2020 External Quality Review

MOLINA HEALTHCARE OF MISSISSIPPI

Submitted: March 4, 2021

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies who contract 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 report contains a description of the process and results of the 2020 External Quality Review (EQR) of Molina Healthcare of Mississippi (Molina) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The goals of the review were to:

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

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

OVERVIEW

The 2020 EQR for Molina's CAN Program shows Molina achieved "Met" scores for 97% of the standards reviewed. As the following chart indicates, 2% of the standards were scored as "Partially Met," and 1% were scored as "Not Met." For the CHIP Program, 96% of the standards were scored as "Met," 2% of the standards were scored as "Partially Met," and 2% were scored as "Not Met."

Figure 1: 2020 Annual EQR Review Results for CAN & CHIP

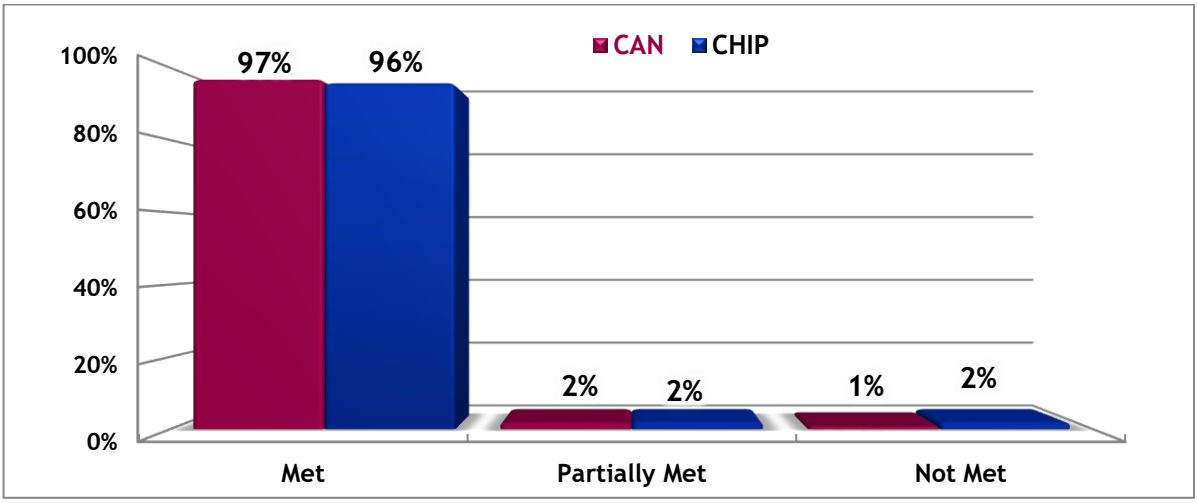


Table 1: Scoring Overview provides an overview of the scores for each review section for the CAN and the CHIP Programs. Standards regarding recredentialing file review (CAN and CHIP) and performance measures (CHIP) were not evaluated because Molina is a new plan in Mississippi. At the time of this review, Molina had not conducted recredentialing of any network providers and had not reported any performance measures for the CHIP population.

Table 1: Scoring Overview

2020	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
CAN	32	0	0	0	0	32
CHIP	32	0	0	0	0	32
Provider Services						
CAN	67	1	1	17	0	86
CHIP	63	2	2	17	0	84
Member Services						
CAN	33	0	3	0	0	36
CHIP	28	0	0	4	0	32
Quality Improvement						
CAN	15	2	2	0	0	19
CHIP	14	2	2	1	0	19
Utilization Management						

2020	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
CAN	54	1	0	0	0	55
CHIP	53	1	0	0	0	54
Delegation						
CAN	1	1	0	0	0	2
CHIP	1	1	0	0	0	2

Overall Findings

An overview of the findings for each section is included in this Executive Summary. Details of the review, as well as specific strengths, weaknesses, applicable corrective action items, and recommendations are found in the respective sections and narrative of this report.

Administration

CCME's review for Administration included the Organization Chart, policies and procedures, the 2020 Code of Business Conduct and Ethics, the Compliance Plan, the Compliance Committee and related documents such as meeting minutes, employee orientation and training materials, information systems, and the Molina website.

Policies and procedures are in place that demonstrate the management of daily operations. Molina's policies and procedures accurately and consistently reflect the language used for CAN and CHIP Contract requirements. There is no written policy to delineate internal processes for the development, review, and revision of policies and procedures, and steps for employee notification of newly developed or revised policies.

The Information Systems Capabilities Assessment documentation and associated data demonstrates the organization has policies, procedures, and system capabilities to meet Mississippi's CCO requirements. Specifically, Molina has a detailed security plan that establishes the overall security posture of the organization. The plan is backed by standard operating procedures addressing the tasks necessary to maintain that security posture. Additionally, Molina has implemented backup and recovery policies and procedures to ensure data integrity and availability. Finally, Molina's documentation shows the organization's claims processing rate exceeds the State's requirements.

Molina has implemented a Compliance Plan with goals of increasing efficiency, reducing waste, minimizing confusion, and improving the quality of services. A Code of Business Conduct and Ethics is in place that governs the way employees, officers, and directors conduct daily business activities. Compliance and confidentiality training and education

are provided to employees that includes information needed about recognition, reporting, investigation, and follow-up of suspected violations regarding non-compliance.

Provider Services

Processes and requirements for credentialing and recredentialing health care providers are found in policies with Mississippi-specific requirements included in addenda. Molina's CHIP policies do not address the requirement from the *CHIP Contract, Section 7 (E) (6)*, which requires the CCO to collect fingerprints for providers determined by DOM to be high-risk and any person with a five percent or more direct or indirect ownership interest in the organization or practice.

CCME's review of initial credentialing files revealed issues such as not collecting admitting plans for nurse practitioners and not conducting site visits at initial credentialing. CCME noted some provider applications did not include a response to the question about conducting laboratory services. Molina staff reported that in this situation, they do not contact the provider to clarify and do not seek a Clinical Laboratory Improvement Amendments (CLIA) certificate for the location. Also, high-risk organizational CHIP provider files contained no evidence of fingerprint submission. Onsite discussion confirmed that Molina is not obtaining fingerprints from any CHIP providers.

Molina's Professional Review Committee (PRC) makes recommendations regarding credentialing decisions and is chaired by the Molina Medical Director. Molina's policy states the PRC's membership should include practitioners from a range of specialties in the Molina network, such as behavioral health, dentistry, family practice, internal medicine, pain management, pediatrics, OB/GYN, surgery, etc. However, CCME noted the voting PRC members include three family medicine providers, one internal medicine provider, and one OB/GYN. Molina staff confirmed they have not attempted to recruit providers with additional specialties to serve on this committee.

Molina has developed policies and procedures for monitoring and managing its network of providers to meet the health care needs of members. Provider choice and specialized services are ensured throughout the network. Geo Access Reports are generated quarterly and are reviewed internally on a regular basis; however, they do not clearly indicate member choice of two or more PCPs within a 15-mile radius for urban counties and within 30 miles for rural counties. Molina does not currently compile an annual report that summarizes findings and trends from the quarterly Geo Access Reports. A formal review process is needed to address the Geo Access Reports to summarize the findings annually and to identify provider gaps based on location or specialization.

Evidence was found that accessibility standards are being measured and, except for the requirement for appointments after discharge from an acute psychiatric hospital, are met. The *CAN Contract, Section 7 (B) (2)* and the *CHIP Contract, Section 7 (B) (2)*

stipulate that follow-up appointments should be scheduled within seven calendar days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavioral Health 1st Quarter 2020 MS CAN and the corresponding report for CHIP indicate the standard was measured using a 14-calendar day parameter.

Provider Services staff conduct orientation and training for new providers within 30 calendar days of joining the network. The Provider Orientation PowerPoint presentation and the Provider Manual are primarily used to conduct initial training. In addition to the Provider Manual, ongoing training and education for providers and office staff includes website functionality and accessing information through provider newsletters and mailings. No issues were identified with the provider education program.

Molina adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) based on scientific evidence and recommendations from Molina's National Quality Improvement Committee. The guidelines are relevant to Molina's member population, are reviewed routinely, and are updated when new scientific evidence and national guidelines are published. Providers are informed of all adopted CPGs and PHGs and the guidelines are available on the website. Individual providers or members may request hard copies as needed.

Standards of medical record documentation are defined in policy; however, the policy does not include that documentation should include any health education provided to members. Also, the policy does not include the frequency of medical record audits. Currently, medical record audits have been placed on hold due to restrictions from Covid-19 and will resume when restrictions are lifted.

Provider Satisfaction Survey validation was performed using a validation worksheet based on the CMS Survey Validation Protocol. Molina's provider satisfaction survey occurred in November 2019. The overall response rate was 15.6%. CCME recommends that the plan work with the vendor to determine other methods to increase response rates. Ensure provider contact information is up to date.

CCME conducted a validation of network access/availability and provider directory accuracy for Molina to determine if the provider contact information was accurate and assess appointment availability. For Molina, this review will serve as the baseline for future reviews. The methodology involved two phases: (1) a telephonic survey to determine if CCO-provided PCP contact information was accurate and (2) an assessment of the accuracy of Molina's online Provider Directories. Appointment availability for urgent and routine care was also evaluated during this process.

For this review, Molina submitted a total of 2,362 unique PCPs for the CAN population and a total of 2,182 unique PCPs for the CHIP population. For CAN, a random sample of 102 PCPs was selected, and for CHIP a random sample of 100 PCPs was selected. Phase 1

(Provider Access Study) was conducted for each. For successful calls, Phase 2 (Provider Directory Validation) was conducted, and Molina's online provider directory was reviewed to determine if the information in the directory matched the information confirmed during the provider access study phase. A summary of the results is provided in *Table 2: Summary Provider Access Study and Provider Directory Validation*.

Table 2: Summary Provider Access Study and Provider Directory Validation

Phase 1 - Provider Access Study					
	Correct Address/Phone Number	Accepting Molina	Accepting New Patients	Access and Availability	
				*Routine Appointments	*Urgent Appointments
CAN	24%	83%	86%	75%	67%
CHIP	66%	72%	85%	68%	33%
Phase 2 - Provider Directory Validation					
	Correct Name	Correct Phone Number	Correct Address	Correct Panel Status	
CAN	86%	71%	71%	71%	
CHIP	95%	93%	93%	93%	

The Provider Directory Validation showed an accuracy rate of 71% among the PCPs evaluated for CAN and 93% among the PCPs evaluated for CHIP. The inaccuracy of provider contact information does not allow easy access for members. Once a PCP is identified, it is difficult for members to contact their PCP to schedule appointments. When issues arise with contacting PCPs for urgent appointments, the member is likely to seek care from another setting such as urgent care or emergency departments. Regarding routine care, the inability to contact a PCP may lead to delays in preventive care for members and their children. The results of the Provider Access Study and Provider Directory Validation for this quarter demonstrated an opportunity for improvement in provider contact information accuracy. Initiatives are needed to address gaps to ensure all members can contact a PCP using the online directory and receive the needed care in an efficient manner.

Full details of the study's results, conclusions, and required corrective actions are included in the Provider Access Study and Directory Validation report.

Member Services

Molina has CAN and CHIP policies and procedures that define and describe member rights and responsibilities as well as methods for notifying members of their rights and

responsibilities. Information is included in the Member Handbook, Provider Manual, on Molina's website, and in member newsletters; however, CCME identified issues with documentation of member responsibilities.

Molina provides the toll-free contact information and descriptions for CAN and CHIP Member Services and the 24-Hour Nurse Advice Line in the Member Handbook and on the website and encourages members to use the services. CAN and CHIP members are also encouraged to obtain recommended preventive services, such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Well-Baby and Well-Child Care services, from information and instructions on the website, in the Member Handbook, and through mailings.

Review of the grievance policies and related information in Member Handbooks, Provider Manuals, and on Molina's CAN and CHIP websites revealed issues such as incomplete grievance procedures and lack of both the definition of a grievance and a description of who can file a grievance.

The initial CAN Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys were conducted in June 2020. Members satisfaction validation for Molina CAN and CHIP was performed based on the *CMS Survey Validation Protocol*. Generalizability of the survey results is difficult to discern due to low response rates and recommendations were provided to address this issue. However, documentation of CAN member satisfaction survey results reported to the Quality Improvement Committee (QIC) and to network physicians was not submitted for review. Molina did not conduct a formal assessment of member satisfaction for the CHIP population.

Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the QI program descriptions for the CAN and CHIP programs, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations.

Molina's 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually. Molina does not have a separate QI Program Description for CHIP.

Annually, Molina's QI Work Plan identifies activities related to program priorities to improve the quality of services provided to CAN and CHIP members. There were errors or missing information noted in the 3rd quarter 2020 work plan, including:

- The objective for identifying a process for managing potential quality of care issues appeared incorrect.

- Goals were missing.
- Standards for measuring practitioner availability and accessibility were incorrect.
- The timeframe for notifying a member of the termination of a PCP was incorrect.

The QIC is responsible for the implementation and ongoing monitoring of the QI Program. The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. The 2020 membership list includes 20 internal voting members, two network pediatricians, and one internal medical physician. CCME recommends Molina recruit additional network providers to serve on the QIC. Consider including a Family Practice, OB/GYN, and Behavioral Health practitioner.

The scope of the QI Program includes providing feedback to practitioners on performance and monitoring provider compliance with clinical practice guidelines. Molina provided an example report given to individual providers regarding their performance data and patterns of utilization. This report is distributed by QI and/or Provider Services staff. The reports can also be downloaded from Molina's Provider Portal.

Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby and Well-Child Services, define the requirements for the EPSDT and Well-Baby and Well-Child Programs. The policies indicate Molina has a tracking system that tracks, at a minimum, initial visits for newborns, EPSDT screenings, and reporting of all screening results and diagnostic and treatment services, including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the EPSDT, Well-Baby or Well-Child service and did not include or indicate the members who received additional treatments or referrals as required by the *CAN* and *CHIP Contracts, Section 5 (D)*.

Annually, Molina evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the Quality Improvement Committee, and to the Division of Medicaid. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight.

Performance Measure Validation

The purpose of the performance measure validation is to assess the accuracy of the performance measures (PMs) reported by the CCOs and to determine the extent to which the PMs follow State specifications and reporting requirements. Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the PMs identified by DOM to evaluate their accuracy as reported by Molina for the CAN and CHIP populations.

Performance measure validation determines the extent to which the CCO followed the specifications established by the National Committee for Quality Assurance (NCQA) for the Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019. Since Molina did not have enrollment in the CHIP product line in 2019, the PM validation was conducted only for CAN.

Aqurate's HEDIS auditor found that the CCO was fully compliant with all information systems standards and determined that Molina submitted valid and reportable rates for most HEDIS measures in the scope of the audit. Some HEDIS measures had a 0.00% rate since Molina members did not meet the continuous enrollment requirements for measures that required enrollment for more than one year. These measures were Adult BMI Assessment (ABA), Breast Cancer Screening (BCS), Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR), Medication Management for People with Asthma (MMA), Asthma Medication Ratio (AMR), Statin Therapy for Patients with Cardiovascular Disease (SPC), and Statin Therapy for Patients with Diabetes (SPD). The Use of Opioids From Multiple Providers (UOP) and Use of Opioids at High Dosage (HDO) measures were assessed as having a Biased Rate (BR). This was the first year that Molina reported measures for CAN; therefore, there are no comparisons from the prior year.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by Molina for 2019 are listed in the Quality Improvement section of this report.

Molina did not report five non-HEDIS measures as required by DOM. The five measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01), Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH), Asthma in Younger Adults Admission Rate (PQI-15-AD), and Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.

The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. All numerator rates were not reported for the Use Of Pharmacotherapy For Opioid Use Disorder (OUD – AD).

Based on Aqurate's validation of PMs, there were no concerns with Molina's data processing, integration, and measure production for the reported CMS Adult and Child Core Set measures. Aqurate determined that Molina followed the measure specifications and produced reportable rates for most measures in the scope of the validation.

Performance Improvement Project Validation

Molina submitted seven CAN projects for validation. Topics included Behavioral Health Readmission, Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal and Postpartum Care, and Sickle Cell. *Table 3: CAN Performance Improvement Project Validation Scores* provides an overview of the current scores for the CAN PIPs.

Table 3: CAN Performance Improvement Project Validation Scores

Project	Current Validation Score
Behavioral Health Readmissions	80/80=100% High Confidence in Reported Results
Medication Management for People with Asthma (MMA)	28/62=45.2% Reported Results Not Credible
Pharmacotherapy Management of COPD Exacerbation (PCE)	28/62=45.2% Reported Results Not Credible
Follow-up After Hospitalization for Mental Illness (FUH)	28/62=45.2% Reported Results Not Credible
Obesity	28/62=45.2% Reported Results Not Credible
Prenatal and Postpartum Care	28/62=45.2% Reported Results Not Credible
Case Management and Follow-up (30 days) Services for Sickle Cell Disease	28/62=45.2% Reported Results Not Credible

The Behavioral Health Readmission was the only PIP that scored in the "High Confidence in Reported Results" range. All others were deemed as Not Credible due to missing elements.

For CHIP, Molina submitted four projects for validation. Topics included Medication Management for People with Asthma (MMA), Follow-Up After Hospitalization for Mental Illness (FUH), Obesity, and Well Care. *Table 4: CHIP Performance Improvement Project Validation Scores* provides an overview of the scores for the CHIP PIPs.

Table 4: CHIP Performance Improvement Project Validation Scores

Project	Current Validation Score
Medication Management for People with Asthma	28/62=45.2% Reported Results Not Credible

Project	Current Validation Score
Follow Up After Hospitalization for Mental Illness	28/62=45.2% Reported Results Not Credible
Obesity	28/62=45.2% Reported Results Not Credible
Well Care	28/62=45.2% Reported Results Not Credible

For this review, the four PIPs scored in the Not Credible range and did not meet the validation requirements due to missing elements.

Utilization Management

CCME's assessment of utilization management (UM) includes reviews of CAN and CHIP program descriptions and evaluations, policies, Member Handbooks, Provider Manuals, approval, denial, appeal, and case management files, and Molina's website. Policies and procedures define how UM services are operationalized and provided to members.

The Health Care Services (HCS) Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Review of approval and denial files confirmed Molina met criteria and timeframe requirements.

The CAN and CHIP Care Management (CM) policies appropriately document care management processes and services provided. CM files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Molina has established policies defining processes for handling both CAN and CHIP appeals of adverse benefit determinations. Review of documentation in policies, Member Handbooks, Provider Manuals, etc. revealed numerous issues, such as incomplete, incorrect, and missing information about appeals processes and requirements. CCME's review of appeal files revealed only isolated issues and it appears that overall appeals are handled properly. Molina uses appeal data to identify opportunities to improve quality of care and service.

Delegation

CCME's review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials. Molina reported 15 current delegation agreements.

Molina has policies that address processes followed to evaluate and monitor the delegated entities' capacity to perform the delegated activities. The monitoring tools used for the credentialing delegates did not include the site assessments and reassessments specified in the *CAN* and *Chip Contracts, Section 7 (E)* and the fingerprinting requirements for high-risk providers as required by the *CHIP Contract, Section 7 (E) (6)*.

METHODOLOGY

On October 16, 2020 CCME sent notification to Molina that the annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Standards for the CAN and CHIP programs.

Further, CCME invited the health plan to participate in a pre-onsite conference call with CCME and DOM. This call offered Molina an opportunity to seek clarification on the review process and ask questions about desk materials CCME requested. The call was conducted on October 27, 2020.

The EQR consisted of two segments. The first was a desk review of materials and documents received from Molina on November 16, 2020 for review at the CCME offices (see *Attachment 1*).

The second segment was a two-day, onsite teleconference conducted on January 20, 2021 and January 21, 2021 via Microsoft Teams due to issues with COVID-19. The onsite teleconference focused on areas not covered by the desk review and areas needing clarification (see *Attachment 2*). CCME's onsite teleconference activities included the following:

- Entrance and exit conferences (open to all interested parties)
- Interviews with Molina's administration and staff

The process used for the EQR is based on the CMS protocols for EQR of MCOs. This review focused on the four federally mandated EQR activities: compliance determination, validation of performance measures, validation of network adequacy, and validation of performance improvement projects. In addition, the review included the optional activities of member and provider satisfaction survey validation.

FINDINGS

EQR findings are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*, and the contract requirements between Molina and DOM. Strengths, weaknesses, corrective actions, and recommendations are identified where applicable.

Areas of review are recorded in a tabular spreadsheet (*Attachment 4*) and identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." Separate tabular spreadsheets for the respective CAN and CHIP programs are included in *Attachment 4*.

A. Administration

Molina Healthcare has policies and procedures in place that demonstrate the management of daily operations. Molina policies accurately and consistently reflect the language used for CAN and CHIP Contract requirements. Onsite discussion revealed a committee is being formed to oversee the management of policies and procedures. There is no written policy to delineate the internal process for the development, review, revision, and steps for employee notification of newly developed or revised policies and procedures.

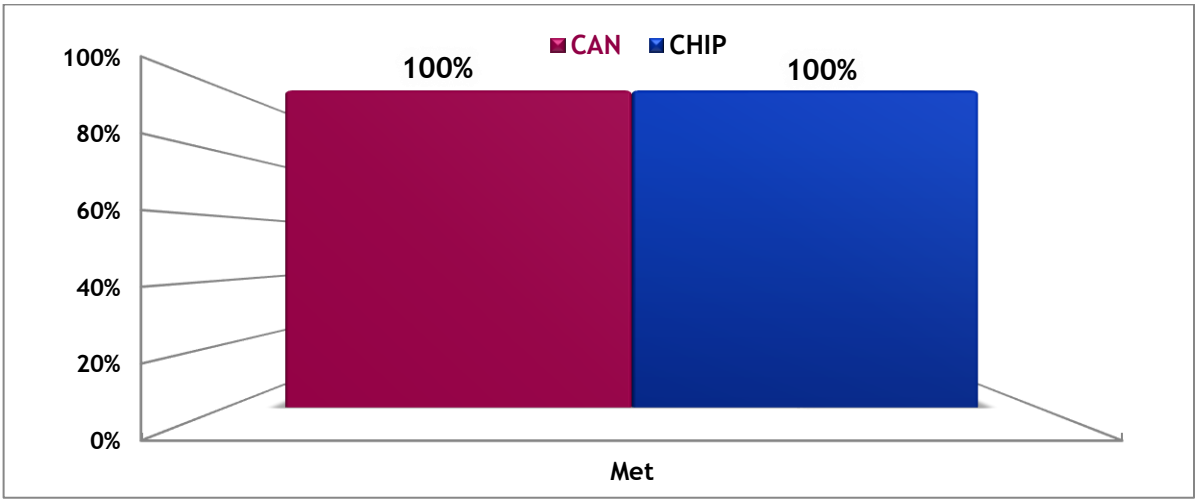
A review of the Organizational Chart was completed. Onsite clarification provided needed information to clearly identify employee position titles with assignments specific to both CAN and CHIP responsibilities. The Organizational Chart does not reflect current departmental totals with regard to employee assignment and vacancies.

The submitted Information Systems Capabilities Assessment documentation and data demonstrate the organization has policies, procedures, and system capabilities to meet Mississippi's CCO requirements. Specifically, Molina has a detailed security plan that establishes the overall security posture for the organization. The security plan is backed by standard operating procedures that address the tasks necessary to maintain that security posture. Additionally, the organization has implemented backup and recovery policies and procedures to ensure data integrity and availability. Finally, Molina's documentation shows that the organization's claims processing rate exceeds the State's requirements.

Molina has implemented a Compliance Plan with goals of increasing efficiency, reducing waste, minimizing confusion, and improving the quality of services. A Code of Business Conduct and Ethics governs the way employees, officers, and directors conduct daily business activities. Training and education activities provide information needed for the recognition, reporting, investigation, and follow-up of suspected violations or non-compliance.

As noted in *Figure 2: Administration Findings*, standards were scored as "Met" for 100% of the standards for both CAN and CHIP.

Figure 2: Administration Findings



Strengths

- Molina policies and procedures accurately reflect the language used for CAN and CHIP Contract requirements.
- Claims processing rates exceed the rates required by DOM.
- Data replication to multiple data centers ensures data availability in the event of a disaster.

Weaknesses

- There is no written policy to outline the internal process for policy development, review, and revision, and steps for employee notification of newly developed or revised policies and procedures.

Recommendations

- Create a policy detailing the process used for policy development and management.

B. Provider Services

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

Processes and requirements for credentialing and recredentialing health care providers are found in the Credentialing Program Policy (Policy CR 01), the Assessment of Organizational Providers Policy (Policy CR 02), and in Mississippi-specific addenda to the policies. For CAN, no issues were identified in the referenced policies and addenda; however, for CHIP, the policies do not address the requirement from the *CHIP Contract*,

Section 7 (E) (6), which states, "Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk Provider and any person with a 5 percent or more direct or indirect ownership interest in the Provider, as those terms are defined in 455.101." Onsite discussion confirmed that Molina is not obtaining fingerprints from CHIP providers identified as high-risk by DOM.

A review of initial credentialing files revealed the following:

- Initial credentialing files for nurse practitioners did not include a documented admitting plan.
- Several provider applications were incomplete regarding whether a practice location conducts laboratory services. During discussion of this issue, Molina staff reported that in this situation, they do not contact the provider to clarify and do not seek a CLIA for the location.
- Many credentialing files from 2018 and 2019 contained no evidence of a site visit being conducted. Molina staff confirmed site visits have not been completed at initial credentialing. However, Policy CR 01, Credentialing Program Policy, Addendum B states, "Molina will conduct an initial site assessment prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the provider office visit." Requirements for site visits are specified in the *CAN Contract, Section 7 (E)* and in the *CHIP Contract, Section 7 (E)*.
- Credentialing files for high-risk CHIP providers contained no evidence of fingerprinting, as required by the *CHIP Contract, Section 7 (E) (6)*.

Molina's Professional Review Committee (PRC) uses a peer review process to make recommendations regarding credentialing decisions. A Molina Medical Director chairs the PRC and appoints all PRC members. Molina policy states the PRC's membership should include practitioners from a range of specialties in the Molina network, such as behavioral health, dentistry, family practice, internal medicine, pain management, pediatrics, OB/GYN, surgery, etc. However, CCME noted the voting PRC members include three family medicine providers, one internal medicine provider, and one OB/GYN. Onsite discussion confirmed no attempts have been made to recruit providers with additional specialty types. As stated in policy, other practitioners may be invited to participate when representation of their discipline is needed, and ad hoc committees representing a specific profession may be appointed by the chair to screen applicants from their respective profession and make credentialing recommendations to the PRC. PRC minutes confirm the presence of a quorum for each meeting and reflect review and discussion of providers for which Level II review was required, review of Quality of Care cases, and review of clean files approved by the medical director.

Molina has developed policies and procedures for monitoring and managing its network of providers to meet the health care needs of members based on requirements in the *CAN Contract, Section 4 (B) (3)* and the *CHIP Contract, Section 4 (B) (2)*. Provider choice and specialized services are ensured throughout. Based on discussion with Molina staff, Geo Access Reports are reviewed internally on a regular basis, but do not clearly indicate members have a choice of two or more PCPs within a 15-mile radius for urban counties and within 30 miles for rural counties. Molina staff confirmed the network is routinely evaluated. However, Molina does not currently complete an annual summary of trends and findings from the quarterly Geo Access Reports.

The network is monitored, and adjustments are made to ensure adequate practitioner panel size. Individualized member needs, including foreign language or cultural requirements, complex medical needs, and accessibility considerations are ensured throughout service provision.

Evidence was found that accessibility standards are being measured and, except for the requirement for appointments after discharge from an acute psychiatric hospital, appear to be met. The *CAN Contract, Section 7 (B) 2* and the *CHIP Contract, Section 7 (B) (2)* stipulate that follow-up appointments should be scheduled within seven days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavioral Health 1st Quarter 2020 MS CAN indicates that the standard was measured using a 14-calendar day parameter.

Review of Molina's CAN and CHIP provider education program included, but was not limited to, the Provider Manuals, provider websites, policies, and provider materials such as the New Provider Orientation presentations and newsletters. Policies and training documents appropriately describe processes and requirements used in implementing the provider education program. Orientation topics include, but are not limited to, an overview of the health plan, policies and procedures, managed care program and services, Quality and HEDIS standards, the Provider Manual, and the website, including registering for the provider portal.

The Provider Services staff conduct orientation and training for new providers and their staff within 30 days of becoming active with the plan. Materials used for orientation include, but are not limited to, the Provider Orientation PowerPoint presentation and the Provider Manual. Orientation can occur in various in-person settings with providers and their office staff. However, due to current Covid-19 restrictions, orientation sessions are presented virtually over a WebEx platform and copies of the training materials are sent to provider.

The CAN and CHIP Provider Manuals and the provider websites are key resources for initial and ongoing provider education. The Provider Manuals include information on Molina's organization, provider and member departments, and programs. The manuals

are updated annually, and the most current versions are posted to the website. The websites include various methods for providers to receive education and important updates, such as a list of available training opportunities and the Molina Matters provider newsletters. Additionally, providers can contact the Provider Services Department or their assigned Provider Services representative with questions or to seek assistance with specific tasks.

Overall, review of the Provider Education program indicates Molina is conducting initial and ongoing trainings for CAN and CHIP providers according to requirements in the *CAN* and *CHIP Contracts*, *Section 7 (H) (2)* and *(3)*. No issues were identified.

Molina adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) based on scientific evidence and recommendations made by Molina's National Quality Improvement Committee. The guidelines are relevant to Molina's member population, are reviewed routinely, and are updated when new scientific evidence is released or national guidelines are published. Adopted PHGs are distributed to providers annually on the website and in the Provider Manual. Providers are notified of the availability of the PHGs in the Molina Provider Newsletter. Adopted CPGs are distributed to appropriate providers/provider groups through provider newsletters, electronic provider bulletins, and other media and are available on the website. Individual providers or members may request copies from the local Molina Quality Department.

Standards of medical record documentation are defined in policy; however, the policy does not include that documentation should include any health education provided. Policy MHMS-QI-124, Standards of Medial Record Documentation, includes a review process for monitoring medial record documentation but does not include the frequency of the monitoring. Onsite discussion confirmed medical record monitoring was last conducted in 2019. It has been placed on hold due to restrictions from Covid-19 and will be resumed when restrictions are lifted.

Provider Access Study and Provider Directory Validation

CCME conducted a validation of network access/availability and provider directory accuracy for Molina. The objectives were to determine if the provider contact information was accurate and assess appointment availability. The methodology involved two phases:

- Phase 1: CCME conducted a telephonic survey to determine if CCO-provided PCP contact information was accurate with regard to telephone, address, accepting the CCO, and accepting new Medicaid patients. Appointment availability for urgent and routine care was also evaluated.

- Phase 2: CCME verified the accuracy of provider directory-listed address, phone, and panel status against access-study confirmed PCP contact information. An overall accuracy rate was determined.

For this review, Molina submitted a total of 2,362 unique PCPs for the CAN population and a total of 2,182 unique PCPs for the CHIP population. For CAN, a random sample of 102 PCPs was selected, and for CHIP a random sample of 100 PCPs was selected. Phase 1 (Provider Access Study) was conducted for each. For successful calls, Phase 2 (Provider Directory Validation) was conducted, and Molina's online directory was reviewed to determine if the information in the directory matched the information confirmed during the provider access study phase.

CAN Summary. Of 102 PCPs contacted, 13 were answered by voicemail and thereby omitted from the denominator in the success rate formula. After accounting for voicemail answered calls, the Phase 1 success rate for CAN was 16% (14 of 89). Phase 1 results found that 21 of 89 (24%) providers called confirmed the file contained the correct address and phone number. Of those 21, 14 (83%) confirmed they accepted Molina CAN. Of those 14, 12 (86%) indicated they were accepting new patients. The 14 providers considered a successful contact and were evaluated for provider directory validation in Phase 2.

Access and availability for routine appointments was 75% and availability for urgent appointments was 67%.

The 14 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for the 14 providers, 71% (n=10) had accurate information for all three components evaluated: address, phone number, and panel status information. There were providers with some specific elements listed accurately and with inaccuracies in other elements.

Of the 14 CAN providers evaluated in the provider directory: 12 (86%) had the provider name listed in the directory; 10 (71%) providers had the accurate phone number listed; 10 (71%) had the accurate address; and 10 (71%) had accurate panel status information.

Discrepancies in the directory were most common for telephone, location, and status for accepting new patients (29% reported a different phone number during the access study call in relation to the phone number provided in the directory and 29% reported a different panel status). When compared to the access study results, 29% (4 out of 14) reported a different address in the provider directory.

CHIP Summary. Of 100 PCPs contacted, 17 were answered by voicemail and therefore omitted from the denominator in the success rate formula. After accounting for voicemail answered calls, the Phase 1 success rate for CHIP was 48% (40 of 83).

Phase 1 results found that 55 of 83 (66%) providers called confirmed the file contained the correct address and phone number. Of those 55, 40 (72%) confirmed they accept Molina CHIP. Of those 40, 34 (85%) indicated they were accepting new patients. Access and availability for routine appointments was 68% and availability for urgent appointments was 33%.

The 40 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found 93% (n=37) of the 40 providers that were evaluated for provider directory validation had accurate information for all three components evaluated including address, phone number, and panel status information. There were providers with specific elements listed accurately, but with inaccuracies in other elements.

Of the 40 CHIP providers evaluated in the provider directory: 38 (95%) had the provider name listed in the directory; 37 (93%) had an accurate phone number, address, and panel status information.

Discrepancies in the directory were most common in status for accepting new patients (33% reported a different panel status). When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

Full details of the study's results, conclusions, and required corrective actions are included in the Provider Access Study and Directory Validation report.

Provider Satisfaction Survey

Provider satisfaction survey validation was performed using a validation worksheet based on the CMS Survey Validation Protocol. The complete worksheet is available as an attachment in this report. Molina's provider satisfaction survey occurred in November 2019. A total of 205 providers completed the survey—79 by mail, 24 via the internet (7.6% response rate) and 102 by phone (18.6%) response rate. Overall, the response rate is 15.6%.

Table 5: CAN Provider Satisfaction Survey Validation Results offers the section of the worksheet that needs improvement, the reason, and the recommendation.

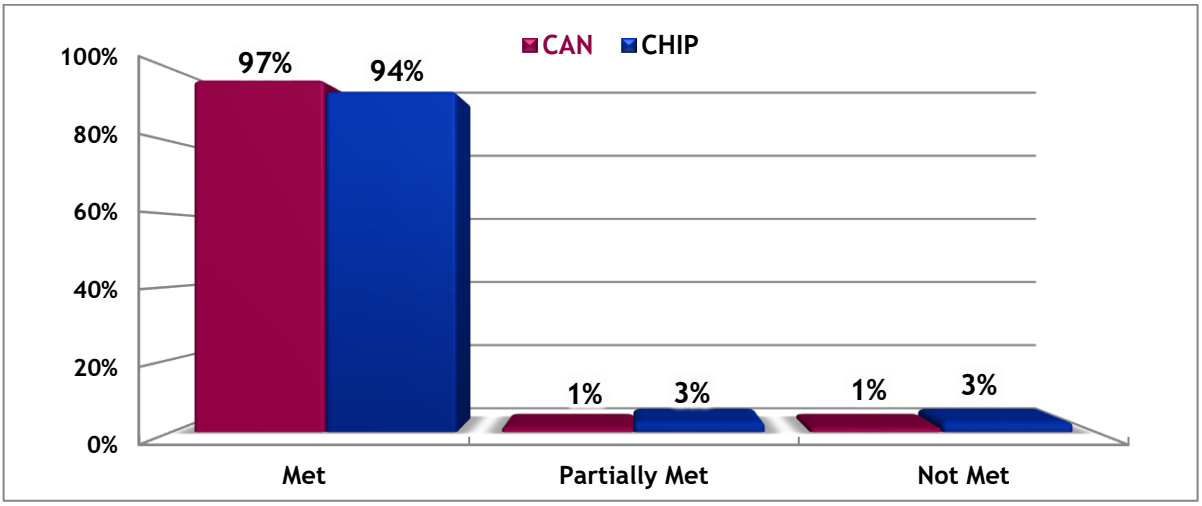
Table 5: CAN Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Provider satisfaction was validated using the CMS Protocol 6. Administration or Validation of Quality of Care Surveys. The provider satisfaction survey occurred in	Work with the vendor to determine other methods to increase response rates. Ensure provider contact information is up to date.

Section	Reason	Recommendation
	November 2019. A total of 205 providers completed the survey: 79 by mail, 24 via the internet (7.6% response rate) and 102 by phone (18.6%) response rate. Overall, the response rate is 15.6%.	

As noted in *Figure 3, Provider Services Findings*, 97% of the Provider Services standards were scored as "Met" for the CAN Program and 94% were scored as "Met" for the CHIP Program. Standards for recredentialing file review for both CAN and CHIP were scored as "Not Evaluated" because Molina is new to the Mississippi market and does not yet have providers due for recredentialing.

Figure 3: Provider Services Findings



Scores were rounded to the nearest whole number.

Table 6: Provider Services provides an overview of standards scored as "Partially Met" and "Not Met" for the Provider Services section of the review.

Table 6: Provider Services

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Credentialing and Recredentialing	Verification of information on the applicant, including: Site assessment	Not Met	Not Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Met	Not Met
Adequacy of the Provider Network	The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Partially Met

Strengths

- The "Providers" tab on Molina's website contains a wealth of information for network providers including frequently used forms, privacy and confidentiality resources, pharmacy information, health resources, newsletters, etc.
- Members of Molina's clinical staff participate in provider trainings when applicable.
- Molina has adapted to Covid-19 restrictions by implementing new methods to ensure provider education continues.

Weaknesses

- Processes and requirements for credentialing and recredentialing health care providers are found in the Credentialing Program Policy (Policy CR 01), the Assessment of Organizational Providers Policy (Policy CR 02), and in Mississippi-specific addenda to the policies. None of the documents address the requirement from the *CHIP Contract, Section 7 (E) (6)*, which states, "Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk Provider and any person with a 5 percent or more direct or indirect ownership interest in the Provider, as those terms are defined in 455.101."
- The voting Professional Review Committee members include three family medicine providers, one internal medicine provider, and one OB/GYN. Onsite discussion confirmed no attempts have been made to recruit providers with additional specialty types.
- Initial credentialing files for two nurse practitioners did not include admitting privileges and had no documented admitting plan.
- CCME noted that on several provider applications, the question about whether a practice location conducts laboratory services was incomplete. During discussion of this issue, Molina staff reported they do not contact the provider to clarify and do not seek a CLIA for the location.

- CCME understands that due to Covid-19, restrictions are in place that prevent provider office site visits from being conducted as part of initial credentialing. However, of 14 initial credentialing files reviewed, 10 were from 2018 and 2019, prior to Covid-19. These 10 files contained no evidence of a site visit being conducted, and onsite discussion confirmed Molina has not been conducting site visits as a part of initial credentialing. However, Policy CR 01, Credentialing Program Policy, Addendum B states, "Molina will conduct an initial site assessment prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the provider office visit." Requirements for site visits are specified in the *CAN Contract, Section 7 (E)* and the *CHIP Contract, Section 7 (E)*.
- Of 11 organizational provider initial credentialing files reviewed, six are considered high-risk by DOM for the purposes of fingerprinting requirements. None of the files included fingerprints, as required by the *CHIP Contract, Section 7 (E) (6)*.
- CCME could not identify in the following documents the timeframe or process for notifying DOM of a provider's suspension or termination for serious quality of care or service issues:
  - Policy CR 01, Credentialing Program Policy or Addendum B of the policy
  - Policy and Procedure MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events
  - Policy CR 03, Fair Hearing Policy
  - Procedure MHMS-PC-09, MHMS Provider Termination Process
- Policy MHMS-NM-017, CHIP PCP Roles and Responsibilities, does not reflect the *CHIP Contract, Section 4 (B) (2)* requirement regarding notifications to PCPs of the members assigned to them within five business days of the date on which the CCO receives the Member Listing Report from the Division.
- Molina Geo Access reports do not clearly indicate the parameters used to measure adequacy of the network, such as member choice of at least two or more PCPs within a 15-mile radius for urban counties and within 30 miles for rural counties.
- Geo Access Reports were provided, but the onsite discussion revealed that there is no formal process in place for Molina to review and summarize gaps and network trends.
- Policy MHMS-QI-124, Standards of Medial Record Documentation, defines Molina's medical record documentation standards. However, the policy does not include that documentation should include any health education provided.
- Policy MHMS-QI-124, Standards of Medial Record Documentation, includes a review process for monitoring medial record documentation; however, the timeframe for how often the monitoring is conducted was not mentioned.

- Overall, the response rate for the provider satisfaction survey was low at 15.6%.

Corrective Actions

- Develop and implement a process to obtain fingerprints from CHIP providers identified by DOM as high-risk. The process must be documented in the appropriate credentialing policies.
- Develop and implement a process to conduct site visits for initial credentialing to begin when restrictions due to Covid-19 are lifted.
- Ensure credentialing files for CHIP providers considered by DOM to be high risk include submitted fingerprints.
- Review and revise the process for measuring follow-up appointments after discharge from an acute psychiatric hospital to reflect the required seven-day appointment timeframe. Refer to the *CAN Contract, Section 7 (B) (2)* and *CHIP Contract, Section 7 (B) (2)*.

Recommendations

- Because the Professional Review Committee serves as a peer review committee, consider attempting to recruit providers with additional specialty types to serve as committee members.
- Ensure admitting plans are collected for nurse practitioners being credentialed into the network.
- To ensure appropriate collection of CLIA certificates or certificates of waiver, develop and implement a process to contact providers when the application is incomplete regarding laboratory services if the provider is being credentialed for the location.
- Update the appropriate policy or policies to include Molina's process and timeframe for notifying DOM of a provider's suspension or termination for serious quality of care or service issues.
- Revise Policy MHMS-NM-017, CHIP PCP Roles and Responsibilities, to reflect the requirement from the *CHIP Contract, Section 4 (B) (2)* regarding notifications to PCPs of the members assigned to them within five business days of the date on which the CCO receives the Member Listing Report from the Division.
- Ensure Geo Access Reports clearly identify the parameters used to measure and evaluate the network, including that members have access to two or more PCPs as required by the *CAN Contract, Section 7 (B)* and the *CHIP Contract, Section 7 (B) (1)*.
- Develop and implement a process to conduct a formal review of Geo Access Reports to summarize the quarterly network findings and any gaps identified.

- Revise Policy MHMS-QI-124, Standards of Medical Record Documentation, to include that any health education provided during a provider visit should be included in the documentation of the visit.
- Revise Policy MHMS-QI-124, Standards of Medial Record Documentation, to include the frequency of medical record documentation audits.
- For provider satisfaction surveys, work with the vendor to determine other methods to increase response rates. Ensure provider contact information is up to date.

C. Member Services

The review of Member Services included policies and procedures, member rights and responsibilities, member informational materials, grievance processes and grievance files, and the member satisfaction survey for the CAN and CHIP lines of business. The CAN and CHIP Member Handbooks are thorough, easily understood, and meet the sixth-grade reading comprehension level required by DOM.

Molina's CAN and CHIP websites have quick links and resources for members to access information. The Member Handbooks and websites inform members about rights and responsibilities, preventive health guidelines, and appointment guidelines, and provide instructions for accessing benefits. CCME identified CAN and CHIP documentation issues with member rights and responsibilities and offered recommendations to address them. Additionally, information that female members can obtain preventive services from a women's health provider and a PCP, and information that Molina informs members of changes to benefits and services within 30 days of the effective date, were not identified in the CAN and CHIP Member Handbooks.

For CAN and CHIP, information on Advanced Directives is provided in the Member Handbooks; however, the term "will" is incorrectly used instead of the term "living will," which can be confusing. Additionally, the Member Handbooks provide information about requesting disenrollment and accessing the Fraud and Abuse Hotline. Upon request, Molina will make the Member Handbooks available in Spanish and alternate formats including large font, audio, and Braille.

Member Services staff are available per contract requirements via a toll-free number. Text telephone (also known as TTY 711) services are available for members with hearing impairments. Members are informed that translation services are available for calls and during appointments with providers. The toll-free Member Services telephone number routes callers to reach appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. CT, Monday through Friday. Callers also have the option to transfer to the 24-hour Nurse Advice Line. Call center functions are conducted as required by the *CAN* and *CHIP Contracts*.

Molina has established CAN and CHIP policies that describe processes for receiving, handling, and responding to member requests for complaints and grievances. Review of grievance information on Molina's CAN and CHIP websites revealed grievance definitions and filing procedures, such as information that a grievance can be filed at any time, orally or in writing, and the address/fax numbers to submit written grievances, are omitted from the websites. Additionally, the manner in which the 14-day grievance extension timeframe is described in the CAN and CHIP Provider Manuals, can be misinterpreted as Molina will have a total of 28 days to issue a determination when the grievance resolution timeframe is extended.

CCME's review of CAN and CHIP grievance files confirmed timely acknowledgement, resolution, and notification to members and a thorough investigation of the member's grievance prior to Molina mailing the resolution notice and closing the case.

Overall, the review of Member Services indicated that Molina is providing member education activities, ensuring member rights and responsibilities, and handling member grievances in compliance with established policies, contractual requirements, and Federal Regulations.

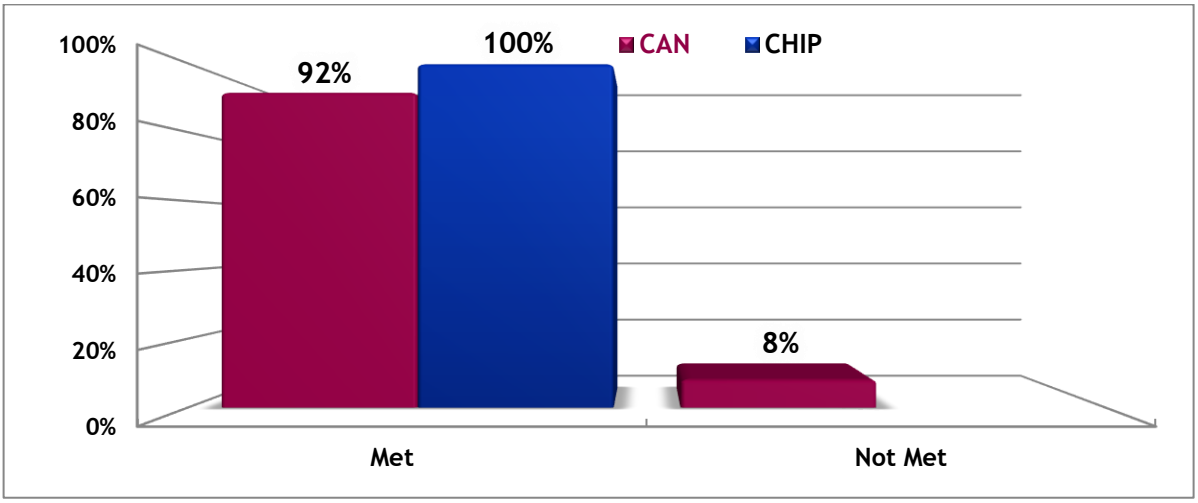
Member Satisfaction Survey

Molina's first Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey was conducted in June 2020. SPH Analytics, a CAHPS Survey vendor, conducted the CAN Adult and Child Surveys. Members satisfaction survey validation for CAN was performed based on the CMS Survey Validation Protocol. Generalizability of the survey results is difficult to discern due to low response rates. Additionally, documentation of CAN member satisfaction survey results reported to the QIC and to network physicians was not submitted for review. CCME provided recommendations to address the issues.

Molina was not required to conduct a formal assessment of member satisfaction for the CHIP population.

As noted in *Figure 4: Member Services Findings,* Molina achieved "Met" scores for 92% of the Member Services Standards for CAN and 100% of the standards for CHIP.

Figure 4: Member Services Findings



Scores were rounded to the nearest whole number

Table 7: Member Services provides an overview of standards scored as "Partially Met" and "Not Met" for the Member Services section of the review.

Table 7: Member Services

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Member Satisfaction Survey	The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	Not Met	Not Evaluated
	The CCO reports results of the member satisfaction survey to providers.	Not Met	Not Evaluated
	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.	Not Met	Not Evaluated

Strengths

- Molina monitors website activity to evaluate if newsletters and other posted member information are being accessed.

Weaknesses

- The Member Rights & Responsibilities sections of the CAN and CHIP websites omit the requirement that members are financially responsible for unauthorized services obtained from non-participating providers.

- CCME identified the following documentation issues with member program education in the Member Handbooks:
  - The CAN and CHIP Member Handbooks do not include information that, in addition to their PCP, female members can obtain women's preventive health services from a women's health provider without prior authorization.
  - The CAN and CHIP Member Handbooks do not include information that members will be informed of changes to programs and benefits within 30 calendar days prior to implementation and changes in the provider network within 15 days after Molina receives notification.
  - The CAN and CHIP Member Handbooks use the term "will" instead of the term "living will" in the section for Advance Directives. This could be confusing to members.
- For CAN and CHIP, the EN_PDF_PCP Termination_Medicaid_MS_831_Ver.2 letter template, used to notify members of provider termination from the network, does not include the date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required by the *CAN* and *CHIP Contracts, Section 7 (D) (4)*.
- Generalizability of the member satisfaction survey results is difficult to discern due to low response rates from the CAN Adult and Child Surveys.
- The CAN member satisfaction survey results were not analyzed to identify potential quality problems and reported to the QIC or shared with network providers.
- The following documentation issues with member grievances were identified:
  - The CAN and CHIP member websites do not include the definition of a grievance or a description of who can file a grievance. Also, the websites do not include information on grievance filing procedures, such as that a grievance can be filed at any time, orally or in writing, and the address and fax number to submit a written grievance, as required by the *CAN* and *CHIP Contracts, Section 6 (H)*.
  - The CAN (pg. 104) and CHIP (pg. 115) Provider Manuals state, "The timeframe for Grievance resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe an additional fourteen (14) calendar days if the extension is in the interest of the Member…" This could be misinterpreted by members to mean that Molina will have a total of 28 days to issue a determination when the grievance resolution timeframe is extended.

Corrective Actions

- Ensure member satisfaction survey results are reviewed/analyzed by the appropriate committee to identify potential quality problems and reported to network providers.

Recommendations

- Edit the Member Rights & Responsibility section of the CAN and CHIP websites to include the requirement that members are financially responsible for unauthorized services obtained from non-participating providers. Refer to the *CAN and CHIP Contracts, Section 6 (J)*.
- Edit the CAN Member Handbook to include the requirement that, in addition to their PCP, female members can have direct access to a women's health provider for routine and women's preventive services as required by the *CAN Contract, Section 7 (B)* and the *CHIP Contract, Section 7 (A)*.
- For CAN and CHIP, capture the requirement that members will be informed of changes to benefits, services, or the provider network, in a policy or other document.
- Consider editing the CAN and CHIP Member Handbooks to indicate members will be notified of a provider's termination and of changes in any benefits or services as noted in the *CAN Contract, Section 6 (D) (8) (g)* and the *CHIP Contract, Section 6 (D) (9) (h),* under the heading, "The Member Handbook must include at a minimum the following information."
- For CAN and CHIP, edit the Member Handbook to ensure the term "living will" is not referred to as a "will."
- Edit the letter template, EN_PDF_PCP Termination_Medicaid_MS_831_Ver.2, to include the date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required by the *CAN* and *CHIP Contracts, Section 7 (D) (4)*.
- Establish an internal goal for response rates for the Adult and Child Surveys that is 2% or 3% greater than the previous year and initiate new interventions to attempt to increase response rates (e.g. website banners, reminders on call center scripts, text reminders).
- Include the definition of a grievance, the description of who may file a grievance, and information on grievance filing procedures on the non-secured section of the CAN and CHIP websites, as required by the *CAN* and *CHIP Contracts, Section 6 (H)*. To meet this requirement, consider adding the term "grievance" to headings where information for filing complaints is provided.
- Edit the description of the grievance extension timeframe in the CAN and CHIP Provider Manuals to clearly specify that Molina can extend the timeframe only 14 days if it is in the member's best interest, in accordance with *42 CFR §438.408 (c),* the *CAN Contract, Section Exhibit D (B),* and the *CHIP Contract, Section Exhibit C (B)*.

D. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the QI program descriptions for the CAN and CHIP programs, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations.

Molina's 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually. Molina does not have a separate QI Program Description for CHIP.

Annually, Molina's QI Work Plan identifies activities related to program priorities to improve the quality of services provided to members. The health plan provided the 2019 and 1st quarter through 3rd quarter 2020 work plans. The 2020 work plan only included a few references to CHIP. The format for the work plans were in Word, PowerPoint, and Excel. Some of the Word and Excel documents contained embedded files that could not be opened. Also, there were errors or missing information noted in the 3rd quarter 2020 work plan. These include:

- The objective for identifying a process for managing potential quality of care issues appeared incorrect.
- Goals were missing.
- Standards for measuring practitioner availability and accessibility were incorrect.
- The timeframe for notifying a member of termination of a PCP was incorrect.

The QIC is responsible for the implementation and ongoing monitoring of the QI Program. This committee reviews data received from the QI activities to ensure performance meets standards and makes recommendations as needed. Molina's Quality Improvement Committee Charter outlines the structure, duties, responsibilities, and the quorum requirements. The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. The 2020 membership list includes 20 internal voting members, two network pediatricians, and one internal medical physician. CCME recommends Molina recruit additional network providers to serve on the QIC. Consider including a Family Practice, OB/GYN, and a Behavioral Health practitioner.

The scope of the QI program includes providing practitioners with feedback on performance and monitoring of provider compliance with clinical practice guidelines. Molina provided an example report given to individual providers regarding their performance data and patterns of utilization. This report is distributed by QI and/or Provider Services staff, and the reports can be downloaded from Molina's Provider Portal.

Per the QI Program Description, to evaluate the effectiveness of the clinical and preventive evidence-based guidelines, Molina measures performance against important

aspects of each clinical practice and preventive guideline. Policy and Procedure MHMS-QI-018 discusses the performance monitoring conducted. On page 8 it states, "All results are incorporated into reports to the Quality Improvement Committee, included in each state health plan's Annual Quality Improvement Work Plan and utilized when planning subsequent QI activities." The monitoring was not included in the QI Work Plan.

Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, and Policy MHMS-QI-005, Well-Baby and Well-Child Services, define the requirements for the EPSDT and Well-Baby and Well-Child Programs. The policies indicate Molina tracks, at a minimum, initial visits for newborns, EPSDT screenings, and reporting of all screening results and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the EPSDT or Well-Baby or Well-Child service, and did not include or indicate the members who received additional treatments or referrals as required by the *CAN* and *CHIP Contracts, Section 5 (D)*.

Annually, Molina evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the Quality Improvement Committee, and to the Division of Medicaid. The Quality Improvement Program 2019 Annual Evaluation, Executive Summary and three Appendices (Appendix A – Member and Provider Experience Report, Appendix B – CLAS Analysis Report, and Appendix C – Population Health Assessment) were provided for review. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight.

Performance Measure Validation

As required by the contract with CCME, Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate accuracy as reported by Molina for the CAN and CHIP populations. DOM has selected a set of PMs to evaluate the quality of care and services delivered by Molina to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019. Since Molina did not have enrollment in the CHIP product line in 2019, the PM validation was conducted only for CAN.

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, DOM also required each CCO to undergo an NCQA HEDIS Compliance Audit. Molina contracted with an NCQA-licensed organization to conduct the HEDIS audit. Aqurate reviewed Molina's 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 systems and processes were compliant with the applicable information system standards and the HEDIS reporting requirements for HEDIS 2020.

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. Several aspects crucial to the calculation of PM data reviewed included: data integration, data control, and documentation of PM calculations. The following are some of the main steps conducted during the validation process:

- Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by Molina, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined that the data integration processes for Molina were acceptable.
- Data Control—Molina's organizational infrastructure must support all necessary information systems; its quality assurance practices, and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated Molina's data control processes and determined that the data control processes in place were acceptable.
- Performance Measure Documentation—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by Molina. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by Molina was acceptable.

All relevant HEDIS performance measures for CAN for the current review year (MY 2019) are reported in *Table 8: CAN HEDIS Performance Measure Results*. This was the first year that Molina reported measures for CAN; therefore, there is no prior year comparison.

Table 8: CAN HEDIS Performance Measure Results

Measure/Element	MY2019 (HEDIS 2020)
Effectiveness of Care: Prevention and Screening	
Adult BMI Assessment (aba)	0.00%
BMI Percentile	57.91%

Measure/Element	MY2019 (HEDIS 2020)
Counseling for Nutrition	50.85%
Counseling for Physical Activity	46.72%
Childhood Immunization Status (cis)	
DTaP	45.45%
IPV	72.73%
MMR	72.73%
HiB	63.64%
Hepatitis B	72.73%
VZV	72.73%
Pneumococcal Conjugate	54.55%
Hepatitis A	72.73%
Rotavirus	54.55%
Influenza	18.18%
Combination #2	45.45%
Combination #3	45.45%
Combination #4	45.45%
Combination #5	45.45%
Combination #6	9.09%
Combination #7	45.45%
Combination #8	9.09%
Combination #9	9.09%
Combination #10	9.09%
Immunizations for Adolescents (ima)	
Meningococcal	48.63%
Tdap	69.18%
HPV	15.75%
Combination #1	46.58%
Combination #2	14.38%
Lead Screening in Children (lsc)	63.64%
Breast Cancer Screening (bcs)	0.00%
Cervical Cancer Screening (ccs)	45.26%
Chlamydia Screening in Women (chl)	
16-20 Years	47.65%
21-24 Years	69.15%
Total	53.91%
Effectiveness of Care: Respiratory Conditions	
Appropriate Testing for Children with Pharyngitis (cwp)	72.75%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	0.00%
Pharmacotherapy Management of COPD Exacerbation (pce)	

Measure/Element	MY2019 (HEDIS 2020)
Systemic Corticosteroid	60.00%
Bronchodilator	77.65%
Medication Management for People with Asthma (mma)	
5-11 Years: Medication Compliance 50%	0.00%
5-11 Years: Medication Compliance 75%	0.00%
12-18 Years: Medication Compliance 50%	0.00%
12-18 Years: Medication Compliance 75%	0.00%
19-50 Years: Medication Compliance 50%	0.00%
19-50 Years: Medication Compliance 75%	0.00%
51-64 Years: Medication Compliance 50%	0.00%
51-64 Years: Medication Compliance 75%	0.00%
Total: Medication Compliance 50%	0.00%
Total: Medication Compliance 75%	0.00%
Asthma Medication Ratio (amr)	
5-11 Years	0.00%
12-18 Years	0.00%
19-50 Years	0.00%
51-64 Years	0.00%
Total	0.00%
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (cbp)	46.72%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	100.00%
Statin Therapy for Patients with Cardiovascular Disease (spc)	
Received Statin Therapy: 21-75 Years (Male)	0.00%
Statin Adherence 80%: 21-75 Years (Male)	0.00%
Received Statin Therapy: 40-75 Years (Female)	0.00%
Statin Adherence 80%: 40-75 Years (Female)	0.00%
Received Statin Therapy: Total	0.00%
Statin Adherence 80%: Total	0.00%
Effectiveness of Care: Diabetes	
Hemoglobin A1c (HbA1c) Testing	88.37%
HbA1c Poor Control (>9.0%)	57.36%
HbA1c Control (<8.0%)	36.05%
HbA1c Control (<7.0%)	0.00%
Eye Exam (Retinal) Performed	53.88%
Medical Attention for Nephropathy	90.31%
Blood Pressure Control (<140/90 mm Hg)	55.43%
Statin Therapy for Patients with Diabetes (spd)	

Measure/Element	MY2019 (HEDIS 2020)
Received Statin Therapy	0.00%
Statin Adherence 80%	0.00%
Effectiveness of Care: Behavioral Health	
Effective Acute Phase Treatment	73.49%
Effective Continuation Phase Treatment	66.27%
Follow-Up Care for Children Prescribed ADHD Medication (add)	
Initiation Phase	66.67%
Continuation and Maintenance (C&M) Phase	100.00%
Follow-Up After Hospitalization for Mental Illness (fuh)	
6-17 years - 30-Day Follow-Up	53.91%
6-17 years - 7-Day Follow-Up	30.45%
18-64 years - 30-Day Follow-Up	37.23%
18-64 years - 7-Day Follow-Up	20.07%
65+ years - 30-Day Follow-Up	0.00%
65+ years - 7-Day Follow-Up	0.00%
Total 30-Day Follow-Up	46.68%
Total 7-Day Follow-Up	25.95%
Follow-Up After Emergency Department Visit for Mental Illness (fum)	
6-17 years - 30-Day Follow-Up	47.06%
6-17 years - 7-Day Follow-Up	25.49%
18-64 years - 30-Day Follow-Up	23.93%
18-64 years - 7-Day Follow-Up	13.68%
65+ years - 30-Day Follow-Up	0.00%
65+ years - 7-Day Follow-Up	0.00%
Total - 30-Day Follow-Up	30.95%
Total- 7-Day Follow-Up	17.26%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)	
30-Day Follow-Up: 13-17 Years	0.00%
7-Day Follow-Up: 13-17 Years	0.00%
30-Day Follow-Up: 18+ Years	4.11%
7-Day Follow-Up: 18+ Years	2.74%
30-Day Follow-Up: Total	3.85%
7-Day Follow-Up: Total	2.56%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	77.90%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	60.00%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	0.00%

Measure/Element	MY2019 (HEDIS 2020)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	53.21%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)	
Blood glucose testing - 1-11 Years	37.4%
Cholesterol Testing - 1-11 Years	21.70%
Blood glucose and Cholesterol Testing - 1-11 Years	19.81%
Blood glucose testing - 12-17 Years	49.40%
Cholesterol Testing - 12-17 Years	30.12%
Blood glucose and Cholesterol Testing - 12-17 Years	28.31%
Blood glucose testing - Totals	44.85%
Cholesterol Testing - Totals	26.84%
Blood glucose and Cholesterol Testing - Total	25.00%
Effectiveness of Care: Overuse/Appropriateness	
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.60%
Appropriate Treatment for Upper Respiratory Infection (uri)	71.40%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	44.87%
Use of Imaging Studies for Low Back Pain (lbp)	81.02%
Use of Opioids at High Dosage (hdo)	BR
Use of Opioids from Multiple Providers (uop)	
Multiple Prescribers	BR
Multiple Pharmacies	BR
Multiple Prescribers and Multiple Pharmacies	BR
Risk of Continued Opioid Use (cou)	
18-64 years - >=15 Days covered	11.37%
18-64 years - >=31 Days covered	2.98%
65+ years - >=15 Days covered	0.00%
65+ years - >=31 Days covered	0.00%
Total - >=15 Days covered	11.37%
Total - >=31 Days covered	2.98%
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (aap)	
20-44 Years	87.66%
45-64 Years	87.40%
65+ Years	0.00%
Total	87.56%
Children and Adolescents' Access to Primary Care Practitioners (cap)	
12-24 Months	94.72%
25 Months - 6 Years	88.87%
7-11 Years	0.00%

Measure/Element	MY2019 (HEDIS 2020)
12-19 Years	0.00%
Annual Dental Visit (adv)	
2-3 Years	47.18%
4-6 Years	66.11%
7-10 Years	67.22%
11-14 Years	60.41%
15-18 Years	50.29%
19-20 Years	39.47%
Total	59.62%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)	
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	71.43%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	100.00%
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	100.00%
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	71.43%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%
Total: Initiation of AOD Treatment: 13-17 Years	68.89%
Total: Engagement of AOD Treatment: 13-17 Years	2.22%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	45.04%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	3.82%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	53.73%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	28.36%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	48.82%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.04%
Total: Initiation of AOD Treatment: 18+ Years	45.80%
Total: Engagement of AOD Treatment: 18+ Years	7.52%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	46.38%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	3.62%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	54.41%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	29.41%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	51.62%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	3.54%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	47.89%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7.04%
Prenatal and Postpartum Care (ppc)	
Timeliness of Prenatal Care	99.03%
Postpartum Care	69.34%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)	
1-11 Years	71.19%
12-17 Years	56.10%

Measure/Element	MY2019 (HEDIS 2020)
Total	62.41%
Utilization	
Well-Child Visits in the First 15 Months of Life (w15)	
0 Visits	7.50%
1 Visit	2.50%
2 Visits	2.50%
3 Visits	12.50%
4 Visits	10.00%
5 Visits	22.50%
6+ Visits	42.50%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	58.64%
Adolescent Well-Care Visits (awc)	44.28%

NA: Indicates denominator was too small or data were not available; BR: Biased rate

Aqurate's HEDIS auditor found that the CCO was fully compliant with all information systems standards and determined Molina submitted valid and reportable rates for most HEDIS measures within scope of the audit. Some HEDIS measures had 0.00% rate since Molina members did not meet the continuous enrollment requirements for measures that required enrollment for more than one year. These measures were Adult BMI Assessment (ABA), Breast Cancer Screening (BCS), Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR), Medication Management for People with Asthma (MMA), Asthma Medication Ratio (AMR), Statin Therapy for Patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with Diabetes (SPD). The Use of Opioids From Multiple Providers (UOP) measure and the Use of Opioids at High Dosage (HDO) measure was assessed as having a Biased Rate (BR).

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by Molina for 2019 are listed in *Table 9: CAN Non-HEDIS Performance Measure Rates*.

Table 9: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2019 Rate
Adult Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)	
Ages 18-65	0.19%
Ages 65+	N/A
Total	0.19%

Measure	MY 2019 Rate
Maternal and Perinatal Health	
PC-01: ELECTIVE DELIVERY (PC-01)	
Women with elective vaginal deliveries or elective cesarean sections	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)	
Most or moderately effective contraception – 3 days	12.78%
Most or moderately effective contraception – 60 days	53.53%
LARC - 3 Days	0.87%
LARC - 60 Days Reported	11.07%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)	
Most or moderately effective contraception – 3 days	0.00%
Most or moderately effective contraception – 60 days	28.78%
LARC - 3 Days	0.00%
LARC - 60 Days Reported	5.26%
Care of Acute and Chronic Conditions	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)	
Ages 18-65	28.19
Ages 65+	0.00
Total	28.19
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)	
Ages 40-64	113.36
Ages 65+	0.00
Total	113.33
HEART FAILURE ADMISSION RATE (PQI-08)	
Ages 18-65	48.65
Ages 65+	0.00
Total	48.64
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)	
Ages 18-39	NR
HIV VIRAL LOAD SUPPRESSION (HVL - AD)	
Ages 18-65	0.00%
Ages 65+	N/A
Total	0.00%
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)	
Ages 18-65	BR
Ages 65+	BR
Total	BR

Measure	MY 2019 Rate
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)	
Ages 18-65	3.35%
Ages 65+	N/A
Total	3.35%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)	
Overall	52.17%
Prescription for Buprenorphine	0.00%
Prescription for Oral Naltrexone	0.00%
Prescription for Long-acting, injectable naltrexone	0.00%
Prescription for Methadone	0.00%
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-CH)	
Ages 12-17	9.84%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	7.30%
Age 2 Screening	0.00%
Age 3 Screening	7.89%
Total Screening	7.29%
Maternal and Perinatal Health	
PC-02: CESEAREAN BIRTH (PC02-CH)	
Ages 9-17	22.57%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NR
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CW)	
Deliveries covered by MD/CHP	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or moderately effective contraception – 3 days	1.72%
Most or moderately effective contraception – 60 days	49.47%
LARC - 3 Days	0.66%
LARC - 60 Days Reported	12.83%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception – 3 days	0.00%
Most or moderately effective contraception – 60 days	29.89%
LARC - 3 Days	0.00%
LARC - 60 Days Reported	4.15%

Measure	MY 2019 Rate
Dental and Oral Health Services	
DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)	
Ages 6-9	NR
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1-20	2.32%

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

Molina did not report five non-HEDIS measures as required by DOM. The five measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01), Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH), Asthma in Younger Adults Admission Rate (PQI-15-AD), and Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH). It is recommended that Molina work proactively with DOM for clarification on measures that are required to be reported.

The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. All numerator rates were not reported for the Use Of Pharmacotherapy For Opioid Use Disorder (OUD – AD).

Based on Aqurate's validation of PMs, there were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Molina followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.

Performance Improvement Project Validation

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

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

DOM required topics for PIPs include: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult- COPD). Molina submitted seven projects for validation. Topics

included Behavioral Health Readmission, Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal and Postpartum Care, and Sickle Cell. *Table 10: CAN Performance Improvement Project Validation Scores* provides an overview of the current scores for the CAN PIPs.

Table 10: CAN Performance Improvement Project Validation Scores

Project	Current Validation Score
Behavioral Health Readmissions	80/80=100% High Confidence in Reported Results
Medication Management for People with Asthma (MMA)	28/62=45.2% Reported Results Not Credible
Pharmacotherapy Management of COPD Exacerbation (PCE)	28/62=45.2% Reported Results Not Credible
Follow-up After Hospitalization for Mental Illness (FUH)	28/62=45.2% Reported Results Not Credible
Obesity	28/62=45.2% Reported Results Not Credible
Prenatal and Postpartum Care	28/62=45.2% Reported Results Not Credible
Case Management and Follow-up (30 days) Services for Sickle Cell Disease	28/62=45.2% Reported Results Not Credible

Only the Behavioral Health Readmission PIP scored in the "High Confidence in Reported Results" range. All others were deemed as Not Credible due to missing elements. The areas needing corrections are displayed in Table 11, *CAN Performance Improvement Project Corrective Actions*.

Table 11: CAN Performance Improvement Project Corrective Actions

Projects	Section	Reason	Recommendation
Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal and Post-partum Care, Sickle Cell Disease	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Data analysis is not offered in PIP report proposal for rationale to initiate study.	Include a summary of the rationale and data analysis that led to initiation of this PIP.
	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the	Sampling information not provided in the report.	Include information on sampling plan; if not applicable, indicate in the

Projects	Section	Reason	Recommendation
	confidence interval to be used, and the margin of error that will be acceptable?		report using a PIP report template.
	Did the plan employ valid sampling techniques that protected against bias?	Information is not documented in the PIP report.	Include information on sampling technique(s); if not applicable, indicate in the report using a PIP report template.
	Did the study design clearly specify the sources of data?	Data sources are not indicated in proposal.	Include information on sources of data.
	Did the study design prospectively specify a data analysis plan? **(1)**	Data analysis plan is not documented.	Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.
	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	No findings presented.	Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.
	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis of baseline is not offered in report and follow-up activities are not documented.	Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.
	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions not documented in the report.	Add the barriers and interventions linked to each barrier to the report.

For the CHIP population Molina submitted four projects for validation. Topics included Medication Management for People with Asthma (MMA), Follow-Up After Hospitalization for Mental Illness (FUH), Obesity, and Well Care. *Table 12: CHIP Performance Improvement Project Validation Scores* provides an overview of the scores for the CHIP PIPs.

Table 12: CHIP Performance Improvement Project Validation Scores

Project	Current Validation Score
Medication Management for People with Asthma	28/62=45.2% Reported Results Not Credible
Follow Up After Hospitalization for Mental Illness	28/62=45.2% Reported Results Not Credible
Obesity	28/62=45.2% Reported Results Not Credible
Well Care	28/62=45.2% Reported Results Not Credible

For this review, the four PIPs scored in the Not Credible range and did not meet the validation requirements due to missing elements. The areas needing corrections are displayed in *Table 13: CHIP Performance Improvement Project Corrective Actions*.

Table 13: CHIP Performance Improvement Project Corrective Actions

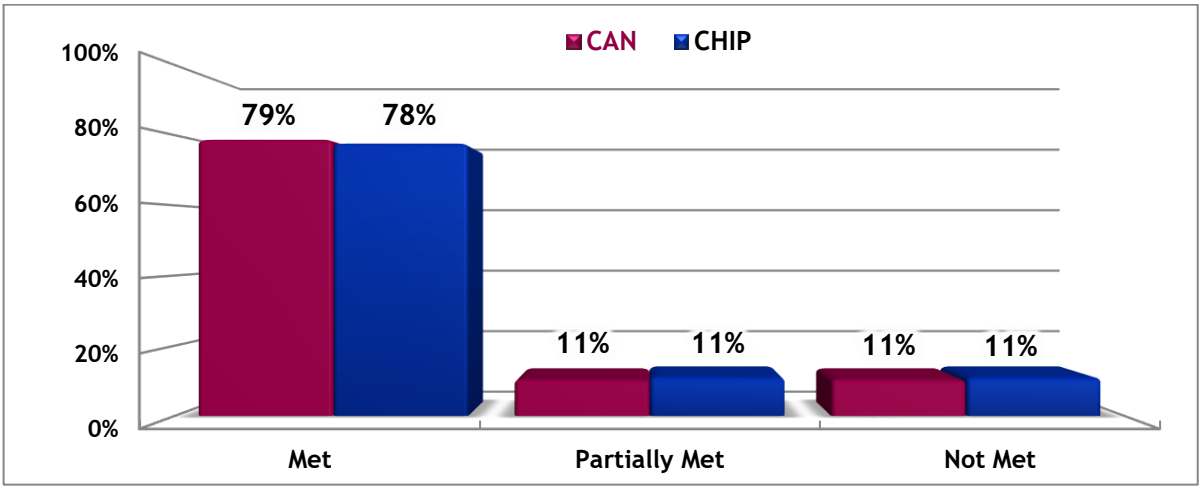
Projects	Section	Reasoning	Recommendation
Medication Management for People with Asthma, Follow Up After Hospitalization for Mental Illness, Obesity, Well Care	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Data analysis is not offered in PIP report proposal for rationale to initiate study.	Include a summary of the rationale and data analysis that led to initiation of this PIP.
	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	Sampling information not provided in the report.	Include information on sampling plan; if not applicable, indicate in the report using a PIP report template
	Did the plan employ valid sampling techniques that protected against bias?	Information is not documented in the PIP report.	Include information on sampling technique; if not applicable, indicate in the report using a PIP report template
	Did the study design clearly specify the sources of data?	Data sources are not indicated in proposal.	Include information on sources of data.
	Did the study design prospectively specify a data analysis plan? **(1)**	Data analysis plan is not documented.	Include the data analysis plan in PIP report. Common

Projects	Section	Reasoning	Recommendation
			analysis plans are annual, quarterly, or monthly.
	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	No findings presented.	Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.
	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis of baseline is not offered in report and follow-up activities are not documented.	Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.
	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions not documented in the report.	Add the barriers and interventions linked to each barrier to the report.

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

For this review period, Molina met 79% of the requirements in the Quality Improvement section for the CAN and 78% of the requirements for CHIP, as noted in *Figure 5: Quality Improvement Findings*.

Figure 5: Quality Improvement Findings



Scores were rounded to the nearest whole number.

Since Molina did not have enrollment in the CHIP product line in 2019, Molina did not report any performance measures for validation. Therefore, this standard was scored as "Not Evaluated" and omitted from the denominator.

Table 14: Quality Improvement provides an overview of standards scored as "Partially Met" and "Not Met" for the Quality Improvement section of the review.

Table 14: Quality Improvement

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Quality Improvement (QI) Program	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)	Partially Met	Partially Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects"	Not Met	Not Met
Provider Participation in Quality Improvement Activities	The CCO tracks provider compliance with EPSDT service provision requirements for: Diagnosis and/or treatment for children The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Diagnosis and/or treatment for children	Not Met	Not Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program is prepared annually	Partially Met	Partially Met

Strengths

- Molina submitted valid and reportable rates for most HEDIS measures within scope of the audit.
- There were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures reported. Aqurate determined Molina followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.

Weaknesses

- The QI Work Plans for 2019 and 2020 only included a few references to CHIP. Also, the format for the work plans included Word, PowerPoint, and Excel. Some of the Word and Excel documents contained embedded files that could not be opened.
- There were errors or missing information noted in the 3rd Quarter 2020 Work Plan, including:
  - In Section 2.0, Patient Safety Initiatives, the objective states, "Identify a process to receive, track, investigate, validate, and manage Potential Quality of Care Issues." This was an activity completed in 2019 even though listed as ongoing for 2020.
  - In Section 5, Availability of Practitioners, the goals are not documented for the ratio of PCPs to members and the ratio of high-volume specialist and high-volume behavioral health providers to members. Also, the goal for the percentage of members with one open behavioral health provider is missing.
  - In Section 5, Availability of Practitioners, the standards for measuring the percentage of adults and children with access to a PCP are incorrect. The *CAN* and *CHIP Contracts, Section 7 (B), Provider Network Requirements* list the standard for adult and pediatric members as two PCPs within 15 miles for urban and two PCPs within 30 miles for rural.
  - In Section 5, Availability of Practitioners, the standards for measuring the percentage of members with one open specialist and the percentage of members with one open behavioral health specialist do not include the time requirements (30 minutes) for urban providers and do not include the requirements for rural providers. The *CAN* and *CHIP Contracts, Section 7 (B)* list the requirements as one specialist and one behavioral health specialist within 30 minutes or 30 miles for urban providers and within 60 minutes or 60 miles for rural providers.
  - In Section 6.0, Accessibility of Services, the standard for measuring a regular and routine PCP appointment is listed as 90% within six weeks. The *CAN* and *CHIP Contracts, Section 7 (B)*, Provider Network Requirements list the standard as not to exceed 30 calendar days for a PCP well visit and not to exceed seven calendar days for a PCP routine sick visit.
  - In Section 7.0, Accessibility of Services: Behavioral Health, the standard used to measure urgent care for behavioral health is listed as within 48 hours. However, the *CAN* and *CHIP Contracts, Section 7 (B)* list this requirement as not to exceed 24 hours. Also, the post discharge follow-up (not to exceed seven calendar days) is not included.
  - In Section 9.0, Continuity and Coordination of Medical Care, the timeframe for notifying members of the termination of a PCP is listed as within 30 days of termination date or within 30 days of notification. However, the *CAN* and *CHIP Contracts, Section 7 (D),* Provider Termination, Number 4, Member Notification,

states the Contractor shall send a written notice within 15 calendar days of notice or issuance of termination of a provider to members who received primary care from the provider.

- The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. The 2020 membership list only included two network pediatricians and one internal medical physician.
- The monitoring of provider compliance with the clinical practice guidelines and preventive health guidelines was not included in the QI Work Plan as mentioned in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.
- The EPSDT and Well-Baby and Well-Child tracking reports failed to link the identified problem(s) with the EPSDT or Well-Baby and Well-Child service and include or indicate members who received additional treatments or referrals as required by the *CAN* and *CHIP Contracts, Section 5 (D)*.
- Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight as required by the *CAN* and *CHIP Contracts, Section 10 (D)* and *Exhibit G*.
- The Use of Opioids From Multiple Providers (UOP) measure and the Use of Opioids at High Dosage (HDO) measure was assessed as having a Biased Rate (BR).
- The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable.
- All numerator rates were not reported for the Use Of Pharmacotherapy For Opioid Use Disorder (OUD – AD).
- Hybrid methodology was not used for Core Set measures that may have resulted in better rates when administrative data is combined with medical record data.
- Molina did not report five non-HEDIS measures as required by DOM. The five measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01), Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH), Asthma in Younger Adults Admission Rate (PQI-15-AD), and Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH.
- The rates produced for the Core Set measures were not reviewed for accuracy and reasonability to confirm that the rates were reflective of services provided during the measurement period.
- All performance improvement projects except for the Behavioral Health Readmission PIP scored within the Not Credible range and did not meet the validation requirements.

Corrective Actions

- Correct the errors identified in the 2020 QI Work Plan.
- The EPSDT and Well-Baby and Well-Child tracking reports should include the date the EPSDT service was provided, ICD 10 or CPT codes for the diagnosis, and treatment and/or referrals for any suspected problem identified during the screening as required by the *CAN* and *CHIP Contracts, Section 5 (D)*.
- The Quality Improvement Program Evaluation must meet all the requirements contained in the *CAN* and *CHIP Contracts, Section 10 (D)* and *Exhibit G*. Specifically, it should include a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.
- The performance improvement projects should be documented on the CCME provided project template and include all required elements.

Recommendations

- It should be clear in the QI work plans that the CHIP line of business is included. Also, consider reporting CAN and CHIP measures separately.
- Develop the QI work plan in a format that is easily reviewed by internal and external stakeholders. Ensure this format allows external stakeholders access to the embedded documents.
- Recruit additional network providers to serve on the QIC. Consider including a Family Practice, OB/GYN, and Behavioral Health practitioner.
- Include in the QI Work Plan the monitoring of provider compliance with clinical practice guidelines and preventive health guidelines.
- Work proactively with DOM for clarification on measures required to be reported.
- Actively monitor Core Set measure data accuracy. Data issues identified in calculating HEDIS measures may also have a negative impact on the accuracy and reliability of Core Set measure rates.
- Ensure that central corporate teams have accurate and timely information needed to report measures as required by DOM. Additionally ensure that Core Set Measure rates produced are accurate and reliable before submitting to DOM.

E. Utilization Management

CCME's assessment of Molina's CAN and CHIP Utilization Management (UM) Programs included reviews of program descriptions and evaluations, policies, Member Handbooks, Provider Manuals, approval, denial, appeal, and case management files, and the website. Utilization Management activities are integrated within the Molina Health Care Services

Program. The Health Care Services (HCS) Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services.

Processes for review of service authorization requests for CAN and CHIP members are conducted using Molina's internal clinical criteria or other established criteria, such as InterQual. Molina assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing of both physician and non-physician reviewers. Review of approval and denial files reflect timely and consistent decision-making. However, CAN denial files included adverse benefit determination letters that use CPT (Current Procedural Terminology) codes to refer to the service requested, rather than describing the service in terms that can be easily understood by the member. Additionally, CCME identified the same issue during review of appeals files. Recommendations are provided to address these issues.

Caremark is delegated to provide pharmacy services for Molina and uses the most current version of the Mississippi Medicaid Program Preferred Drug List (PDL), located on the State's website, to fulfill pharmacy requirements.

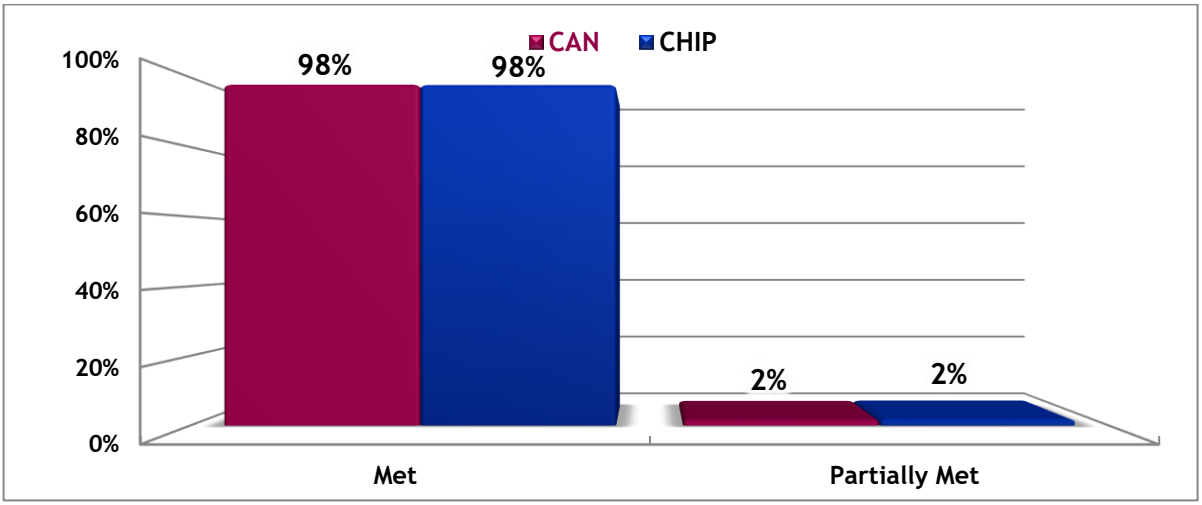
Molina has established policies defining processes for handling both CAN and CHIP appeals. Review of documentation revealed issues such as incomplete and missing definitions of appeal terminology, use of terminology that is not consistent with definitions in the *CAN* and *CHIP Contracts* and *Federal Regulations*, lack of information about who can file an appeal, incorrect and incomplete information about the appeal filing timeframe and filing requirements, and incomplete information about continuation of benefits pending the resolution of an initial member appeal, State Fair Hearing, and Independent External Review.

Review of appeal files reflect timely acknowledgement, resolution, and notification of determinations. However, CCME identified three appeals cases that were reviewed by the same physician reviewer who issued the initial determination. Summaries of appeal actions, trends, and root causes are reported to the Quality Improvement Committee and used to identify opportunities to improve quality of care and service.

Molina uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels and follows a standard outreach process as it applies to continual care, transitional care, and discharge planning. Case Management (CM) files indicate care management activities are conducted as required and HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed.

As noted in *Figure 6: Utilization Management Findings*, Molina achieved "Met" scores for 98% of the CAN standards and 98% of the CHIP standards.

Figure 6: Utilization Management Findings



Scores were rounded to the nearest whole number.

Table 15: Utilization Management provides an overview of standards scored as "Partially Met" and "Not Met" for the Utilization Management section of the review.

Table 15: Utilization Management

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Appeals	The procedure for filing an appeal;	Partially Met	Partially Met

Strengths

- Care managers consistently conduct HIPAA verification and assess for gaps in care during member outreach.

Weaknesses

- CAN and CHIP websites incorrectly state that pharmacy prior authorizations will be responded to in 72 hours.
- CAN adverse benefit determination letters use CPT codes to refer to the service requested, rather than describing the service in terms that can be easily understood by the member. Additionally, CCME identified the same issue in the appeal files.
- CCME identified the following documentation issues with definitions of the terms "appeal," "adverse benefit determination," and a description of who can file an appeal:

  - The HCS Program Description and the CAN and CHIP websites incorrectly use the term "action" instead of "adverse benefit determination" when defining an appeal.
  - The CAN and CHIP Provider Manuals and the CAN and CHIP websites incorrectly define an adverse benefit determination.
  - A description of who can file an appeal is not clearly defined on the CAN and CHIP websites.
- The following issues regarding appeals were identified on Molina's website:
  - For CAN, the address provided to submit written appeals is listed as a P.O. Box in North Charleston, SC instead of Capitol St. in Jackson, MS.
  - For CAN and CHIP, it incorrectly states that appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the Adverse Benefit Determination letter.
  - The CAN and CHIP websites do not mention an authorized representative may file an appeal on the member's behalf or that a member can present evidence and examine their appeal file at any time during the appeals process.
- The CHIP Member Handbook, Provider Manual, and website do not specify that a written appeal request must follow a verbal appeal request within 30 days after the call, unless expedited, as required by the *CHIP Contract Section 6 (K)*.
- The CAN (pages 105 and 106) and CHIP (page 117) Provider Manuals state, "The timeframe for appeals resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe an additional fourteen (14) calendar days if the extension is in the interest of the Member…" This could be misinterpreted by members to mean that Molina will have a total of 28 days to issue a determination when the appeal resolution timeframe is extended.
- Three of the CHIP appeal files were reviewed by the same physician reviewer who made the initial determination.
- Policy MHMS-HCS-CM-061, Health Risk Assessment, incorrectly states health risk assessments are completed within 90 days.

Corrective Actions

- Correct the CAN and CHIP websites to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal, to meet requirements in the *CAN* and *CHIP Contracts, Section 6 (H) and (K)*.

Recommendations

- For CAN and CHIP websites, correct the timeframe for completing prior authorization requests from 72 hours to 24 hours, to align with the timeframes noted in Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures.
- Ensure CAN and CHIP adverse benefit determination notices are written in terms that are easily understood by members, according to requirements in *CAN* and *CHIP Contracts Section 6 (F) (1)* and *42 CFR § 438.10*.
- Edit the HCS Program Description and CAN and CHIP websites to indicate current terminology of "adverse benefit determination" instead of "action." Include the correct definition of "adverse benefit determination" in the CAN and CHIP Provider Manuals and websites.
- Edit the CAN and CHIP websites to include a complete description or definition of who can file an appeal as noted in the *CAN* and *CHIP Contracts, Section 2 (A)* and *42 CFR § 438.400 (b)*.
- For CAN and CHIP Provider Manuals, remove the term "additional" in the appeal extension timeframe description to clearly specify that Molina can extend the timeframe only 14 days, in accordance with *42 CFR §438.408 (c), the CAN Contract, Exhibit D (B)* and *CHIP Contract, Exhibit C (B)*.
- For CHIP, ensure that individuals who make appeal decisions were not involved in any previous level of review, as noted in Policy MHMS-MRT-02, Standard Member Appeals.
- Edit Policy MHMS-HCS-CM-061, Health Risk Assessment, to indicate health risk assessments are completed in 30 days, instead of 90 days, for members newly assigned to the High or Medium risk levels, as required by the *CAN Contract, Section (9) (A)*.

F. Delegation

CCME's External Quality Review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials.

Molina reported 15 current delegation agreements, as shown in *Table 16: Delegated Entities and Services*.

Table 16: Delegated Entities and Services

Delegated Entities	Delegated Services
Avesis	Dental and Hearing Benefit Administration Services
Caremark	Pharmacy Benefit Administration Services

Delegated Entities	Delegated Services
MARCH Vision Care	Vision and Eye Care Benefit Administration Services
Southeastrans Medical Transportation Management	Non-Emergency Transportation
Baptist Memorial Medical Center George Regional Health System Hattiesburg Memorial Medical Group Magnolia Regional Health Mississippi Physician Care Network Memorial Hospital at Gulfport North Mississippi Health Services Ochsner Health System Premier Health University of Mississippi Medical Center	Credentialing

Per Policy DO001, Delegation Pre Assessment Audits, Molina ensures all potential delegates have a pre-assessment audit completed to determine the provider's ability to meet the requirements. Results of the pre-assessment audits are presented to the Delegation Oversight Committee for review and decision. Decisions of the committee are communicated to the delegate within five business days of the decision. Once the delegate is approved, Molina monitors the delegate's ongoing compliance at least annually, as outlined in Policy DO002, Performance Monitoring and Annual Audits of Delegation. Ongoing compliance will be ensured by annual audits and by monitoring monthly and/or quarterly reports of delegated activities. If corrective action is needed for identified deficiencies, Molina follows the process outlined in Policy DO003, Corrective Action and Termination of Delegation.

Pharmacy benefit administration services for CAN and CHIP are delegated to Caremark. Molina provided an oversight policy (Policy MHMS-PH-007, Pharmacy Oversight of the Pharmacy Benefit Manager); however, this policy only covers the CHIP line of business.

Molina provided copies of the delegation agreements, pre-delegation/annual oversight monitoring, and quarterly monitoring for each delegated entity. Deficiencies and applicable corrective actions were noted in the monitoring reports.

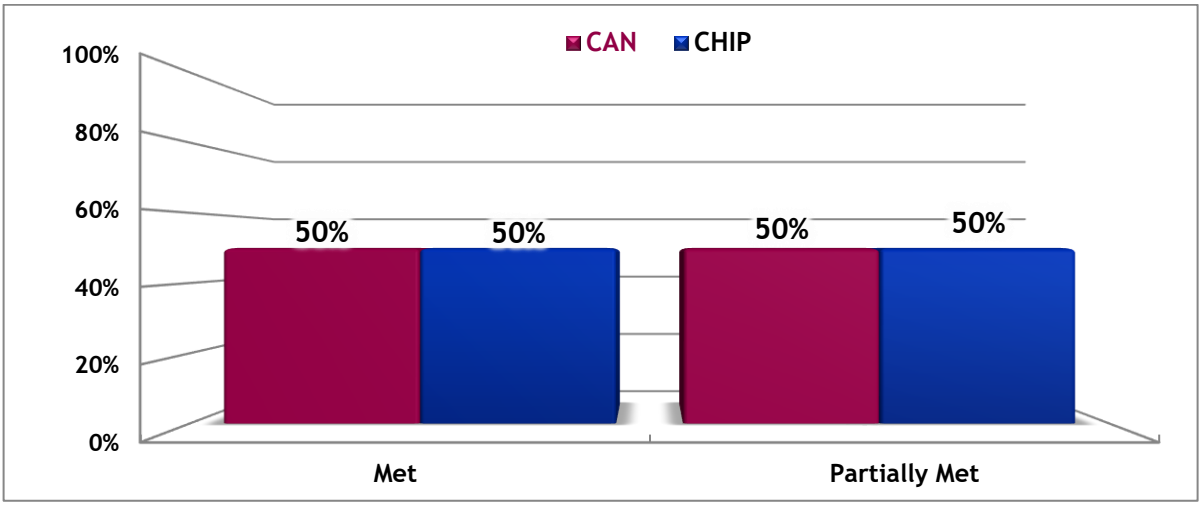
The monitoring tools used for the credentialing delegates did not include query of the Social Security Death Master File (SSDMF) or the Mississippi sanctioned provider list. Molina staff indicated these requirements remained the responsibility of the health plan and are not required functions for the delegates. However, the criteria listed on page five of Policy DO005, Credentialing Delegation Requirements, includes "(10). Medicaid

sanctions from all published state Medicaid sanctions lists" and "(12) Social Security Administration's Death Master file." CCME recommends the functions that remain the responsibility of the health plan be reflected in the delegation policies.

The site assessments and reassessments specified in the *CAN* and *CHIP Contracts, Section 7 (E)* and the fingerprinting requirements for high-risk providers as required by the *CHIP Contract, Section 7 (E) (6)* were not included on the monitoring tools.

As indicated in *Figure 7: Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met" for CAN and CHIP.

Figure 7: Delegation Findings



Molina demonstrated that monitoring oversight was conducted. However, the tools used for monitoring credentialing and recredentialing deletes did not include all the Mississippi requirements and, therefore, received a partially met score as shown in *Table 17: Delegation*.

Table 17: Delegation

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Delegation	The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions	Partially Met	Partially Met

Weaknesses

- Pharmacy benefit administration services for CAN and CHIP are delegated to Caremark. Molina's oversight policy (Policy MHMS-PH-007, Pharmacy Oversight of the Pharmacy Benefit Manager) only covers the CHIP line of business.
- The monitoring tools used for credentialing delegates did not include query of the SSDMF or the Mississippi sanctioned provider list. Molina staff indicated these requirements remained the responsibility of the health plan and are not required functions for the delegates. However, the criteria listed on page five of Policy DO005, Credentialing Delegation Requirements, includes "Medicaid sanctions from all published state Medicaid sanctions lists" and "Social Security Administration's Death Master File."
- The site assessments and reassessments specified in the *CAN* and *CHIP Contracts, Section 7 (E),* along with the fingerprinting requirements for high-risk providers, as required by the *CHIP Contract, Section 7 (E) (6),* were not included in the credentialing and recredentialing monitoring tools.

Corrective Actions

- Update the credentialing and recredentialing monitoring tools to include the site assessments and reassessments as specified in the *CAN* and *CHIP Contracts, Section 7 (E)*, along with the fingerprinting requirements for high-risk providers, as required by the *CHIP Contract, Section 7 (E) (6)*.

Recommendations

- Update the language in Policy MHMS-PH-007, Pharmacy Oversight of the Pharmacy Benefit Manager, to include the CAN line of business.
- The functions that remain the responsibility of the health plan should be reflected in delegation policies.

ATTACHMENTS

Attachment 1: Initial Notice, Materials Requested for Desk Review

Attachment 2: Materials Requested for Onsite Review

Attachment 3: EQR Validation Worksheets

Attachment 4: Tabular Spreadsheet

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

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

October 16, 2020

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

Dear Ms. Galatas:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2020 External Quality Review (EQR) of Molina Healthcare is being initiated. The review will include the MississippiCAN Program (MSCAN) and MississippiCHIP Program (MSCHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

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

The onsite visit will be conducted via teleconference on **January 20, 2021** and **January 21, 2021** for the MississippiCAN and Mississippi CHIP Programs.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **November 16, 2020**.

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

External Quality Review 2020 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

5. Submit a complete list of network providers from the current provider directory for the MSCAN members. The list should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for MississippiCAN Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Type/Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions
Medicaid ID	Tax ID
NPI	Contract Date Spans

Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information. (Note: this information will be requested twice yearly.)

6. 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.

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

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

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

10. The Quality Improvement work plans for MSCAN for 2019 and 2020.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program planned or completed during the previous year. Also include any interim information available for any projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 sample records from those abstracted charts.
    c. For projects with measures derived from administrative electronic systems:
        - full source code documentation of how the measure was processed and calculated for the PIP, and
        - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

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

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

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

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

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

18. Provide reports for measuring provider adherence to medical record standards for 2019 and 2020.

19. A complete list of all MSCAN members enrolled in the Care Management program from the date you began enrolling members into your health plan through September 2020. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

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

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

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

25. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program from the date you began enrolling members into your health plan through September 2020.

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

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

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

29. 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.

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

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

32. A sample provider contract for the MSCAN program.

33. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    h. A copy of the Information Security Plan & Security Risk Assessment.
    i. A copy of the claims processing monitoring reports covering the period from the date you began enrolling members into your health plan through September 2020.

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

35. Contracts for all delegated entities.

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

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

Folder	Requested Document	Description
a.	HEDIS 2020 (Measurement Year 2019) Roadmap (Record of Administration, Data Management and Processes) (Roadmap)	• Please submit the same Roadmap your CCO completed for the 2020 [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 each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN.
c.	HEDIS 2020 Final Audit Report (from Licensed Organization) for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that EQR reviewer may contact the vendor to review source code/process flow for measure production.
f.	List of measures rotated for HEDIS 2020 due to COVID-19 impact	Please submit a table/list of measures that were rotated for HEDIS 2020 due to COVID-19 impact.
g.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37g) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite visit.*
h.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37.*

Folder	Requested Document	Description
		h) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.
i.	Reporting template populated with data for Non-HEDIS measure rates	CCME will provide the reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.

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

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

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

These materials:

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

External Quality Review 2020 for Mississippi CHIP

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

5. Submit a complete list of network providers from the current provider directory for the CHIP members. The lists should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for Mississippi CHIP Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Type/Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions
Medicaid ID	Tax ID
NPI	Contract Date Spans

   Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information. (Note: this information will be requested twice yearly.)

6. 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.

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

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

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

10. The Quality Improvement work plans for CHIP for 2019 and 2020.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 sample records from those abstracted charts.
    c. For projects with measures derived from administrative electronic systems:
        - full source code documentation of how the measure was processed and calculated for the PIP, and
        - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

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

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

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

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

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

18. Provide reports for measuring provider adherence to medical record standards for 2019 and 2020.

19. A complete list of all CHIP members enrolled in the Care Management program from the date you began enrolling members into your health plan through September 2020. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

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

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

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

25. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program from the date you began enrolling members into your health plan through September 2020.

26. 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.

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

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

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

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

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

32. A sample provider contract for the CHIP program.

33. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    h. A copy of the Information Security Plan & Security Risk Assessment.
    i. A copy of the claims processing monitoring reports covering the period from the date you began enrolling members into your health plan through September 2020.

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

35. Contracts for all delegated entities.

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

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

Folder	Requested Document	Description
a.	HEDIS 2020 (Measurement Year 2019) Roadmap (Record of Administration, Data Management and Processes) (Roadmap)	• Please submit the same Roadmap your CCO completed for the 2020 [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 each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for CHIP	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for CHIP.
c.	HEDIS 2020 Final Audit Report (from Licensed Organization) for CHIP	Please submit the CHIP Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that EQR reviewer may contact the vendor to review source code/process flow for measure production.
f.	List of measures rotated for HEDIS 2020 due to COVID-19 impact	Please submit a table/list of measures that were rotated for HEDIS 2020 due to COVID-19 impact.
g.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite visit.*
h.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 h) a list of the first 100 hits that are identified through medical*

Folder	Requested Document	Description
		record review. CCME will select a random sample to conduct the medical record review validation.
i.	Reporting template populated with data for Non-HEDIS measure rates	CCME will provide the reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.

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

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

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copies of Provider Newsletter or DRAFT Provider Newsletter for Q3 and Q4 2020, if available.

3. Results of the monitoring conducted to evaluate the effectiveness of the clinical and preventive practice guidelines.

4. A copy of the CAN and CHIP tacking reports for any problem identified during the EPSDT and Well-Baby/Well Child exam (referenced in Policy MHMS-QI-003 and MHMS-QI-005). Please include the referrals.

5. Provide a sample of the performance data and patterns of utilization shared with providers and referenced in Policy MHMS-QI122.

6. The following information for the delegate Teledoc.
    a. Delegation agreement
    b. Pre-delegation monitoring
    c. Annual monitoring if applicable

C. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN and CHIP
- Member Satisfaction Survey Validation CAN (Adult)
- Member Satisfaction Survey Validation CAN (Child)
- PM Validation CAN
- PIP Validation CAN
- PIP Validation CHIP

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

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 tested for validity. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Only 205 providers (15.6%) completed the survey. This is a low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019 **Recommendation**: Identify methods to improve response rate by providers – include more reminders and consider incentives for survey completion.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,318. The total completed surveys was 136 for a 10.3% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,630. The total completed surveys was 166 for a 10.2% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the child member population. Continue to work with SPH Analytics to improve response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN AGE 18 AND OLDER (CDF – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**Not Met**	The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. *Recommendation: Molina should work proactively to identify the root cause and take steps to mitigate this concern from reoccurring in the future.*
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Met**	The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. *Recommendation: Molina should work proactively to identify the root cause and take steps to mitigate this concern from reoccurring in the future.*

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Met**	The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. *Recommendation: Molina should work proactively to identify the root cause and take steps to mitigate this concern from reoccurring in the future.*
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Met**	The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. *Recommendation: Molina should work proactively to identify the root cause and take steps to mitigate this concern from reoccurring in the future.*
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**N/A**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Not Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Not Met**	**0**
D2	**5**	**Not Met**	**0**
N1	**10**	**Not Met**	**0**
N2	**5**	**Not Met**	**0**
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	**45**
Measure Weight Score	**75**
Validation Findings	**60%**

AUDIT DESIGNATION
Not Valid

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**ELECTIVE DELIVERY (PC-01)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Not Applicable**	This measure was not reported.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
NOT REPORTED

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE ((PQI01 – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI05 - AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI08 - AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI15 – AD)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
N5 Numerator–Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Not Applicable**	This measure was not reported.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
NOT REPORTED

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD – AD)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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).	**Partially Met**	All rates were not reported. Only the overall rate was reported. Missing rates for: - Buprenorphine (Rate 2) - Oral naltrexone (Rate 3) - Long-acting, injectable naltrexone (Rate 4) - Methadone (Rate 5)
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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

Plan's Measure Score	**74**
Measure Weight Score	**75**
Validation Findings	**98.67%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare MSCAN**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD – CH)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
N5 Numerator–Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Not Applicable**	This measure was not reported.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
NOT REPORTED

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Health MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP – CH)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW – CH)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF – CH)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV – CH)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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.	**N/A**	This hybrid measure was reported using only administrative methodology
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	This hybrid measure was reported using only administrative methodology

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW – CH)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
N5 Numerator–Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Not Applicable**	This measure was not reported.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
NOT REPORTED

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**CESAREAN BIRTH (PC02-CH)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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.	**N/A**	This hybrid measure was reported using only administrative methodology
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	This hybrid measure was reported using only administrative methodology

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**PRECENTAGE OF ELIGIBLES WHO RECEIVED PREVENTATIVE DENTAL SERVICES (PDENT -CH)**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL – CH)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
N5 Numerator–Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Not Applicable**	This measure was not reported.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
NOT REPORTED

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2020**
Review Performed:	**01/20/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Specifications

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.	**Partially Met**	Two measures, Use of Opioids from multiple providers (UOP) and Use of Opioids at High Dosage (HDO) received a Biased rate (BR) designation: The calculated rate was materially biased. *Recommendation: Molina should work proactively to identify the root cause and take steps to mitigate this concern from reoccurring in the future.*
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.	**Partially Met**	Two measures, Use of Opioids from multiple providers (UOP) and Use of Opioids at High Dosage (HDO) received a Biased rate (BR) designation: The calculated rate was materially biased. *Recommendation: Molina should work proactively to identify the root cause and take steps to mitigate this concern from reoccurring in the future.*
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	Partially Met	9
D2	5	Met	5
N1	10	Partially Met	9
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	**72**
Measure Weight Score	**75**
Validation Findings	**97.33%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA (MMA)**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for the rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study question was documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities are not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*

Component / Standard (Total Points)	Score	Comments
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS- HINDS COUNTY**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis was provided as rationale for PIP.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**N/A**	Sampling not used for this outcome.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**N/A**	Sampling not used for this outcome.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sampling not used for this outcome.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for readmissions and enrollment in case management.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources were indicated in proposal.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Claims data was utilized.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Information provided in section C.5.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data was analyzed according to planned.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Q1 2020 and Q2 2020 were presented in table format with percentage, benchmark, and statistical testing.
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**	Two measurements were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis is included in the report for each measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were documented in the report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Readmission rate reduced substantially.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Chi square test for change in rates was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge as study is still ongoing.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan as not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly rates. HEDIS 2019 is not calendar 2019- please clarify if baseline is HEDIS 2019 ,which is calendar year 2018 or if the baseline is calendar year 2019 HEDIS 2020.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities were not documented**.**

Component / Standard (Total Points)	Score	Comments
		***Corrective Action**: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**Pharmacotherapy Management of COPD Exacerbation (PCE)**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis is not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions are documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addresses key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP does not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information is not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*

Component / Standard (Total Points)	Score	Comments
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources are not indicated in proposal. ***Corrective Action:*** *Include information on sources of data*.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources are not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection are not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan is not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly rates. HEDIS 2019 is not calendar 2019- please clarify if baseline is HEDIS 2019 ,which is calendar year 2018 or if the*

Component / Standard (Total Points)	Score	Comments
		baseline is calendar year 2019 HEDIS 2020.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline is not offered in report and follow-up activities are not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action****: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**OBESITY**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources are not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly rates. HEDIS 2019 is not calendar 2019- please clarify if baseline is HEDIS 2019 ,which is calendar year 2018 or if the baseline is calendar year 2019 HEDIS 2020.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.

Component / Standard (Total Points)	Score	Comments
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities were not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action****: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**PRENATAL AND POSTPARTUM CARE (PPC)**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for Prenatal care timeliness and postpartum care/visit.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly rates. HEDIS 2019 is not calendar 2019- please clarify if baseline is HEDIS 2019 ,which is calendar year 2018 or if the baseline is calendar year 2019 HEDIS 2020.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities were not documented**.**

Component / Standard (Total Points)	Score	Comments
		***Corrective Action**: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CAN**
Name of PIP:	**CASE MANAGEMENT AND FOLLOW-UP (30 DAY) SERVICES FOR SICKLE CELL DISEASE**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for case management services and follow-up within 30 days after hospitalization for sickle cell diagnosed members.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly rates. Baseline is shown as 2019 calendar year data. Rate is not presented in report.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.

Component / Standard (Total Points)	Score	Comments
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities were not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action****: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA (MMA)**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study question was documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. **Corrective Action:** Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2018 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline is not offered in report and follow-up activities are not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*

Component / Standard (Total Points)	Score	Comments
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)- 6 TO 19 YEAR OLDS**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for FUH 7-day and FUH 30-day.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2018 will be used as baseline. ***Corrective Action****: Include the results for baseline rate in PIP report with comparison to benchmark rate.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities are not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans*

Component / Standard (Total Points)	Score	Comments
		are annual, quarterly, or monthly.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**28**
Project Possible Score	**62**
Validation Findings	**45.2%**

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**OBESITY- 3 TO 19 YEAR OLDS**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan is not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate (HEDIS 2018) in the PIP report.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities were not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans are annual, quarterly, or monthly.*

Component / Standard (Total Points)	Score	Comments
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina CHIP**
Name of PIP:	**WELL CARE- W15, W34, AWC**
Reporting Year:	2019-2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Data analysis was not offered in PIP report proposal for rationale to initiate study. ***Corrective Action:*** *Include a summary of the rationale and data analysis that led to initiation of this PIP.*
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study questions were documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Study addressed key aspect of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP did not exclude enrollees that are eligible.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NOT MET**	Sampling information not provided in the report. ***Corrective Action:*** *Include information on sampling plan; if not applicable, indicate in the report using a PIP report template.*
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NOT MET**	Information was not documented in the PIP report. ***Corrective Action:*** *Include information on sampling technique; if not applicable, indicate in the report using a PIP report template.*
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**N/A**	Sample not provided as rate is not provided in report for baseline.
STEP 5: Review Selected PIP Variables and Performance Measures		

Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were clearly defined for Prenatal care timeliness and postpartum care/visit.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were specified in report as part of study indicator.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data sources were not indicated in proposal. ***Corrective Action:*** *Include information on sources of data.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**N/A**	Unable to judge as data sources were not reported.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**N/A**	Instruments for data collection were not specified in report.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan was not documented. ***Corrective Action****: Include the data analysis plan in PIP report. Common analysis plans are annual, quarterly, or monthly.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**N/A**	Unable to judge
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**N/A**	No data analysis performed.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	No findings presented although report says HEDIS 2019 will be used as baseline. ***Corrective Action****: Include the results for baseline rate of HEDIS 2018 in report. Analyze in comparison to the decided benchmark rate.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**N/A**	No repeat measurements yet.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NOT MET**	Analysis of baseline was not offered in report and follow-up activities are not documented**.** ***Corrective Action****: Include the results for baseline rate in PIP report. Common analysis plans*

Component / Standard (Total Points)	Score	Comments
		are annual, quarterly, or monthly.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions not documented in the report. ***Corrective Action**: Add the barriers and interventions linked to each barrier to the report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**N/A**	No findings presented.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	No improvement to assess.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	0
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	0
4.2	1	0
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	0
6.3	NA	NA
6.4	NA	NA
6.5	1	0
6.6	NA	NA
Step 7		
7.1	NA	NA
7.2	10	0
7.3	NA	NA
7.4	1	0
Step 8		
8.1	10	0
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	28
Project Possible Score	62
Validation Findings	45.2%

AUDIT DESIGNATION
NOT CREDIBLE

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

D. Attachment 4: Tabular Spreadsheet

CCME MSCAN Data Collection Tool

Plan Name:	**Molina Healthcare MSCAN**
Review Performed:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies and procedures are in place that demonstrate Molina's commitment to the quality of care for its members. However, there is no policy addressing an overall process for policy development and management. Onsite discussion indicated that a committee is being developed to oversee policies and procedures. All employees have access to policies and procedures via a shared drive until a platform has been obtained to house policies and procedures. *Recommendation: Create a policy detailing the process used for policy development and management.*
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Chief Executive Officer;	X					Bridget Galatas is the Plan President and Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Keshia Lymuel is the AVP of Health Plan Operations and serves as the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Ed Mohr is the Chief Financial Officer.
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Nancy Vasquez is the Claims Director.
1.6 *Provider Services Manager;	X					Chinwe Nichols is the Director of Provider Services.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					The Member Services Manager is Juan (Emilio) Bellizzia Arriaga.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					Bert Emrick is the Appeals and Grievances Manager.
1.9 Utilization Management Coordinator;	X					Chris Cauthen is the Utilization Management Director.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Phil Collins is the Health Plan Quality Improvement Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 *Marketing, member communication, and/or public relations staff;	X					Jovante Johnson is the Communications Manager.
1.12 *Medical Director;	X					Dr. Thomas Joiner is the Medical Director and Dr. Nazmul Talukdar, a board-certified psychiatrist, was identified as the Behavioral Health Medical Director.
1.13 *Compliance Officer.	X					David Estorge is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Submitted claims performance data demonstrates Molina exceeds the claims processing requirements of the *CAN Contract*. The contract requires 90% of clean claims to be processed within 30 days; Molina averages 99.7% of clean claims processed within 30 days. The contract requires 99% of clean claims to be processed within 90 days; Molina averages 100% of clean claims processed within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina's systems capture enrollment and demographic data and the data is updated as Molina receives updates from the State. Additionally, Molina noted their systems have been upgraded for improved efficiency while maintaining accuracy.
3. The CCO management information system is sufficient to support data reporting to the State and	X					Molina's information systems are capable of generating the HEDIS and HEDIS-like reports required by the State. Molina's Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
internally for CCO quality improvement and utilization monitoring activities.						documentation also noted that regular testing and validation exercises are conducted to ensure the accuracy of data stored within its HEDIS data repository.
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 disaster recovery plan that incorporates best practice backup routines and data retention policies. The organization conducts disaster recovery testing on a yearly basis and has deployed IT systems with integrated redundancies for business continuity.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					With the approval of the Molina Board of Directors, a Compliance Plan was developed to benefit the company, its employees, payors, and regulators with the goals of increasing efficiency, reducing waste, minimizing confusion, and improving the quality of services.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Code of Business Conduct and Ethics governs and provides guidance about appropriate and ethical business conduct for Company employees, officers, and directors.
2.2 Identification of the Compliance Officer;						
2.3 Information about the Compliance Committee;						The Compliance Committee seeks to increase the understanding of the legal and contractual responsibilities for employees by providing education and training to Molina Healthcare

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						representatives regarding compliance requirements.
2.4 Compliance training and education;						Training and education are part of the Compliance orientation for new employees and includes information about the responsibility to report any suspected compliance issues and concerns for investigation and appropriate follow-up.
2.5 Lines of communication;						
2.6 Enforcement and accessibility;						
2.7 Internal monitoring and auditing;						Auditing and monitoring are used to identify areas of compliance deficiency, respond to reports of suspected non-compliance, and to assess continuing compliance and the effectiveness of corrective measures implemented to address previously identified compliance deficiencies.
2.8 Response to offenses and corrective action;						
2.9 Exclusion status monitoring.						
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Policy MHMS-PH004, Pharmacy Lock-In Program, describes processes to identify members who display high controlled substance utilization and/or fraudulent sale or transfer of pharmaceutical products. Members who are identified for the Pharmacy Lock-In Program can obtain controlled substances and prescribed medications from the designated pharmacy provider and from no other provider during the outlined time frame.
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy HP-16, Confidential Information, indicates that "Molina Healthcare maintains the confidentiality of all Confidential Information, including but not limited to Protected Health Information (PHI), Personally Identifiable Information (PII), Nonpublic Information (NI), Nonpublic Personal Information (NPI), practitioner/provider-specific information and proprietary information through the adoption, implementation and ongoing review and revision of this policy and other related policies and procedures."

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Processes and requirements for credentialing and recredentialing health care providers are found in the Credentialing Program Policy (Policy CR 01), the Assessment of Organizational Providers Policy (Policy CR 02), and in Mississippi-specific addenda to the policies.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					Policy CR 01, Credentialing Program Policy, defines requirements and responsibilities of the Professional Review Committee (PRC). Molina's PRC uses a peer review process to make recommendations regarding credentialing decisions and reports to the Quality Improvement Committee (QIC). A Molina Medical Director chairs the PRC and appoints all PRC Members. The policy states the PRC meets quarterly at minimum, but usually meets every four to six weeks. Onsite discussion confirmed the committee typically meets every six weeks, but some meetings over the past year have been canceled due to lack of provider files to review. The policy states the PRC's membership includes at least four practitioners from a range of specialties in the Molina network, such as behavioral health, dentistry, family practice, internal medicine, pain management, pediatrics, OB/GYN, surgery, etc. Other ad hoc practitioners may be invited to participate when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						representation of their discipline is needed, and ad hoc committees representing a specific profession may be appointed by the chair to screen applicants from their respective profession and make credentialing recommendations to the PRC. CCME noted the voting PRC members include three family medicine providers, one internal medicine provider, and one OB/GYN. Onsite discussion confirmed no attempts have been made to recruit providers with additional specialty types. PRC minutes confirm the presence of a quorum for each meeting and reflect review and discussion of providers for which Level II review was required, review of QOC cases, and review of clean files approved by the medical director. *Recommendation: Because the Professional Review Committee serves as a peer review committee, consider recruiting providers with additional specialty types to serve as committee members.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Processes for initial credentialing are detailed in Policy CR 01, Credentialing Program Policy. Mississippi-specific requirements are included in Addendum B to this policy.
3.1 Verification of information on the applicant, including:						Issues identified in the initial credentialing files are addressed in the standards below.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice insurance coverage / claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;						
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					Initial credentialing files for two nurse practitioners did not include admitting privileges and had no documented admitting plan. CCME understands nurse practitioners typically do not admit members but should have a plan in place for situations in which a member needs to be admitted. *Recommendation: Ensure admitting plans are collected for nurse practitioners credentialed into the network.*
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					File review revealed missing CLIA certificates for some practice locations listed on provider applications. Molina staff responded that these locations were not being credentialed and, therefore, no CLIA was required. CCME also noted that on several provider applications, the question about whether a practice location conducts laboratory services was incomplete. During discussion of this issue, Molina staff reported they do not contact the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider to clarify and do not seek a CLIA for the location. *Recommendation: To ensure appropriate collection of CLIA certificates or certificates of waiver, develop and implement a process to contact providers when the application is incomplete regarding laboratory services if the provider is being credentialed for the location.*
3.1.15 Ownership Disclosure form.					X	Per a directive from DOM, CCOs are no longer required to collect Ownership Disclosure Forms.
3.2 Site assessment.			X			CCME understands that due to Covid-19, restrictions are in place that prevent provider office site visits from being conducted as part of initial credentialing. However, of 14 initial credentialing files reviewed, 10 were from 2018 and 2019, prior to Covid-19. These 10 files contained no evidence of a site visit being conducted, and onsite discussion confirmed Molina has not been conducting site visits as a part of initial credentialing. However, Policy CR 01, Credentialing Program Policy, Addendum B states, "Molina will conduct an initial site assessment prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the provider office visit." Requirements for site visits are specified in the *CAN Contract, Section 7 (E).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Develop and implement a process to conduct site visits for initial credentialing to begin when Covid-19 restrictions are lifted.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					Processes for recredentialing are detailed in Policy CR 01, Credentialing Program Policy. Mississippi-specific requirements are included in Addendum B to this policy.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						Because Molina is a new health plan in Mississippi, recredentialing is expected to begin in mid-2021.
4.2.1 Current valid license to practice in each state where the practitioner will treat members;					X	
4.2.2 Valid DEA certificate and/or CDS Certificate;					X	
4.2.3 Board certification if claimed by the applicant;					X	
4.2.4 Malpractice claims since the previous credentialing event;					X	
4.2.5 Practitioner attestation statement;					X	
4.2.6 Re-query the National Practitioner Data Bank (NPDB);					X	

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Re-query the System for Award Management (SAM);					X	
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;					X	
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));					X	
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);					X	
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);					X	
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;					X	
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;					X	
4.2.14 Ownership Disclosure form.					X	
4.3 Provider office site reassessment, when applicable.					X	
4.4 Review of practitioner profiling activities.					X	

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					CCME could not identify the timeframe or process for notifying DOM of a provider's suspension or termination for serious quality of care or service issues in the following documents: •Policy CR 01, Credentialing Program Policy or Addendum B of the policy •Policy and Procedure MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events •Policy CR 03, Fair Hearing Policy •Procedure MHMS-PC-09, MHMS Provider Termination Process Onsite discussion confirmed that for provider suspensions or terminations related to serious quality of care or service issues, Molina notifies DOM within 48 hours of the termination decision. *Recommendation: Update the appropriate policies and procedures to include Molina's process and timeframe for notifying DOM of a provider's suspension or termination for serious quality of care or service issues.*
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					Credentialing and recredentialing guidelines for organizational providers are addressed in Policy MHI-CR 02, Assessment of Organizational Providers Policy and in Addendum B of the policy.
II B. Adequacy of the Provider Network						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					The member roster with primary care provider assignments is accessible on the Provider Web Portal for review and is updated with the Member Listing Report from the Division.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
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					Molina Geo Access Reports do not clearly indicate the parameters used to measure adequacy of the network, such as member choice of at least two or more PCPs within a 15-mile radius for urban counties and within 30 miles for rural counties. *Recommendation: Ensure Geo Access Reports clearly identify the parameters used to measure and evaluate the network, including that members have access to two or more PCPs as required by the CAN Contract, Section 7 (B).*
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					
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					
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Onsite discussion revealed that the network is evaluated regularly. However, Molina does not currently compile a report to identify gaps within the network or an annual summary of patterned findings from the quarterly Geo Access Report. *Recommendation: Develop and implement a process to conduct a formal review of Geo Access Reports to summarize the quarterly network findings and any gaps identified.*
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				Evidence was found that accessibility standards are being measured and, except for the requirement for appointments after discharge from an acute psychiatric hospital, appear to be met. The *CAN Contract, Section 7 (B) (2)* stipulates that follow-up appointments should be scheduled within 7 days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavior Health 1st Quarter 2020 MSCAN indicates that the standard was measured using a 14-calendar day parameter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Review and revise the process for measuring follow-up appointments after discharge from an acute psychiatric hospital to reflect the required 7-day appointment timeframe as required by the CAN Contract, Section 7 (B) (2).
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					The Provider Services team conducts orientation and training for new providers and their staff within 30 days of active status, as noted in Policy MHMS-NM-008, Provider Education and Training, and the MHMS MSCAN Provider Training Plan. Orientation can occur in-person with large provider groups or individual practices. Due to Covid-19 restrictions, Molina is currently conducting orientation sessions virtually and copies of the training materials are sent to the provider. Members of Molina's clinical staff participate in provider trainings when applicable. Molina's initial provider education program meets requirements of the *CAN Contract, Section 7 (H) (3)*.
2. Initial provider education includes:						The MississippiCAN Provider Orientation PowerPoint presentation is used for orientation of new network providers. The orientation covers such topics as, but not limited to, care guidelines, covered services, billing and claims payments, and grievance and appeals processes. Additionally, the CAN Provider Manual and other provider materials are used during the orientation process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual is updated at least annually, and the most current version is accessible on Molina's website and meets requirement as noted in the *CAN Contract, Section 7 (H) (2).*
2.1 A description of the Care Management system and protocols;	X					The Care Management Program and the role of care managers are covered in the MississippiCAN New Provider Orientation presentation and the Provider Manual.
2.2 Billing and reimbursement practices;	X					Instructions for billing guidelines and processes are noted throughput the Provider Manual.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					The Provider Manual and the orientation presentation inform providers of appointment availability standards. Additionally, information is posted on the website.
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					Clinical practice guidelines and standards of care are available on the website and throughout the Provider Manual. Early Periodic Screening Diagnostic and Treatment (EPSDT) services are offered to members under 21 years old.
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					Providers receive quarterly encounter lists from Molina of members who are non-compliant with EPSDT services. Providers are responsible for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						contacting the members, documenting reasons for the noncompliance, and documenting results of their outreach efforts to encourage the member complete the service.
2.8 Medical record handling, availability, retention, and confidentiality;	X					Policy MHMS-QI-124, Standards of Medical Record Documentation, defines medical record documentation standards. Provider requirements for medical record handling and documentation standards are available in the Provider Manual and on the website.
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					Policies MHMS-PRT-01, Provider Complaint & Grievances, and MHMS-PRT-02, Provider Reconsiderations and Appeals, describe the requirements for providers to file an appeal on behalf of a member and provider claim appeals. The Provider Manual and the website have information and instructions for submitting an appeal, complaint, or grievance, and describes the resolution process.
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					Policy No. MHMS-PH002, Pharmacy Benefit, gives an overview of pharmacy services. Information on Molina's pharmacy program is noted on the website and in the Provider Manual. It includes information on, but not limited to, the prior authorization process, accessing the Universal Preferred Drug List (PDL), and the process for members to receive a 3-day emergency supply of medication while waiting for prior authorization. The PDL link on Molina's website transfers directly to the Division of Medicaid's PDL page, where specific pharmacy benefit information and procedures are addressed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					The role of the PCP is to manage and coordinate all aspects of the member's care, as noted in Policy MHMS-NM-002, PCP Roles and Responsibilities, and the Provider Manual.
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					During orientation and in the Provider Manual, providers are informed of the requirement to notify Molina 30 days prior to closing their panel to new members.
2.14 Medical record documentation requirements;	X					Policy MHMS-QI-124, Standards of Medical Record Documentation, describes medical record documentation requirements. Molina requires providers to maintain medical records in a manner that is organized and meets all documentation standards. Requirements are communicated in the Provider Manual and on the website.
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with contract requirements.	X					Policy MHMS-PC-01, MHMS Provider Directory Requirements, and the Provider Manual describe Molina's process for creating, maintaining, and making available the Provider Directory, both in print and online according to the *CAN Contract, Section 6 (E) and 42 CFR § 438.10(h).* Providers are trained to use the online Provider Directory during the initial orientation and informed of the requirement to validate the information for accuracy at least quarterly and to notify Molina 30 days prior to needed corrections. Molina staff reported that updates to the Provider Directory occur nightly for the online version and quarterly for the printed copy.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Per policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) based on scientific evidence and recommendations made by Molina's National Quality Improvement Committee. The guidelines are based on the relevance to Molina's population. Periodic review is conducted for guidelines that have been in effect for two or more years. The CPGs and PHGs are reviewed at least quarterly to and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						updated when new scientific evidence is released or when national guidelines are published.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Molina is responsible for informing providers of the selected CPGs and PHGs. Per policy, the QI Department is responsible for the distribution of new and revised guidelines. The Provider Manual states PHGs are distributed to providers annually on the website and in the Provider Manual. Providers are notified of the availability of the PHGs in the Molina Provider Newsletter. CCME confirmed the guidelines are available on Molina's website.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Per policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina adopts CPGs and PHGs based on scientific evidence and recommendations made by Molina's National Quality Improvement Committee. The guidelines are based on the relevance to Molina's population. Periodic review is conducted for guidelines that have been in effect for two or more years. The CPGs and PHGs are reviewed at least quarterly to and updated when new scientific evidence is released or when national guidelines are published.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	X					The Provider Manual states adopted CPGs are distributed to appropriate providers/provider groups through provider newsletters, electronic provider bulletins, and other media and are available on the website. Individual providers or members may request copies from the local Molina Quality Department. CCME confirmed the guidelines are accessible on Molina's website.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MHMS-QI-124, Standards of Medial Record Documentation, defines Molina's medical record documentation standards. However, the policy does not include that documentation should

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include any health education provided to members. *Recommendation: Revise Policy MHMS-QI-124, Standards of Medial Record Documentation to include that any health education provided during a provider visit should be included in the documentation of the visit.*
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 Medial Record Documentation, includes a review process for monitoring medial record documentation; however, the timeframe for how often the monitoring is conducted was not mentioned. Onsite discussion confirmed medical record monitoring was last conducted in 2019. It has been placed on hold due to restrictions from Covid-19 and will be resumed when restrictions are lifted. *Recommendation: Revise Policy MHMS-QI-124, Standards of Medial Record Documentation to include the frequency of medical record documentation audits.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Provider satisfaction was validated using CMS Protocol 6. Administration or Validation of Quality of Care Surveys. Molina's provider satisfaction survey occurred in November 2019. 205 providers completed the survey—79 by mail, 24 via the internet (7.6% response rate) and 102

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by phone (18.6%) response rate. Overall, the response rate was 15.6%. *Recommendation: Work with the vendor to determine other methods to increase response rates. Ensure provider contact information is up to date.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Evidence that the health plan analyzes data obtained from the provider satisfaction survey to identify quality problems was noted in the MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019 and in the Quality Improvement Program 2019 Annual Evaluation.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QIC committee during the March 2020 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Molina ensures member rights and responsibilities in accordance with *42 CFR § 438.100* and as described in Policy MHMS-ME-003, Member Rights and Responsibilities. Members are informed of their rights in the Member Handbook, member materials, and on the website. The Provider Manual includes a link for providers to access the list of member rights and responsibilities from the website.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in Policy MHMS-ME-003, Member Rights and Responsibilities, the Member Handbook, the CAN member website, and in member materials. Molina ensures members receive information on Advance Directives according to *42 CFR 422.128* and the *CAN Contract, Section 5 (K)* by providing information in the Member Handbook, on the website and other member materials, as described in Policy MHMS-QI-001, Advance Directives.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					The complete requirements of member responsibilities are not documented in Policy MHMS-ME-003, Member Rights and Responsibilities, the CAN Member Handbook, or on the member website. See standards 3.1 – 3.5 for specific comments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						The CAN member website omits the requirement that members are financially responsible for unauthorized services obtained from out of network providers. *Recommendation: Edit the CAN member website to clearly specify that members are financially responsible unauthorized health care services obtained from non-participating providers, as required in the CAN Contract, Section 6 (J) and 42 CFR § 438.100.*
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					Policy MHMS-ME-002, Member Information Packet, states members are provided a New Member Welcome Packet within 14 days after Molina receives the member's enrollment data from DOM. It includes all contractually required information such as an introduction letter, CAN

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ID card, Member Handbook, and instructions to access the Provider Directory. See standards 1.1 – 1.20 for specific comments.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						The CAN member website includes information that female members can obtain women's preventive health services from a women's health provider in addition to their PCP and without prior authorization. However, this requirement is not identified in the CAN Member Handbook or any other member material. During the virtual onsite Molina confirmed that female members can receive services from their PCP in addition to a women's health provider. *Recommendation: Edit the CAN Member Handbook to include the requirement that, in addition to their PCP, female members can have direct access to a women's health provider for routine and women's preventive services as required in the CAN Contract, Section 7 (B).*
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						The Covered Services chart in the Member Handbook lists services that do and do not require prior authorization and lists any applicable limitations. Members are informed that they may have to cover the costs for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						unauthorized services from out-of-network providers. It includes a chart with copayment fees that members pay providers based on their coverage plan.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The process and requirements for prior approval of medical, behavioral health (BH), and pharmaceutical services is described in the CAN Member Handbook. Services that require prior approval are indicated in the benefits grid. Prior approval is not required for family planning services, emergency visits, or BH services. Additionally, services requiring prior authorization are clearly listed in the Provider Manual.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook and Molina's website provide clear and specific information instructing members on the appropriate level of care for a routine, urgent, or emergent healthcare needs for medical, dental, and behavioral health services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and find participating pharmacies or contact Member Services to obtain this information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						CCME could not identify how Molina informs members of changes to benefits, services, or the provider network in the CAN Member Handbook. During the virtual onsite Molina explained that all members are notified of changes to CAN programs and benefits no later than 30 calendar days prior to implementation with approval from DOM and changes in the provider network within 15 days after receiving notification. Staff submitted examples of recent written notification of ongoing benefit changes and provider terminations and responded that the requirement to have documentation in member materials is not stated in the *CAN Contract*. *Recommendation: Capture the requirement, that members will be informed of changes to benefits, services, or the provider network, in a policy or other document. Consider editing the CAN Member Handbook to include this requirement, as noted in CAN Contract, Section 6 (D) (8) (g), under the heading, "The Member Handbook must include at a minimum the following information."*
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						The Member Handbook includes toll-free telephone numbers, hours of operation and descriptions of services provided by Member Services and the 24-Hour Nurse Advice Line. It has information on accessing the secure Member Portal and performing various self-service functions, such as viewing a benefit summary, changing the PCP, updating contact information, and requesting a new ID Card.
1.13 A description of EPSDT services;						The CAN Member Handbook includes information and instructions for eligible members under 21 years of age to obtain Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Additionally, Molina conducts written, telephonic and in-person outreach to inform and remind members of necessary EPSDT services. Preventive health guidelines for age-appropriate checkups and the 2020 Recommended Immunization Schedule are available on the website.
1.14 Procedures for disenrolling from the CCO;						The CAN Member Handbook provides information on the requirements for disenrollment and instructs members to call Member Services or DOM to terminate their membership.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						Fraud and Abuse are defined and appropriately described in the Member Handbook and the website in accordance with *42 CFR §455.2* and the *CAN Contract, Sections 2 (A) (1)* and *6 (D) (9)*. Instructions are provided for members to anonymously report fraud and abuse to the Molina Healthcare AlertLine or use an online form at MolinaHealthcare.alertline.com.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						Molina's Care Management Program is described in the Member Handbook and on the website. Members are instructed to contact Member Services for information on the various disease and care management programs offered for chronic health conditions, such as asthma, diabetes, obesity, and hospital discharge. Social service programs for WIC and special education services are also available.
1.19 Information about advance directives;						An Advanced Directive is correctly described and defined in the Member Handbook. However, the term "will" is used instead of the term "living will," which is incorrect. *Recommendation: Edit the Member Handbook to ensure the term "living will" is not referred to as a "will."*
1.20 Additional information as required by the contract and by federal regulation.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Molina notifies members by mail of significant changes in benefits 30 days prior to the effective date as discussed during the virtual onsite. Staff submitted the letter template used to notify members of changes to non-emergency transportation service, "Member Transportation Termination Notice" with the corresponding member brochure, according to requirements in the *CAN Contract, Section 6 (D) (8).* Policy MHMS-PC-09, MHMS Provider Termination Process, states Molina sends members written notice of any provider termination within 15 days after being notified of the termination. However, CCME could not determine the information included in the written notice to enrollees. During the onsite, staff submitted the written notice template, EN_PDF_PCP Termination_Medicaid_MS_831_Ver.2 and a sample member letter for review. CCME identified the notice does not include the requirement to provide the date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required by the *CAN Contract, Section 7 (D) (4).* Molina confirmed final document approval is received from DOM prior to sending member notices. *Recommendation: Edit letter template, EN_PDF_PCP Termination_Medicaid_MS_831_Ver.2, to include*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required by the CAN Contract, Section 7 (D) (4).
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policies MHMS-CE-01, Marketing, and MHMS-COMM-01, Member Communication Standards, describe and outline processes that Molina uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. Member materials have a minimum 12-point font size for regular print items and 18-point font size for large print items.
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Molina arranges trained interpreter or bilingual services to communicate with eligible individuals in a language other than English. Interpreter and translation services are provided free of charge to non-English speaking members, members who have limited English proficiency, and members who are deaf or hearing impaired, as described in the Member Handbook and Policy MHMS-QI-010, Access and Availability of Language Services. Contact information for Member Services, the Nurse Advice Line, and Relay 711 for members with hearing and speech limitations are noted on the website, in member materials, and on the member's ID card.

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					Review of appeals and grievance files reflect Members are appropriately educated and informed about Molina's programs and processes. Examples include, but not limited to, staff providing education on covered benefits and services and participating providers.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					Molina maintains a Member Services Call Center, Provider Services Call Center, and 24-Hour Nurse Advice Line. Additionally, the 24-Hour Nurse Advice Line is staffed with mental health professionals who can address the member's urgent BH needs. Relay 711 is communicated in several member materials and on the website.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Molina monitors and evaluates member and provider Call Center staff for the quality of call handling. No less than 3% of calls are randomly selected monthly. Provider Telephone Access Standards reported in the 2019 Quality Improvement Program Evaluation indicates one out of three Call Center goals were met.
III D. Member Enrollment and Disenrollment						

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					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHMS-ME-008, Enrollment Reports, and Policy MHMS-ME-009, Enrollment Accounting, describes instances when Molina can request a member to be disenrolled.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Policy MHMS-QI-125, Member Education and Prevention (ME), describes the process Molina uses to provide health education to new and established members. Members can access the CAN website or Member Handbook for information on recommended preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services. Additionally, the plan sends targeted and general mailings and makes calls to eligible members reminding them of screenings and well visits. During the virtual onsite staff explained that member newsletters are one of the methods used to communicate preventive health and chronic disease management services. Postcards are mailed to all members notifying them when the annual newsletter is available on the website. Molina monitors website activity to evaluate if newsletters and other member information are being accessed.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.						
3. The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					Molina ensures the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under 21 years of age as noted in Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					Molina conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. Molina contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers System (CAHPS) Survey vendor, to conduct the Adult and Child Surveys. The actual sample size of the Adult Survey (n=136, N=1,318) and the Child Survey (n=166, N=1630) were not adequate and did not meet the National Committee for Quality Assurance (NCQA) minimum sample size and number of valid surveys (at least 411). The response rates were below the NCQA target of 40%. Generalizability of the survey results is difficult to discern due to low response rate for the following surveys:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•For adults, the response rate is 10.3% which is lower than the Book of Business average response rate of 15.5% •For the child survey, the response rate is 10.2% which is lower than the Book of Business average response rate of 12.6%. *Recommendation: Establish an internal goal for response rates for the CAN Adult and Child Surveys that is 2% or 3% greater than the previous year and initiate new interventions to attempt to increase response rates (e.g. website banners, reminders on call center scripts, text reminders).*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.			X			Molina submitted no evidence that results of the member satisfaction survey were analyzed to identify potential quality problems. *Corrective Action: Ensure member satisfaction survey results are reviewed/analyzed by the appropriate committee to identify potential quality problems.*
3. The CCO reports results of the member satisfaction survey to providers.			X			Documentation of survey results reported to network providers was not submitted for review. *Corrective Action: Report the results of the member satisfaction surveys to network providers.*
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any			X			Documentation that Molina reported results of the member satisfaction surveys and the impact of measures taken to address any quality

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
quality problems that were identified to the appropriate committee.						problems that were identified to the QIC, was not submitted for review. *Corrective Action: Report the results of the member satisfaction surveys to the QIC.*
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MHMS-MRT-01, Member Complaints and Grievances, outlines processes for handling member grievances. Molina's health information system date-stamps, tracks, and documents the status of grievances. All grievances are assigned a unique case number and the Grievance and Appeals Coordinator ensures the case is appropriately documented. The database tracks and trends grievances in the following categories: Transportation, Access to Service/Providers, Provider Care and Treatment, Contractor Customer Services, Payment and Reimbursement Issues, and Administrative issues.
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance and the description of who can file a grievance are correctly documented in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN Member Handbook, and Provider Manual; however, they are not included on the CAN member website. *Recommendation: Edit the non-secured section of the CAN member website to include the definition of a grievance and who may file a*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievance, as required by the CAN Contract, Section 6 (H).
1.2 The procedure for filing and handling a grievance;	X					The procedure for filing a grievance is correctly described in Policy MHMS-MRT-01, Member Complaints and Grievances, the CAN Member Handbook, and Provider Manual. During the onsite teleconference, CCME explained that the CAN member website does not include information that a grievance can be filed at any time, orally or in writing, or the address/fax number to submit a written grievance. However, these instructions are clearly noted for filing a complaint. *Recommendation: Include information on grievance filing procedures on the non-secured section of the CAN website, as required by the CAN Contract, Section 6 (H). To meet this requirement, consider adding the term "grievance" to headings where information for filing complaints is provided.*
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					Timeliness guidelines for grievance resolution are correctly documented in Policy MHMS-MRT-01, Member Complaints and Grievances. Molina resolves grievances within 30 calendar days from when they receive it. Page 104 of the CAN Provider Manual states, "The timeframe for Grievance resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe an additional fourteen (14) calendar days if the extension is in the interest of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Member…" This could be misinterpreted by members to mean that Molina will have a total of 28 days to issue a determination when the grievance resolution timeframe is extended. *Recommendation: Edit the description of the grievance extension timeframe to clearly specify that Molina can extend the timeframe only 14 days if it is in the member's best interest, in accordance with 42 CFR §438.408 (c) and CAN Contract, Section Exhibit D (B).*
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					Per Policy MHMS-MRT-01, Member Complaints and Grievances, Molina ensures decision-makers involved in grievances were not involved in any previous level of review. Additionally, this requirement is communicated in the CAN Member Handbook and Provider Manual.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					Review of grievance files indicates timely acknowledgement, resolution, and notification to members. Files reflect thorough investigation of the member's grievance prior to Molina mailing the resolution and closing the case.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					Molina, tracks, trends, and analyzes grievances and reports results to the SQIC and the QIC quarterly as noted in Policy MHMS-MRT-01, Member Complaints and Grievances. The committees analyze grievance information to identify trends, address barriers, and identify

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						opportunities for improvement. Review of SQIC and QIC meeting minutes and presentations reflect discussion of member grievances.
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					Molina staff investigate all grievances and assist members in changing their PCP when requested.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.	X					The 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The QI Program Description provided a description of Molina's scope including addressing members with special health care needs and efforts to reduce health disparities.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).		X				Annually, Molina's QI Work Plan identifies activities related to program priorities aimed at improving the quality of services provided to members. The health plan provided the 2019 and 1st quarter through 3rd quarter work plans. The formats for the work plans included Word, PowerPoint, and Excel. The Word and Excel documents contained embedded files that could not be opened. *Recommendation: Develop the QI Work Plan in a format that is easily reviewed by internal and external stakeholders. Ensure this format allows external stakeholders access to the embedded documents.* Also, there were errors or missing information noted in the 3rd quarter 2020 work plan. These included: •Section 2.0, Patient Safety Initiatives—the objective states "Identify a process to receive, track, investigate, validate, and manage Potential Quality of Care Issues." This was an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						activity completed in 2019 even though listed as ongoing for 2020. •Section 5, Availability of Practitioners—the goals are not documented for the ratio of PCPs to members and the Ratio of High-Volume Specialist and High-Volume Behavioral Health Providers to members. Also, the goal for the percentage of members with one open Behavioral Health provider is missing. •Section 5, Availability of Practitioners—the standards for measuring the percentage of adults and children that have access to a PCP is incorrect. The *CAN Contract, Section 7 (B), Provider Network Requirements* lists the standard for adult and pediatric members as two PCPs within 15 miles for urban and two PCPs within 30 miles for rural. •Section 5, Availability of Practitioners—the standards for measuring the percentage of members with one open specialist and the percentage of members with one open Behavioral Health specialist does not include the time requirements (30 minutes) for urban providers and does not include the requirements for rural providers. The *CAN Contract, Section 7 (B)* lists the requirements as one specialist and one Behavioral Health specialist within 30 minutes or 30 miles for urban and within 60 minutes or 60 miles for rural providers. •Section 6.0, Accessibility of Services—the standard for measuring a regular and routine PCP appointment is listed as 90% within six weeks. The *CAN Contract, Section 7 (B), Provider Network Requirements* lists the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standard as not to exceed 30 calendar days for a PCP Well Visit and not to exceed seven calendar days for a PCP Routine Sick Visit. •Section 7.0 Accessibility of Services: Behavioral Health—the standard used to measure urgent care for Behavioral Health is listed as within 48 hours. However, the *CAN Contract, Section 7 (B)* lists this requirement as not to exceed 24 hours. Also, the post discharge follow-up (not to exceed seven calendar days) is not included. •Section 9.0, Continuity and Coordination of Medical Care—the timeframe for notifying members of the termination of a PCP is listed as within 30 days of termination date or within 30 days of notification. However, the *CAN Contract, Section 7 (D), Provider Termination, Number 4, Member Notification*, states the Contractor shall send a written notice within 15 calendar days of notice or issuance of termination of a Provider to Members who received primary care from the Provider. *Corrective Action: Correct the errors identified in the 2020 QI Work Plan.*
IV B. Quality Improvement Committee						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QIC is responsible for the implementation and ongoing monitoring of the QI program. This committee reviews data received from the QI activities to ensure performance meets standards and make recommendations as needed. Molina's Quality Improvement Committee Charter outlines the structure, duties, responsibilities, and quorum requirements.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. The 2020 membership list includes 20 internal voting members, two network pediatricians, and one internal medical physician. *Recommendation: Recruit additional network providers to serve on the QIC. Consider including a Family Practice, OB/GYN, and a Behavioral Health practitioner.*
3. The QI Committee meets at regular intervals.	X					The minutes reviewed for the QIC reflect the committee met quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions. The minutes provided with the desk materials indicated the required quorums were met for each meeting. Separate meetings were not held for the CAN and the CHIP programs.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures (PMs) reported by each CCO and to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determine the extent to which PMs reported by the CCOs follow State specifications and reporting requirements. Molina did not report five non-HEDIS measures as required by DOM. The five measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01), Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH), Asthma in Younger Adults Admission Rate (PQI-15-AD), and Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH). The Use of Opioids at High Dosage in Persons without Cancer (OHD-AD) measure rate was not accurate and was considered not reportable. All numerator rates were not reported for the Use Of Pharmacotherapy For Opioid Use Disorder (OUD – AD). Additionally, based on Aqurate's validation of PMs, there were no concerns with Molina's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that Molina followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs. Molina was found to meet all the data requirements to report required PMs. Since Molina did not have enrollment in the CHIP product line in 2019, the PMV was conducted only for the Mississippi CAN population. This was the first year Molina reported measures for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						MSCAN; therefore, there are no comparison comments from the prior year. Details of the validation activities and recommendations for the Performance Measures may be found in *Attachment 3, CCME EQR Validation Worksheets.* *Recommendation: Work proactively with DOM for clarification on measures required to be reported. Actively monitor Core Set measure data accuracy. Data issues identified in calculating HEDIS measures may also have a negative impact on the accuracy and reliability of Core Set measure rates. Ensure central corporate teams have accurate and timely information needed to report measures as required by DOM. Additionally ensure that Core Set measure rates produced are accurate and reliable before submitting to DOM.*
IV D. Quality Improvement Projects						
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					The topics required by DOM for PIPs include: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). Molina submitted the Behavioral Health Readmission, Asthma, COPD, Follow-up After Hospitalization for Mental Illness, Obesity, Prenatal and Postpartum Care, and Sickle Cell PIPs for validation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."			X			All projects except Behavioral Health Readmission received a validation score within the Not Credible range and did not meet the validation requirements. The following items were not documented: •Data analysis and rationale for choosing the topic •Sampling information •Data analysis plan •Goal and benchmark rates •Analysis of findings •Barriers and interventions linked to each barrier Details of the validation activities and recommendations for the PIPs are found in *Attachment 3, CCME EQR Validation Worksheets*. *Corrective Action: The performance improvement projects should be documented on the CCME provided template and include all required elements.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					Per Provider Service Agreement, Attachment D, Section 1.4, Program Participation, providers agree to comply with the requirements specified in the Quality Management section of the contract between Molina and DOM. The Provider Manual, page 26 also instructs

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers about the expectations of participating in QI activities.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Provider HEDIS profile reports are generated to provide feedback on performance. Molina provided an example report given to individual providers regarding their performance data and patterns of utilization. This report is distributed by QI and/or Provider Services staff and the reports can be downloaded from Molina's Provider Portal.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per the QI Program Description, to evaluate the effectiveness of the clinical and preventive evidence-based guidelines, Molina measures performance against important aspects of each clinical practice and preventive guideline. Policy and Procedure (MHMS-QI-018), page 7, discusses the performance monitoring conducted. On page 8 of that procedure, it states "All results are incorporated into reports to the Quality Improvement Committee, included in each state health plan's Annual Quality Improvement Work Plan and utilized when planning subsequent QI activities." This was discussed during the onsite. Molina indicated provider compliance is monitored using HEDIS data. Individual provider reports are generated and distributed by Molina staff. The monitoring was not included in the QI Work Plan as mentioned in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Include in the QI Work Plan the monitoring of provider compliance with Clinical Practice Guidelines and Preventive Health Guidelines.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						Molina's Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment defines the requirements for the EPSDT Program.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			Per Policy MHMS-QI-003, EPSDT-Early and Periodic Screening, Diagnosis, and Treatment, Molina has a tracking system that tracks at a minimum, initial visits for newborns, EPSDT screenings and reporting of all screening results and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with the EPSDT service and did not include or indicate members who received additional treatments or referrals as required by the *CAN Contract, Section 5 (D)*. *Corrective Action Plan: The EPSDT tracking report should include the date the EPSDT service was provided, ICD 10 or CPT codes for the diagnosis, treatment and/or referrals for any suspected problem identified during the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						EPSDT screening as required by the CAN Contract, Section 5 (D).
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.		X				Annually, Molina evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the Quality Improvement Committee and to the Division of Medicaid. The Quality Improvement Program 2019 Annual Evaluation, Executive Summary and three Appendices (Appendix A – Member and Provider Experience Report, Appendix B – CLAS Analysis Report and Appendix C – Population Health Assessment) was provided for review. Per the *CAN Contract, Section 10 (D) and Exhibit G*, the annual performance evaluation of the QI program includes: a description of completed and ongoing QI activities including Case Management effectiveness evaluation, identified issues, including tracking of issues over time, trending of measures to assess performance in quality of clinical care and quality of service to Members and an analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care and quality of service to members, and overall effectiveness of the QI program. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						improvement projects, and delegation oversight. *Corrective Action: The Quality Improvement Evaluation must meet all the requirements contained in the CAN Contract, Section 10 (D) and Exhibit G. Specifically a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	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					Utilization Management activities are integrated within the Molina Health Care Services Program. The 2020 Health Care Services (HCS) Program Description outlines the goals, scope, and staff roles for physical health, behavioral health (BH), and support services for members in Mississippi. The Pharmacy Program Description outlines the pharmacy benefit program. Several policies

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						describe UM processes and requirements: Policy MHMS-HCS-UM-325, Service Authorization and Policy MHMS-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making MSCAN. See Standards 1.1-1.7 for specific comments.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures, states the timeframe for pharmacy prior authorization is 24 hours; however, the CAN website indicates 72 hours. Pharmacy staff confirmed the correct timeframe is 24 hours. *Recommendation: Edit the website to correct the pharmacy authorization timeframe 72 hours to 24 hours, to align with documentation in Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures.*
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	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 roles of the Molina's Medical Director and Chief Medical Officer (CMO) are described in the 2020 Health Care Services (HCS) Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, and chairing committees. The Behavioral Health (BH) Medical Director and the Pharmacy Director collaborate with the Medical Director and CMO and have clinical oversight of the respective programs.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the Health Care Services Committee (HCSC) and the QIC for review and were approved on June 10, 2020 and June 26, 2020, respectively. In addition to plan staff, the HCSC includes the Manager for Network/Provider Services who is selected to represent primary care, high volume specialists, and delegated provider groups. Committee responsibilities include, but are not limited to, reviewing and approving clinical policies, monitoring utilization trends and evaluating provider and member satisfaction with the HCS Program.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					Utilization management standards/criteria are documented in Policy MHMS-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making MSCAN. Molina has a hierarchical approach for evaluating service

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						authorization requests. Internal clinical criteria for utilization determinations are primarily used. These standards are based upon applicable state/federal law, contract or government program requirements, and the adoption of evidence-based clinical coverage determination guidelines, such as InterQual, and meet requirements of the *CAN Contract, Section 5 (J)*.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of approval files reflect staff are following guidelines described in Policy MHMS-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making MSCAN, for utilization determinations.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MHMS-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. A physician reviewer can approve requested services when criteria is not met, and the clinical evidence supports the decision.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Molina conducts inter-rater reliability (IRR) testing annually for Medical Directors, medical and BH clinical reviewers, and pharmacy staff to evaluate consistency in the application of UM criteria. InterQual guidelines are used for IRR testing. Discussion during the onsite teleconference confirmed remediation and education are given to reviewers who do not achieve the passing score of 90%. Results reported in the 2019 Health Care Services Program Evaluation indicate Medical Directors scored 87% but

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						achieved concordance of 100% after group discussion. Additionally, the Medical Director and HCS Director have the opportunity to assess consistency of criteria during weekly rounds with the UM staff.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Caremark is the pharmacy benefit manager (PBM) and is responsible for implementing all pharmaceutical services for Molina, including but not limited to, prior authorizations and pharmacy network management. A link to the most current version of the Universal Preferred Drug List (PDL) is posted on Molina's website and takes the user to DOM's to access the PDL in a searchable, electronic format.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures, explains Molina has policies and procedures following DOM's prior authorization criteria for drugs listed on the PDL and for drugs not listed. Molina uses the most current version of the PDL available on DOM's website. The Pharmacy Benefit Manager conducts the prior authorization process within 24 hours and according to state, federal, and regulatory requirements. Molina ensures a 72-hour (3-day) supply of medication will be approved while a prior authorization request is pending.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Molina ensures UM decisions are rendered by appropriate staff as described in Policy MHMS-HCS-UM-364, Appropriate Professionals Making UM Decisions. An initial clinical review is performed by a licensed nurse, and a Mississippi-licensed physician or other appropriate healthcare practitioner performs Level II medical necessity review resulting in an adverse benefit determination. Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists, such as dentists, pharmacists, or BH specialists.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes reviewed in approval files are consistent with Policy MHMS-HCS-UM-383, Timeliness of UM Decision Making and Notification, and contractual requirements.
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					UM denial files for CAN members reflect reviewers attempted to obtain additional clinical information when needed, prior to rendering an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Policy MHMS-HCS-UM-364, Appropriate Professionals Making UM Decisions MSCAN, and Policy MHMS-HCS-UM-325, Service Authorization, state currently licensed physicians, dentists, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pharmacists will render adverse benefit determinations. The Medical Director or appropriate health professional is available to discuss medical necessity determinations within one business day with the provider if needed, as noted in Policy MHMS-HCS-UM-371, Practitioner Access to Plan Physician Reviewer MSCAN. Denial files reflect review by a medical director, or other appropriate physician, when UM clinical staff cannot approve requests that do not meet medical necessity criteria. Additionally, denials for pharmacy requests are determined by a licensed pharmacist with sign-off by a health plan medical director.
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 denial files revealed adverse benefit determinations were made timely and communicated to the requesting provider and member according to processes described in Policy MHMS-HCS-UM-383, Timeliness of UM Decision Making and Notification. The adverse benefit determination notice included the basis for the denial, criteria used, and instructions for the appeal process. However, the following issues were noted with adverse benefit determination notices: •Notices in 8 of the 25 denial files provided instructions to submit written appeals to an address in N. Charleston, SC instead of Jackson, MS. During the onsite teleconference, Molina staffed explained that denial letters were updated during the past year and provided letter

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						templates with the correct mailing address in Jackson, MS. •Notices in 6 of the 25 denial files used CPT codes to refer to the service requested, instead of describing the service in terms that can be easily understood by members. *Recommendation: Ensure adverse benefit determination notices are written in terms that can be easily understood by members, according to requirements in the CAN Contract, Section 6 (F) and 42 CFR § 438.10.*
V C. Appeals						
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					The 2020 Health Care Services (HCS) Program Description, Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals, outline the processes for member appeals. Molina's Appeal and Grievance database information system date-stamps, tracks, and documents the status of appeals. All appeals are assigned a unique case number.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definitions of the terms "appeal" and "adverse benefit determination" as well as a description of who can file an appeal are included in Policy MHMS-MRT-02, Standard Member Appeals, Policy MHMS-MRT-03, Expedited Member Appeals, the CAN Member Handbook, Provider Manual, and on the website. However, the following issues are identified: •The Health Care Services (HCS) Program Description and the CAN website incorrectly

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						define an appeal as "a request for a review of an action (decision) by Molina to limit or deny coverage for a requested service or prescription drug." The correct term is "adverse benefit determination" instead of "action." •The term "adverse benefit determination" is incorrectly defined on page 104 of the Provider Manual, which states, "An Adverse Benefit Determination for a Member may include a decision to deny or limit health care services a Member believes he or she is entitled to get…" Additionally, the term is incorrect on the website, stating, "An action is any denial that is: Limited, Reduced, Suspended, Terminated, or Payment is denied". • A description of who can file an appeal is not clearly defined on the website. *Recommendation: Edit the HCS Program Description and CAN website to indicate current terminology of "adverse benefit determination" instead of "action." Include the correct definition of "adverse benefit determination" in the CAN Provider Manual and the website. Edit the CAN website to include a complete description or definition of who can file an appeal. Adhere to CAN Contract, Section 2 (A) and 42 CFR § 438.400 (b).*
1.2 The procedure for filing an appeal;		X				Appeals procedures and instructions are documented in Policy MHMS-MRT-02, Standard Member Appeals, the CAN Member Handbook, the Provider Manual, and on the website. CCME identified the following documentation issues on the website:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The address provided to submit written appeals includes has a P.O. Box in North Charleston, SC instead of Capitol St. in Jackson, MS. •The website incorrectly states appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the notice of Adverse Benefit Determination. •The website does not indicate that an authorized representative can file on the member's behalf. •The website does not address that members can present evidence or examine their case file at any time during the appeals process. *Corrective Action: Edit the CAN website to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal to meet requirements of the CAN Contract, Section (K).*
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					Policy MHMS-MRT-02, Standard Member Appeals, states Molina ensures decision-makers involved in an appeal were not involved in any previous level of review. Additionally, this requirement is communicated in the CAN Member Handbook, Provider Manual, and on the website.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy MHMS-MRT-03, Expedited Member Appeals, describes the process when an expedited appeal is requested. The Medical Director will determine if the requests meet criteria for an urgent review and a decision will be made within 72 hours from Molina receiving the request. Review of appeals files reflect

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appropriate handling of expedited appeal requests. Members were given written notification if the request was downgraded to a standard appeal.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Timeliness guidelines for standard and expedited appeals are described in Policy MHMS-MRT-02, Standard Member Appeals. Molina resolves standard appeals and provides notice within 30 calendar days from the date the initial verbal or written appeal is received. Expedited appeals are resolved within 72 hours from receipt. Page 105 and 106 in the CAN Provider Manual state, "The timeframe for Grievance resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe an additional fourteen (14) calendar days if the extension is in the interest of the Member…" This could be misinterpreted by members to mean that Molina will have a total of 28 days to issue a determination when the appeal resolution timeframe is extended. *Recommendation: Edited the description of the appeal extension timeframe to clearly specify that Molina can extend the timeframe only 14 days if it is in the member's best interest, in accordance CAN Contract, Section Exhibit D.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO applies the appeal policies and procedures as formulated.	X					CCME's review of appeal files reflected timely acknowledgement, resolution, and notification of determinations. Additionally, the 2019 CAN UM Program Evaluation noted 100% compliance in the turnaround time for CAN appeals.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Molina tracks, trends, and analyzes appeals for medical and behavioral health services, and reports results to the SQIC and the QIC quarterly, as noted in Policy MHMS-MRT-02, Standard Member Appeals and 2020 Health Care Services (HCS) Program Description. The SQIC reviews appeal information to identify and address trends.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					The 2020 Health Care Services Program Description gives an overview of the Integrated Care Management Program. Molina CAN has an established Care Management Program, within the Health Care Services Program, to ensure and promote access and delivery of physical and behavioral health services and access to community resources. Initiatives from the population health program assist in addressing the needs of members in complex case management. During the onsite teleconference Molina staff explained that data obtained from population health assessments assists in driving case management interventions for specific sub-populations.

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					The HCS Program Description details Molina's process for identifying eligible members and referring them into case management. In addition to referral guidelines and results from advanced data sources, Molina uses claims, health risk assessment results, medical records, and utilization management data to identify members who can benefit from case management. The Health Risk Assessment tool is primarily used to screen and identify eligible members into case management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Health risk assessments are completed in 30 days as described in Policy MHMS-HCS-CM-054, Individualized Care Plan Development, identified in CM files, and confirmed during the onsite teleconference. However, Policy MHMS-HCS-CM-061, Health Risk Assessment, outlines the process for staff to complete health risk assessments while incorrectly stating HRAs are completed within 90 days. *Recommendation: Edit Policy MHMS-HCS-CM-061, Health Risk Assessment, to indicate HRAs are completed in 30 days for members newly assigned to the High or Medium risk levels of CM, as required in CAN Contract, Section (9) (A).*
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					The integrated care plan is developed by a medical or BH Care Manager, in collaboration with the member, within 30 days after the HRA is completed. Review of CM files reflected qualified health professionals conduct HRAs and other CM services.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Molina uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach processes, such as face-to-face, telephonic or mailings.
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
medium risk levels and the specific services required by the contract including high risk perinatal and infant services.						
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MHMS-HCS-CM-081, Continuity of Care and Access to Care for New and Existing Members, describes the process for providing continuity of care when a member leaves the health plan.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Molina's Health Management Program is Level I care management, which includes health promotion and disease management activities such as member education, coordination of medical transportation, and scheduling medical appointments.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Molina's Transition of Care Program provides support, continuity, and coordination of care from one care setting to another to reduce avoidable readmissions. The HCS program Description states the purpose of the program is to "improve clinical outcomes, identify and address transition of care needs, and promote member self-determination and satisfaction, while reducing hospital readmissions and emergency department visits." Transition of care procedures are described in Policy HCS-CM-068, Molina Transitions of Care.
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					Policy HCS-CM-068, Molina Transitions of Care, and the HSC Program Description describe Molina's process for monitoring new members and members transferring across settings, such as from Home, Hospital/Acute Care, Skilled

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Nursing, Rehabilitation, Inpatient Psychiatric Centers and Long-Term Acute Care facilities.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					The interdisciplinary transitional care team coordinates and manages required services to ensure continuity of care and prevent duplication of services as members return to their home or other community setting. The team includes Care Managers, Social Workers, Behavioral Health staff, Pharmacy staff, and Medical Directors.
4. The CCO meets other Transition of Care Requirements.	X					
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The 2019 Health Care Services (HCS) Program Evaluation is a narrative summary of initiatives and activities conducted in 2019, used to identify opportunities for improvement and program effectiveness.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the Health Care Services Committee (HCSC) and the QIC for review. The evaluation was approved on June 10, 2020.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Molina has delegation agreements with: •Avesis - Dental and Hearing Benefit Administration Services •Caremark – Pharmacy Benefit Administration Services •MARCH - Vision and Eye Care Benefit Administration Services •Southeastrans – Non-Emergency Transportation Services •Medical Transportation Management – Non-Emergency Transportation Services Molina delegates credentialing and recredentialing to the following organizations: •Baptist Memorial Medical Center •George Regional Health System •Hattiesburg Memorial Medical Group •Magnolia Regional Health •Mississippi Physician Care Network •Memorial Hospital at Gulfport •North Mississippi Health Services •Ochsner Health System •Premier Health •University of Mississippi Medical Center
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed		X				Per Policy DO001, Delegation Pre Assessment Audits, Molina ensures all potential delegates have a pre-assessment audit completed to determine

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
using standards that would apply to the CCO if the CCO were directly performing the delegated functions.						the provider's ability to meet the requirements. Results of the pre-assessment audits are presented to the Delegation Oversight Committee for review and decision. Decisions of the committee are communicated to the delegate within 5 business days of the decision. Once the delegate is approved, Molina monitors the delegate's ongoing compliance at least annually, as outlined in Policy DO002, Performance Monitoring and Annual Audits of Delegation. Ongoing compliance will be ensured by monitoring monthly and/or quarterly reports of delegated activities and annual audits. If corrective is needed for identified deficiencies, Molina follows the process outlined in Policy DO003, Corrective Action and Termination of Delegation. Pharmacy benefit administration services for CAN and CHIP are delegated to Caremark. Molina provided an oversight policy (Policy MHMS-PH-007, Pharmacy Oversight of the Pharmacy Benefit Manager); however, this policy only covers the CHIP line of business. *Recommendation: Update the language in Policy MHMS-PH-007, Pharmacy Oversight of the Pharmacy Benefit Manager, to include the CAN line of business.* Molina provided copies of the pre-delegation and/or the annual oversight monitoring along with the quarterly monitoring for each delegated entity. Deficiencies and applicable corrective actions were noted in the monitoring reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The monitoring tools used for credentialing delegates did not include query of the SSDMF and the Mississippi sanctioned provider list. Molina staff indicated these requirements remained the responsibility of the health plan and are not required functions for the delegates. However, the criteria listed on page five in Policy DO005, Credentialing Delegation Requirements, includes Medicaid sanctions from all published state Medicaid sanctions lists and the SSDMF. *Recommendation: Credentialing and recredentialing functions that remain the responsibility of the health plan should be reflected in the delegation policies.* The site assessments and reassessments specified in the *CAN Contract, Section 7 (E)*, were not included in the monitoring tools. *Corrective Acton: Update the credentialing and recredentialing monitoring tools to include the site assessments and reassessments as specified in the CAN Contract, Section 7 (E).*

CCME CHIP Data Collection Tool

Plan Name:	**Molina Healthcare CHIP**
Review Performed:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policies and procedures are in place that demonstrate Molina's commitment to the quality of care for its members. However, there is no policy addressing an overall process for policy development and management. Onsite discussion indicated that a committee is being developed to oversee policies and procedures. All employees have access to policies and procedures via a shared drive until a platform has been obtained to house policies and procedures. *Recommendation: Create a policy detailing the process used for policy development and management.*
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Bridget Galatas is the Plan President and Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Keshia Lymuel is the AVP of Health Plan Operations and serves as the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Ed Mohr is the Chief Financial Officer.
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Nancy Vasquez is the Claims Director.
1.6 *Provider Services Manager;	X					Chinwe Nichols is the Director of Provider Services.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					The Member Services Manager is Juan (Emilio) Bellizzia Arriaga.
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					Bert Emrick is the Appeals and Grievances Manager.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Utilization Management Coordinator;	X					
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Phil Collins is the Health Plan Quality Improvement Director.
1.11 *Marketing and/or Public Relations;	X					Jovante Johnson is the Communications Manager.
1.12 *Medical Director;	X					Dr. Thomas Joiner is the Medical Director and Dr. Nazmul Talukdar, a board-certified psychiatrist, was identified as the Behavioral Health Medical Director.
1.13 *Compliance Officer.	X					David Estorge is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Submitted claims performance data demonstrates Molina exceeds the claims processing requirements of the *CAN Contract*. The contract requires 90% of clean claims to be processed within 30 days; Molina averages 99.7% of clean claims processed within 30 days. The contract requires 99% of clean claims to be processed within 90 days; Molina averages 100% of clean claims processed within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Molina's systems capture enrollment and demographic data, and the data is updated as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina receives updates from the State. Additionally, Molina noted that their systems have been upgraded for improved efficiency while maintaining accuracy.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					Molina's information systems are capable of generating the HEDIS and HEDIS-like reports required by the State. Molina's documentation also noted that regular testing and validation exercises are conducted to ensure the accuracy of data stored within its HEDIS data repository.
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 disaster recovery plan that incorporates best practice backup routines and data retention policies. The organization conducts disaster recovery testing on a yearly basis and has deployed IT systems with integrated redundancies for business continuity.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					With the approval of the Molina Board of Directors, a Compliance Plan was developed to benefit the company, its employees, payors, and regulators with the goals of increasing efficiency, reducing waste, minimizing confusion, and improving the quality of services
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Code of Business Conduct and Ethics governs and provides guidance about appropriate and ethical business conduct for Company employees, officers, and directors.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Identification of the Fraud and Abuse Compliance Officer;						
2.3 Information about the Compliance Committee;						The Compliance Committee seeks to increase the understanding of the legal and contractual responsibilities for employees by providing education and training to Molina Healthcare representatives regarding compliance requirements.
2.4 Compliance training and education;						Training and education are part of the Compliance orientation for new employees and includes information about the responsibility to report any suspected compliance issues and concerns for investigation and appropriate follow-up.
2.5 Lines of communication;						
2.6 Enforcement and accessibility;						
2.7 Internal monitoring and auditing;						Auditing and monitoring are used to identify areas of compliance deficiency, respond to reports of suspected non-compliance, and to assess continuing compliance and the effectiveness of corrective measures implemented to address previously identified compliance deficiencies.
2.8 Response to offenses and corrective action;						
2.9 Exclusion status monitoring.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					Policy MHMS-PH004, Pharmacy Lock-In Program, describes processes to identify members who display high controlled substance utilization and/or fraudulent sale or transfer of pharmaceutical products. Members who are identified for the Pharmacy Lock-In Program can obtain controlled substances and prescribed medications from the designated pharmacy provider and from no other provider during the outlined time frame.
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy HP-16, Confidential Information, indicates that "Molina Healthcare maintains the confidentiality of all Confidential Information, including but not limited to Protected Health Information (PHI), Personally Identifiable Information (PII), Nonpublic Information (NI), Nonpublic Personal Information (NPI), practitioner/provider-specific information and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						proprietary information through the adoption, implementation and ongoing review and revision of this policy and other related policies and procedures."

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Processes and requirements for credentialing and recredentialing health care providers are found in the Credentialing Program Policy (Policy CR 01), the Assessment of Organizational Providers Policy (Policy CR 02), and in Mississippi-specific addenda to the policies. None of the documents address the requirement from the *CHIP Contract, Section 7 (E) (6)*, which states, "Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk Provider and any person with a 5 percent or more direct or indirect ownership interest in the Provider, as those terms are defined in 455.101." Onsite discussion confirmed that Molina is not obtaining fingerprints from CHIP providers identified as high-risk by DOM.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Develop and implement a process to obtain fingerprints from identified high-risk CHIP providers. The process must be documented in the appropriate credentialing policies.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					Policy CR 01, Credentialing Program Policy, defines requirements and responsibilities of the Professional Review Committee (PRC). Molina's PRC uses a peer review process to make recommendations regarding credentialing decisions and reports to the Quality Improvement Committee (QIC). A Molina Medical Director chairs the PRC and appoints all PRC Members. The policy states the PRC meets quarterly at minimum, but usually meets every four to six weeks. Onsite discussion confirmed the committee typically meets every six weeks, but some meetings over the past year have been canceled due to lack of provider files to review. The policy states the PRC's membership includes at least four practitioners from a range of specialties in the Molina network, such as behavioral health, dentistry, family practice, internal medicine, pain management, pediatrics, OB/GYN, surgery, etc. Other ad hoc practitioners may be invited to participate when representation of their discipline is needed, and ad hoc committees representing a specific profession may be appointed by the chair to screen applicants from their respective

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						profession and make credentialing recommendations to the PRC. CCME noted the voting PRC members include three family medicine providers, one internal medicine provider, and one OB/GYN. Onsite discussion confirmed no attempts have been made to recruit providers with additional specialty types. PRC minutes confirm the presence of a quorum for each meeting and reflect review and discussion of providers for which Level II review was required, review of QOC cases, and review of clean files approved by the medical director. *Recommendation: Because the Professional Review Committee serves as a peer review committee, consider attempting to recruit providers with additional specialty types to serve as committee members.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Processes for initial credentialing are detailed in Policy CR 01, Credentialing Program Policy. Mississippi-specific requirements are included in Addendum B to this policy.
3.1 Verification of information on the applicant, including:						Issues identified in the initial credentialing files are addressed in the standards below.
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF)	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					Initial credentialing files for two nurse practitioners did not include admitting privileges and had no documented admitting plan. CCME understands nurse practitioners typically do not admit members but they should have a plan in place for situations in which a member needs to be admitted. *Recommendation: Ensure admitting plans are collected for nurse practitioners being credentialed into the network.*
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number or providers billing laboratory services;	X					File review revealed missing CLIA certificates for some practice locations listed on provider applications. Molina staff responded that these locations were not being credentialed and, therefore, no CLIA was required. CCME also noted that on several provider applications, the question about whether a practice location conducts laboratory services was incomplete. During discussion of this issue, Molina staff reported they do not contact the provider to clarify and do not seek a CLIA for the location. *Recommendation: To ensure appropriate collection of CLIA certificates or certificates of*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						waiver, develop and implement a process to contact providers when the application is incomplete regarding laboratory services if the provider is being credentialed for the location.
3.1.15 Ownership Disclosure form.					X	Per a directive from DOM, CCOs are no longer required to collect Ownership Disclosure Forms.
3.1.16 Fingerprints, when applicable.	X					None of the individual provider files reviewed required fingerprints.
3.2 Site assessment.			X			CCME understands that due to Covid-19, restrictions are in place that prevent provider office site visits from being conducted as part of initial credentialing. However, of 14 initial credentialing files reviewed, 10 were from 2018 and 2019, prior to Covid-19. These 10 files contained no evidence of a site visit being conducted, and onsite discussion confirmed Molina has not been conducting site visits as a part of initial credentialing. However, Policy CR 01, Credentialing Program Policy, Addendum B states, "Molina will conduct an initial site assessment prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the provider office visit." Requirements for site visits are specified in the *CHIP Contract, Section 7 (E).* *Corrective Action: Develop and implement a process to conduct site visits for initial*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						credentialing to begin when Covid-19 restrictions are lifted.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Processes for recredentialing are detailed in Policy CR 01, Credentialing Program Policy. Mississippi-specific requirements are included in Addendum B to this policy.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						Because Molina is a new health plan in Mississippi, recredentialing is expected to begin in mid-2021.
4.2.1 Current valid license to practice in each state where the practitioner will treat members;					X	
4.2.2 Valid DEA certificate and/or CDS Certificate;					X	
4.2.3 Board certification if claimed by the applicant;					X	
4.2.4 Malpractice claims since the previous credentialing event;					X	
4.2.5 Practitioner attestation statement;					X	
4.2.6 Re-query the National Practitioner Data Bank (NPDB);					X	

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Re-query the System for Award Management (SAM);					X	
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;					X	
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));					X	
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);					X	
4.2.11 Re-query of the National Plan and Provider Enumeration (NPPES);					X	
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;					X	
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;					X	
4.2.14 Ownership Disclosure form.					X	
4.3 Provider office site reassessment, when applicable.					X	
4.4 Review of practitioner profiling activities.					X	

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					CCME could not identify the timeframe or process for notifying DOM of a provider's suspension or termination for serious quality of care or service issues in the following documents: •Policy CR 01, Credentialing Program Policy or Addendum B of the policy •Policy and Procedure MHMS-QI-008, Potential Quality of Care, Serious Reportable Adverse Events, and Never Events •Policy CR 03, Fair Hearing Policy •Procedure MHMS-PC-09, MHMS Provider Termination Process Onsite discussion confirmed that for provider suspensions or terminations related to serious quality of care or service issues, Molina notifies DOM within 48 hours of the termination decision. *Recommendation: Update the appropriate policies and procedures to include Molina's process and timeframe for notifying DOM of a provider's suspension or termination for serious quality of care or service issues.*
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.			X			Credentialing and recredentialing guidelines for organizational providers are addressed in Policy MHI-CR 02, Assessment of Organizational Providers Policy, and in Addendum B of the policy. Of 11 initial organizational provider credentialing files reviewed, six are considered

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						high-risk by DOM for the purposes of fingerprinting requirements. None of the files included fingerprints. *Corrective Action: Ensure credentialing files for CHIP providers considered by DOM to be high risk include submitted fingerprints.*
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Page 5 of Policy MHMS-NM-017, CHIP PCP Roles and Responsibilities, indicates that "Once per month, Molina will send written notification to PCPs that have newly assigned members." However, the *CHIP Contract, Section 4 (B) (2)* stipulates that Contractors must notify PCPs of the members assigned to them within 5 business days of the date on which the Contractor receives the Member Listing Report from the Division. *Recommendation: Revise Policy MHMS-NM-017 to reflect the CHIP Contract, Section 4 (B) (2) requirement that the health plan must notify PCPs of the members assigned to them within 5 business days of the date on which the Contractor receives the Member Listing Report from the Division.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
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					Molina Geo Access Reports do not clearly indicate the parameters used to measure adequacy of the network, such as member choice of at least two or more PCPs within a 15-mile radius for urban counties and within 30 miles for rural counties. *Recommendation: Ensure Geo Access Reports clearly identify the parameters used to measure and evaluate the network, including that members have access to two or more PCPs as required by the CHIP Contract, Section 7 (B) (1).*
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
requirements, complex medical needs, and accessibility considerations.						
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Onsite discussion revealed that the network is evaluated regularly. However, Molina does not currently compile a report to identify gaps within the network or an annual summary of patterned findings from the quarterly Geo Access Report. *Recommendation: Develop and implement a process to conduct a formal review of Geo Access Reports to summarize the quarterly network findings and any gaps identified.*
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				Evidence was found that accessibility standards are being measured and, except for the requirement for appointments after discharge from an acute psychiatric hospital, appear to be met. The *CHIP Contract, Section 7 (B) (2)* stipulates that follow-up appointments should be scheduled within 7 days from the date of discharge from an acute psychiatric hospital. However, the Appointment Availability Report Behavior Health 1st Quarter 2020 CHIP indicates that the standard was measured using a 14-calendar day parameter. *Corrective Action: Review and revise the process for measuring follow-up appointments*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						after discharge from an acute psychiatric hospital to reflect the required seven-day appointment timeframe, as required by the CHIP Contract, Section 7 (B) (2).
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					The Provider Services team conducts orientation and training for new providers and their staff within 30 days of active status, as noted in Policy MHMS-NM-018, Provider Education and Training, and the MHMS CHIP Provider Training Plan. Orientation can occur in-person with large provider groups or individual practices. Due to Covid-19 restrictions, Molina is currently conducting orientation sessions virtually and copies of the training materials are sent to the provider. Members of Molina's clinical staff participate in provider trainings when applicable. Molina's initial provider education program meets requirements of the *CHIP Contract, Section 7 (H) (3).*
2. Initial provider education includes:						The Mississippi CHIP Provider Orientation PowerPoint presentation is used for orientation of new network providers. The orientation covers such topics as, but not limited to, care guidelines, covered services, billing and claims payments, and grievance and appeal processes. Additionally, the CHIP Provider Manual and other provider materials are used during the orientation process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual is updated at least annually, and the most current version is accessible on the website. The manual includes an introduction to the CHIP program, an explanation of Molina's organization and addresses as required by the *CHIP Contract, Section 7 (H)*.
2.1 A description of the Care Management system and protocols, including transitional care management;	X					The Care Management Program and the role of care managers are covered in the Mississippi CHIP Provider Orientation presentation and the Provider Manual.
2.2 Billing and reimbursement practices;	X					Instructions for billing guidelines and processes are noted throughput the Provider Manual.
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	X					
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					The Provider Manual and the orientation presentation inform providers of appointment availability standards. Additionally, information is posted on the website.
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					Clinical practice guidelines and standards of care are available on the website and throughout the Provider Manual. Well-Baby and Well-Child services are offered through the end

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of the month in which the member turns 19 years old.
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					Providers receive quarterly encounter lists from Molina of members who are non-compliant with Well-Baby and Well-Child services. Providers are responsible for contacting the members, documenting reasons for the noncompliance, and documenting results of outreach efforts to encourage the member to complete the service.
2.8 Medical record handling, availability, retention and confidentiality;	X					Policy MHMS-QI-124, Standards of Medical Record Documentation, defines medical record documentation standards. Provider requirements for medical record handling and documentation standards are available in the Provider Manual and on the website.
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					Policies MHMS-PRT-01, Provider Complaint & Grievances, and MHMS-PRT-02, Provider Reconsiderations and Appeals, describe the requirements for providers to file an appeal on behalf of a member and provider claim appeals. The Provider Manual and the website have information and instructions for submitting an appeal, complaint, or grievance, and describes the resolution process.
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					Policy No. MHMS-PH002, Pharmacy Benefit, gives an overview of pharmacy services. Information on Molina's pharmacy program is noted on the website and in the Provider Manual. It includes information on, but not limited to, the prior authorization process and accessing the Universal PDL. The PDL link on Molina's website transfers directly to the Division of Medicaid's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PDL page where specific pharmacy benefit information and procedures are addressed.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					The role of the PCP is to manage and coordinate all aspects of the member's care, as noted in Policy MHMS-NM-002, PCP Roles and Responsibilities, and in the Provider Manual.
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					During orientation and in the Provider Manual, providers are informed of the requirement to notify Molina 30 days prior to closing their panel to new members.
2.14 Medical record documentation requirements;	X					Policy MHMS-QI-124, Standards of Medical Record Documentation, describes medical record documentation requirements. Molina requires providers to maintain medical records in a manner that is organized and meets all documentation standards. The requirements are communicated in the Provider Manual and on the website.
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.	X					Policy MHMS-PC-01, MHMS Provider Directory Requirements, and the Provider Manual describe Molina's process for creating, maintaining, and making available the Provider Directory, both in print and online. Providers are trained to use the online Provider Directory during the initial orientation. They are informed of the requirement to validate the information for accuracy at least quarterly and to notify Molina 30 days prior to needed corrections. Molina staff reported that updates to the Provider Directory occur nightly for the online version and quarterly for the printed copy.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Per policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina adopts CPGs and PHGs based on scientific evidence and recommendations made by Molina's National Quality Improvement Committee. The guidelines are based on the relevance to Molina's population. Periodic review is conducted for guidelines that have

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						been in effect for two or more years. The CPGs and PHGs are reviewed at least quarterly to and updated when new scientific evidence is released or when national guidelines are published.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Molina is responsible for informing providers of the selected CPGs and PHGs. Per policy, the QI Department is responsible for the distribution of new and revised guidelines. The Provider Manual states PHGs are distributed to providers annually on the website and in the Provider Manual. Providers are notified of the availability of the PHGs in the Molina Provider Newsletter. CCME confirmed the guidelines are available on Molina's website.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to member high-risk groups;	X					
3.5 Behavioral health.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Per Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, Molina adopts CPGs and PHGs based on scientific evidence and recommendations made by Molina's National Quality Improvement Committee. The guidelines are based on the relevance to Molina's population. Periodic review is conducted for guidelines that have been in effect for two or more years. The CPGs and PHGs are reviewed at least quarterly to and updated when new scientific evidence is released or when national guidelines are published.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO members.	X					The Provider Manual states adopted CPGs are distributed to appropriate providers/provider groups through provider newsletters, electronic provider bulletins, and other media and are available on the website. Individual providers or members may request copies from the local Molina Quality Department. CCME confirmed the guidelines are accessible on Molina's website.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MHMS-QI-124, Standards of Medial Record Documentation, defines Molina's medical record documentation standards. However, the policy does not include that documentation should

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include any health education provided to members. *Recommendation: Revise Policy MHMS-QI-124, Standards of Medial Record Documentation, to include that any health education provided during a provider visit should be included in the documentation of the visit.*
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 Medial Record Documentation, includes a review process for monitoring medial record documentation however, the timeframe for how often the monitoring is conducted was not mentioned. Onsite discussion confirmed medical record monitoring was last conducted in 2019. It has been placed on hold due to restrictions from Covid-19 and will be resumed when restrictions are lifted. *Recommendation: Revise Policy MHMS-QI-124, Standards of Medial Record Documentation, to include the frequency of medical record documentation audits.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					Provider satisfaction was validated using the CMS Protocol 6. Administration or Validation of Quality of Care Surveys. Molina's provider satisfaction survey occurred in November 2019. 205 providers completed the survey—79 by mail, 24 via the internet (7.6% response rate) and 102

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by phone (18.6%) response rate. Overall, the response rate was 15.6%. *Recommendation: Work with the vendor to determine other methods to increase response rates. Ensure provider contact information is up to date.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					Evidence that the health plan analyzes data obtained from the provider satisfaction survey to identify quality problems was noted in the MHMS 2019 Provider Satisfaction Survey Final Report by SPH Analytics 2019 and in the Quality Improvement Program 2019 Annual Evaluation.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QIC committee during the March 2020 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining member rights and responsibilities and	X					Molina ensures member rights and responsibilities in accordance with *42 CFR § 438.100* and as described in Policy MHMS-ME-003, Member Rights and Responsibilities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
procedures for informing members of these rights and responsibilities.						Members are informed of their rights in the Member Handbook, member materials, and on the website. The Provider Manual includes a link for providers to access the list of member rights and responsibilities from the website.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in Policy MHMS-ME-003, Member Rights and Responsibilities, the Member Handbook, on the CHIP member website, and in member materials. Policy MHMS-QI-001, Advance Directives, describes Molina's process of providing information on Advance Directives to CHIP members. The following member rights were not identified in the Member Handbook as required by the *CHIP Contract, Section 6 (J)* and *42 CFR § 438.10*: •Free exercise of rights and the exercise of those rights do not adversely affect the way the Contractor and its Providers treat the Member. •Receive information in a manner and format that may be easily understood in accordance with *42 C.F.R. § 438.10*. *Recommendation: Edit the CHIP Member Handbook to include the complete requirements for member rights, as specified in the CHIP Contract, Section 6 (J) and 42 CFR § 438.100.*
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						Requirement not included 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;						
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;						Requirement not included in the CHIP Member Handbook.
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Member responsibilities are listed in Policy MHMS-ME-003, Member Rights and Responsibilities and communicated in the CHIP

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Member Handbook, Provider Manual, and the member website. See standards 3.1 – 3.5 for specific comments.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						The CHIP member website omits the requirement that members are financially responsible for unauthorized services obtained from out of network providers. *Recommendation: Edit the CHIP member website to clearly specify that members are responsible to pay for unauthorized health care services obtained from non-participating providers, as required in the CHIP Contract, Section 6 (J) and 42 CFR § 438.100.*
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:	X					Policy MHMS-ME-012, CHIP Member Information Packet, states members are provided a Member Information Packet within 14 days after Molina receives the member's enrollment data from DOM. It includes all contractually required information such as, an introduction letter, CHIP ID card, Member Handbook, information about disenrollment rights, and instructions to access the Provider Directory. Written member materials will not exceed the 6th-grade reading level as noted in Policy MHMS-COMM-01, Member Communication Standards.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						The CHIP member website includes information that female members can obtain women's preventive services from a women's health provider in addition to their PCP without prior authorization. However, this requirement is not identified in the CHIP Member Handbook. During the onsite teleconference Molina confirmed that female members can receive services from their PCP in addition to a women's health provider. *Recommendation: Edit the Member Handbook to include the requirement that, in addition to their PCP, female members can have direct access to a women's health provider for routine and women's preventive services required in CHIP Contract, Section 7 (A).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						The Covered Services chart in the CHIP Member Handbook lists services that do and do not require prior authorization and any applicable limitations. Members are informed that they may have to cover the costs for unauthorized services from out-of-network providers.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook and the website provide clear and specific information instructing members on the appropriate level of care for routine, urgent, or emergent healthcare needs for medical, dental, and behavioral health services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and find participating pharmacies or contact Member Services to obtain this information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						CCME could not identify how Molina inform members of changes to benefits, services, or the provider network in the CHIP Member Handbook. During the onsite teleconference Molina explained that all members are notified of changes to CHIP programs and benefits no later than 30 calendar days prior to implementation with approval from DOM and changes in the provider network within 15 days after receiving notification. Staff submitted examples of recent written notification of ongoing benefit changes and provider terminations and responded that the requirement to have documentation in member materials is not stated in the Contract. *Recommendation: Capture the requirement, that members will be informed of changes to benefits, services, or the provider network, in a policy or other document. Consider editing the CHIP Member Handbook to include this requirement, as noted into CHIP Contract, Section 6 (D) (9) (h), under the heading, "The Member Handbook must include at a minimum the following information."*
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						The Member Handbook includes toll-free telephone numbers, hours of operation and descriptions of services provided by Member Services and the 24-Hour Nurse Advice Line. It has information on accessing the secure Member Portal and performing various self-service functions, such as viewing a benefit summary, changing the PCP, updating contact information, and requesting a new ID Card.
1.13 A description of the Well-Baby and Well-Child services which include:						The CHIP Member Handbook lists a complete description of Well-Baby and Well-Child services for eligible members under 19 years of age, indicating the guidelines are from the American Academy of Pediatrics. Molina conducts written, telephonic and in-person outreach to inform and remind members of necessary Well-Baby and Well-Child services. Preventive health guidelines for age-appropriate checkups and the 2020 Recommended Immunization Schedule are available on the website.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/education and referral for identified problems.						
1.14 Procedures for disenrolling from the CCO;						The CHIP Member Handbook provides information on the requirements for disenrollment and instructs members to call Member Services or DOM to terminate their membership.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.15 Procedures for filing complaints/grievances and appeals;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						The CHIP Member Handbook informs members to contact Member Services or use the Provider Directory to select and obtain specific information about providers. Additionally, the Provider Directory lists whether a provider will accept new patients and whether the office/facility has accommodations for people with physical disabilities.
1.17 Instructions on reporting suspected cases of fraud and abuse;						Fraud and abuse are defined and appropriately described in the Member Handbook and the website in accordance with *42 CFR §455.2* and *the CHIP Contract, Sections 2 (A) (1)* and *6 (D) (10)*. Instructions are provided for members to anonymously report fraud and abuse to the Molina Healthcare AlertLine or use an online form at MolinaHealthcare.alertline.com.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						Molina's Care Management Program is described in the Member Handbook and on the website. Members are instructed to contact Member Services for information on the various disease and care management programs offered for chronic health conditions, such as asthma, diabetes, obesity, and hospital discharge. Social service programs for WIC and special education services are also available.
1.19 Information about advance directives;	X					An Advanced Directive is correctly described and defined in the Member Handbook. However, the term "will" is used instead of the term "living will," which is incorrect.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Edit the Member Handbook to ensure the term "living will" is not referred to as a "will."
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					Molina notifies members by mail of significant changes in benefits 30 days prior to the effective date as discussed during the onsite teleconference. Staff submitted the letter template used to notify members of changes to non-emergency transportation service, "Member Transportation Termination Notice" with the corresponding member brochure, according to requirements in the *CHIP Contract, Section 6 (D)*. Policy MHMS-PC-09, MHMS Provider Termination Process, describes that Molina sends members written notice of any provider termination, within 15 days after being notified of the termination. However, CCME could not determine the information included in the written notice to enrollees. During the onsite, staff submitted the written notice template, EN_PDF_PCP Termination_Medicaid_MS_831_Ver.2 and a sample member letter for review. CCME identified the notice does not include the requirement to provide the date after which members who are receiving an ongoing course of treatment cannot use the terminated provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Molina confirmed approval from DOM is received prior to sending member notices. *Recommendation: Edit letter template, EN_PDF_PCP Termination_Medicaid_MS_831_Ver.2, to include the date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required by the CHIP Contract, Section 7 (D) (4).*
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages.	X					Policies MHMS-CE-01, Marketing, and MHMS-COMM-01, Member Communication Standards, describe and outline processes that Molina uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. Member materials have a minimum 12-point font size for regular print items and 18-point font size for large print items.
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Molina arranges trained interpreter or bilingual services to communicate with eligible individuals in a language other than English. Interpreter and translation services are provided free of charge to non-English speaking members, members who have limited English proficiency, and members who are deaf or hearing impaired, as described in the Member Handbook and Policy MHMS-QI-010, Access and Availability of Language Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Contact information for Member Services, the Nurse Advice Line, and Relay 711 for members with hearing and speech limitations are noted on the website, in member materials, and on the member's ID card.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					Review of appeals and grievance files reflect Members are appropriately educated and informed about Molina's programs and processes. Examples include, but not limited to, staff providing education on covered benefits and services and participating providers.
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					Molina maintains a Member Services Call Center, Provider Services Call Center, and 24-Hour Nurse Advice Line. Additionally, the 24-Hour Nurse Advice Line is staffed with mental health professionals who can address the member's urgent BH need. Relay 711 is communicated in several member materials and on the website.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Molina monitors and evaluates member and provider Call Center staff for the quality of call handling. No less than 3% of calls are randomly selected on a monthly basis. Provider Telephone Access Standards reported in the 2019 Quality Improvement Program Evaluation indicates one out of three Call Center goals were met.
III D. Member Enrollment and Disenrollment						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHMS-ME-008, Enrollment Reports, and Policy MHMS-ME-009, Enrollment Accounting, describes instances when Molina can request a member to be disenrolled.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about available preventive health and chronic disease management services and encourages members to utilize these benefits.	X					Policy MHMS-QI-125, Member Education and Prevention (ME), describes the process Molina uses to provide, health education to new and established members. Members can access the CHIP website or Member Handbook for information on recommended preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services. Additionally, the plan sends targeted and general mailings and makes calls to eligible members reminding them of screenings and well visits. During the onsite teleconference staff explained that postcards are mailed to all members notifying them that the annual newsletter is available on the website. Additionally, website activity is monitored to evaluate if newsletters and other member information are being accessed.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the	X					Molina has various methods for identifying members for the High-Risk Obstetrical Program,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
participation of pregnant members in their recommended care, including participation in the WIC program.						such as self-referrals, provider referrals, the Medicaid enrollment list, and claims data.
3. The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					Molina ensures the availability of Well-Baby and Well-Child services for members under 19 years of age, as described in Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.					X	Molina did not have enrollment in the CHIP product line in 2019.
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.					X	
3. The CCO reports the results of the member satisfaction survey to providers.					X	
4. The CCO reports the results of the member satisfaction survey and the impact of measures taken to address quality problems that were identified to the appropriate committee.					X	
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member	X					Policy MHMS-MRT-01, Member Complaints and Grievances, outlines processes for handling member grievances. Molina's health information system date-stamps, tracks, and documents the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
grievances in a manner consistent with contract requirements, including, but not limited to:						status of grievances. All grievances are assigned a unique case number and the Grievance and Appeals Coordinator ensures the case is appropriately documented. The database tracks and trends grievances in the following categories: Transportation, Access to Service/Providers, Provider Care and Treatment, Contractor Customer Services, Payment and Reimbursement Issues, and Administrative issues.
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance and the description of who can file a grievance are correctly documented in Policy MHMS-MRT-01, Member Complaints and Grievances, the CHIP Member Handbook, and Provider Manual; however, they are not included on the CHIP member website. *Recommendation: Edit the non-secured section of the CHIP member website to include the definition of a grievance and who may file a grievance, as required by the CHIP Contract, Section 6 (H).*
1.2 The procedure for filing and handling a grievance;	X					Grievance filing procedures are correctly described in Policy MHMS-MRT-01, Member Complaints and Grievances, the CHIP Member Handbook, and Provider Manual. During the onsite teleconference, CCME explained that the CHIP member website does not include information that a grievance can be filed at any time, orally or in writing, or the address/fax number to submit a written grievance. However,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						these instructions are clearly noted for filing a complaint. Recommendation: *Include information on grievance filing procedures on the non-secured section of the CHIP website, as required by the CHIP Contract, Section 6 (H). To meet this requirement, consider adding the term "grievance" to headings where information for filing complaints is provided.*
1.3 Timeliness guidelines for resolution of the grievance;	X					Timeliness guidelines for grievance resolution are correctly documented in Policy MHMS-MRT-01, Member Complaints and Grievances, the CHIP Member Handbook and website. Molina resolves grievances within 30 calendar days from when they receive it. Page 115 of the CHIP Provider Manual states, "The timeframe for Grievance resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe an additional fourteen (14) calendar days if the extension is in the interest of the Member…" This could be misinterpreted by members to mean that Molina will have a total of 28 days to issue a determination when the grievance resolution timeframe is extended. *Recommendation: Edit the description of the grievance extension timeframe to clearly specify that Molina can extend the timeframe only 14 days if it is in the member's best*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						interest, in accordance with 42 CFR §438.408 (c) and CHIP Contract, Section Exhibit C (B).
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					Per Policy MHMS-MRT-01, Member Complaints and Grievances, Molina ensures decision-makers involved in grievances were not involved in any previous level of review. Additionally, this requirement is communicated in the CHIP Member Handbook and Provider Manual.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					Review of grievance files indicates timely acknowledgement, resolution, and notification to members. Files reflect thorough investigation of the member's grievance prior to Molina mailing the resolution and closing the case.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Molina, tracks, trends, and analyzes grievances and reports results to the SQIC and the QIC quarterly as noted in Policy MHMS-MRT-01, Member Complaints and Grievances. The committees analyze grievance information to identify trends, address barriers, and identify opportunities for improvement. Review of SQIC and QIC meeting minutes and presentations reflect discussion of member grievances.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Molina staff investigate all grievances and assist members in changing their PCP when requested.
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.	X					The 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually. Molina does not have a separate QI program description for the CHIP population.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The QI Program Description provided a description of Molina's scope that includes addressing members with special health care needs and efforts to reduce health disparities.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
analysis that demonstrate potential health care delivery problems.						
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				Annually, Molina's QI Work Plan identifies activities related to program priorities to improve the quality of services provided to members. Molina does not maintain a separate work plan for the CHIP Program. The health plan provided the 2019 and 1st quarter through 3rd quarter 2020 work plans. The 2020 work plan only included a few references to CHIP. *Recommendation: It should be clear in the QI Work Plans that the CHIP line of business is included. Also, consider reporting CAN and CHIP measures separately.* Also, there were errors or missing information noted in the 3rd Quarter 2020 work plan. These included: •Section 2.0, Patient Safety Initiatives—the objective states "Identify a process to receive, track, investigate, validate, and manage Potential Quality of Care Issues." This was an activity completed in 2019 even though listed as ongoing for 2020. •Section 5, Availability of Practitioners—the goals are not documented for the ratio of PCPs to members and the Ratio of High-Volume Specialist and High-Volume Behavioral Health Providers to members. Also, the goal for the percentage of members with one open Behavioral Health provider is missing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Section 5, Availability of Practitioners—the standards for measuring the percentage of adults and children that have access to a PCP is incorrect. The *CHIP Contract, Section 7 (B), Provider Network Requirements* lists the standard for adult and pediatric members as two PCPs within 15 miles for urban and two PCPs within 30 miles for rural. •Section 5, Availability of Practitioners—the standards for measuring the percentage of members with one open specialist and the percentage of members with one open Behavioral Health specialist does not include the time requirements (30 minutes) for urban providers and does not include the requirements for rural providers. The *CHIP Contract, Section 7 (B)* lists the requirements as one specialist and one Behavioral Health specialist within 30 minutes or 30 miles for urban and within 60 minutes or 60 miles for rural providers. •Section 6.0, Accessibility of Services—the standard for measuring a regular and routine PCP appointment is listed as 90% within six weeks The *CHIP Contract, Section 7 (B), Provider Network Requirements* lists the standard as not to exceed 30 calendar days for a PCP Well Visit and not to exceed seven calendar days for a PCP Routine Sick Visit. •Section 7.0 Accessibility of Services: Behavioral Health—the standard used to measure urgent care for Behavioral Health is listed as within 48 hours. However, the *CHIP Contract, Section 7 (B)* lists this requirement as not to exceed 24

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						hours. Also, the post discharge follow-up (not to exceed seven calendar days) is not included. •Section 9.0, Continuity and Coordination of Medical Care—the timeframe for notifying members of the termination of a PCP is listed as within 30 days of termination date or within 30 days of notification. However, the *CHIP Contract, Section 7 (D), Provider Termination, Number 4, Member Notification* states the Contractor shall send a written notice within 15 calendar days of notice or issuance of termination of a Provider to Members who received primary care from the Provider. *Corrective Action: Correct the errors identified in the 2020 QI Work Plan.*
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Oversight of the QI activities for the CHIP population has been delegated to the QIC.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is co-chaired by the Chief Medical Officer and the Quality Leads. Membership includes Molina's senior leaders, department directors and other health plan staff. Three network providers are included as voting members. *Recommendation: Recruit additional network providers to serve on the QIC. Consider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						including a Family Practice, OB/GYN, and a Behavioral Health practitioner.
3. The QI Committee meets at regular intervals.	X					Separate meetings are not held for the CHIP population.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."					X	Since Molina did not have enrollment in the CHIP product line in 2019, the PMV was conducted only for the Mississippi CAN population.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					For the CHIP population Molina submitted four projects for validation. Topics included Asthma, Follow-up After Hospitalization for Mental Illness, Obesity, and Well Care.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."			X			All projects received a validation score within the Not Credible rage and failed to meet the validation requirements. The following items were not documented: •Data analysis and rationale for choosing the topic •Sampling information •Data analysis plan •The goal and benchmark rates •Analysis of findings

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Barriers and interventions linked to each barrier Details of the validation activities and recommendations for the PIPs may be found in *Attachment 3, CCME EQR Validation Worksheets.* *Corrective Action: The performance improvement projects should be documented on the CCME provided template and include all required elements.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					Per Provider Service Agreement, Attachment D, Section 1.4, Program Participation, providers agree to comply with the requirements specified in the Quality Management section of the contract between Molina and DOM.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per the QI Program Description, to evaluate the effectiveness of the clinical and preventive evidence-based guidelines, Molina measures performance against important aspects of each clinical practice and preventive guideline. Policy and Procedure (MHMS-QI-018), page 7, discusses the performance monitoring conducted. On page 8 of that procedure, it states "All results are incorporated into reports to the Quality Improvement Committee, included in each state health plan's Annual

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Work Plan and utilized when planning subsequent QI activities." This was discussed during the onsite. Molina indicated provider compliance is monitored using HEDIS data. Individual provider reports are generated and distributed by Molina staff. The monitoring was not included in the QI Work Plan as mentioned in Policy MHMS-QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. *Recommendation: Include in the QI Work Plan the monitoring of provider compliance with Clinical Practice Guidelines and Preventive Health Guidelines.*
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						Molina's Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services was provided.
4.1 Initial visits for newborns;	X					
4.2 Well-Baby and Well-Child screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			Per Policy MHMS-QI-005, Well-Baby and Well-Child Services and Immunization Services, Molina has a tracking system that tracks at a minimum, initial visits for newborns, Well-Baby and Well-Child screenings and reporting of all screening results and diagnostic and treatment services including referrals. Molina provided a sample of the tracking report. However, the tracking report failed to link the identified problem with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Well-Baby and Well-Child service and did not include or indicate members who received additional treatments or referrals as required by the *CHIP Contract, Section 5 (D)*. *Corrective Action Plan: The Well Baby and Well Child Services tracking report should include the date the service was provided, ICD 10 or CPT codes for the diagnosis, treatment and/or referrals for any suspected problem identified during the Well Baby and/or Well Child Services screening as required by the CHIP Contract, Section 5 (D).*
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.		X				The Quality Improvement Program 2019 Annual Evaluation, Executive Summary and three Appendices (Appendix A – Member and Provider Experience Report, Appendix B – CLAS Analysis Report and Appendix C – Population Health Assessment) was provided for review. Per Molina staff this program evaluation included CHIP. The *CHIP Contract, Section 10 (D) and Exhibit G*, requires the annual performance evaluation of the QI program to include a description of completed and ongoing QI activities including Case Management effectiveness evaluation, identified issues, including tracking of issues over time, trending of measures to assess performance in quality of clinical care and quality of service to Members and an analysis of whether there have been demonstrated

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						improvements in members' health outcomes, the quality of clinical care and quality of service to members, and overall effectiveness of the QI program. Molina's 2019 annual evaluation did not include the analysis and results of the availability of practitioners, accessibility of services, performance measures, performance improvement projects, and delegation oversight. *Corrective Action: The Quality Improvement Evaluation must meet all the requirements contained in the CHIP Contract, Section 10 (D) and Exhibit G. Specifically a description of completed and ongoing QI activities, identified issues or barriers, trending measures to assess performance, and any analysis to demonstrate the overall effectiveness of the QI program.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	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					Utilization Management activities are integrated within the Molina Health Care Services Program. The 2020 Health Care Services (HCS) Program Description outlines the goals, scope, and staff roles for physical health, behavioral health (BH), and support services for members in Mississippi. The Pharmacy Program Description outlines the pharmacy benefit program. Several policies describe UM processes and requirements: Policy MHMS-HCS-UM-325-1, Service Authorization and Policy MHMS-HCS-UM-365.1, Clinical Criteria for Utilization Management Decision Making CHIP. See Standards 1.1-1.7 for specific comments:
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					UM Timeframe requirements are correctly documented in Policy MHMS-HCS-UM-383, Timeliness of UM Decision Making and Notification, and Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures. CCME identified the CHIP website states pharmacy PA will be responded to in 72 hours.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit the website to correct the pharmacy authorization timeframe from 72 hours to 24 hours, to align with documentation in Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures.
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The roles of the Molina's Medical Director and Chief Medical Officer (CMO) are described in the 2020 Health Care Services (HCS) Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, and chairing committees. The Behavioral Health (BH) Medical Director and the Pharmacy Director collaborate with the Medical Director and CMO and have clinical oversight of the respective programs.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the Health Care Services Committee (HCSC) and the QIC for review and were approved on June 10, 2020 and June 26, 2020, respectively. In addition to plan staff, the HCSC includes the Manager for Network/Provider Services, who is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						selected to represent primary care, high volume specialists, and delegated provider groups. Committee responsibilities include, but are not limited to, reviewing and approving clinical policies, monitoring utilization trends and evaluating provider and member satisfaction with the HCS Program.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Utilization management standards/criteria are documented in Policy MHMS-HCS-UM-365.1, Clinical Criteria for Utilization Management Decision Making. Molina uses clinical criteria for Utilization Review (UR) coverage determinations and uses a hierarchical approach for evaluating service authorization requests. Internal clinical criteria for utilization determinations are primarily used. These standards are based upon applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical coverage determination guidelines, such as InterQual, and meet requirements of the *CHIP Contract, Section 5 (I).*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of approval files reflect staff are following guidelines described in Policy MHMS-HCS-UM-365.1, Clinical Criteria for Utilization Management Decision Making CHIP, for utilization determinations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy MHMS-HCS-UM-365.1, Clinical Criteria for Utilization Management Decision Making CHIP, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. A physician reviewer can approve requested services when criteria is not met, and the clinical evidence supports the decision.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Molina conducts IRR testing annually for Medical Directors, medical and BH clinical reviewers, and pharmacy staff to evaluate consistency in the application of UM criteria. InterQual guidelines are used for IRR testing. Discussion during the onsite teleconference confirmed remediation and education are given to reviewers who do not achieve the passing score of 90%. Results reported in the 2019 Health Care Services Program Evaluation indicate Medical Directors scored 87% but achieved concordance of 100% after group discussion. Additionally, the Medical Director and HCS Director have the opportunity to assess consistency of criteria during weekly rounds with the UM staff.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					Caremark is the pharmacy benefit manager (PBM) and is responsible for implementing all pharmaceutical services for Molina, including but not limited to, prior authorizations and pharmacy network management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A link to access the most current version of the Universal PDL is posted on Molina's website which takes the user to DOM's website to access the PDL is available in a searchable, electronic format.
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Policy MHMS-PH001, Pharmacy Prior Authorization and Denials Procedures, explains Molina has policies and procedures that follow DOM's prior authorization criteria for drugs listed on the PDL and for drugs not listed. Molina uses the most current version of the PDL available on DOM's website. The Pharmacy Benefit Manager conducts the prior authorization process within 24 hours and according to state, federal and regulatory requirements. Molina ensures a 72-hour (3-day) supply of medication will be approved while a prior authorization request is pending.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Molina ensures UM decisions are rendered by appropriate staff as described in Policy MHMS-HCS-UM-364.1, Appropriate Professionals Making UM Decisions. An initial clinical review is performed by a licensed nurse, and a Mississippi-licensed physician or other appropriate healthcare practitioner performs

STANDARD	SCORE					COMMENTS
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						Level II medical necessity review resulting in an adverse benefit determination. Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists such as dentists, pharmacists or BH specialists.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes reviewed in approval files are consistent with Policy MHMS-HCS-UM-383.1, Timeliness of UM Decision Making and Notification and contractual requirements.
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					UM denial files for CHIP members reflect reviewers attempted to obtain additional clinical information when needed, prior to rendering an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Policy MHMS-HCS-UM-364.1, Appropriate Professionals Making UM Decisions CHIP, and Policy MHMS-HCS-UM-325-1, Service Authorization, state that currently licensed physicians, dentists, and pharmacists will render adverse benefit determinations. The Medical Director or appropriate health professional is available to discuss medical necessity determinations within one business day with the provider if needed, as noted in Policy MHMS-HCS-UM-371.1, Practitioner Access to Plan Physician Reviewer CHIP. Denial files reflect review by a medical director, or other appropriate physician, when

STANDARD	SCORE					COMMENTS
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						UM clinical staff cannot approve requests that do not meet medical necessity criteria. Additionally, denials for pharmacy requests are determined by a licensed pharmacist with sign-off by a health plan medical director.
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 denial files revealed adverse benefit determinations were made timely and communicated to the requesting provider and member according to processes described in Policy MHMS-HCS-UM-383.1 Timeliness of UM Decision Making and Notification CHIP. The adverse benefit determination notice included the basis for the denial, criteria used, and instructions for the appeal process.
V C. Appeals						
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					The 2020 Health Care Services (HCS) Program Description, Policy MHMS-MRT-02, Standard Member Appeals, and Policy MHMS-MRT-03, Expedited Member Appeals outline the processes for member appeals. Molina's Appeal and Grievance database information system date-stamps, tracks, and documents the status of appeals. All appeals are assigned a unique case number.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definition of the term "appeal," "adverse benefit determination" and a description of who can file an appeal are described in Policies MHMS-MRT-02, Standard Member Appeals and MHMS-MRT-03, Expedited Member Appeals, the CHIP Member Handbook, Provider Manual and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	website. However, the following issues are identified: •Health Care Services (HCS) Program Description and the CHIP website incorrectly define appeal as "a request for a review of an action (decision) by Molina to limit or deny coverage for a requested service or prescription drug." The correct term is "adverse benefit determination", "action". •The term "adverse benefit determination" is incorrectly defined on page 104 in the Provider Manual stating, "An Adverse Benefit Determination for a Member may include a decision to deny or limit health care services a Member believes he or she is entitled to get…" Additionally, the term is incorrect on the website, stating, "An action is any denial that is: Limited, Reduced, Suspended, Terminated, or Payment is denied". •A description of who can file an appeal is not clearly defined on the website. *Recommendation: Edit the HCS Program Description and CHIP website to indicate current terminology of "adverse benefit determination" instead of "action". Include the correct definition of "adverse benefit determination" in the CHIP Provider Manual and the website. Edit the CHIP website to include a complete description or definition of who can file an appeal. Adhere to CHIP*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Contract, Section 2 (A) and 42 CFR § 438.400 (b).
1.2 The procedure for filing an appeal;		X				Appeals procedures and instructions are documented in Policy MHMS-MRT-02, Standard Member Appeals, the CHIP Member Handbook, Provider Manual, and on the website. CCME identified the following documentation issueson the website: •The website ncorrectly states that appeals must be filed in 60 days from the day of the denial, instead of 60 calendar days from the date on the notice of Adverse Benefit Determination letter. •The website does not address or describe that someone else, an authorized representative, can file on the member's behalf. •The website does not address that members can present evidence or examine their case file at any time during the appeals process. Additionally, the CHIP Member Handbook, Provider Manual, and website do not specify that a written appeal request must follow a verbal appeal request within 30 days after the call, unless expedited, as required by the *CHIP Contract, Section 6 (K).* *Corrective Action: Edit the CHIP website to include the correct address to submit a written appeal request and include all instructions and procedures for filing an appeal. Revise the CHIP Member Handbook, Provider Manual and website to indicate written appeal request*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						must follow a verbal appeal request within 30 days after the call, unless expedited to meet requirements in the CHIP Contract, Section (K).
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					Policy MHMS-MRT-02, Standard Member Appeals, states Molina ensures decision-makers involved in an appeal were not involved in any previous level of review. Additionally, this requirement is communicated in the CHIP Member Handbook, Provider Manual, and on the website.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy MHMS-MRT-03, Expedited Member Appeals, describes the process when an expedited appeal is requested. The Medical Director will determine if the request meets criteria for an urgent review and a decision will be made within 72 hours from Molina receiving the request.
1.5 Timeliness guidelines for resolution of the appeal;	X					Timeliness guidelines for appeal resolution are correctly documented in Policy MHMS-MRT-01, Member Complaints and Grievances, the CHIP Member Handbook, and website. Molina resolves grievances within 30 calendar days from when they are received. Page 117 in the CHIP Provider Manual states, "The timeframe for Grievance resolution may be extended by up to fourteen (14) calendar days if the Member requests the extension. Molina may extend the timeframe an additional fourteen (14) calendar days if the extension is in the interest of the Member…". This could be misinterpreted by members to mean that Molina will have a total of 28 days to issue a

STANDARD	SCORE					COMMENTS
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						determination when the appeal resolution timeframe is extended. *Recommendation: Edit the description of the grievance extension timeframe to clearly specify that Molina can extend the timeframe only 14 days if it is in the member's best interest, in accordance with 42 CFR §438.408 (c) and CHIP Contract, Section Exhibit C (B).*
1.6 Written notice of the appeal resolution;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.	X					CCME's review of appeal files reflected timely acknowledgement, resolution, and notification of determinations. CCME identified that 4 of the 20 appeals were reviewed by the same physician or dental reviewer who issued the initial denial. During the onsite teleconference, Molina staff acknowledged this finding and confirmed this is not normal procedure for reviewers. *Recommendation: Ensure decision makers on appeals cases are not involved in previous levels of review or decision making, as noted in Molina's Policy MHMS-MRT-02, Standard Member Appeals.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement	X					Molina tracks, trends and analyzes appeals for medical and behavioral health services, and

STANDARD	SCORE					COMMENTS
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opportunities, and reported to the Quality Improvement Committee.						reports results to the SQIC and the QIC quarterly, as noted in Policy MHMS-MRT-02, Standard Member Appeals and 2020 Health Care Services (HCS) Program Description. The SQIC reviews appeal information to identify and address trends
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					The 2020 Health Care Services Program Description gives an overview of the Integrated Care Management Program. Molina CHIP has an established Care Management Program, within the Health Care Services Program, to ensure and promote access and delivery of physical and behavioral health services and access to community resources. Initiatives from the Population Health Program assist in addressing the needs of members in complex case management. During the onsite teleconference Molina staff explained the data obtained from population health assessments assists in driving case management interventions for specific sub-populations.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The HCS Program Description details Molina's process for identifying eligible members and referring them into case management. In addition to referral guidelines and results from advanced data sources, Molina uses claims, health risk assessment results, medical records, and utilization management data to identify

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members who can benefit from case management. The Health Risk Assessment tool is primarily used to screen and identify eligible members into case management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Health risk assessments are completed in 30 days as described in Policy MHMS-HCS-CM-054.1, Individualized Care Plan Development, identified in CM files, and confirmed during the onsite teleconference. However, Policy MHMS-HCS-CM-061.1, Health Risk Assessment, outlines the process for staff to complete health risk assessments while incorrectly stating HRAs are completed within 90 days. *Recommendation: Edit Policy MHMS-HCS-CM-061.1, Health Risk Assessment, to indicate HRAs are completed in 30 days, instead of 90 days, for members newly assigned to the High or Medium risk levels of CM, as required in CHIP Contract, Section (8) (A).*
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 integrated care plan is developed by a medical or BH Care Manager, in collaboration with the member, within 30 days after the HRA is completed. Review of CM files reflected qualified health professionals conduct HRAs and other CM services.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					Molina uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach processes, such as face-to-face, telephonic, or mailings.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as Individuals with Disabilities						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy MHMS-HCS-CM-081, Continuity of Care and Access to Care for New and Existing Members, describes the process for providing continuity of care when a member leaves the health plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.	X					Molina's Health Management Program is Level I care management, which includes health promotion and disease management activities such as member education, coordination of medical transportation and scheduling medical appointments.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Molina's Transition of Care Program provides support, continuity, and coordination of care from one care setting to another to reduce avoidable readmissions. The HCS program Description states the purpose of the program is to "improve clinical outcomes, identify and address transition of care needs, and promote member self-determination and satisfaction, while reducing hospital readmissions and emergency department visits." Transition of care procedures are described in Policy HCS-CM-068.1, Molina Transitions of Care.
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Policy HCS-CM-068.1, Molina Transitions of Care and the HSC Program Description, describes Molina's process for monitoring new members and members transferring across settings, such as from Home, Hospital/Acute Care, Skilled Nursing, Rehabilitation, Inpatient Psychiatric Centers and Long Term Acute Care facilities.
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					The interdisciplinary transitional care team coordinates and manages required services to ensure continuity of care and prevent duplication of services as members return to their home or other community setting. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						team includes Care Managers, Social Workers, Behavioral Health staff, Pharmacy staff, and Medical Directors.
4. The CCO meets other Transition of Care Requirements.	X					
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The 2019 Health Care Services (HCS) Program Evaluation is a narrative summary of initiatives and activities conducted in 2019, used to identify opportunities for improvement and program effectiveness.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations were presented to the HCSC and the QIC for review. The evaluation was approved on June 10, 2020.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Molina has delegation agreements with: •Avesis - Dental and Hearing Benefit Administration Services •Caremark – Pharmacy Benefit Administration Services •MARCH - Vision and Eye Care Benefit Administration Services •Southeastrans – Non-Emergency Transportation Services •Medical Transportation Management – Non-Emergency Transportation Services Molina delegates credentialing and recredentialing to the following organizations: •Baptist Memorial Medical Center •George Regional Health System •Hattiesburg Memorial Medical Group •Magnolia Regional Health •Mississippi Physician Care Network •Memorial Hospital at Gulfport •North Mississippi Health Services •Ochsner Health System •Premier Health •University of Mississippi Medical Center

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				Per Policy DO001, Delegation Pre Assessment Audits, Molina ensures all potential delegates have a pre-assessment audit completed to determine the provider's ability to meet the requirements. Results of the pre-assessment audits are presented to the Delegation Oversight Committee for review and decision. Decisions of the committee are communicated to the delegate within five business days of the decision. Once the delegate is approved, Molina monitors the delegate's ongoing compliance at least annually, as outlined in Policy DO002, Performance Monitoring and Annual Audits of Delegation. Ongoing compliance will be ensured by monitoring of monthly and/or quarterly reports of delegated activities and annual audits. If corrective action is needed for identified deficiencies, Molina follows the process outlined in Policy DO003, Corrective Action and Termination of Delegation. Molina provided copies of the pre-delegation and/or the annual oversight monitoring and the quarterly monitoring for each delegated entity. Deficiencies and applicable corrective actions were noted in the monitoring reports. The monitoring tools used for the credentialing delegates did not include query of the SSDMF and the Mississippi sanctioned provider list. Molina staff indicated these requirements remain the responsibility of the health plan and are not required functions for the delegates. However, the criteria listed on page five of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy DO005, Credentialing Delegation Requirements, include Medicaid Sanctions from all published state Medicaid sanctions lists and the SSDMF. *Recommendation: The credentialing and recredentialing functions that remain the responsibility of the health plan should be reflected in the delegation policies.* The site assessments and reassessments specified in the *CHIP Contract, Section 7 (E)* and the fingerprinting requirements for high-risk providers, as required by the *CHIP Contract, Section 7 (E) (6),* were not included on the monitoring tools. *Corrective Action: Update the credentialing and recredentialing monitoring tools to include the site assessments, reassessments, and the fingerprinting requirements noted in the CHIP Contract Section 7 (E).*