIP Topic	2025 Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
Sickle Cell Disease	80/80=100% High Confidence in Reported Results	Percentage of members 6 years of age and older with sickle cell disease who receive case management services during the measurement year.	4.9% (2021)	15.9%	8.7% ↑ (2022)	9.5% ↑ (2023)	8.3% ↓ (2024)*	11.0% ↑ (Q2 2025)
Obesity	85/85=100% High Confidence in Reported Results	Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile during the measurement year.	12.6% (2021)	61.3%	27.9% ↑ (2022)	27.7% ↓ (2023)	14.0% ↓ (2024)*	20.9% ↓ (Q2 2025)
		Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	11.5% (2021)	52.3%	14.9% ↑ (2022)	15.7% ↑ (2023)	7.5% ↓ (2024)*	14.1% ↑ (Q2 2025)
		Percentage of MSCAN members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	8.4% (2021)	57.4%	15.5% ↑ (2022)	15.6% ↑ (2023)	7.3% ↓ (2024)*	12.4% ↑ (Q2 2025)

Statistically significant improvement in performance *Statistically significant decline in performance*

R1 – Remeasurement 1; R2 – Remeasurement 2;R3 – Remeasurement 3; 4th quarter rates are reported for remeasurements;

** Q1 2024 which is the most recent remeasurement as of validation*

Table 29: Molina CAN PIP Interventions

Interventions
Asthma Medication Ratio
• Molina continues to actively promote the LANDYNN Project across the state aimed at educating members and empowering asthmatic Molina members and communities • Asthma education video on proper use of inhalers • Asthma action plans for members • Provider education on controller prescribing • Case management for persistent asthma patients

Interventions
Pharmacotherapy Management of COPD Exacerbation
• Smoking Cessation Program that provides access to over-the-counter tobacco cessation products • Provider education tools on COPD clinical guideline • Quality Performance Tool Dashboard • Case management enrollment • Staff training
Follow-up After Hospitalization for Mental Illness
• Discharge planning protocols • Post-discharge follow-up calls • Case manager engagement with members • Coordination between behavioral health and PCPs • Crisis line promotion and member outreach
Prenatal and Postpartum Care
• OB provider outreach and engagement • Automated prenatal and postpartum reminders • Case management for high-risk pregnancies • Nurse home visiting program for postpartum support
Sickle Cell Disease
• Case management for high-risk members • Provider education SCD guidelines • Coordination with specialty hematology clinics • Patient education on hydroxyurea and preventive care
Obesity
• Provider training on BMI documentation • Parental reminders for well-child visits • Family nutrition and physical activity counseling • School-based wellness support • Expanded tracking through Molina's dashboard

Molina CHIP submitted four PIPs, as shown in *Table 30*.

Table 30: Molina CHIP PIP Performance Findings

PIP Topic	Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
Asthma Medication Ratio	85/85=100% High Confidence in Reported Results	Percentage of MS CHIP asthmatic members 5-19 years of age who were compliant for a ratio of controller medications to total asthma medications of 0.50 or greater (HEDIS AMR measure).	84.5% (2021)	72.9%	82.6% ↓ (2022)	75.8% ↓ (2023)	80.7% ↑ (2024)	92% ↑ (Q2 2025)
Follow-up After Hospitalization for Mental Illness	80/80=100% High Confidence in Reported Results	Percentage of discharges for which the CHIP members received follow-up within 30 days of discharge.	14.3% (2021)	50.0%	67.0% ↑ (2022)	55.0% ↓ (2023)	37.5% ↓ (2024)*	56.8% ↑ (Q2 2025)
		Percentage of discharges for which the CHIP members received follow-up within 7 days of discharge.	7.1% (2021)	28.3%	36.1% ↑ (2022)	32.0% ↓ (2023)	25.0% ↓ (2024)*	39.2% ↑ (Q2 2025)
Obesity	80/80=100% High Confidence in Reported Results	Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile during the measurement year.	0% (2021)	61.3%	23.1% ↑ (2022)	24.5% ↑ (2023)	11.1% ↓ (2024)*	18.8% ↑ (Q2 2025)
		Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.	0%	52.3%	13.2% ↑ (2022)	16.2% (2023)	6.4% ↓ (2024)*	14.0% ↑ (Q2 2025)
		Percentage of CHIP members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.	0%	57.4%	13.6% ↑ (2022)	15.6% (2023)	6.0% ↓ (2024)*	12.2% ↑ (Q2 2025)
Well Care/Well Child	80/80=100% High Confidence in Reported Results	The percentage of members who turn 15 months old during the measurement period who had six or more well-child visits with a PCP during their first 15 months of life.	42.6% (2021)	56.1%	72.8% ↑ (2022)	69.0% ↓ (2023)	63.1% ↓ (2024)*	63.3% ↑ (Q2 2025)

Statistically significant improvement in performance

Statistically significant decline in performance

R1 – Remeasurement 1; R2 – Remeasurement 2; R3 – Remeasurement 3; 4th quarter rates are reported for remeasurements; * Q1 2024 which is the most recent remeasurement as of validation

Table 31: PIP Interventions – Molina CHIP

Interventions
Asthma Medication Ratio
• Pharmacy adherence monitoring • Asthma action plans for pediatric members • Case management outreach for families • Provider education on controller prescribing • Use of MHMS dashboard for real-time tracking
Follow-up After Hospitalization for Mental Illness
• Hospital discharge planning protocols • Case manager follow-up calls at 7 and 30 days • Provider outreach • Integration of behavioral health with PCP follow-up care • Crisis line prometon and member education
Obesity
• Provider training on BMI documentation • Automated reminder for parents about well-child visits • School-based wellness and health promotion campaigns • Pediatric nutrition counseling and physical activity counseling • Expanding monitoring through MHMS Quality Dashboard
Well Care/Well Child
• Extended pediatric clinical hours (evening/weekends) • Automated text reminders for families. • Telehealth availability for preventive care appointments • Targeted outreach for infants, adolescents, and high-risk members • Case management follow-up form members missing multiple visits

Constellation provided recommendations for five PIPs wherein a decline in at least one indicator was identified. These are displayed in *Table 32*.

Table 32: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Management of COPD	Result	Minimal (non-statistically significant) improvement and below benchmark.	Strengthen care management model, expand, provider engagements and implement stronger follow-up scheduling and tracking systems.
Prenatal and Postpartum Care	Result	Postpartum visits remained below benchmark	Increase postpartum outreach, including home visiting nurses and automated remainders targeting new mothers.

Table 33 describes the recommendations provided for the CHIP PIPs.

Table 33: CHIP Performance Improvement Project Recommendation

Project	Section	Reason	Recommendation
Well Care/ Well Child	Result	Some improvement but still below benchmark.	Enhance adolescent outreach, increase evening/weekend clinic hours, and expand use of telehealth for preventive visits.
Obesity (WCC)	Results	Significant gains but performance remains below national average.	Continue provider training, strengthen school-based interventions, and increase parental reminders.
FUH	Result	Significant improvement but still under benchmark.	Address barriers in appointment availability by expanding behavioral health provider network and embedding care managers.

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

Molina CAN and CHIP met 84% of the standards in the Quality Improvement section.

Figure 6: Quality Improvement Findings

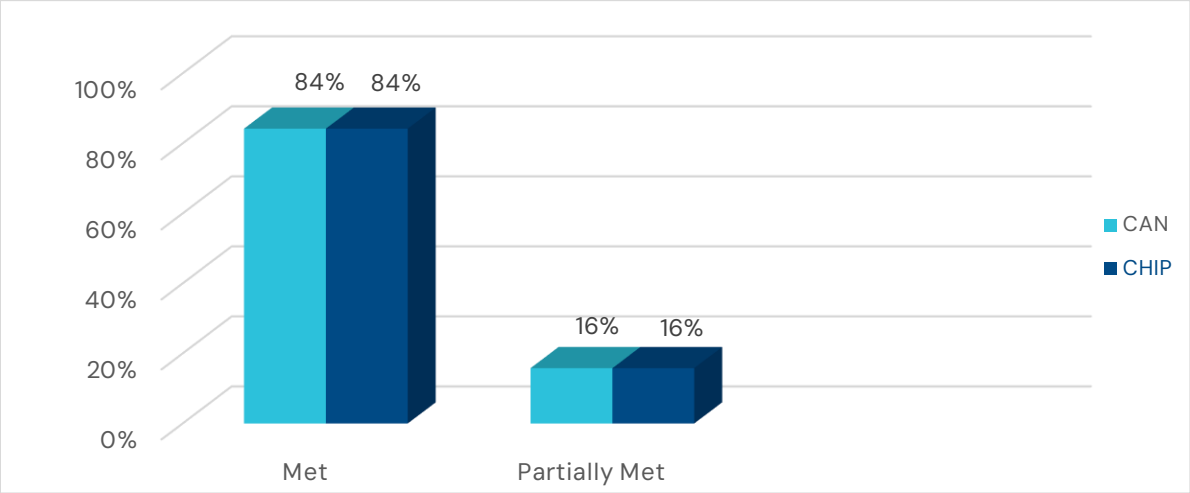


Table 34: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The QI Program promotes health equity by integrating behavioral health and substance use services and using data on demographics and social factors to ensure culturally and linguistically appropriate care for all members.	✓		
The QI Program outlines objectives, actions, and outcomes, showcasing Molina's commitment to improving healthcare quality and removing barriers through ongoing evaluation.	✓		
Molina demonstrated full compliance with all information systems standards, and the audit verified that valid and reportable rates were submitted for all HEDIS measures within scope.	✓		
Molina has a comprehensive QI structure which integrates PIPs, network adequacy monitoring and satisfaction surveys that aligned with CMS and state requirements.	✓		
Reliable data collection, sources, and analysis methods using statistical testing were noted during the validation review.	✓		
All QI findings were shared with stakeholders and QI committees showing oversight process.	✓		

Table 35: Quality Improvement Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
The QI Program Description (page four, "Program Component 2") incorrectly states that Molina credentials and recredentials	*Corrective Action: Update the QI Program Description to eliminate any references to Molina's role in credentialing or*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
providers. Molina does not perform these functions. This issue was previously identified in the 2023 and 2024 EQRs and has not been corrected.	*recredentialing individual practitioners, provider organizations, facilities, and institutions.*			
The behavioral health appointment standards in the 2024 and 2025 QI Work Plans (pages 36 and 179) are not consistent with Policy MHMS-QI-006. The Work Plans allow 21 business days for routine and 30 business days for follow-up appointments, whereas the policy requires 14 calendar days for routine and 7 calendar days for follow-up appointments.	*Corrective Action Plan: Update the behavioral health appointment standards in the 2024 and 2025 QI Work Plans to ensure accuracy and alignment.*	✓		
The 2024 QI Work Plan (pages 63 and 65) references an annual review of HEDIS medical records and delegation oversight activities, but the results of these audits were not incorporated into the 2024 QI Program Evaluation, limiting the ability to fully assess the effectiveness of the QI Program.	*Corrective Action: Ensure that the results and outcomes of all studies and activities are fully documented and incorporated into the QI Program Evaluation, in accordance with the CAN Contract, Section 10 (D), Exhibit G, and the CHIP Contract, Section 9(D)(8) and Exhibit F.*	✓		
Policy MHMS-QI-005 references the planned development of a tracking dashboard, but the dashboard is already in use, indicating the policy is outdated.	*Recommendation: Revise policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, to remove the reference to the development of a tracking system.*	✓		
A concern was identified regarding the documentation of source code for certain CMS Core Set non-HEDIS measures.	*Recommendation: Improve monitoring of measure coding and related measure rate output for the CMS non-HEDIS core set measures.*	✓		
Performance declined on pharmacy data–dependent measures, including PCE.	*Recommendation: Improve monitoring of pharmacy data and track changes potentially attributed to the pharmacy carve out to proactively track quality measure performance and impact.*	✓		
Some PIPs showed weak or non-significant improvements.	*Recommendation: Continue implementing interventions and monitoring performance.*	✓		

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 provided the 2025 Quality Improvement Program Description, which outlines a comprehensive framework designed to enhance healthcare quality, accessibility, and equity for its members. The program is built on structures, processes, and strategies, emphasizing continuous improvement. It focuses on addressing the unique needs of members, including those with complex health conditions, through personalized care, effective case management, and culturally competent services. The program integrates behavioral health, chemical dependency, and substance abuse services, while promoting health equity and reducing disparities. The QI Program Description was approved by Quality Improvement and Health Equity Transformation Committee on: 3/26/2025. On page four of the QI Program Description, under the section labeled "Program Component 2" it states, "Molina contracts with, credentials, and recredentials individual practitioners, provider organizations, facilities, and institutions to deliver health care and services to members, particularly individuals with complex health issues." Molina does not credential or recredential providers. This was an issue identified in the 2023 and 2024 EQRs and not corrected.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the QI Program Description to eliminate any references to Molina's role in credentialing or recredentialing individual practitioners, provider organizations, facilities, and institutions.
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 monitors services furnished to members with special needs by collecting and analyzing data on race, ethnicity, language, sexual orientation, gender identity, social determinants of health, and geography to identify disparities within the member population. These efforts are part of Molina's Health Equity and Cultural Competency Program, which aims to deliver equitable, culturally competent, and linguistically appropriate services across the healthcare continuum.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Molina employs utilization data in various aspects of its Quality Improvement Program. Utilization data is used to evaluate clinical and service quality, identify trends, and assess over- and under-utilization of services. This includes reviewing practitioner medical, pharmacy, and utilization data.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).		X				The Quality Improvement/Healthcare Services Work Plan includes specified timelines that will allow Molina to meet highlighted goals and objectives. The document provides an analysis and evaluation of the QI and Utilization Management programs for 2024 and 2025. It highlights objectives, timelines, action plans, and results across various areas, including program descriptions, committee structures, policies, interrater reliability, delegation oversight, credentialing, pharmacy, appeals, and performance improvement projects. The document reflects ongoing efforts to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meet regulatory requirements, improve healthcare quality, and address barriers through proactive strategies and continuous monitoring. The appointment access standards for behavioral health providers found on pages 36 and 179 are not aligned with Policy MHMS-QI-006, Access to Care. The 2024 and 2025 QI Work Plans identify the standard for a routine behavioral health appointment as 90% within 21 business days, and for a follow-up routine behavioral health appointment as 90% within 30 business days. In contrast, the policy establishes stricter requirements, defining a routine behavioral health appointment as within 14 calendar days and a follow-up appointment as within 7 calendar days. *Corrective Action Plan: Update the behavioral health appointment standards in the 2024 and 2025 QI Work Plans to ensure accuracy and alignment.*
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 Molina Board of Directors has ultimate authority and responsibility for the quality of care and services delivered by Molina. The Board is responsible for the direction and oversight of Molina's Quality Improvement Program. The Board delegates authority for Molina's Quality Improvement Program to the Quality Improvement and Health Equity Transformation Committee. Through discussion by the committee and subcommittees, the Quality Improvement and Health Equity Transformation Committee recommends policy decisions, analyzes

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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					Molina's Quality Improvement and Health Equity Transformation Committee is co-chaired by the Chief Medical Officer and the Quality Lead. Voting members include external network physicians and practitioners. According to the committee charter, these may include, but are not limited to, primary care physicians, medical specialists, behavioral health practitioners, and non-physician providers such as pharmacists and psychologists. Currently, the committee has three participating providers: two specializing in pediatrics and one in internal medicine. A designated Behavioral Health practitioner is also included as a voting member. A quorum of at least 51% of the committee members with no less than half of network provider participants will be necessary to enact and/or implement decisions. All vote outcomes shall be determined by a simple majority of a quorum. If a voting member is unable to attend, a substitute may be appointed in their absence.
3. The QI Committee meets at regular intervals.	X					The Quality Improvement and Health Equity Transformation Committee convenes on a quarterly basis. Additional meetings or distribution of materials may occur more frequently at the request of the co-chairs.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting. The minutes submitted by Molina demonstrated the Quality

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Improvement and Health Equity Transformation Committee met at the appropriate intervals.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the PM rates. A concern was identified regarding the documentation of source code for certain CMS Core Set non-HEDIS measures. Performance declined on pharmacy data–dependent measures, including PCE. *Recommendation: Improve monitoring of measure coding and related measure rate output for the CMS non-HEDIS core set measures. Improve monitoring of pharmacy data and track changes potentially attributed to the pharmacy carve out to proactively track quality measure performance and impact.*
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					Six PIPs for CAN were submitted. Rationale for measures selected was discussed and showed that they were aimed at addressing priority health issues pertinent to the population.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					The study designs adhered to CMS protocol with clear aims, baseline data, interventions, and ongoing measurements, which include statistical testing of improvements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					The provider agreement requires providers to participate in and comply with Molina's QI program.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers receive updates on their performance, including adherence to clinical practice guidelines, utilization data, and other metrics. Molina involves contracted medical and behavioral health practitioners and providers in the planning and implementation of clinical programs and activities, such as Performance Improvement Projects and quality improvement activities.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Molina evaluates provider compliance with practice guidelines by reviewing HEDIS measure results to assess the effectiveness of preventive care, as well as the utilization of behavioral health, chemical dependency, and substance use services. These activities help ensure providers follow established guidelines.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					According to Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, Molina tracks initial visits for newborns and conducts outreach to ensure compliance with EPSDT service provision requirements.
4.2 EPSDT screenings and results;	X					Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment outlines Molina's EPSDT program that details the procedures for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						outreach, education, tracking, reporting and follow-up to ensure members receive periodic health screenings, immunizations, and other medically necessary services.
4.3 Diagnosis and/or treatment for children.	X					Molina's EPSDT policy ensures compliance with federal and state Medicaid requirements to provide preventive and medically necessary services to eligible children and young adults under 21. The policy also includes processes for follow-up on abnormal findings, ensuring referrals and treatments are completed, and tracking compliance with periodicity schedules.
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				Molina evaluates the effectiveness of the QI Program at least annually. The 2024 QI Program Evaluation provides a thorough review of the program's activities, including those underway or completed during 2024. The evaluation concludes with recommendations for restructuring the QI Program in 2025, emphasizing health equity, member and provider satisfaction, and addressing identified barriers to improve healthcare quality and outcomes. The 2024 QI Work Plan (pages 63 and 65) references an annual review of HEDIS medical records and delegation oversight activities; however, the results of these audits were not included in the 2024 QI Program Evaluation.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Ensure that the results and outcomes of all studies and activities are fully documented and incorporated into the QI Program Evaluation, in accordance with the CAN Contract, Section 10 (D), and Exhibit G.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					This QI Program Evaluation was approved by the Quality Improvement and Health Equity Transformation Committee in June 2025 and reported to the Board of Directors.

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 provided the 2025 Quality Improvement Program Description, which outlines a comprehensive framework designed to enhance healthcare quality, accessibility, and equity for its members. The program is built on structures, processes, and strategies, emphasizing continuous improvement. It focuses on addressing the unique needs of members, including those with complex health conditions, through personalized care, effective case management, and culturally competent services. The program integrates behavioral health, chemical dependency, and substance abuse services, while promoting health equity and reducing disparities. The QI Program

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description was approved by Quality Improvement and Health Equity Transformation Committee on: 3/26/2025. On page four of the QI Program Description, under the section labeled "Program Component 2" it states, "Molina contracts with, credentials, and recredentials individual practitioners, provider organizations, facilities, and institutions to deliver health care and services to members, particularly individuals with complex health issues." Molina does not credential or recredential providers. This was an issue identified in the 2023 and 2024 EQRs and not corrected. *Corrective Action: Update the QI Program Description to eliminate any references to Molina's role in credentialing or recredentialing individual practitioners, provider organizations, facilities, and institutions*.
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 monitors services furnished to members with special needs by collecting and analyzing data on race, ethnicity, language, sexual orientation, gender identity, social determinants of health, and geography to identify disparities within the member population. These efforts are part of Molina's Health Equity and Cultural Competency Program, which aims to deliver equitable, culturally competent, and linguistically appropriate services across the healthcare continuum.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that	X					Molina employs utilization data in various aspects of its Quality Improvement Program. Utilization data is used to evaluate clinical and service quality, identify

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
demonstrate potential health care delivery problems.						trends, and assess over- and under-utilization of services. This includes reviewing practitioner medical, pharmacy, and utilization data.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				The Quality Improvement/Healthcare Services Work Plan includes specified timelines that will allow Molina to meet highlighted goals and objectives. The document provides an analysis and evaluation of the QI and Utilization Management programs for 2024 and 2025. It highlights objectives, timelines, action plans, and results across various areas, including program descriptions, committee structures, policies, interrater reliability, delegation oversight, credentialing, pharmacy, appeals, and PIPs. The document reflects ongoing efforts to meet regulatory requirements, improve healthcare quality, and address barriers through proactive strategies and continuous monitoring. The appointment access standards for behavioral health providers found on pages 36 and 179 are not aligned with Policy MHMS-QI-006, Access to Care. The 2024 and 2025 QI Work Plans identify the standard for a routine behavioral health appointment as 90% within 21 business days, and for a follow-up routine behavioral health appointment as 90% within 30 business days. In contrast, the policy establishes stricter requirements, defining a routine behavioral health appointment as within 14 calendar days and a follow-up appointment as within 7 calendar days.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the behavioral health appointment standards in the 2024 and 2025 QI Work Plans to ensure accuracy and alignment.
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 Molina Board of Directors has ultimate authority and responsibility for the quality of care and services delivered by Molina. The Board is responsible for the direction and oversight of Molina's Quality Improvement Program. The Board delegates authority for Molina's Quality Improvement Program to the Quality Improvement and Health Equity Transformation Committee. Through discussion by the committee and 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					Molina's Quality Improvement and Health Equity Transformation Committee is co-chaired by the Chief Medical Officer and the Quality Lead. Voting members include external network physicians and practitioners. According to the committee charter, these may include, but are not limited to, primary care physicians, medical specialists, behavioral health practitioners, and non-physician providers such as pharmacists and psychologists. Currently, the committee has three participating providers: two specializing in pediatrics and one in internal medicine. A designated Behavioral

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Health practitioner is also included as a voting member. A quorum of at least 51% of the committee members with no less than half of network provider participants will be necessary to enact and/or implement decisions. All vote outcomes shall be determined by a simple majority of a quorum. If a voting member is unable to attend, a substitute may be appointed in their absence.
3. The QI Committee meets at regular intervals.	X					The Quality Improvement and Health Equity Transformation Committee convenes on a quarterly basis. Additional meetings or distribution of materials may occur more frequently at the request of the co-chairs.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting. The minutes submitted by Molina demonstrated the Quality Improvement and Health Equity Transformation Committee met at the appropriate intervals.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the performance measure (PM) rates. A concern was identified regarding the documentation of source code for certain CMS Core Set non-HEDIS measures.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Improve monitoring of measure coding and related measure rate output for the CMS non-HEDIS core set measures.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					Four PIPs for CHIP were submitted. Rationale for measures selected was discussed and showed that they were aimed at addressing priority health issues pertinent to the population.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					The study designs adhered to CMS protocol with clear aims, baseline data, interventions, and ongoing measurements, which include statistical testing of improvements.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					The provider agreement requires providers to participate in and comply with Molina's QI program.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers receive updates on their performance, including adherence to clinical practice guidelines, utilization data, and other metrics. Molina involves contracted medical and behavioral health practitioners and providers in the planning and implementation of clinical programs and activities, such as Performance Improvement Projects and quality improvement activities.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Molina evaluates provider compliance with practice guidelines by reviewing HEDIS measure results to assess the effectiveness of preventive care, as well as the utilization of behavioral health, chemical dependency, and substance use services. These

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						activities help ensure providers follow established guidelines.
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, references on page seven the planned development of a tracking system, stating that "QI is collaborating with the Enterprise Information Management Team to create an automated tracking dashboard." However, this dashboard has already been created and is currently in use, indicating the policy is outdated and does not reflect current practice. *Recommendation: Recommendation: Revise Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, to remove the reference to the development of a tracking system.*
4.1 Initial visits for newborns;	X					Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, includes the tracking of initial visits for newborns.
4.2 Well-Baby and Well-Child screenings and results;	X					Well-Baby and Well-Child screenings and results are covered in Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services.
4.3 Diagnosis and/or treatment for children.	X					Molina tracks Well-Baby and Well–Child Services and immunization compliance through their tracking system. This system tracks initial visits for newborns, screening and reporting of all results including diagnostic and treatment services and referrals. Written notifications, telephone outreach, and transportation assistance are provided to ensure members attend appointments as well as scheduling

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						follow-up appointments if initial appointments are missed.
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				Molina evaluates the effectiveness of the QI Program at least annually. The 2024 QI Program Evaluation provides a thorough review of the program's activities, including those underway or completed during 2024. The evaluation concludes with recommendations for restructuring the QI Program in 2025, emphasizing health equity, member and provider satisfaction, and addressing identified barriers to improve healthcare quality and outcomes. The 2024 QI Work Plan (pages 63 and 65) references an annual review of HEDIS medical records and delegation oversight activities; however, the results of these audits were not included in the 2024 QI Program Evaluation. *Corrective Action: Ensure that the results and outcomes of all studies and activities are fully documented and incorporated into the QI Program Evaluation, in accordance with the CHIP Contract, Section 9 (D) (8) and Exhibit F.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The QI Program Evaluation was approved by the Quality Improvement and Health Equity Transformation Committee in June 2025 and reported to the Board of Directors.

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 HCS Program comprises essential components, including Utilization Management, Care Management, Transitions of Care, and other critical services that support health plan members. Constellation's evaluation of Molina's CAN and CHIP UM Programs involved a review of the HCS Program descriptions, procedures related to service authorizations and medical necessity determinations, pharmacy requirements, and an examination of the CAN and CHIP Member Handbooks and Provider Manuals.

Molina's UM Program operates under the broader HCS framework and is designed to ensure that all services provided are medically necessary and reflect appropriate resource utilization based on members' levels of care. The program's objectives, functions, and goals are outlined in the HCS Program Description and supporting policies.

Oversight of the UM Program is shared by the Vice President, Health Care Services, Assistant Vice President, Health Care Services, and Chief Medical Officer. Together, they are responsible for the development, implementation, and management of clinical policies, procedures, and UM operations. The Chief Medical Officer, who maintains an unrestricted medical license in their state of practice, provides clinical oversight, consultation, and holds responsibility for medical necessity determinations. Ultimate authority and accountability for the program rest with Molina's Board of Directors, which provides governance and strategic oversight.

The HCS Committee reports its activities and outcomes directly to the Quality Improvement and Health Equity Transformation Committee and the Board of Directors. The HCS Program Description is reviewed and approved annually by both the HCS Committee and the Quality Improvement and Health Equity Transformation Committees. A member of HCS leadership serves on each subcommittee within the Quality Improvement and Health Equity Transformation governance structure.

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

Benefit determinations are guided by established clinical criteria and standards, which are reviewed regularly and approved annually by the HCS Committee. These criteria are communicated to providers through the Provider Manuals, newsletters, and orientation sessions. Practitioners can access the clinical review and HCS criteria online or request them via telephone, fax, or email. They may also request criteria specific to a review in progress.

Sample file audits confirm that both approval and denial decisions are consistently made using approved criteria and within an established, structured decision-making process. Qualified professionals render decisions within required timeframes, and approval notifications are

promptly issued to providers with all necessary information. In accordance with regulatory requirements, Adverse Benefit Determination notices are issued in clear language and include detailed appeal instructions to ensure members understand their rights and next steps.

Molina provides coverage for medications listed on the Mississippi Division of Medicaid PDL. CAN and CHIP Member Handbooks include information about covered medications, with additional resources available at MyMolina.com. As of July 1, 2024, a single pharmacy benefit administrator began managing pharmacy services for all CAN and CHIP members. Gainwell, the pharmacy benefit manager, is responsible for prescription drug prior authorizations, claims processing, and related services.

Appeals

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

Policy MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing and member materials outline the process for requesting a reconsideration of an adverse benefit determination. Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), includes statements addressing the requirements and variances for those requirements. However, page one incorrectly states: "A verbal Appeal shall be followed by a written Appeal that is signed by the Member. The Contractor shall use its best efforts to assist Members as needed with the written Appeal and may continue to process the Appeal." This statement is inaccurate, as members are not required to submit a written appeal request when filing verbally.

The term "appeal" is defined appropriately, along with options for filing verbally or in writing, in CAN and CHIP member and provider materials. Timelines associated with the acknowledgement and resolution of standard and expedited appeals with an extension if needed, are clear. Members are informed of their right to file a grievance if they disagree with a request to extend the appeal resolution timeframe. The CAN and CHIP Member Handbooks explain the requirement for written consent for anyone other than the member or the authorized representative to file an appeal on the member's behalf. Appeals are monitored for trends each quarter and reported to the Quality Improvement and Health Equity Transformation Committee Meeting.

The appeal files reviewed for the 2025 EQR were all addressed in a timely manner and by the appropriate reviewer. No issues were identified.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

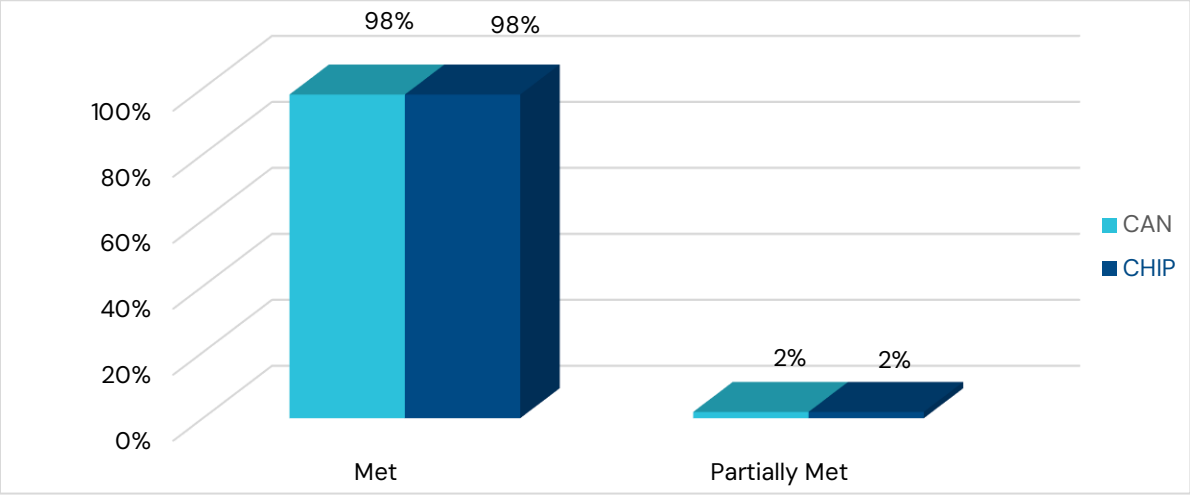
Molina's HCS Program Description and various policies provide a descriptive overview of the health plan's Integrated Care Management Program, which includes care coordination, transitional care, behavioral health case management, and disease management services for CAN and CHIP members. Members are referred to care management through various sources

such as encounter forms, claims data, provider referrals, and health assessments. Referral prioritization is based on risk factors such as prospective risk scores, emergency visit frequency, and comorbidities. Upon referral, a Health Risk Assessment is completed within 30 calendar days, and a treatment plan is completed to aid in developing a plan of care needs.

Molina's care management framework integrates an interdisciplinary team and care management activities to address the member's identified needs. Recent program updates include the designation of Mental Health Assessor positions and specialized models of care to further address tailored needs for members. Constellation's review of CHIP case management files confirmed that members received appropriate services aligned with their acuity levels; however, there were gaps in documentation of follow-up care for four CAN case management files. The health plan also provides transition of care services for members when they are transitioning between services and health plan network. Regarding transition of care for new members, Molina states that services may continue for up to 90 calendar days or until a safe transition is completed. However, the policy does not clearly define prior authorization requirements beyond the initial 30 days.

As shown in *Figure 7*, 98% of the Utilization Management 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 36: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Molina has implemented automation to improve UM processes and increase efficiency. Decision letters are autogenerated and immediately available to providers.		✓	✓
Molina reduced the volume of codes requiring prior authorization by eliminating approximately 20% of all CPT codes from the prior authorization process.		✓	✓
Molina has specialized models of care, such as Behavioral Health and Foster Care, etc. to ensure members receive tailored services based on their identified needs.	✓		✓
Molina recently designated specific Mental Health Assessor positions to ensure the appropriate and timely completion of Comprehensive Health Risk Assessments.	✓	✓	
All CAN and CHIP appeal files selected for the 2025 EQR were addressed in a timely manner and by appropriately credentialed reviewers.		✓	

Table 37: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Constellation's review of the UM Physician Listing identified a need for updates.	*Recommendation: Update UM Physician Listing to include current practitioners available for UM decision determinations.*	✓	✓	✓
Constellation's review of the CAN case management files identified gaps in the documentation of follow-up care in four files.	*Recommendation: Ensure that all service notes accurately reflect referrals, follow-up care, and care management activities provided for members.*	✓		
Molina's policies do not clearly define prior authorization requirements beyond the initial 30 calendar days for new members transitioning into the health plan.	*Recommendation: Clarify in a policy or program description whether prior authorization for continuation of services is required beyond the 30 calendar days, as outlined in the CAN Contract, Section 8 (B) and CHIP Contract, Section 8 (B).*	✓		
Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), includes incorrect information regarding the appeal submission process. It inaccurately states that a verbal appeal must be followed by a signed written appeal, which conflicts with regulatory requirements.	*Corrective Action: Remove the requirement that a verbal appeal must be followed by a written appeal.*	✓		✓

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					Molina's HCS Program Description and various policies and procedures outline the UM program scope, functions, and goals. The Health Care Services Program Description is revised and approved annually by the Health Care Services Committee.
1.1 Structure of the program;	X					The UM program is governed by the Molina Health Care Services program as outlined in the UM Program Description.
1.2 Lines of responsibility and accountability;	X					The Vice President, Health Care Services, Assistant Vice President, Health Care Services, and Chief Medical Officer of Health Care Services have authority and responsibility of the UM program development and implementation.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Clinical review criteria are reviewed, modified, and adopted by the HCS Committee at least annually. HCS staff follow the appropriate hierarchy of decisions according to policy and procedure.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Molina adheres to the standards for timeliness and notification of utilization determinations based on regulatory requirements, contracts, and policies.
1.5 Consideration of new technology;	X					Molina's Clinical Policy Committee and P&T Committee evaluate new technology and scientific advances to provide current guidelines for determining coverage criteria through evidence-based decision making.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					Procedure MHMS-01.1 defines the process for handling standard and expedited appeals as well as State Fair Hearings.
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					Policy HCS-362.01, Monitoring to Ensure Appropriate Utilization, affirms that there is no reward or financial incentive given to encourage denying coverage or service.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The HCSC Program Description outlines the management activities of the Chief Medical Officer, Vice President, Health Care Services, and Assistant Vice President, Health Care Services, which provide clinical and operational oversight of the UM program.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					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 § 4*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					Policy HCS-365, Clinical Criteria for Utilization Management (UM) Decision Making, establishes the appropriate review, use, availability, and application of objective evidence based clinical criteria to determine medical necessity and appropriateness of requested services.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					All CAN approval files reviewed contained decisions consistent with criteria and contained necessary information to make determinations.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Procedure HCS-365.02, Clinical Criteria for Utilization Management (UM) Decision Making, permits the physician reviewer to use clinical judgement when

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						established criteria do not appropriately address the individual member's needs or unique circumstances.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Molina HCS staff receives orientation and training programs designed to provide an understanding of the decision-making process. Education includes systems training classes, web casts, and individual mentoring. Inter-Rater Reliability testing of medical directors and clinicians is performed annually or more frequently if opportunities for improvement are identified.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Providers are required to adhere to the Mississippi Division of Medicaid's PDL. Information regarding the current PDL is provided in the Member Handbook, Provider Manual, and on Molina's website.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					Molina is not required to cover pharmacy services other than the limited pharmacy services described in provider manual including Physician Administered Drugs. All other pharmacy benefits are covered by DOM's single pharmacy benefit administrator, Gainwell Technologies. Gainwell Technologies is responsible for all pharmacy prior authorizations, claims processing, and managing the network pharmacies.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Molina has policies and procedures regarding emergency and post stabilization services for both participating and non-participating providers in accordance with the contract and federal regulations. Members are informed of their rights to receive emergency and post-stabilization care in the Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Utilization management standards/criteria are available to providers.	X					Information on the UM criteria and standards is provided in New Provider Orientation, the Member Handbook and on the Molina Website.
8. Utilization management decisions are made by appropriately trained reviewers.	X					In Policy HCS-364: Appropriate Professionals Making UM Decisions, Molina affirms that it requires appropriate licensed health professionals to supervise all medical necessity decisions and specifies the type of personnel responsible for each level of UM decision making.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					The sample of CAN approval files reviewed indicated utilization decisions were made promptly after essential information was received.
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 CAN denial files found that additional clinical information is requested appropriately if needed, prior to making an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					The sample of CAN denial files reviewed consistently contained evidence of appropriate specialty physician review.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of CAN denial files found that members and providers were informed of the denial decision promptly and included the basis for the denial. Information regarding the appeal process was provided in the determination notice.
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	X					Policy MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing Policy, and Addendum MHMS-A&G-01.1.12a,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:						the CAN Member Handbook, and the CAN Provider Manual describe steps for filing and managing 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 term "appeal" is appropriately defined as a request to reconsider an adverse benefit determination and is provided in the CAN Member Handbook, Provider Manual, and website.
1.2 The procedure for filing an appeal;		X				Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), includes incorrect information regarding the appeal submission process. It inaccurately states that a verbal appeal must be followed by a signed written appeal, which conflicts with regulatory requirements. *Corrective Action: Remove the requirement that a verbal appeal must be followed by a written appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Procedure MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing, indicates that an appeal will be sent to an independent reviewer who has the same or similar medical or clinical credentials as the specialist provider requesting services when needed.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Expedited appeal resolution occurs within 24 hours of the request receipt. If the appeal request does not meet the guidelines for an expedited appeal, it will be processed within the regular 30 calendar-day timeframe.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					The CAN Member Handbook and website outline the timelines for resolving standard and expedited appeals, with an extension if needed.
1.6 Written notice of the appeal resolution as required by the contract;	X					Procedure MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing, indicates that written notice of the appeal resolution will be sent with the specific reason for the decision.
1.7 Other requirements as specified in the contract.	X					The guidelines for continuing to receive benefits during the appeal process are outlined in Procedure MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing and the CAN Member Handbook.
2. The CCO applies the appeal policies and procedures as formulated.	X					All CAN appeal files selected for review were addressed in a timely manner and by the appropriately credentialed reviewer. No issues were identified.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Quality Improvement and Health Equity Transformation Committee meeting minutes detail patterns of CAN appeals along with identified opportunities for improvement and achieved goals.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					Policy HP-03, Privacy and Confidentiality of Protected Health Information (PHI), describes Molina's approach to the use, creation, collection, storage, transmission, access to and disclosure of PHI.
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 a thorough overview of Molina's Healthcare Integrated Care Management Program that offers care coordination, transitional care, behavioral health case management, and disease management to CAN members.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					As outlined in the HCS Program Description, members are referred to care management services through various resources such as encounter forms, mental health risk assessments, claims data, pharmacy claims, provider referrals, data from external sources, etc. Prioritization of the referral process is refined by the member's prospective risk score, emergency visit counts, comorbidity counts, etc., as this ensures immediate attention is focused on the members with the greatest needs and who are most likely to benefit from care management activities. Additionally, members are identified for behavioral health care management through health risk assessments, depression and substance use screenings, etc.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					As outlined in various policies and the HCS Program Description, once a member is referred to care management services, a Health Risk Assessment is completed within 30 calendar days. The HCS Program Description, and Policy HCS- 151, Risk Stratification and Member Management, describe that Molina members are stratified using data-driven methodologies both prior to enrollment and throughout their care management journey. Additionally, Policy HCS- 162, Comprehensive Needs Assessment MS Addendum, states that a Comprehensive Needs Assessment must be completed within 30 calendar days of referral if the member is identified as medium or high risk, there is a change in acuity, or immediately following a Health Risk Assessment that reveals a potentially high-risk condition.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						During the onsite discussion, Molina shared that they recently designated specific Mental Health Assessor positions to ensure that the Comprehensive Health Risk Assessments are completed appropriately and timely.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					Policy HCS -161, Health Risk Assessment, states that the Health Risk Assessment assesses members' current health status, behavioral status, and social determinants of health.
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					Policies HCS-161.01, Health Risk Assessment MS Addendum, and HCS-162, Comprehensive Needs Assessment, state that if a member is identified as potentially high risk due to the presence of comorbidities, a Comprehensive Needs Assessment is initiated to further evaluate the member's medical history and overall health status.
4.3 Demographic information;	X					The Health Risk Assessment assesses the members' demographic information and current social determinants of health as outlined in Policy HCS- 161 Health Risk Assessment.
4.4 Member's current treatment provider and treatment plan, if available.	X					As outlined in Policy HCS -161.01, Health Risk Assessment Procedure and the HCS Program Description, the assessment process includes gathering information about current services and community resources to support the development of the treatment plan and interdisciplinary care team involvement.
5. The health risk assessment is reviewed by a qualified health professional and a treatment	X					Policy HCS- 154, Individualized Plan Development, and the HCS Program Description outline that care plan goals and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
plan is completed within 30 days of completion of the health risk assessment.						interventions are developed based on the member's identified needs, ensuring that the member and/or their representative are actively involved in the care planning process.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					The HCS Program Description and Policy HCS -151, Risk Stratification and Member Management, outline that a member's risk level assignment is conducted using data-driven methodologies prior to enrollment and throughout their care management journey.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Molina provides comprehensive integrated care services that include assessment, referrals to appropriate resources, discharge planning, and coordination of services for members with behavioral health needs, as detailed in various policies and the HCS Program Description. During the onsite discussion, Molina also shared that they have specialized models of care, such as Behavioral Health and Foster Care, etc. to ensure members receive tailored services based on their identified needs. Constellation's review of the CAN care management files indicated that Molina conducted appropriate assessments to support identification of members' treatment needs. However, in four files, there was gap in follow-up care documented in the member's case management file. While Molina provided clarification during the onsite discussion, this information was not reflected in the documentation submitted for review.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure that all service notes accurately reflect referrals, follow-up care, and care management activities provided for members.
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;						Members are provided with contact information to contact their assigned team members as outlined in the HCS Program Description.
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						As outlined in the HCS Program Description, referral and scheduling assistance is provided to members.
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						Constellation's review of the CAN care management files indicated that Molina conducted appropriate assessments to support identification of members' treatment needs. However, in four files, there was gap in follow-up care documented in the member's case management file. While Molina provided clarification during the onsite discussion, this information was not reflected in the documentation submitted for review. *Recommendation: Ensure that all service notes accurately reflect referrals, follow-up care, and care management activities provided for members.*
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						Policy HCS 120.01, Documentation Policy, and the HCS Program Description outline that medical care and follow up is documented in the member's medical record.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.5 Coordination of discharge planning;						As outlined in the HCS Program Description, discharge planning is provided to members.
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;						Policy HCS-105.01 MHI Clinical Programs MS Addendum describes that coordination with additional social programs is provided to members.
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;						Policy HCS-407.01, Continuity of Care and Access to Care for New and Existing Members, describes that members are able to have continued access to a provided for 90 calendar days.
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						Policy HCS-154.01, Individualized Care Development, outlines the process when members changs physicians. The care manager ensures that there is no disruption in service.
7.9 Monitoring and follow-up with members and providers including regular						Policy HCS-105.01, MHI Clinical Programs MS Addendum, states that educational materials and newsletters are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
mailings, newsletters, or face-to-face meetings as appropriate.						provided to members throughout care management processes to promote engagement and prevention.
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					As described in Policy HCS-105.01MHI Clinical Programs MS Addendum, members assigned to the medium risk level receive services that are included in the low risk level.
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					As described in Policy HCS-105.01, MHI Clinical Programs MS Addendum, members assigned to the high risk level receive services included in the medium risk level.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Molina 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.
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					As outlined in the health plan's HCS Program Description and Policy HCS-151.01, Risk Stratification and Member Management Procedure, Molina's Health Management Program is designed to promote education, health awareness, and prevention for a range of medical conditions. Support is provided through health coaching, educational materials, etc.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					In accordance with Policy MHMS-QI-004, Monitoring of Continuity of Care, Molina conducts an annual review using data from various sources to evaluate the coordination of care between behavioral health and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medical care systems, as well as the continuity and collaboration among medical practitioners throughout the healthcare network.
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Molina has updated its transitional care management process to align with the 2025 contractual requirements for members discharged from the hospital or transitioning from inpatient care, as outlined in Policy HCS-168, Transitions of Care MS and the HCS Program Description.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs, and implements a transition of care plan, and provides oversight to the transition process.	X					As outlined in Policy HCS-168.01, Transitions of Care MS Addendum and the HCS Program Description, a Transition of Care Coach, in collaboration with an Interdisciplinary Care Team, including providers, physicians, and other team members work together to support members transitioning to a less restrictive level of care, ensuring a successful and coordinated transition.
4. The CCO meets other Transition of Care requirements.	X					The Member Handbook, along with Policy HCS-407.01, Continuity of Care and Access to Care for New and Existing Members, and Policy HCS-406.1, Transition to Other Care When Benefits End, outline Molina's continuity of care process for CAN members. Molina states that continuation of services may be provided to new members for up to 90 calendar days or until the member can be reasonably transitioned to a network provider without disruption. However, the policy does not clearly indicate whether prior authorization for continuation of services beyond the initial 30 calendar days is required. During the onsite discussion, the health plan indicated that they honor existing prior authorizations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Clarify in a policy or program description whether prior authorization for continuation of services is required beyond the initial 30 calendar days for new members, as outlined in the Mississippi DOM Contract Regulation CAN Contract, Section 8(B).
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					The Health Care Services Annual Evaluation incorporates initiatives included in the Health Care Services work plan and contains a narrative summary of the Utilization Management and Care Management activities conducted during 2024. Molina describes that annual evaluation is used to assess the effectiveness in achieving Health Care Services program goals and provides direction for the upcoming year's Health Care Services Program.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					Molina provides the annual report of the UM program to necessary stakeholders as defined by the contract.

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					Molina's HCS Program Description and various policies and procedures outline the UM program scope, functions, and goals. The Health Care Services

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Description is revised and approved annually by the Health Care Services Committee.
1.1 Structure of the program;	X					The UM program is governed by the Molina Health Care Services program as outlined in the UM Program Description.
1.2 Lines of responsibility and accountability;	X					The Vice President, Health Care Services, Assistant Vice President, Health Care Services, and Chief Medical Officer of Health Care Services have authority and responsibility of the UM program development and implementation.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Clinical review criteria are reviewed, modified, and adopted by the HCS Committee at least annually. HCS staff follow the appropriate hierarchy of decisions according to policy and procedure.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Molina adheres to the standards for timeliness and notification of utilization determinations based on regulatory requirements, contracts, and policies.
1.5 Consideration of new technology;	X					Molina's Clinical Policy Committee and P&T 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					Procedure MHMS-01.1 defines the process for handling standard and expedited appeals as well as State Fair Hearings.
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					Policy HCS-362.01, Monitoring to Ensure Appropriate Utilization, affirms that there is no reward or financial incentive given to encourage denying coverage or service.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The HCS Program Description outlines the management activities of the Chief Medical Officer, Vice President, Health Care Services, and Assistant Vice President, Health Care Services, which provide clinical and operational oversight of the UM program.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					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 used are in place for determining medical necessity for all covered benefit situations.	X					Policy HCS-365, Clinical Criteria for Utilization Management (UM) Decision Making, establishes the appropriate review, use, availability, and application of objective evidence based clinical criteria to determine medical necessity and appropriateness of requested services.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					All CHIP approval files reviewed contained decisions consistent with criteria and contained necessary information to make determinations.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Procedure HCS-365.02, Clinical Criteria for Utilization Management (UM) Decision Making, permits the physician reviewer to use clinical judgement when established criteria do not appropriately address the individual member's needs or unique circumstances.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Molina HCS staff receives orientation and training programs designed to provide an understanding of the decision-making process. Education includes systems training classes, web casts, and individual mentoring. Inter-Rater Reliability testing of medical directors and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						clinicians is performed annually or more frequently if opportunities for improvement are identified.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Providers are required to adhere to the Mississippi Division of Medicaid's PDL. Information regarding the current PDL is provided in the Member Handbook, provider manual and on Molina's website.
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Molina is not required to cover pharmacy services other than the limited pharmacy services described in provider manual including Physician Administered Drugs. All other pharmacy benefits are covered by DOM's single pharmacy benefit administrator, Gainwell Technologies. Gainwell Technologies is responsible for all pharmacy prior authorizations, claims processing, and managing the network pharmacies.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Molina has policies and procedures regarding emergency and post stabilization services for both participating and non-participating providers in accordance with the contract and federal regulations. Members are informed of their rights to receive emergency and post-stabilization care in the member handbook.
7. Utilization management standards/criteria are available to providers.	X					Information on the UM criteria and standards is provided in New Provider Orientation, the Member Handbook and on the Molina Website.
8. Utilization management decisions are made by appropriately trained reviewers.	X					Policy HCS-364: Appropriate Professionals Making UM Decisions, Molina affirms that it requires appropriate licensed health professionals to supervise all medical

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						necessity decisions and specifies the type of personnel responsible for each level of UM decision making.
9. Initial utilization decisions are made promptly after all necessary information is received.						The sample CHIP approval files reviewed indicated utilization decisions were made promptly after essential information was received.
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 CHIP denial files found that additional clinical information is requested appropriately if needed, prior to making an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					The sample of CHIP denial files reviewed consistently contained evidence of appropriate specialty physician review.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of CHIP denial files found that members and providers were informed of the denial decision promptly and included the basis for the denial. Information regarding the appeal process was provided in the determination notice.
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-01, Core Medicaid Appeals and State Fair Hearing Policy, and Addendum MHMS-A&G-01.1.12a, the CHIP Member Handbook, and the CHIP Provider Manual describe steps for filing and managing member appeals of Adverse Benefit Determinations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The term "appeal" is appropriately defined as a request to reconsider an adverse benefit determination and is provided in the CHIP Member Handbook, Provider Manual, and website.
1.2 The procedure for filing an appeal;		X				Procedure MHMS-A&G-01.1, MHMS Medicaid Appeals and State Hearings Procedure (Addendum 1.12a), includes incorrect information regarding the appeal submission process. It inaccurately states that a verbal appeal must be followed by a signed written appeal, which conflicts with regulatory requirements. *Corrective Action: Remove the requirement that a verbal appeal must be followed by a written appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Procedure MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing, indicates that an appeal will be sent to an independent reviewer who has the same or similar medical or clinical credentials as the specialist provider requesting services when needed.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Expedited appeal resolution occurs within 24 hours of the request receipt. If the appeal request does not meet the guidelines for an expedited appeal, it will be processed within the regular 30 calendar-day timeframe.
1.5 Timeliness guidelines for resolution of the appeal;	X					The CHIP Member Handbook and website outline the timelines for resolving standard and expedited appeals, with an extension if needed.
1.6 Written notice of the appeal resolution;	X					Procedure MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing, indicates that written notice of the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appeal resolution will be sent with the specific reason for the decision.
1.7 Other requirements as specified in the contract.	X					The guidelines for continuing to receive benefits during the appeal process are outlined in Procedure MHI-A&G-01, Core Medicaid Appeals and State Fair Hearing and the CHIP Member Handbook.
2. The CCO applies the appeal policies and procedures as formulated.	X					All CHIP appeal files selected for review were addressed in a timely manner and by the appropriately credentialed reviewer. No issues were identified.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Quality Improvement and Health Equity Transformation Committee meeting minutes detail patterns of CHIP appeals along with identified opportunities for improvement and achieved goals.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					Policy HP-03, Privacy and Confidentiality of Protected Health Information (PHI), describes Molina's approach to the use, creation, collection, storage, transmission, access to and disclosure of PHI.
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					The Molina HCS Program Description provides a comprehensive overview of Molina's Integrated Care Management Program, which delivers care coordination, transitional care, behavioral health case management, and disease management services to CHIP members.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					As outlined in the HCS Program Description, members are referred to care management services through various resources such as encounter forms, mental health risk assessments, claims data, pharmacy claims, provider referrals, data from external sources, etc. Prioritization of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the referral process is refined by the members' prospective risk score, emergency visit counts, comorbidity counts, etc., as this ensures immediate attention is focused on the members with the greatest needs and who are most likely to benefit from care management activities. Additionally, members are identified for behavioral health care management through health risk assessments, depression and substance use screenings, etc.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					As outlined in various policies and the HCS Program Description, once a member is referred for care management services, a Health Risk Assessment (HRA) is completed within 30 calendar days. The HCS Program Description, and Policy HCS- 151, Risk Stratification and Member Management, outline that Molina members are risk stratified using data-driven methodologies both prior to enrollment and throughout their care management journey. Based upon their acuity level, members are assigned to one of the four care levels which entails: Level 1: Health Condition Support, Level 2: Care Management, Level 3 Complex Care Management, and Level 4: Intensive Needs. During the onsite discussion, Molina shared that they recently designated specific Mental Health Assessor positions to ensure the Comprehensive Health Risk Assessments are completed appropriately and timely.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					Policy HCS -161, Health Risk Assessment, states that the Health Risk Assessment assesses the members' current

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						health status, behavioral status, and social determinants of health.
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					Policies HCS-161.01, Health Risk Assessment MS Addendum, and HCS-162, Comprehensive Needs Assessment, state when a member is identified as potentially high risk due to the presence of comorbidities, a Comprehensive Needs Assessment is initiated to further evaluate the member's medical history and overall health status.
4.3 Demographic information;	X					As outlined in Policy HCS-161 Health Risk Assessment, the Health Risk Assessment assesses the member's demographic information and current social determinants of health.
4.4 Member's current treatment provider and treatment plan, if available.	X					The assessment process includes gathering information about current services and community resources to support the development of the treatment plan and interdisciplinary care team involvement as outlined in Policy HCS-161.01, Health Risk Assessment Procedure, and the HCS Program Description.
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					The care plan goals and interventions are developed based on the member's identified needs, ensuring that the member and/or their representative are actively involved in the care planning process as described in Policy HCS- 154, Individualized Plan Development, and the HCS Program Description.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					The HCS Program Description and Policy HCS -151, Risk Stratification and Member Management, outline that a member's risk level assignment is conducted using data-driven methodologies prior to enrollment and throughout their care management journey.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					As described in various policies and the HCS Program Description, Molina provides comprehensive integrated care services that include assessment, referrals to appropriate resources, discharge planning, and coordination of services for members with behavioral health needs. During the onsite discussion, Molina also shared that they have specialized models of care, such as Behavioral Health and Foster Care, etc. to ensure members receive tailored services to address their identified needs. Constellation's review of the CHIP care management files demonstrated that members received appropriate care management services according to their assigned acuity levels.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						Members are provided with contact information to contact their assigned team members as outlined in the HCS Program Description.
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						As outlined in the HCS Program Description, referral and scheduling assistance is provided to members.
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						Constellation's review of the CHIP care management files demonstrated that members received appropriate care management services according to their assigned acuity levels.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						Policy HCS 120.01, Documentation Policy, and the HCS Program Description outline that medical care and follow up is documented in the member's medical record.
7.5 Coordination of discharge planning;						As outlined in the HCS Program Description, discharge planning is provided to members.
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;						Policy HCS-105.01 MHI Clinical Programs MS Addendum describes that coordination with additional social programs is provided to members.
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;						Policy HCS-407.01, Continuity of Care and Access to Care for New and Existing Members, describes that members are able to have continued access to a provided for 90 calendar days.
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						Policy HCS-154.01, Individualized Care Development, outlines the process when members changs physicians. The care manager ensures that there is no disruption in service.
7.9 Monitoring and follow-up with members and providers including regular						Policy HCS-105.01, MHI Clinical Programs MS Addendum, describes that educational materials and newsletters, are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
mailings, newsletters, or face-to-face meetings as appropriate.						provided to members throughout care management process to promote engagement and prevention.
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					As described in Policy HCS-105.01, MHI Clinical Programs MS Addendum, members assigned to the medium risk level receive all of the services included in the low risk level.
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					As described in Policy HCS-105.01, MHI Clinical Programs MS Addendum, members assigned to the high risk level receive the services that are included in the medium risk level.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Molina 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.
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					As outlined in the HCS Program Description and Policy HCS-151.01, Molina's Health Management Program promotes education, awareness, and prevention through health coaching, educational materials, etc.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Per Policy MHMS-QI-004, Monitoring of Continuity of Care, Molina conducts an annual review of data to assess care coordination between behavioral health and medical systems, and continuity among providers across the network.
2. The CCO formulates and acts within policies and procedures to facilitate transition	X					Molina has updated its transitional care management process to align with the 2025 contractual requirements

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
of care from institutional clinic or inpatient setting back to home or other community setting.						for members discharged from the hospital or transitioning from inpatient care, as outlined in Policy HCS-168, Transitions of Care MS and the HCS Program Description.
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					As outlined in Policy HCS-168.01 and the HCS Program Description, a Transition of Care Coach, in coordination with the Interdisciplinary Care Team, support members transitioning to a less restrictive level of care to ensure a smooth, coordinated process.
4. The CCO meets other Transition of Care Requirements.	X					The Member Handbook, along with Policy HCS-407.01, Continuity of Care and Access to Care for New and Existing Members, and Policy HCS-406.1, Transition to Other Care When Benefits End, outline Molina's continuity of care process for CHIP members. Molina states that continuation of services may be provided to new members for up to 90 calendar days or until the member can be reasonably transitioned to a network provider without disruption. However, the policy does not clearly indicate whether prior authorization for continuation of services beyond the initial 30 calendar days is required. During the onsite discussion, the health plan indicated that they honor existing prior authorizations. *Recommendation: Clarify in a policy or program description whether prior authorization for continuation of services is required beyond the initial 30 calendar days for new members, as outlined in the Mississippi DOM Contract Regulation CHIP Contract, Section 8(B).*
V F. Annual Evaluation of the Utilization Management Program						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The Health Care Services Annual Evaluation incorporates initiatives included in the Health Care Services work plan and contains a narrative summary of the Utilization Management and Care Management activities conducted during 2024. Molina describes that annual evaluation is used to assess the effectiveness in achieving Health Care Services program goals and provides direction for the upcoming year's Health Care Services Program.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					Molina provides the annual report of the UM program to necessary stakeholders as defined by the contract.

Delegation

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

Molina's Policy MHI-DO-01, Delegation Oversight Program, provided a description of the delegation oversight program to ensure compliance with federal, state, and contractual requirements. The process includes pre-delegation audits, annual audits, and monthly monitoring to ensure the delegate meets all regulatory and performance standards. The Delegation Oversight Committee and the Quality Improvement and Health Equity Transformation Committee oversee the performance metrics, audits, and any compliance issues.

Molina requires a written agreement for all entities performing any delegated functions. These agreements include a business associate's agreement. Molina provided a sample of the delegated agreement. The agreement included the requirements for policies and procedures, pre-delegation process, monitoring requirements, corrective actions if needed, reporting requirements, and the scope of work.

For this review, Molina reported eight delegation agreements for CAN and CHIP, as shown in *Table 38*.

Table 38: Delegated Entities and Services

Date of Initial Delegation	Delegated Entities	Delegated Services
7/1/18	March Vision	Vision Administration
9/1/20	Medical Transportation Management (MTM)	Non-Emergent Transportation
7/1/21	Progeny	Care management, utilization management
10/1/21	Skygen	Dental Administration
7/2/23	HealthMap	Case Management
4/1/19	Infomedia Group, Inc. d/b/a Carenet Healthcare Services	Nurse Advice Line
4/15/24	Accordant Care – CVS Caremark	Case Management
4/1/24	Evolent Health (New Century Health)	Utilization Management

The delegated services include vision, non-emergent transportation, care management, dental services, nurse advice line, and utilization management. Copies of the annual audits, pre-delegation audit and/or the post implementation audits were provided. The results of the audits are reviewed by the Delegation Oversight Committee. The Delegation Oversight Committee is responsible for making recommendations, including the imposition of corrective action plans based on audit and monitoring results. The Delegation Oversight Committee monitors and reposts the status of corrective action plans addressing deficiencies.

For the 2025 EQR, Molina successfully met all delegation requirements for CAN and CHIP, as outlined in *Figure 8*.

Figure 8: Delegation Findings

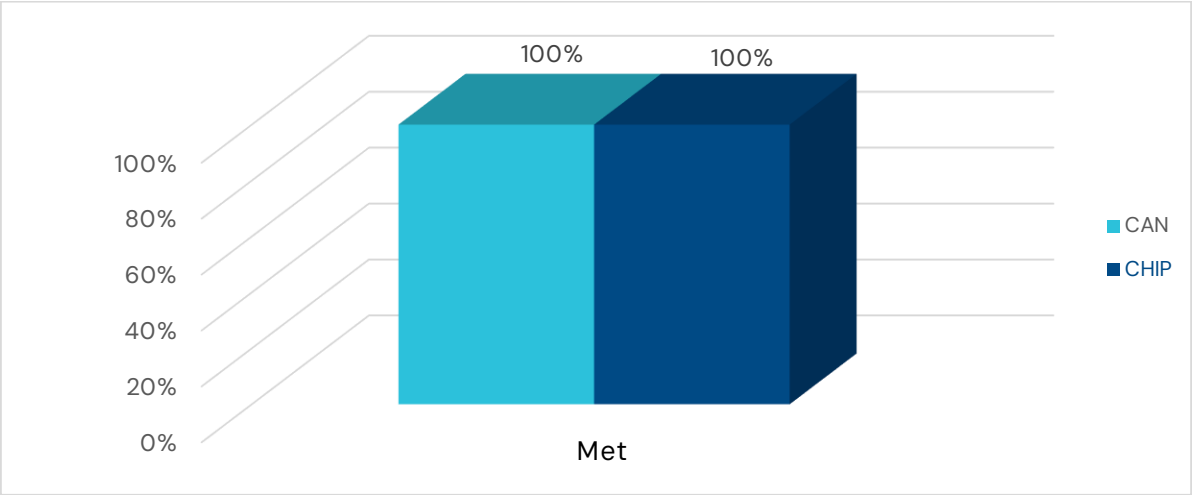


Table 39: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
The delegation oversight program is designed to ensure compliance with federal, state, and local laws, regulations, and contractual requirements.	✓		
Molina retains accountability for services provided by Third-Party Entities, ensuring oversight and compliance with applicable requirements.	✓		
A thorough assessment process is conducted before entering into delegation agreements, including operational capacity, accreditation, financial resources, and IT security.	✓		
Regular audits and monitoring activities ensure compliance and performance standards are met. Tools like dashboards, performance reports, and grievance tracking are used to maintain oversight.	✓		

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 MHI-DO-01, Delegation Oversight Program, provided a description of the delegation oversight program to ensure compliance with federal, state, and contractual requirements. The process includes pre-delegation audits, annual audits, and monthly monitoring to ensure the delegate meets all regulatory and performance standards. The Delegation Oversight Committee and the Quality Improvement and Health Equity Transformation Committee oversee the performance metrics, audits, and any compliance issues.
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					Molina requires a written agreement for all entities performing any delegated functions. These agreements include a business associate's agreement. Molina provided a sample of the delegated agreement. The agreement included the requirements for policies and procedures, pre-delegation process, monitoring requirements, corrective actions if needed, reporting requirements and the scope of work.
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					Molina reported delegation agreements for eight entities. The delegated services include vision, non-emergent transportation, care management, dental services, nurse advice line, and utilization management. Copies of the annual audits, pre-delegation audit and/or the post implementation audits were provided. The results of the audits are reviewed by the Delegation Oversight Committee. The Delegation Oversight

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee is responsible for making recommendations, including the imposition of corrective action plans based on audit and monitoring results. The Delegation Oversight Committee monitors and reposts the status of corrective action plans addressing deficiencies.

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 MHI-DO-01, Delegation Oversight Program, provided a description of the delegation oversight program to ensure compliance with federal, state, and contractual requirements. The process includes pre-delegation audits, annual audits, and monthly monitoring to ensure the delegate meets all regulatory and performance standards. The Delegation Oversight Committee and the Quality Improvement and Health Equity Transformation Committee oversee the performance metrics, audits, and any compliance issues.
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					Molina requires a written agreement for all entities performing any delegated functions. These agreements include a business associate's agreement. Molina provided a sample of the delegated agreement. The agreement included the requirements for policies and procedures, pre-delegation process, monitoring

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements, corrective actions if needed, reporting requirements and the scope of work.
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					Molina reported delegation agreements for eight entities. The delegated services include vision, non-emergent transportation, care management, dental services, nurse advice line, and utilization management. Copies of the annual audits, pre-delegation audit and/or the post implementation audits were provided. The results of the audits are reviewed by the Delegation Oversight Committee. The Delegation Oversight Committee is responsible for making recommendations, including the imposition of corrective action plans based on audit and monitoring results. The Delegation Oversight Committee monitors and reposts the status of corrective action plans addressing deficiencies.

ATTACHMENTS

Attachment 1: Initial Notice and Materials Requested for Desk Review

July 3, 2025

David Livingston
Plan President/Chief Executive Officer
Molina Healthcare of Mississippi
188 E Capitol St Ste 700
Jackson, MS 39201

Dear Mr. Livingston:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2025 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 (Constellation).

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) 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 September 10, 2025, and September 11, 2025, for the MississippiCAN and Mississippi CHIP Programs.

In preparation for the desk review, the items on the enclosed MississippiCAN Materials Request for Desk Review and Mississippi CHIP Materials Request for Desk Review lists should be provided to Constellation no later than August 4, 2025.

Please upload all the desk materials electronically to Constellation 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 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 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 can also send written instructions on how to use the file transfer site if needed. 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 2025 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, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. Provider identified limitations on panel size considered in the network assessment
5. The total number of unique specialty providers for MSCAN as well as the total number of unique primary care providers, broken down by specialty, currently in the network.
6. A completed Provider Network File Questionnaire
7. A current provider directory/list as supplied to MSCAN members.
8. A copy of the current Fraud, Waste & Abuse/Compliance Plan for the MSCAN Program, any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.
9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for MSCAN.
10. The Quality Improvement work plans for MSCAN for 2024 and 2025.
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 all committee meetings 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. 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 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 2024 and 2025 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 July 2024 through June 2025. 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 July 2024 to June 2025. 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 July 2024 through June 2025.
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 July 2024 through June 2025.
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 SFY 2025. *(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 July 2024 through June 2025.

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 2024 (MY 2024) Record of Administration,	• Please submit the same Roadmap your CCO completed for the MY 2024 [1]NCQA HEDIS Compliance Audit™, that was

Folder	Requested Document	Description
	Data Management and Processes (Roadmap)	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 file and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) CSV file and Excel workbooks for MSCAN for MY 2024.
c.	HEDIS MY 2024 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 2024.
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 the 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 g) a list of all the 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.

Folder	Requested Document	Description
h.	Rate Reporting template populated with data for HEDIS Admin-only rates and non-HEDIS measure rates	Constellation Quality Health will provide the rate reporting template for both the CMS Adult and Child Core Set HEDIS Admin only rates and 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 July 2024 through June 2025. 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 July 2024 through June 2025, 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 2025 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, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. Provider identified limitations on panel size considered in the network assessment.
5. The total number of unique specialty providers for CHIP as well as the total number of unique primary care providers, broken down by specialty, currently in the network.
6. A completed Provider Network File Questionnaire
7. A current provider directory/list as supplied to CHIP members.
8. A copy of the current Fraud, Waste & Abuse/Compliance Plan for the CHIP Program, any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.
9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for CHIP.
10. The Quality Improvement work plans for CHIP for 2024 and 2025.

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 2024 and 2025 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 July 2024 through June 2025. 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 July 2024 to June 2025. 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 July 2024 through June 2025.
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 July 2024 through June 2025.
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 SFY 2025. *(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 July 2024 through June 2025.
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 2024 (MY 2024) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2024 [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 file and Excel workbooks) for MS CHIP	Please submit auditor locked Interactive Data Submission System (IDSS) CSV file and Excel workbooks for MS CHIP for MY 2024.
c.	HEDIS MY 2024 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 2024.
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	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

Folder	Requested Document	Description
	the HEDIS measures	portal, folder 36.g) a list of all the 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 HEDIS Admin only rates and non-HEDIS measure rates	Constellation Quality Health will provide the rate reporting template for both the CMS Adult and Child Core Set HEDIS Admin only rates and 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 July 2024 through June 2025. 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 July 2024 through June 2025, 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

2025 External Quality Review

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted to Constellation
2. Copy of the 2025 Annual audit for Accordant Care
3. Copy of the pre-delegation audit for Evolent Health (New Century Health)
4. The most recent CAN and CHIP geographic access reports that include a county-by-county breakdown, parameters used to measure access, and percentages of members with and without access to each provider type
5. The current Health Equity and Cultural Competency Program Description and/or Culturally and Linguistically Appropriate Services Program Description

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
- Provider Satisfaction Survey Validation CAN and 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	2024
Review Performed	2025

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**	Purpose of CAHPS is clearly described (member experience and satisfaction).
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Objectives such as evaluating access, care quality, and service experience are documented.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Audience identified (leadership, quality committee)

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 (NCQA/CAHPS).
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	CAHPS is tested for reliability.

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.

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	Frame consistent with CAHPS protocol.
3.3	Review that the sampling method appropriate to the survey purpose	MET	Random sampling per CAHPS specifications.
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.
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Vendor use CAHPS protocols.

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.
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.

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	QA plan is documented. Survey vendor (press Ganey) QA plan includes administration, data handling, coding, and edits.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan.
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data documented and applied.

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.
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized.
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis.

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.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 10.1%, which is a decline from 13% in the previous year. While the survey provides valuable insights into member experiences, the response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
7.3	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
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.

EQR Survey Validation Worksheet

Plan Name	Molina Child Medicaid
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD MEDICAID
Validation Period	2024
Review Performed	2025

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	The report states that the CAHPs survey purpose is to capture member experience.
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Objectives include measuring satisfaction, identifying drivers or plan rating and benchmarking against NCQA benchmark.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Audience identified (leadership, quality committee)

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 (NCQA/CAHPS).
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	CAHPS is tested for reliability.

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.
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Frame consistent with CAHPS protocol.
3.3	Review that the sampling method appropriate to the survey purpose	MET	Random sampling per CAHPS specifications.
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.
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Vendor use CAHPS protocols.

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.
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.

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	QA plan is documented. Survey vendor (press Ganey) QA plan includes administration, data handling, coding, and edits.

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.
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data documented and applied.

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.
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized.
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis.

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.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 7.7%, which has declined from 9.4% in the previous year. While the survey provides valuable insights into member experiences, the response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
7.3	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
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.

EQR Survey Validation Worksheet

Plan Name	Molina CHIP
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2024
Review Performed	2025

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	Purpose of CAHPS is clearly described (member experience and satisfaction).
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Objectives such as evaluating access, care quality, and service experience are documented.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Audience identified (leadership, quality committee)

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 (NCQA/CAHPS).
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	CAHPS is tested for reliability.

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.
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Frame consistent with CAHPS protocol.
3.3	Review that the sampling method appropriate to the survey purpose	MET	Random sampling per CAHPS specifications.
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.
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Vendor use CAHPS protocols.

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.
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.

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	QA plan is documented. Survey vendor (press Ganey) QA plan includes administration, data handling, coding, and edits.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan.

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data documented and applied.

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.
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized.
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis.

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.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 9.4%, which is a decline from 11.2% in the previous year. While the survey provides valuable insights into member experiences, the response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings.
7.3	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
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.

EQR Survey Validation Worksheet

Plan Name	Molina CAN/CHIP
Survey Validated	PROVIDER SATISFACTION SURVEY
Validation Period	2024
Review Performed	2025

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	The purpose was clearly stated.
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Objectives are clearly stated and align with provider satisfaction.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Audience are identified in the report.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	The survey was conducted by NCQA certified survey vendor which implies that the instruments meets face validity standard.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey instrument is based on the NCQA-validated questions. Reliability is implied by use of an external vendor and NCQA compliance.

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.

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 described as all eligible providers in the network.
3.3	Review that the sampling method appropriate to the survey purpose	MET	Random sampling was applied.
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient to calculate statistically meaningful results.
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Vendor procedures used to protect against bias.

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.
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.	NA	Response rate was reported and discussion about low response was noted and acknowledged the rate did not meet Molina's target but unable to judge if discussion about bias and generalizability was made

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	QA plan is documented specifically about removing duplicates before sampling.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan.
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	NA	Unable to judge.

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 and results reported.
6.2	Were appropriate statistical tests used and applied correctly?	Met	The report included descriptive percentages and compared results.
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis.

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?	Unable to judge.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 7.5%, which is a slight decrease from 7.7% in 2023. While the survey provides valuable insights into member experiences, the response rate is lower than the Molina target and may introduce bias into the generalizability of the findings.
7.3	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan.
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.

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare MSCAN
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2025
Review Performed:	9/10/2025

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare MSCAN
Name of PM:	ALL ADULT AND CHILD CMS CORE MEASURES – CAN
Reporting Year:	2025
Review Performed:	9/10/2025

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare MSCHIP
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2025
Review Performed:	9/10/2025

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

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

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

SAMPLING ELEMENTS (IF ADMINISTRATIVE MEASURE THEN N/A FOR SECTION)			
Audit Elements	Audit Specifications	Validation	Comments
S1 Sampling	Sample treated all measures independently.	Met	
S2 Sampling	Sample size and replacement methodologies met specifications.	Met	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PM Validation Worksheet

Plan Name:	Molina Healthcare MSCHIP
Name of PM:	ALL ADULT AND CHILD CMS CORE MEASURES – CHIP
Reporting Year:	2025
Review Performed:	9/10/2025

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	ASTHMA AMR
Reporting Year:	2024
Review Performed:	2025

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	Prevalence, physical, emotional, and economic burden stated in the rational section.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Increase Compliance rate of persistent asthma patients with AMR >0.50 during measurement year.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Addresses key aspects of enrollee care and services.
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	Defines population and no report of exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	N/A	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	N/A	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	N/A	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	HEDIS AMR measure was used.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	Measures Asthma control and health outcomes.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	Met	Report specifies data source and collection method.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source – claims, pharmacy, Quality Performance Tool Dashboard.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	Instruments provided accurate and consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Statistical testing defined and applied.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	Met	Analysis, success, improvement areas, and interventions discussed.
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 implemented and barriers addressed were reported.
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	Improvements noted in multiple Quarters except for Q4
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear	Met	Intervention linked to better adherence.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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 comparison documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	Met	Sustained improvement shown for some of the quarters.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

Audit Designation
High Confidence in Reported Results

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
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:	2024
Review Performed:	2025

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	Prevalence, Mortality, disparity, and opportunity for improvement.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Increase systematic corticosteroid (14days) or bronchodilator (30 days) post-discharge for. COPD exacerbations.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Addresses key aspects of enrollee care and services.
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	Defines population and no report of exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	HEDIS PCE indicators were used.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	Medication adherence post exacerbation was strongly linked to reduced rehospitalizations and improved outcomes.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	Met	Report specifies data source and collection method.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source – claims, pharmacy, Quality Performance Tool Dashboard.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	Instruments provided accurate and consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Statistical testing defined and applied.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Declines noted, improvement opportunities discussed.
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	Reported Interventions implemented.
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	Some quarters such as Q1 2025 exceeded benchmarks.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear	Met	Intervention linked to improvements.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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 comparison 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	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	Follow-up After Hospitalization for Mental Illness (FUH) – 30 days, Follow-up After Hospitalization Mental Illness (FUH) – 7 days
Reporting Year:	2024
Review Performed:	2025

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	Among others, FUH topic was justified with MS Depression/suicide rates and provider shortage.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aims to increase members who receive FUH within 7 and 30 days.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Applies to members, age >=6, hospitalized for selected MH diagnoses.
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	Includes all eligible discharges, no exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	HEDIS FUH 7/30 days, defined numerator and denominator.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	FUH is evidence-based, tied to reduced readmissions and improved MH outcomes.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	Met	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source – claims, encounter, MHMS Quality tool, etc.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on a quarterly basis.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	HEDIS standard specifications ensured consistency. Instruments provided accurate and consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Statistical testing defined and applied.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and noted interventions.
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	Reported Interventions implemented.
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	Quantitative improvement documented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear	Met	Intervention linked to improvements.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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 comparison documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	Met	Noted sustained improvement through repeated measure.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

Audit Designation
High Confidence in Reported Results

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
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:	2024
Review Performed:	2025

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	Obesity identified as major issue for MS youth, high prevalence, and disparities.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aims to increase BMI percentile documentation and counseling rates.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Applies to all members age 3–17.
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	Includes all eligible discharges, no exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	HEDIS WCC (wight assessment and counseling for Nutrition and physical activity for Children/Adolescents measure.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	Counseling tied to improved obesity management.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	Met	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source – claims, encounter, provider records.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on a quarterly basis.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	HEDIS standard specifications ensured consistency. Instruments provided accurate and consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Statistical testing defined and applied.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan comparing baseline and remeasurement.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and improvement strategies, planning, and next steps.
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	Listed Interventions implemented.
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	Quantitative improvement documented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear	Met	Intervention linked to improvements.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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 comparison documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	Met	Noted sustained improvement through repeated measure.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

Audit Designation
High Confidence in Reported Results

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
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 (PPC)
Reporting Year:	2024
Review Performed:	2025

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	Prenatal/ postpartum care identified as priority due to maternal health disparities in MS.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aims to improve timeliness and rates of prenatal visits and postpartum visits.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Applies to all pregnant women members who delivered live birth.
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	Includes all eligible members, no exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	Uses HEDIS PPC measure with defined specs.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	Measures address maternal care processes with strong ties to improved outcome.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	Met	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source – claims, encounter data, chart review.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on a quarterly basis.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	HEDIS standard specifications ensured consistency. Instruments provided accurate and consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Statistical testing defined and applied.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan comparing baseline and remeasurement.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and improvement strategies, planning, and next steps.
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	Listed Interventions implemented such as provider engagement and education on visit scheduling.
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	Quantitative improvement documented, across both components of the measure.

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	Intervention linked to improvements.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	Met	Statistical comparison documented across several quarters.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	Met	Noted improvement in majority of the quarters through repeated measure.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Molina CAN
Name of PIP:	Sickle Cell Disease
Reporting Year:	2024
Review Performed:	2025

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	High prevalence of SCD in MS, racial disparities, high costs, etc.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aims percent of members with SCD in case management and receiving FUH after hospitalization.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Applies to all members age >=6 with sickle cell diagnosis.
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	Includes all eligible members, no exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	Defines numerator and denominator.
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	Enrollment in case management and FUH linked to improved SDC outcomes.

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	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source such as claims, encounter data are listed.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on a quarterly basis.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	IPro database/claims provide consistency.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Statistical testing defined and applied.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan comparing baseline and remeasurement.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and intervention impacts.
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	Listed Interventions implemented such outreach and collaboration with a community foundation.
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	Quantitative improvement documented in some quarters.
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	Intervention linked to improvements.

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 comparison documented across several quarters.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	Follow-up After Hospitalization for Mental Illness (FUH) – 30 days, Follow-up After Hospitalization Mental Illness (FUH) – 7 days
Reporting Year:	2024
Review Performed:	2025

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	Noted depression prevalence in MS on children and adolescents.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aim stated to increase 30 and 7 days follow up.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Defined numerator and denominator.
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	Included all eligible members.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	NCQA/HEDIS aligned.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	Indicators measures continuity of care post-behavioral discharge.

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	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source such as claims, encounter data are listed.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on based on numerator and denominator specifications.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	HEDIS Specifications ensure consistency.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Document included planed annual trending and comparison against benchmarks.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan comparing baseline and remeasurement.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and interventions.
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	Listed Interventions implemented such as Transition of Care assessments and discharge planning checklist.
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	Reported increased across several periods for both 30 and 7 days.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear	Met	Intervention linked to improvements.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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 test performed and z tests performed to test significance.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	Met	Multi-year trending shows consistent improvement.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	Obesity
Reporting Year:	2024
Review Performed:	2025

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	Rational included high prevalence, and need for preventive nutrition and activity interventions.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aim stated to increase percentage of CHIP members receiving nutrition and physical activity counseling.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Address key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	Met	Included all eligible members.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	Used NCQA/HEDIS weight assessment and counseling measures used.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	Met	Indicators measures processes of care (BMI assessment, counseling)
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	Met	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source such as claims, encounter data are listed.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on based on numerator and denominator specifications.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	HEDIS Specifications ensure consistency.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Document included planned annual trending and comparison against benchmarks.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan comparing baseline and remeasurement.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and interventions.
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	Listed Interventions implemented such outreach and provider education on documentation.
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	Reported increase in BMI documentation and nutrition counseling rates.

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	Intervention linked to improvements.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	Met	Statistical test performed and p value provided for significance.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	Met	Multi-year trending shows consistent improvement.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	Well Care- Well Child
Reporting Year:	2024
Review Performed:	2025

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	Document notes low performance in well child visit rates.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	Met	Aim stated clearly to increase recommended well child visit within reporting year.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	Met	Address key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	Met	includes all eligible members (age 0-21), no exclusions.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used. Census data.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	Met	Used NCQA/HEDIS Well-Child measure (W30, WCV, AWC) with standard numerator/denominator.
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 tracks process of care (preventive visits) strongly linked to child health outcome.

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	Report provided specifications for numerator and denominator.
6.2 Did the study design clearly specify the sources of data? (1)	Met	Specifies data source such as claims, encounter data are listed.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	Met	Data pulled from data sources on based on numerator and denominator specifications.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	Met	HEDIS Specifications ensure consistency.
6.5 Did the study design prospectively specify a data analysis plan? (1)	Met	Document included planned annual trending and comparison against benchmarks.
6.6 Were qualified staff and personnel used to collect the data? (5)	Met	Team members listed with credentials.
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 Conducted according to Plan comparing baseline and remeasurement.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	Met	Data presented in tables and graphs.
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	Compared bassline vs repeat measurements.
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	Includes interpretation of results and intervention such as reminder calls and improved scheduling access listed.
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	Listed Interventions implemented such outreach and provider education.
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	Reported increase in well-child visit rates from baseline year to follow-up year.
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	Intervention linked to improvements.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	Met	Statistical test performed and p value provided for significance.

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	Multi-year trending shows consistent improvement.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Molina CHIP
Name of PIP:	ASTHMA AMR
Reporting Year:	2024
Review Performed:	2025

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	MS child asthma prevalence, burden and has the highest mortality rate in the country.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims to increase AMR compliance among CHIP members.
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 and defined. MS CHIP asthmatic members ages 5-19 with persistent asthma per HEDIS.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are clearly defined using HEDIS measures.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator 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	Data collection method was included in the report.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Claims/encounter, pharmacy data were listed as sources of data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Quarterly report pulls.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection methods and tools use provide consistency.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis was described.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Responsible staff with credentials were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	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 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	Provider, member, and community interventions listed. 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	91.67% performance in Q1 2025 which is above the benchmark 72.89% and an improvement from Q4 of 2024.

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	The document ties the improvement with the interventions implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical tests were conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	MET	Performance has been above benchmark for multiple quarters.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

Audit Designation
High Confidence in Reported Results

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
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 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

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

Molina Healthcare of Mississippi 2024 Corrective Action Plan – CAN

2024 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
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.			
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 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.	MSCAN Item #1 (Same as CHIP item # 7) Revised the CAN Provider Manual on pg. 63 and the CAN website to reflect the correct timeframe of 21 days for routine visits with BH/SUD providers. Website changes can be reviewed here. 2/12/25 CORRECTIONS: • Policy MHMS-QI-006 (page 4) has been edited: Deleted statement, "and thirty (30) calendar days from previous appointment". • Policy MHMS-QI-006 (page 4) has been edited: Corrected statement: "Molina's goal is to have ninety (90) percent" (rather than "Molina's goal is to have seventy-five (75) percent").	✓	

2024 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
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 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.*			
II B. Provider Education			
2. Initial provider education includes: 2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;			
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.	MSCAN Item #2 Revised the CAN Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center on pg. 31 using the following statement: *"Additionally, members can call Molina's Member Contact Center at (844) 809-8438 to obtain a list of participating providers for self-referral if needed."*	✓	

2024 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
Corrective Action Plan: Revise the CAN Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center.			
2. Initial provider education includes: 2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.			
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.*	MSCAN Item # 3 Revised the CAN Provider Manual to include the required the following non-exclusivity statement on pg. 17. *"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."* 2.4.2025- Corrected the non-exclusivity statement by removing the CHIP reference and adding "MississippiCAN" to reference the correct program.	✓	
II B. Preventive Health and Clinical Practice Guidelines			
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.			
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…"	MSCAN Item # 4 (Same as CHIP Item # 9) Revised the CAN Provider Manual on pg. 71 to list the annual review frequency of the CPGs and PHGs. 2-12-2025 CORRECTIONS: • Policy MHMS-QI-018 (page 6) has been edited to read, consistently with Provider Manual: "All clinical practice guidelines and preventive health guidelines are updated at least annually, and more frequently, as needed" (rather than, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer. All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly.) QI Program Description (page 45) has been edited to read, consistently with Provider Manual: "All clinical practice and preventive health	✓	

2024 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
• 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. *Corrective Action Plan: Revise the specified documents to consistently and correctly list the frequency of review of the CPGs and PHGs.*	guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee" (rather than, "Topics and effectiveness of clinical practice and preventive health guidelines are reviewed and approved by the Quality Improvement and Health Equity Transformation Committee at least annually, with review of changes occurring at least quarterly to identify new guidelines or changes to existing guidelines."		
MEMBER SERVICES			
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;			
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	<u>Eye Car Benefit</u> Molina has revised the MSCAN member website to ensure that the eye care benefit language states that the benefit is being administered every fiscal year. This change can be found on the website here at: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx <u>Genetic Testing</u> The Molina website has been updated to accurately reflect the language regarding genetic testing. This language can also be found in the MSCAN member handbook. The updated language states: *Inheritable disease diagnosis, such as Sickle Cell*. This change can be found on the website here at: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx <u>Non-emergency transportation services</u>	✓	

2024 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
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.*	The Molina website has been updated to accurately reflect the language regarding non-emergency transportation services. The updated language states: *To medical appointments, vision exams and pharmacy visits immediately following a medical appointment.* This change can be found on the website here at: https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx		
QUALITY IMPROVEMENT			
IV A. Quality Improvement (QI) Program			
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.			
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 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.*	*Per EQR recommendations, the section that described the credentialing and recredentialing program (listed below) has been removed from QI Program Description (page 39). <u>Implementing a Credentialing and Recredentialing Program</u>: Molina maintains a comprehensive and detailed credentialing and recredentialing program designed to assure the network consists of quality practitioners who meet clearly defined criteria and standards. The credentialing and recredentialing program activities meet National Committee for Quality Assurance standards and regulatory requirements. This program includes, but is not limited to: • reviewing credentialing and recredentialing policies and procedures, including processes to check Opt-Out providers that elect not to provide services to Medicaid and CHIP members; • conducting peer reviews of credentialing and recredentialing decisions; • presenting Potential Quality of Care case summaries as directed by the designed Medical Director and quality staff to the Professional Review Committee for confidential peer review and		✓

2024 EQR Findings - CAN	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
	oversight with the network team for proposed corrective action plans; • overseeing delegated credentialing activities; and • reviewing member Appeals and Grievances. Policies and procedures within the credentialing program describe the types of practitioners who are under the scope of the credentialing program as well as the process to assure the quality of the practitioners. The policies and procedures are reviewed annually and revised and updated as needed. The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners, and additional information as required. The information gathered is confidential, and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law. Molina designates the Professional Review (e.g., Credentialing) Committee, to make recommendations about credentialing decisions using a peer review process. Molina works with the Professional Review Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina enrollees. A practitioner may not provide care to Molina enrollees until the final decision from the Professional Review Committee is made. In situations of "clean files," network practitioners may not provide care for Molina enrollees until the final decision is made by the Molina Plan Chief Medical Officer.		

Molina Healthcare of Mississippi 2024 Corrective Action Plan – CHIP

2024 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II A. Adequacy of the Provider Network			
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.			
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 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	CHIP Item #7 CHIP Provider Manual on pg. 64 and the CAN website reflect the correct timeframe of 21 days for routine visits with BH/SUD providers. Website changes can be reviewed here. 2/12/25 CORRECTIONS: • Policy MHMS-QI-006 (page 4) has been edited: Deleted statement, "and thirty (30) calendar days from previous appointment". • Policy MHMS-QI-006 (page 4) has been edited: Corrected statement: "Molina's goal is to have ninety (90) percent" (rather than "Molina's goal is to have seventy-five (75) percent"). Item #1 revised document represents Item#7 as well.	✓	

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
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.*			
II B. Provider Education			
2. Initial provider education includes: 2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;			
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. 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.*	CHIP Item #8 Revised the CHIP Provider Manual to clarify the statement that members may self-refer to behavioral health care by calling the Member Contact Center on pg. 31 using the following statement: *"Additionally, members can call Molina's Member Contact Center at (844) 809-8438 to obtain a list of participating providers for self-referral if needed."*	✓	
II C. Preventive Health and Clinical Practice Guidelines			

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
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.			
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 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.*	CHIP Item # 9 Revised the CHIP Provider Manual on pg. 70 to list the annual review frequency of the CPGs and PHGs. 2-12-2025 CORRECTIONS: • Policy MHMS-QI-018 (page 6) has been edited to read, consistently with Provider Manual: "All clinical practice guidelines and preventive health guidelines are updated at least annually, and more frequently, as needed" (rather than, "Molina has a periodic review process for guidelines that have been in effect for two (2) years or longer. All clinical practice guidelines and preventive health guidelines will be reviewed at least quarterly.) • QI Program Description (page 45) has been edited to read, consistently with Provider Manual: "All clinical practice and preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee" (rather than, "Topics and effectiveness of clinical practice and preventive health guidelines are reviewed and approved by the Quality Improvement and Health Equity Transformation Committee at least annually, with review of changes occurring at least quarterly to identify new guidelines or changes to existing guidelines." Item #4 revised document represents Item# 9 as well.	✓	
2. The CCO communicates the preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members to providers.			
Molina submitted an explanation that the adopted guidelines are the same for CAN and CHIP; however, there were	CHIP Item #10 The webpage with the non-functional hyperlinks was deleted as it is no longer needed.		

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
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: 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.*	Revised the CHIP website to include the current "Standards of Care in Diabetes—2023" guideline. Molina plans to utilize the following page for Clinical Practice Guidelines		
MEMBER SERVICES			
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;			
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 Molina website has been revised to indicate that prior authorization is required for ambulatory surgical center services. This is also included in the CHIP member handbook on page 19. Substance Abuse Services Inpatient/Outpatient Care - Molina has revised the language on the Molina website to align with the language pertaining to Substance Abuse Services Inpatient/ Outpatient Care in the MSCAN member handbook. This change can be found on the website here at:	✓	

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
• 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.*	https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Disease Management – Molina has revised the website to align with the language that is included in the CHIP member handbook. The language " as indicated by PCP" was added on the website located here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Emergency Ambulance Services – The language " Unlimited based on life threatening condition present" was added on the website located here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx Radiology/X-ray – Molina has added "Prior authorization is required" for Radiology/X-rays on the website located here at: https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx This language is also located in the CHIP member handbook, page 21.		
QUALITY IMPROVEMENT			
IV A. Quality Improvement (QI) Program			
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.			
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 Description be updated or removed. This recommendation was not completed.	*Per EQR recommendations, the section that described the credentialing and recredentialing program (listed below) has been removed from QI Program Description (page 39). Implementing a Credentialing and Recredentialing Program: Molina maintains a comprehensive and detailed credentialing and recredentialing program designed to assure the network consists of quality practitioners who meet clearly defined criteria and standards. The credentialing and recredentialing program activities meet National Committee for Quality Assurance standards and		✓

2024 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2025 EQR Findings	
		Corrected	Not Corrected
Corrective Action Plan: Correct the QI Program Description and remove or update the section that describes the credentialing and recredentialing program.	regulatory requirements. This program includes, but is not limited to: •reviewing credentialing and recredentialing policies and procedures, including processes to check Opt-Out providers that elect not to provide services to Medicaid and CHIP members; •conducting peer reviews of credentialing and recredentialing decisions; •presenting Potential Quality of Care case summaries as directed by the designed Medical Director and quality staff to the Professional Review Committee for confidential peer review and oversight with the network team for proposed corrective action plans; •overseeing delegated credentialing activities; and •reviewing member Appeals and Grievances. Policies and procedures within the credentialing program describe the types of practitioners who are under the scope of the credentialing program as well as the process to assure the quality of the practitioners. The policies and procedures are reviewed annually and revised and updated as needed. The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners, and additional information as required. The information gathered is confidential, and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law. Molina designates the Professional Review (e.g., Credentialing) Committee, to make recommendations about credentialing decisions using a peer review process. Molina works with the Professional Review Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina enrollees. A practitioner may not provide care to Molina enrollees until the final decision from the Professional Review Committee is made. In situations of "clean files," network practitioners may not provide care for Molina enrollees until the final decision is made by the Molina Plan Chief Medical Officer.		