CCME

2022 External Quality Review

MOLINA HEALTHCARE OF SOUTH CAROLINA

Submitted: May 5, 2022

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that 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 the results of the 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Molina Healthcare of South Carolina (Molina) since the 2021 Annual Review.

The goals and objectives of the review are to:

- Determine if Molina is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2021 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate that contracted health care services are being delivered and are of good quality.

The process CCME used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day virtual onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects, validation of performance measures, and validation of satisfaction surveys.

Summary and Overall Findings

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

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

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess Molina's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

Administration:

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

Molina has established policies and procedures as outlined in Policy and Procedure MHSC-AD-02, Annual Policy Renewal, indicating that policies and procedure are reviewed annually to reflect current regulatory, SCDHHS contractual, and accreditation requirements and practices. The Administrative and Policy (A&P) Committee and other governing unit committees work collaboratively to review and revise policies as needed.

A review of the Executive Organizational Chart and Organizational Chart Companion Matrix found that sufficient staffing is in place to ensure that health care products and services required by the State of South Carolina are provided to members.

The 2021 Compliance Plan describes Molina's integrated internal controls, interventions, and activities dedicated to compliance with state and federal laws, regulations, and contract requirements and summarizes the compliance activities. The Compliance Plan contains Molina's Code of Conduct and Ethics Code, which describes the expectation that business is conducted in accordance with applicable laws, rules, and contract requirements, as well as ethical business and professional practices.

The 2021 Compliance Committee Charter identifies the Compliance Committee as a senior management level entity overseeing the Molina Healthcare program and compliance with regulatory and contractual requirements. Training and education are tracked in the iLearn system and made available at the time of employment and annually.

The Compliance Plan describes processes for internal and external auditing and investigations. The Compliance Officer works with management for oversight and responses to instances of non-compliance. Avenues for reporting compliance violations and instances of suspected or actual fraud, waste, and abuse are available to staff, members, providers, and other stakeholders.

Policies and procedures indicate that Molina maintains the confidentiality of members' protected health information in accordance with state and federal laws and contractual requirements.

Management Information Systems: Molina's Information Systems Capabilities Assessment documentation provides an overview of the systems, processes, and polices that are in place to service the State's contract. The organization leverages industry standards to define security policies and procedures, and frequently performs self-audits to ensure those policies and procedures are adhered to. Finally, Molina performs actual disaster recovery testing (as opposed to tabletop testing), and the most recent test proved that systems could be recovered in accordance with the organization's objectives.

Provider Services:

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

Molina's Professional Review Committee, chaired by a Molina Medical Director, uses a peer-review process for credentialing determinations. Voting members of the committee include at least four network practitioners from a range of specialties. Credentialing and recredentialing processes are documented in policies and procedures, with addenda specifying state-specific requirements. A review of a sample of initial credentialing and recredentialing revealed only one finding related to verification of CLIA certification. When issues with provider performance or quality of care are noted, Molina may implement actions up to and including network termination.

Geographic access standards for primary care providers (PCPs), specialists, and hospitals are found in health plan policies and are compliant with contractual requirements. Molina uses appropriate parameters to determine geographic access and all required Status 1 providers are included. Molina conducts annual provider availability and after-hours telephonic surveys to evaluate appointment availability against established appointment access standards. Survey results are used to identify noncompliant providers and take action to re-educate and re-survey providers as applicable.

For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time when omitting 13 calls answered by personal or general voicemail messaging services. This represents a statistically significant decline from last year's rate of 63%. For calls not answered successfully, most were because the physician was no longer practicing at the location.

The Provider Directory Validation procedure (MHSC-PNA-01) lists elements that must be included in the Provider Directory but fails to include provider website addresses. Review of the print version of the Provider Directory showed it did not include practitioner

website addresses. Onsite discussion revealed Molina continues to collect provider website addresses and will include them in an upcoming version of the directory in 2022.

Initial provider orientation is conducted within 30 days of contract initiation, and ongoing provider education is conducted during monthly or quarterly provider visits, as needed, and upon request. Education and updates may also be provided through facsimiles, electronic communications, mailed provider newsletters, webinars, and the health plan website. Molina holds at least annual Provider Office Manager Meetings to provide education and updates to office staff/managers.

Appropriate processes are in place for selection, review, and initial and annual approval of preventive health guidelines and clinical practice guidelines. The adopted guidelines are based on scientific evidence and recommendations made by national clinical-based organizations and are appropriate to Molina's membership. Providers are informed of the guidelines through provider orientation materials, Provider Manuals, newsletters, mailings/faxes, Molina's website, etc. Paper copies are provided upon request.

Molina's standards for medical record documentation and the process for evaluating PCP compliance with the documentation standards are addressed in policies and procedures. Molina conducts annual medical record audits and has established processes for scores that fall below the 90% benchmark. Medical record audit results are reported to the Quality Improvement Committee Quality Improvement Committee and to SCDHHS annually.

Member Services:

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Members are informed of their rights and responsibilities in the Member Handbook, annual newsletters, and on the Molina website. New members are provided with enrollee information as outlined in Policy and Procedure MHSC-ME-01, New Medicaid Member Outreach and Education. A Welcome Packet that includes the member's ID card along with directions to access the Member Handbook and Provider Directory, and the Notice of Privacy Practices, is provided within 14 days of Molina receiving the member's enrollment data from SCDHHS.

The Member Handbook includes a benefit grid that lists and describes core benefits, covered services, extra benefits provided by Molina, co-payments, and any applicable limits or restrictions.

Member Services staff are available for member questions or assistance. Services that require prior authorization are listed in the Member Handbook. Molina notifies members within 15 days if a provider is terminated from the network. Processes for notifying members of changes in benefits are outlined in Procedure MHSC-ME-07, Changes in

Benefits. Molina will provide written notice 30 days before the expected change of benefits, when possible, in writing and on the Molina website.

Preventive health and wellness topics and care tip Information and materials is made available to members on the Molina website. The Communications Team adds new information to the website and member newsletters throughout the year. HEDIS text alerts are launched to members if they opt to receive information in electronic notification format.

Member Satisfaction Survey: Molina contracts with SPH Analytics, a certified CAHPS survey vendor to conduct both the child and adult surveys. The results have been presented to the QIC committee and Providers. The analysis and implementation of interventions to improve member satisfaction is conducted by QIC committee. Documentation regarding the committee meetings and analysis was submitted in the desk materials. The response rates were below the NCQA target of 40%. The Adult survey had 306 responses out of 1701 for a 18.1% response rate. This is an 1.9% decline from the 2020 response rate of 20%. For the Child survey, there were 476 responses out of 3,663 responses for a 13.1% response rate. This is a 1.4% decline from the 2020 response rate of 14.5%. For Child with CCC: There were 304 completed surveys out of 2409 for a response rate of 12.7%. This is a 2.1% decline from the 2020 response rate of 14.8%.

Grievances: Information about grievance processes is found in Policy MHSC-MRT-001, Grievance Disposition Process, the Member Handbook, Provider Manual, and on the Molina website. Grievances are defined clearly, and processes are provided for who can and how to file a grievance. Members are informed that an authorized representative may file or assist them with filing a grievance. Member grievances are reviewed by the Quality Improvement Committee to identify trends and opportunities for improvement. Molina tracks and monitors member grievance data quarterly. Of the grievance files reviewed, no issues were identified.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

The 2021 Medicaid Quality Improvement Program Description were submitted. The QI Program Description clearly outlines the programs goals and objectives. Specific activities are identified to support the achievement of the program's goals.

Molina's Provider Manual and website includes details regarding their Quality Management program and a copy of the QI program is available upon request. In the QI work plan, 2021 and 2022, Molina included an objective to include information about the QI Program and/or Progress Reports on the website and in the Member Handbook. However, there was no information found in the Member Handbook regarding the QI

program. During the onsite, staff explained information regarding the QI Program is provided to members in a newsletter.

Molina develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. Molina presented the 2020 and 2021 QI Work Plans for review. Under Section 6.0, Accessibility of Services: Primary Care and Member Services, the goals were missing for the Appointment Access Audit. Molina agreed the goals for this activity was missing and updated the workplan after the onsite.

The Quality Improvement Committee (QIC) is responsible for oversight of the QI program and the implementation, coordination, and integration of all QI activities. The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. Network practitioner participants include physicians specializing in pediatrics, OB/GYN, Family Medicine, and Cardiology.

Providers are advised that Molina requires their participation and compliance with the QI Program. Molina offers network providers reports of their QI performance data and feedback. Molina provided two examples of the quality reports generated for providers. However, there was no documentation found regarding the process for how often these reports are generated and shared with providers. There was also no information found to inform network providers of the availability of these reports.

Molina evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors and the Quality Improvement Committee. The Quality Improvement Program 2020 Medicaid Annual Evaluation was provided. The program evaluation included the Executive Summary and several appendices. Activities related to the availability of practitioners (section 5.0 of the work plan), the continuity and coordination of care (section 9.0 and 10 of the work plan), and the provider directory analysis (section 11 of the work plan) were not included.

The section in the Executive Summary regarding the focus for upcoming year incorrectly included the focus for 2022 instead of 2021. These errors and omissions were discussed during the onsite. Molina indicated those activities omitted from the program evaluation were conducted and provided copies of some of the reports after the onsite. However, these activities were not considered when the 2020 QI Program Evaluation was conducted.

Performance Measure Validation: CCME conducted a validation review of the HEDIS measures following CMS protocol (Protocol 2, Validation of Performance Measures). This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Molina was fully compliant with all HEDIS measures and met the requirements per 42 CFR §438.330 (c) and §457.1240 (b). All relevant HEDIS performance measures for the current review year

(Measure Year 2020), as well as the previous year (Measure Year 2019) and the change from 2019 to 2020 are reported in the Quality Improvement section of this report.

The comparison from the previous year to the current year revealed a substantial improvement (>10%) for Persistence of Beta-Blocker Treatment After a Heart Attack, which was 12.85%. Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%: 21-75 Years (Male) improved by 15.49%, Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%: 40-75 Years (Female) improved by 11.91%, Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%: Total improved by 13.77%, Statin Therapy for Patients With Diabetes Statin Adherence 80% improved by 11.27%. The measures with substantial decreases were Controlling High Blood Pressure, which declined by 10.22%, and Follow-Up After High-Intensity Care for Substance Use Disorder which declined as follows: the 18-64 had a 10% decline in 30 day follow up and a 14% decline in 7-day follow up. Table 1 highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Substantial Increase in Rate (>10% improvement)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	64.29%	77.14%	12.85%
Statin Therapy for Patients With Cardiovascular Disease (spc)Statin Adherence 80%: 21-75 Years (Male)	47.31%	62.8%	15.49%
Statin Therapy for Patients With Cardiovascular Disease (spc)Statin Adherence 80%: 40-75 Years (Female)	48.59%	60.5%	11.91%
Statin Therapy for Patients With Cardiovascular Disease (spc)Statin Adherence 80%: Total	47.90%	61.67%	13.77%
Statin Therapy for Patients With Diabetes (spd) Statin Adherence 80%	47.06%	58.33%	11.27%
Substantial Decrease in Rate (>10% decrease)			
Controlling High Blood Pressure (cbp)	57.18%	46.96%	-10.22%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
18-64 years - 30-Day Follow-Up	53.81%	43.62%	-10.19%
18-64 years - 7-Day Follow-Up	43.65%	29.79%	-13.86%
Total - 30-Day Follow-Up	53.43%	42.86%	-10.57%
Total - 7-Day Follow-Up	43.14%	29.06%	-14.08%

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. For this EQR, Molina implemented two new PIPs (Improving Encounters Acceptance Rates and Immunizations for Adolescents) and modified the Child and Adolescent Well-Care Visits Program PIP with a new indicator and baseline data. The PIPs met the validation requirements and were scored within the "High Confidence Range." A summary of each PIP's status and the interventions are included in the tables that follow.

Table 2: Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates (Non Clinical)	
The focus for this PIP is to improve the encounter acceptance rates for professional (837P) encounters. This PIP has two indicators. The initial acceptance rate was 97.5% at baseline and declined to 96.9% at year 1 with a goal of 100%. For the 837P taxonomy rejection rate, the baseline was 2.63% and increased to 2.82%. The target goal for this indicator was set at 2%. Both indicators did not show improvement.	
Previous Validation Score	Current Validation Score
Not Submitted	73/74=99% High Confidence in Reported Results
Interventions	
The interventions included a provider crosswalk, review of QNXT claims setup, logic checks, review of rejected encounters, and logic adjustment focusing on billing NPI.	

Table 3: Child and Adolescent Well-Care Visits Program PIP

Child and Adolescent Well-Care Visits Program (Clinical)	
Molina Healthcare of South Carolina (MHSC) is implementing the Child and Adolescent Well-Care Visits Program to offer eligible Members and Providers incentives for Members receiving a Well-Visit or Comprehensive Well-Visit (for Ages 3 to 21). The baseline measurement rate for this PIP was 43.16%. using the administrative data. The interventions included member and provider education and outreach, incentive programs, and transportation assistance.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	72/72=100% High Confidence in Reported Results
Interventions	

Child and Adolescent Well-Care Visits Program (Clinical)
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for Member Transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate Provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was Developed and Placed on the Provider Portal. • Calendar Year 2021 Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.

Table 4: Immunizations for Adolescents Program PIP

Immunizations for Adolescents Program (Clinical)	
Molina chose this PIP to target rural and urban areas across South Carolina to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV related cancers. The baseline rate for this PIP was reported as 27.98%.	
Previous Validation Score	**Current Validation Score**
Not Submitted	72/72=100% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for Member Transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate Provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was Developed and Placed on the Provider Portal. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members.	

Utilization Management:

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

Molina's Utilization Management (UM) Program is incorporated within the Healthcare Services Department. The responsibilities for oversight are delegated to the South Carolina Quality Improvement Committee, of which the Health Care Services Committee is a subcommittee. Molina has developed a program description and policies and procedures to guide staff in conducting UM functions and activities. Inconsistencies were noted in policies regarding the criteria used for medical necessity determinations, and the IRR methodology described in the UM Program Evaluation was not consistent with the methodology in the IRR policy and procedures reviewed. Onsite discussion and additional

documentation submitted revealed that a different process is used for IRR in South Carolina.

File review reflected prompt notifications to members and providers of decisions to deny requested services. For one file for which the requested service was a non-covered benefit, the standard Adverse Benefit Determination Notice template stated, "You will have to meet all of the set rules before this can be approved." The notice further stated, "you or your doctor may ask for a copy of the criteria used for this review decision." This standard language did not appear appropriate in this case.

Molina provides coverage for medications through their Pharmacy Benefit Manager. The Pharmacy and Therapeutics (P&T) Committee is responsible for the development and updating of the preferred drug list (PDL), including restrictions, limitations, and prior authorization criteria. Processes are in place to consider exceptions to the PDL. Information about the PDL and any PDL changes is found on Molina's website; however, the PDL change document found on the website did not indicate when changes were approved by the P&T Committee or when they were published on the website, as required by the *SCDHHS Contract, Section 4.2.21.2.1 and 4.2.21.3*.

Molina's Star Provider Program allows practitioners who meet specific indicators to be eligible for increased member assignment and reduction and simplification of the prior authorization process.

Appeals: Policies and procedures define how Molina handles requests for appeals. Appeal information is provided in the Member Handbook, Provider Manual, and on the website. The website also includes forms for members and providers to file the appeal. Incorrect information that a standard appeal request received verbally must be followed up with a written request within 30 days was noted in multiple documents and on Molina's website.

A sample of appeal files was reviewed and revealed instances of untimely determinations and appeal decisions made by reviewers not of the same or similar specialty as the ordering physician. According to staff, physicians reviewing appeal requests are directed to use criteria and matching specialty was not necessary. Molina was cautioned regarding allowing physician reviewers to only utilize criteria when making medical necessity decisions on appeals.

The Molina Healthcare of South Carolina, Inc. Healthcare Services (HCS) Program Description and related policies and procedures guide staff conducting CM and TOC activities. Onsite discussion revealed quick reference guides supplement the information in policies and procedures. No issues or concerns were identified in the sample of CM files reviewed.

Molina conducts data monitoring and analysis to detect and correct patterns of actual or potential under- or over-utilization. Topics included in the monitoring include emergency room utilization, medical/surgical admissions, behavioral health admissions, and readmissions. Quarterly Health Care Services Committee meeting minutes reflected the data were analyzed and recommendations were offered based on the findings.

Delegation:

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

Policies and procedures define processes and requirements for delegation of health plan activities to external entities, including pre-delegation assessment, annual oversight and ongoing monitoring, sub-delegation, and delegation termination. Delegation agreements are implemented upon approval of delegation and define delegation terminology, activities to be delegated, general terms and conditions for delegation, and include information about actions that may result from non-performance or non-compliance with the delegation agreement. Delegates are also informed about reporting requirements and ongoing and annual monitoring activities.

Documentation of pre-delegation assessment and annual oversight was submitted for review. The documentation confirmed annual oversight is conducted for each delegate. Also, the documentation indicated Molina initiates corrective action when warranted and conducts appropriate follow-up of the corrective action. It was noted that one delegate was terminated due to non-compliance with delegated credentialing requirements. Onsite discussion revealed two additional delegation agreements were terminated for delegates whose services were no longer needed.

State Mandated Services:

42 CFR § Part 441, Subpart B

Molina has adopted the American Academy of Pediatrics (AAP) Children and Adolescents Preventive Health Guidelines and conducts monitoring to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including immunizations, are timely. The Quality Improvement Department tracks members that are non-compliant for EPSDT services/Well Care and required immunizations by monitoring HEDIS® data sets. Members are notified of services for which they are eligible, and staff make attempts to follow up with non-compliant members until identified gaps in care are closed. Quality Reports are run monthly and as needed and distributed to providers. The reports include detailed information about ER utilization and member-specific gaps in care.

The 2022 EQR confirms Molina provides all contractually required core benefits.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were three standards scored as "Partially Met" and one standard scored as "Not Met." Following the 2021 EQR, Molina submitted a Quality Improvement Plan to address the deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on July 1, 2021. The following is a high-level summary of those deficiencies:

- The *SCDHHS Contract, Section 3.13.5.1.1,* and *42 CFR §438.10 (h) (vii)* define elements that must be included in Provider Directories. The following required elements were not noted in Molina's Provider Directory:
  - Provider website addresses
  - Whether the provider can accommodate physical disabilities
- The information for specialty appointments in Procedure MHSC-PS-005, Provider Availability Standards, does not include standards for emergent visits or urgent medical condition care appointments. Also, the policy defines the timeframe for routine care (non-symptomatic) specialty appointments as "within 12 weeks." This timeframe is also noted in the Provider Manual, page 71.
- For the Provider Access Study conducted by CCME, Molina was noted to have a statistically significant decrease in the number of successfully answered calls.
- Documentation issues in the Correlation Between Member Assignment and Engagement PIP caused a lower validation score.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plans for all items were implemented.

Conclusions

Overall, Molina met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Molina's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Standards	Category	Total Number of Standards	Number of Standards Scored as "Met"	2022 Overall Score
Provider Services, Section II. B. Adequacy of the Provider Network	• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	8	7	87.5%
Utilization Management, Section V. D. – Care Management	• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	8	8	100%
Utilization Management, Section V. B. – Medical Necessity Determinations	• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	14	13	92.8%
Provider Services, Section II. A. – Credentialing and Recredentialing	• Provider Selection *(§ 438.214, § 457.1233)*	39	39	100%
Administration, Section I. E. - Confidentiality	• Confidentiality *(§ 438.224)*	1	1	100%
Member Services, Section III. G. – Grievances Utilization Management, Section V. C. - Appeals	• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	20	18	90%
Delegation Section	• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	2	2	100%
Provider Services, Section II. D. – Primary and Secondary Preventive Health Guidelines Provider Services, Section II. E. – Clinical Practice Guidelines for Disease and Chronic Illness Management	• Practice Guidelines *(§ 438.236, § 457.1233)*	11	11	100%

Standards	Category	Total Number of Standards	Number of Standards Scored as "Met"	2022 Overall Score
Administration, Section I. C. – Management Information Systems	• Health Information Systems *(§ 438.242, § 457.1233)*	7	7	100%
Quality Improvement Section	• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	14	13	92.8%

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

As noted in the table above:

- For Availability of Services and Assurances of Adequate Capacity and Services, one of eight standards was scored as "Not Met" due to a decrease from the previous study's results in the percentage of successful contacts in the Telephonic Provider Access Study conducted by CCME.
- For Coverage and Authorization of Services, one of 14 standards was scored as "Partially Met" related to information published on the website regarding negative PDL changes.
- For Grievance and Appeal Systems, two standards were scored as "Partially Met" due to documentation of the procedure for filing an appeal, untimely resolutions, and the physicians who made some of the appeal decisions were not of the same or similar specialty as the ordering physician.
- For the Quality Assessment and Performance Improvement Program, one standard was scored as "Partially Met" related to failure to address all QI activities when conducting an evaluation of the QI Program.

Table 6: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review. For 2022, 207 out of 214 standards received a score of "Met." There were four standards scored as "Partially Met" and one standard that received a "Not Met" score.

Table 6: Scoring Overview

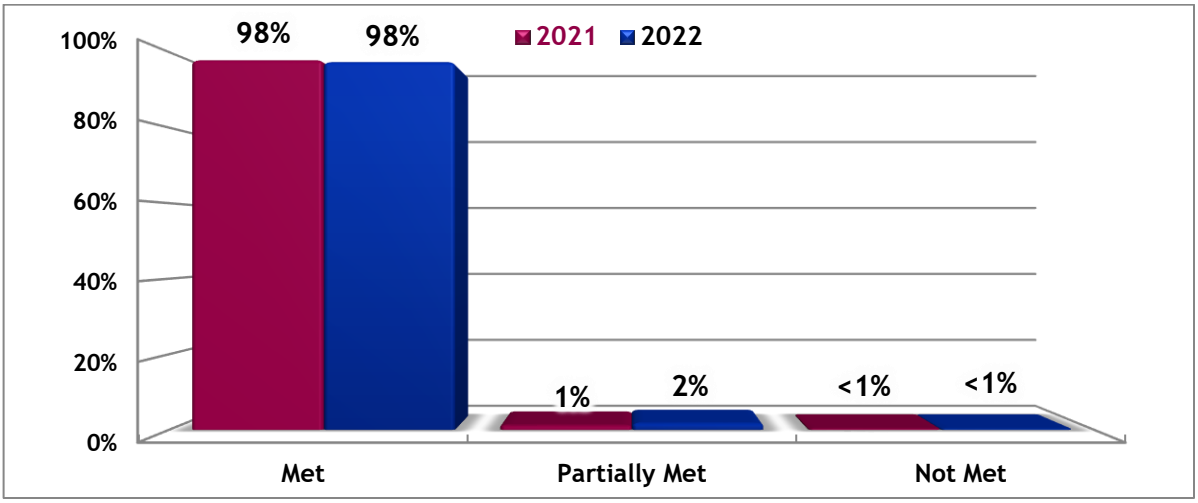
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	40	0	0	0	0	40	100%
2022	40	0	0	0	0	40	100%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Provider Services							
2021	73	2	1	0	0	76	96%
2022	75	0	1	0	0	76	99%
Member Services							
2021	33	0	0	0	0	33	100%
2022	31	0	0	0	0	31	100%
Quality Improvement							
2021	13	1	0	0	0	14	93%
2022	13	1	0	0	0	14	93%
Utilization							
2021	45	0	0	0	0	45	100%
2022	43	2	0	0	0	45	93%
Delegation							
2021	2	0	0	0	0	2	100%
2022	2	0	0	0	0	2	100%
State Mandated Services							
2021	4	0	0	0	0	4	100%
2022	4	0	0	0	0	4	100%
Totals							
2021	**210**	**3**	**1**	**0**	**0**	**214**	**98%**
2022	**207**	**4**	**1**	**0**	**0**	**212**	**98%**

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

The 2022 Annual EQR shows that Molina achieved "Met" scores for 98% 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." The chart that follows provides a comparison of the current review results to the 2021 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 7: Evaluation of Quality

Strengths Related to Quality
• The electronic FWA reporting form on Molina's website is very user friendly and provides an option for follow-up to ensure quality of care and service provision. • Molina has policies and procedures and an Administrative and Policy Committee to track and maintain the development and ongoing review of policies and procedures. • Documentation was provided specific to the management of information systems that demonstrates frequent review and revisions. • Molina works to ensure quality of care by promoting resources specific to Preventive Health and Chronic Disease Management Education and the collaborative efforts on behalf of member education. • Policies and procedures are in place including the Member Handbook, Provider Manual, and website that clearly outline member rights and responsibilities. • Credentialing processes and requirements are well-documented in policies and procedures, and with one exception, credentialing and recredentialing files were thorough and included all required elements. • The Professional Review Committee (PRC) uses a peer-review process to make credentialing decisions. Membership includes an array of network providers, and the PRC reports to the Quality Improvement Committee. • Provider education processes are adequate, and the Provider Manual and plan website include resources for providers regarding health plan operations and requirements, clinical practice and preventive health guidelines, cultural competency, etc.

Strengths Related to Quality
• Medical record audit results are reported to the QIC and to SCDHHS annually. Results for Calendar Year 2020 were reported to the QIC in June 2021. Scores ranged from a low of 90.43% to high of 99.31% and no providers required re-audit. • The performance improvement projects met the validation requirements and received scores within the "High Confidence Range." • The Persistence of Beta-Blocker Treatment After a Heart Attack and the Statin Therapy for Patients with Cardiovascular Disease and for Patients with Diabetes rates showed an improvement in the rates. • Molina has several network providers that actively participate on their Quality Improvement Committee. • UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination. • Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-rater Reliability testing. • In addition to Care Management Programs, separate programs, such as the Sickle Cell Disease Program, for members with special, specific needs are in place. • Policies and procedures appropriately document processes and requirements for delegation of health plan activities to external entities. • Delegation agreements define terminology and include activities to be delegated, general terms and conditions for delegation, and information about actions that may result from non-performance or non-compliance with the delegation agreement. • Documentation of pre-delegation assessment and annual oversight confirmed annual oversight is conducted for each delegate, Molina initiates corrective action when warranted, and conducts appropriate follow-up of any corrective action. • Molina monitors member and provider compliance with EPSDT services and immunizations recommended by the Academy of Pediatrics Children and Adolescents Preventive Health Guidelines. Steps are taken to notify both members and providers of gaps in care. • All contractually required core benefits are covered. Molina also covers additional benefits outside of the required core benefits for members, such as non-ambulance transportation, limited dental services for adult members, and adult vision services.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• One initial credentialing file for an ambulatory surgery center was missing verification of the CLIA certificate. It was noted that the provider did not complete the Health Delivery Organization (HDO) Application section labeled "Additional Location Credentials."	• Recommendation: If the credentialing application is incomplete regarding laboratory services and/or CLIA certification, reach out to the provider and/or conduct independent verification of CLIA certification status.
• Procedure MHSC-PNA-01, Provider Directory Validation lists elements that must be included in the Provider Directory but fails to include provider website addresses.	• Recommendation: Revise Procedure MHSC-PNA-01, Provider Directory Validation, to include provider website addresses as a required element in the "Pertinent Demographic Attributes" section.
• The process for initial provider orientation is found in Procedure MHSC-PS-010; however, the procedure and its associated policy do not specify the timeframe within which the initial orientation is conducted. Onsite discussion revealed it is conducted within 30 days.	• Recommendation: Revise the Provider and Practitioner Education policy or procedure (MHSC-PS-010) to include the timeframe within which initial provider orientation is conducted.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• The "Assessing for Standards of Medical Record Documentation" procedure describes the process for annual assessment of provider compliance with medical record documentation standards. The procedure does not define the timeframe for conducting a re-audit when a provider does not pass the initial audit and over-read.	• Recommendation: Revise the procedure titled, "Assessing for Standards of Medical Record Documentation" to include the timeframe for re-audits for providers who do not successfully pass the initial audit and over-read.
• Follow-Up After High-Intensity Care for Substance Use Disorder and Controlling High Blood Pressure showed a decline in the reported rates.	• Recommendation: Evaluate the cause for the decline in the Follow-Up After High-Intensity Care for Substance Use Disorder and Controlling High Blood Pressure rates and implement interventions to improve those rates.
• Molina offers network providers reports of their QI performance data and feedback. There was no documentation found regarding the process for how often the quality reports are generated and shared with providers. There was also no information found to inform network providers of the availability of these reports.	• Recommendation: Include in a policy, program description and in the Provider Manual information regarding the process followed for sharing provider performance data and feedback.
• The QI Program Evaluation did not include the analysis, results and interventions for the availability of practitioners, the continuity and coordination of care, and the provider directory analysis.	• Quality Improvement Plan: When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.
• Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, indicates Molina utilizes InterQual. During the onsite discussion, staff indicated MCG criteria is currently being used for medical necessity determinations.	• Recommendation: Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making and remove the reference to InterQual Criteria.
• In one denial file, it was noted the denial was issued for a non-covered service. The standard language in the Adverse Benefit Notification template did not appear appropriate in this case.	• Recommendation: Develop an Adverse Benefit Determination Notice template for denials issued for non-covered services.
• A sample of appeal files were reviewed found three files that were untimely and the physician who made the appeal decision in four files was not of the same or similar specialty as the ordering physician.	• Quality Improvement Plan: For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate the physician reviewers regarding only utilizing review criteria and not considering individual medical conditions when making appeal determinations.

Table 8: Evaluation of Timeliness

Strengths Related to Timeliness
• Molina has clear procedures in place to reflect the consistent and timely policy review cycles annually.
• Molina provides a timely, comprehensive training and curriculum for her employees and annually thereafter with a strong agenda addressing issues of compliance.

Strengths Related to Timeliness
• Training on staff security policy is conducted timely to increase security awareness for updated information. • Utilization management decisions were timely, and members were notified of these decisions appropriately.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
• There was no documentation to indicate when the negative PDL changes were published on Molina's website as required by the *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3*.	• Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Molina's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3*.
• Molina's process for filing an appeal incorrectly indicates a standard request for an appeal received verbally must be followed up with a written request within 30 days.	• Quality Improvement Plan: Revise all documents related to the process for filing an appeal and remove the requirement that indicates a standard request for an appeal received verbally must be followed up with a written request.

Table 9: Evaluation of Access to Care

Strengths Related to Access to Care
• Molina has a solid disaster recovery program that accomplishes the objectives that it is designed to do. • Molina routinely monitors and evaluates the adequacy of its provider network and takes action to address any identified gaps. • Molina works to ensure quality of care by promoting resources specific to Preventive Health and Chronic Disease Management Education and the collaborative efforts on behalf of member education.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• The print version of the Molina Provider Directory did not include practitioner website addresses. Staff reported Molina is currently collecting website addresses from applicable providers and will produce an updated print version Provider Directory in 2022.	• Recommendation: To comply with requirements in *42 CFR §438.10(h)(1)* and the *SCDHHS Contract, Section 3.13.5.1.1*, include practitioner website addresses in the print version of the Provider Directory.
• For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time, a statistically significant decline from last year's rate of 63%. For calls not answered successfully (n= 54 out of 105 calls), the majority (n = 40, 74%) were because the physician was no longer practicing at the location.	• Quality Improvement Plan: Provide documentation of specific processes in development or recently initiated to improve accuracy of provider contact information and status/location.

METHODOLOGY

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

On February 14, 2022, CCME sent notification to Molina that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Molina to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on February 28, 2022 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on April 6th and 7th. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Molina's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between Molina and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

Policy and Procedure MHSC-AD-02, Annual Policy Renewal, indicates that policies and procedure are reviewed annually to reflect current regulatory, SCDHHS contractual, and accreditation requirements and practices. The Administrative and Policy (A&P) Committee and other governing unit committees work collaboratively to review and

revise policies as needed. A supplementary procedural document accompanies the policy and outlines specific steps taken and workflows between departments to track and accomplish initial and ongoing policy review.

The Executive Organizational Chart and Organizational Chart Companion Matrix indicate sufficient staffing is in place to ensure health care products and services required by the State of South Carolina are provided to members. Onsite discussion addressed changes in the Organizational Chart since the date of submission to CCME, vacant positions, and the process for filling positions identified as currently backfilled.

The 2021 Compliance Plan describes Molina's integrated internal controls, interventions, and activities dedicated to compliance with state and federal laws, regulations, and contract requirements and summarizes the compliance activities.

The 2021 Compliance Committee Charter identifies the Compliance Committee as a senior management level entity overseeing the Molina Healthcare program and compliance with regulatory and contractual requirements. Training materials were provided for review on topics including the Health Insurance Portability and Accountability Act, fraud, waste and abuse (FWA), Advanced Directives, etc. Compliance training is conducted at the time of new hire and annually, thereafter. Electronic reports are maintained for employee training completed via the iLearn system to track compliance with Molina's training requirements.

Molina employees and associates, members, and providers are provided with clear lines of reporting for compliance violations and instances of suspected or actual fraud, waste, and abuse. These include the AlertLine, Molina's website, fax, and email options. For instances of non-compliance or fraud, waste, and abuse, the Compliance Officer works with Molina's management personnel to oversee and provide input for responses to offences.

Molina's approach to confidentiality is outlined in Policy MHSC HP-03, Privacy and Confidentiality Of PHI, indicating that privacy and confidentiality of member protected health information is in accordance with state and federal laws and contractual requirements.

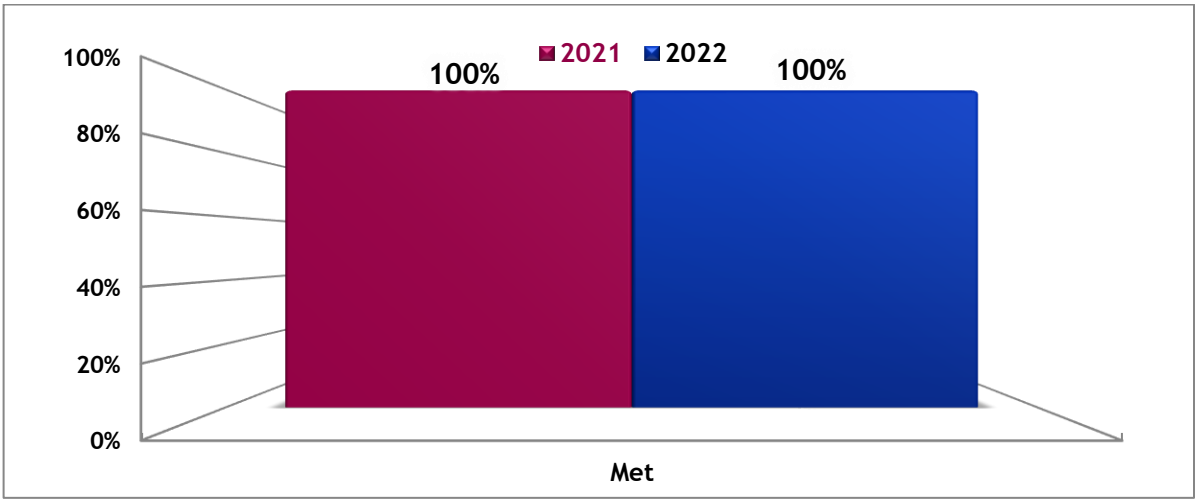
Management Information Systems

Molina's Information Systems Capabilities Assessment (ISCA) documentation provides an overview of the systems, processes, and polices that are in place to service the State's contract. The organization leverages industry standards to define security policies and procedures, and frequently performs self-audits to ensure adherence to those policies and procedures. Finally, Molina performs actual disaster recovery testing (as opposed

tabletop testing), and the most recent test proved that systems could be recovered in accordance with the organization's objectives.

All Administration standards were scored as "Met" for the Molina 2022 EQR.

Figure 2: Administration Findings



Strengths

- Molina has policies and procedures and an Administrative and Policy Committee to track and maintain the development and ongoing review of policies and procedures.
- Molina provides timely, comprehensive training with a strong agenda regarding compliance for new employees and annually for all employees .
- The electronic FWA reporting form on Molina's website is user friendly and provides an option for follow-up to improve needs, including access to care.
- Documentation regarding the management of information systems demonstrated frequent review and revisions.
- Training on the staff security policy is conducted periodically to increase security awareness for updated information.
- Molina has a solid disaster recovery program that accomplishes the objectives that it is designed to do.

B. Provider Services

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

The review of Provider Services encompasses credentialing and recredentialing processes and files, adequacy of the provider network, provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical records.

Provider Credentialing and Selection

Molina's Professional Review Committee (PRC) reports to the Quality Improvement Committee and uses a peer-review process to make credentialing determinations. Documentation specifies the frequency of and quorum for PRC meetings. A Molina Medical Director chairs the PRC and voting members of the committee must be actively practicing practitioners who are credentialed into Molina's provider network. Members of the PRC include at least four network practitioners from a range of specialties.

Processes and requirements for credentialing and recredentialing of practitioners and organizational providers are documented in policies and procedures, with addenda specifying state-specific requirements. A review of a sample of initial credentialing and recredentialing files reflected that, overall, staff follow the established processes and requirements. One initial credentialing file for an ambulatory surgery center was missing verification of the Clinical Laboratory Improvement Amendments (CLIA) certificate.

When issues with provider performance or quality of care are identified, Molina may implement actions including placing a provider on a "Watch Status," requiring formal corrective action, placing the provider on summary suspension, and/or terminating a provider from network participation. These processes are detailed in Procedure MHSC QI 500.000, Potential Quality of Care Issues, and Procedure CR01, Credentialing and Recredentialing Practitioners.

Availability of Services

Health plan policies document geographic access standards for primary care providers (PCPs), specialists, and hospitals. The documented standards are compliant with contractual requirements, and Geo Access reports reviewed by CCME confirm appropriate parameters are used to determine geographic access. All required Status 1 provider types are included in the geographic access measurements.

In addition to ensuring geographic adequacy of the provider network, Molina has implemented a Culturally and Linguistically Appropriate Services (CLAS) Program and conducts various activities to ensure the provider network is capable of meeting special sensory, language, and cultural needs of the membership population. These activities include, but are not limited to, analyzing membership and network practitioner race, ethnicity, and language data annually, providing translation and language services, ensuring member materials to meet the cultural, linguistic, and other special needs of the membership, and educating staff and network providers about cultural competency.

The CLAS Program is routinely evaluated for effectiveness and opportunities for improvement. The Molina website's "Culturally and Linguistically Appropriate Resources / Disability Resources" page includes a variety of tools and resources to assist providers in the provision of culturally competent care and services.

Procedure MHSC-PNA-01, Provider Directory Validation, lists elements that must be included in the Provider Directory but fails to include provider website addresses. The print version of the Provider Directory did not include practitioner website addresses. Molina explained that provider website addresses continue to be collected and will be included in an upcoming version of the printed Provider Directory in 2022. CCME reminded Molina of the requirement to include practitioner website addresses in the Provider Directory. See *42 CFR §438.10(h)(1)* and the *SCDHHS Contract, Section 3.13.5.1.1.* The print version of the Provider Directory contains a notation in the footer that indicates any provider site that is not compliant with the Americans with Disabilities Act (ADA) is notated with an asterisk. No practitioner entries in the printed Provider Directory contained this indicator. Staff reported that providers are educated about their responsibility to notify Molina if their practice location is not ADA compliant through the Provider Manual, newsletters, the Molina website, and e-blasts.

As noted in *Table 10: Previous Adequacy of the Provider Network QIP Items*, Molina has made progress toward remedying findings from the previous EQR. Provider website addresses and compliance with ADA requirements are found in the online provider directory, and the health plan has updated its printed Provider Directory to include a notation that providers are ADA compliant unless indicated. The plan anticipates publishing a revised Provider Directory (printed version) including website addresses in 2022.

Table 10: Previous Provider Directory QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	The *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR §438.10 (h) (vii)* define elements that must be included in Provider Directories. CCME's review of the hard copy Provider Directory and the online Provider Directory (via the "Find A Provider" function of Molina's website) revealed most required elements are included. However, the following required elements were not noted: •Provider website addresses. •Whether the provider has completed cultural competency training. •Whether providers can accommodate physical disabilities.

Standard	EQR Comments
	Quality Improvement Plan: Revise the Provider Directory to include all elements required by the SCDHHS Contract, Section 3.13.5.1.1 and 42 CFR §438.10 (h) (vii).
Molina Response: Molina respectfully submits that we met the intent of the contract requirements by including this information in the footer of the directory. However, as requested by SCDHHS, we can and will add an icon in the directory related to providers that can accommodate physical disabilities and add website addresses for providers who provide to us. Since the cultural competency requirement has been discontinued for the 2021 version of the contract (related to inclusion in the directory), it is agreed that we will not retroactively adjust the directory and that no further remediation is required for this item.	

Policy MHSC-PS-005, Provider Availability Standards, outline Molina's methods to measure the availability of primary care, urgent care, and emergency care services. Appointment access standards documented in the policy are compliant with contractual requirements. As noted in the associated procedure, Molina conducts annual provider availability and after-hours telephonic surveys to evaluate appointment availability for routine and urgent visits and average wait time. Survey results are evaluated to identify noncompliant providers. An action plan is developed for provider education and can include educational outreach and regional trainings, and re-survey within 3-6 months. Molina corrected a deficiency identified in Procedure MHSC-PS-005 during the previous EQR. See *Table 11* for the previous finding and Molina's response to the finding.

Table 11: Previous Appointment Access QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Procedure MHSC-PS-005, Provider Availability Standards, defines standards for appointment access for PCPs and specialists. However, standards for specialty emergent visits and urgent medical condition care appointments are not included. The timeframe for routine care (non-symptomatic) specialty appointments is defined as "within 12 weeks." This timeframe is also noted in the Provider Manual, page 71. The *SCDHHS Contract, Section 6.2.3.1.5.3* defines the standard as within 4 weeks and a maximum of 12 weeks for unique specialists. *Quality Improvement Plan: Revise Procedure MHSC-PS-005, Provider Availability Standards, to include all contractually required specialty appointment standards. Refer to the SCDHHS Contract, Sections 6.2.3.1.5.1 through 6.2.3.1.5.3.*

Standard	EQR Comments
Molina Response: MHSC-PS-005_Provider Availability Standards has been redlined with the necessary updates, see submission. The policy will be taken to our policy committee for approval in August.	

Provider Access and Availability Study

42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

As part of the annual EQR process for Molina, a provider access study focusing on primary care providers was conducted by CCME. Molina provided CCME with a list of 2,316 current providers, and from that list a random sample of 118 PCPs was selected for the provider access study. Attempts were made to contact the sample of providers to ask a series of questions regarding the access that members have with the contracted providers.

For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time (51 out of 105) when omitting 13 calls answered by personal or general voicemail messaging services. This represents a statistically-significant decline from last year's rate of 63%. When compared to last year's results of 63%, this year had a decrease in successful calls at 43%, (p=.021).

Table 12 displays the success rate for the previous and current review years.

Table 12: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2021 Review	180	63%	.021
2022 Review	118	43%	

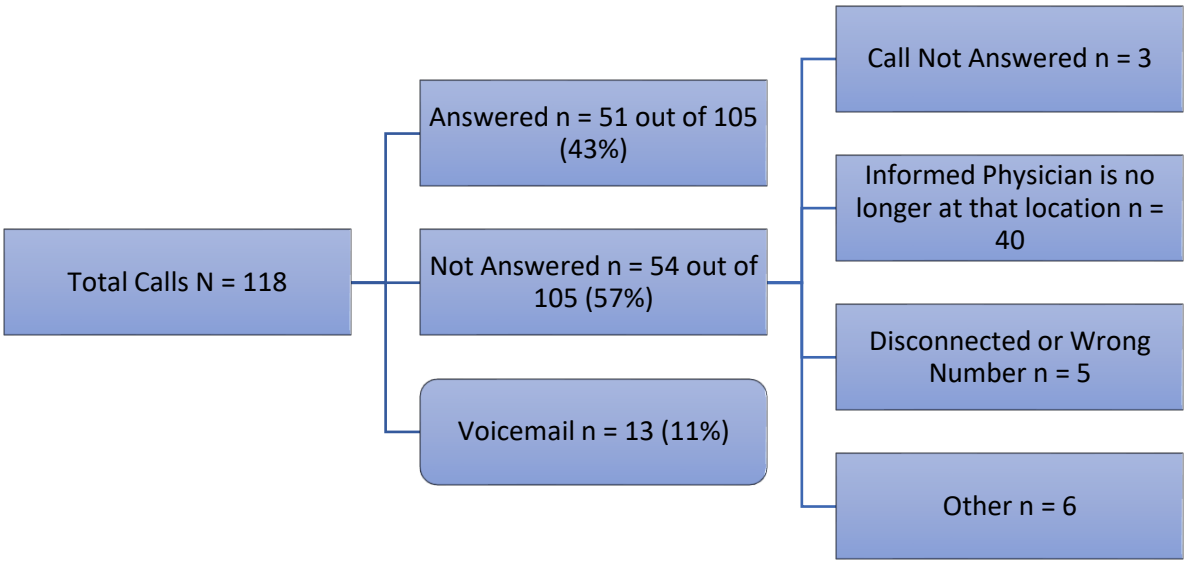
A total of 118 calls were completed and 13 were answered by voicemail. The voicemail calls were omitted from the success rate, making the denominator 105. For those not answered successfully (n= 54 out of 105 calls), the majority (n = 40, 74%) were because the physician was no longer practicing at that location.

There were 51 out of 105 calls that were actively practicing at the called location and considered successful (43%). Of the 51 providers, 42 (82%) indicated that they accept Molina. Of the 42 that accept Molina, 29 (69%) were accepting new patients. The 29 providers that were accepting new patients were asked if a screening process was in place for new patients. 22 (76%) did not require a prescreening and seven (24%) did require a prescreening. Of those seven, six (86%) indicated that an application must be

filled out and one (14%) required a medical record review. 22 out of 29 providers (76%) had appointment availability within contract requirements for a new patient routine appointment.

Figure 3: Telephonic Provider Access Study Results provides an overview of the findings of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



As noted in *Table 13: Previous Provider Access and Availability Study QIP Items*, Molina also had a decline in the rate of successfully answered calls for the previous EQR. Specific information regarding last year's findings and Molina's response are included in the table.

Table 13: Previous Provider Access and Availability Study QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	Molina submitted a Provider File containing a population of 2,459 unique providers, from which a random sample of 180 PCPs was selected for the provider access study conducted by CCME. For the telephonic Provider Access Study conducted by CCME, attempts were made to contact sample of providers to ask a series of questions regarding the access that members have with the providers. Calls were successfully answered 63% of the time (103 of 164) when omitting 16 calls answered by personal or

Standard	EQR Comments
	general voicemail messaging services. This is a statistically-significant decline from last year's rate of 74%. *Quality Improvement Plan: Provide documentation of specific methods and action steps to improve accuracy of provider contact information and status/location. Determine if additional applications need to be involved to maintain accurate files for provider location, number, and active status.*
Molina Response: Molina is aware of the need for accurate and correct contact information for each provider in our network directory. We make every attempt to maintain current information for the benefit of our members. Several of the "fails" that you listed are included under a delegated agreement with Prisma Health. Upon receipt of the list of providers contacted by CCME, we did a follow-up survey of those who were listed as "failed" and found that these providers were included in the rosters for January 2021 and April 2021 with the same address and phone number as provided in our listing to you. A sample of providers from the 'fail' list was contacted with the following results: One (1) provider got married and changed their last name; we found multiple others that were still with the provider group, however, were no longer practicing at that specific location. In attempt to improve our directory for the future, we will send a request via fax blast 2x/year for updated current information that can be cross-walked with the information in our system that is included in provider rosters. Additionally, we will use CAQH ProView for all non-delegated groups and have providers attest that their information is current at least annually. Contractually, providers are required to notify Molina within 30 days of any provider changes, however, this does not always occur.	

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

The process for initial provider orientation is found in Procedure MHSC-PS-010, Provider and Practitioner Education. The procedure and its associated policy do not specify the timeframe for conducting the initial orientation. Onsite discussion revealed the timeframe is 30 days.

As noted in Procedure MHSC-PS-010, Provider and Practitioner Education, ongoing provider education is conducted during monthly or quarterly provider visits, as needed, and upon request. Education and updates may also be provided through facsimiles, e-communications, mailed provider newsletters, webinars, and the health plan website. Molina holds at least annual Provider Office Manager Meetings to provide education and updates to office staff/managers.

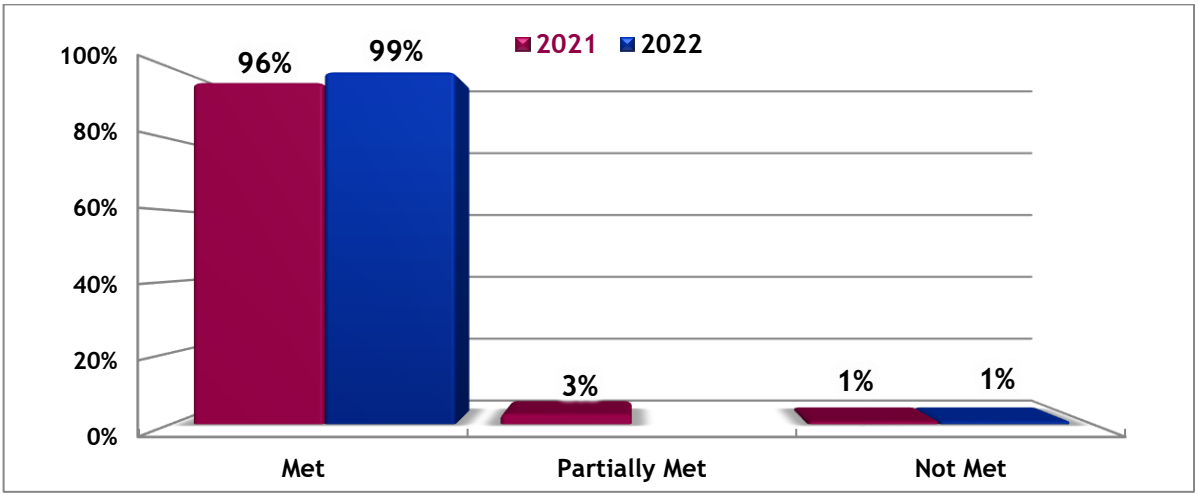
Molina, through its National Quality Improvement Committee (NQIC), which includes participation of physicians and other health professionals, selects, reviews, and approves preventive health guidelines (PHGs) and clinical practice guidelines. The adopted guidelines are based on scientific evidence and recommendations made by national

clinical-based organizations and focus on membership demographics, characteristics, age- and condition-specific needs of Molina's membership, and high-risk, problem-prone, and/or high-cost population sub-sets. Local health plans are informed of the selected PHGs, and the plans then review and adopt the guidelines through the Quality Improvement Committee (QIC). Molina's QIC reviews and updates the guidelines at least annually. Molina distributes new and/or revised PHGs and CPGs to providers in a variety of ways, including provider orientation materials, Provider Manuals, newsletters, mailings/faxes, Molina's website, etc. Paper copies are available upon request. The Provider Manual includes information about PHGs, CPGs, and a hyperlink to the guidelines on Molina's website.

Molina's standards for medical record documentation and the process for evaluating PCP compliance with the documentation standards are included in the "Assessing for Standards of Medical Record Documentation" procedure associated with Policy MHSC QI 120.000, Standards of Medical Record Documentation. Molina conducts annual medical record audits and has established processes for scores that fall below the 90% benchmark, including an over-read and re-audit when the over-read scores are below 90%. Medical record audit results are reported to the QIC and to SCDHHS annually. Results for Calendar Year 2020 were reported to the QIC in June 2021. Scores ranged from a low of 90.43% to high of 99.31%, and no providers required re-audit.

As noted in *Figure 4: Provider Services Findings*, 99% of the Provider Services standards were scored as "Met." *Table 15: Provider Services Comparative Data* displays standards with a change in score from 2021 to 2022.

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 14: Provider Services Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Adequacy of the Provider Network	The MCO maintains a provider directory that includes all requirements	Partially Met	Met
	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Credentialing processes and requirements are well-documented in policies and procedures, and with one exception of one finding, credentialing and recredentialing files were thorough and included all required elements.
- The Professional Review Committee uses a peer-review process to make credentialing decisions. Membership includes an array of network providers, and the PRC reports to the Quality Improvement Committee.
- Molina routinely monitors and evaluates the adequacy of its provider network and takes action to address any identified gaps.
- Provider education processes are adequate, and the Provider Manual and plan website include resources for providers regarding health plan operations and requirements, clinical practice and preventive health guidelines, cultural competency, etc.
- Medical record audit results are reported to the QIC and to SCDHHS annually. Results for Calendar Year 2020 were reported to the QIC in June 2021. Scores ranged from a low of 90.43% to high of 99.31% and no providers required re-audit.

Weaknesses

- One initial credentialing file for an ambulatory surgery center was missing verification of the CLIA certificate. CCME noted that the provider did not complete the Health Delivery Organization (HDO) Application section labeled “Additional Location Credentials.”
- The print version of the Molina Provider Directory did not include practitioner website addresses. Staff reported Molina is currently collecting website addresses from applicable providers and will produce an updated print version Provider Directory in 2022.

- Procedure MHSC-PNA-01, Provider Directory Validation, lists elements that must be included in the Provider Directory but fails to include provider website addresses.
- For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time, a statistically significant decline from last year's rate of 63%. For calls not answered successfully (n= 54 out of 105 calls), the majority (n = 40, 74%) were because the physician was no longer practicing at the location.
- Procedure MHSC-PS-010 includes the process for initial provider orientation; however, the procedure and its associated policy do not specify the timeframe for conducting the initial orientation. Onsite discussion revealed the timeframe is 30 days.
- The "Assessing for Standards of Medical Record Documentation" procedure describes the process for annual assessment of provider compliance with medical record documentation standards. The procedure does not define the timeframe for conducting a re-audit when a provider does not pass the initial audit and over-read.

Quality Improvement Plans

- Provide documentation of specific processes in development or recently initiated to improve accuracy of provider contact information and status/location.

Recommendations

- If the credentialing application is incomplete regarding laboratory services and/or CLIA certification, reach out to the provider and/or conduct independent verification of CLIA certification status.
- To comply with requirements in *42 CFR §438.10(h)(1)* and the *SCDHHS Contract, Section 3.13.5.1.1*, include practitioner website addresses in the print version of the Provider Directory.
- Revise Procedure MHSC-PNA-01, Provider Directory Validation, to include provider website addresses as a required element in the "Pertinent Demographic Attributes" section.
- Revise the Provider and Practitioner Education policy or procedure (MHSC-PS-010) to include the timeframe within which initial provider orientation is conducted.
- Revise the procedure titled, "Assessing for Standards of Medical Record Documentation" to include the timeframe for re-audits for providers who do not successfully pass the initial audit and over-read.

C. Member Services

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

Policy MHSC-ME-04, Member Bill of Rights and Responsibilities, describes members rights and responsibilities. Members are informed of their rights and responsibilities the Member Handbook, annual newsletters, and on Molina's website. New members are provided with enrollee information as outlined in Policy and Procedure MHSC-ME-01, New Medicaid Member Outreach and Education. A Welcome Packet that includes the member's ID card along with directions to access the Member Handbook, Provider Directory, and the Notice of Privacy Practices is provided within 14 days of Molina receiving the member's enrollment data from SCDHHS. A benefit grid in the Member Handbook lists and describes core benefits, covered services, extra benefits provided by Molina, co-payments, and applicable limits or restrictions. Information about member benefits is outlined in the Member Handbook and on Molina's website. Services that require prior authorization are listed in the Member Handbook. Prior approval is not required for family planning services, emergency visits, or behavioral health services. Molina notifies members within 15 days if a provider is terminated from the network and 30 days before the expected change of benefits.

Member Services staff are available for member questions or assistance. The Nurse Advice Line is available 24 hours per day and 7 days per week. The Member Handbook and the Molina website clearly describe routine, urgent, or emergent healthcare services.

Preventive health and wellness topics information and materials are made available to members on the Molina website. The Communications Team adds new information to the website and member newsletters throughout the year. HEDIS text alerts are launched to members if they opt to receive information in electronic notification format.

Member Satisfaction Survey

Molina contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct both the child and adult surveys. Response rates were below the NCQA target of 40%. The Adult survey had 306 responses out of 1701 for a response rate of 18.1%. This represents a decline of 1.9% from the 2020 response rate of 20%. For the Child survey, there were 476 responses out of 3,663 responses, a 13.1% response rate. This is a 1.4% decline from the 2020 response rate of 14.5%. For the Child with Chronic Conditions survey, there were 304 completed surveys out of 2409 for a response rate of 12.7%. This is a 2.1% decline from the 2020 response rate of 14.8%. The analysis and implementation of interventions to improve member satisfaction was conducted by the QIC, and results have been presented providers.

Grievances

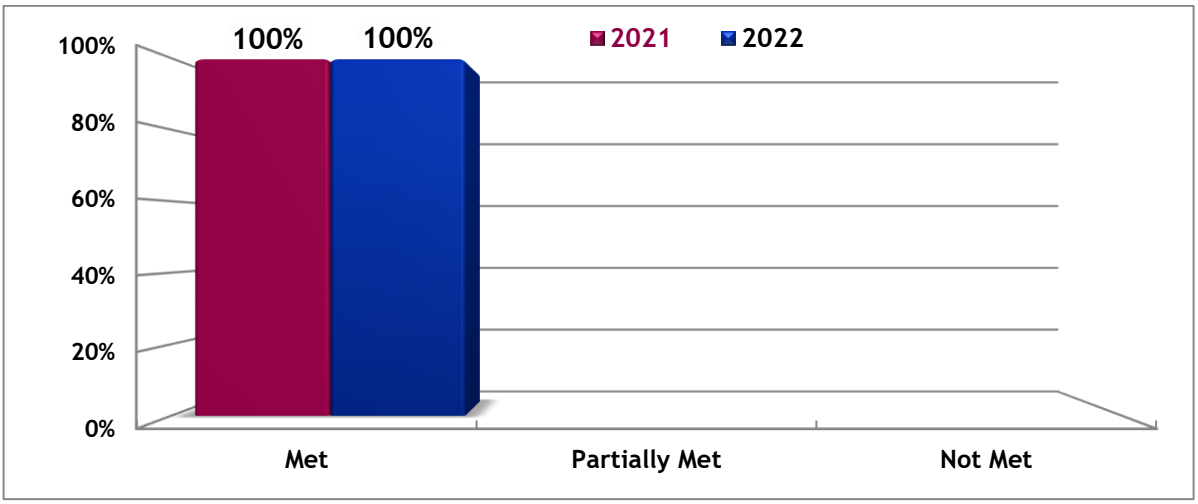
42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Information about grievance processes is found in Policy MHSC-MRT-001, Grievance Disposition Process, the Member Handbook, Provider Manual, and on the Molina website.

Grievances are defined clearly, and processes are provided for who can and how to file a grievance. Members are informed that an authorized representative may file a grievance on their behalf or assist them with filing a grievance. Member grievances are reviewed by the Quality Improvement Committee to identify trends and opportunities for improvement. Molina tracks and monitors member grievance data quarterly. Of the files randomly selected for review, it was found that Molina is reviewing and resolving grievances according to their policies and the SCDHHS contract requirements.

All Member Services standards were scored as "Met" for the 2022 EQR as indicated in *Figure 4: Member Services Findings*.

Figure 4: Member Services Findings



Strengths

- Policies and procedures and the Member Handbook, Provider Manual, and website clearly outline member rights and responsibilities.
- Molina works to promote resources and educate members about preventive health and chronic disease management.

D. Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

The 2021 Medicaid Quality Improvement Program Description is updated annually and presented to the Board of Directors and the Quality Improvement Committee for approval. The QI Program Description clearly outlines the program's goals and objectives. Specific activities are identified to support the achievement of the program's goals.

Molina's Provider Manual includes details regarding the Quality Management Program and a copy of the QI program description is available upon request. Molina's website contained information regarding the QI Program for providers and for members. In the 2021 and 2022 QI work plans, Molina included an objective to include information about the QI Program and/or Progress Reports on the website and in the Member Handbook. However, there was no information found in the Member Handbook regarding the QI Program. During the onsite, staff explained information regarding the QI Program is provided to members in a newsletter.

Molina develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. Molina presented the 2020 and 2021 QI Work Plans for review. Under Section 6.0, Accessibility of Services: Primary Care and Member Services, the goals were missing for the Appointment Access Audit. Molina agreed the goals for this activity were missing and updated the workplan after the onsite.

The QIC is responsible for oversight of the QI Program and the implementation, coordination, and integration of all QI activities. The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. Network practitioner participants include physicians specializing in pediatrics, OB/GYN, family medicine, and cardiology. The committee meets at least quarterly. A quorum is defined as at least 51% of the committee members with no less than half of network provider participants. A review of the minutes provided found the quorum requirements were met for each meeting.

Providers are advised that Molina requires their participation and compliance with the QI Program, and Molina offers network providers reports of their QI performance data and feedback. Molina provided two examples of the quality reports generated for providers. However, there was no documentation found regarding the process for how often these reports are generated and shared with providers. There was also no information found to inform network providers of the availability of these reports.

Molina evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors and the Quality Improvement Committee. The Quality Improvement Program 2020 Medicaid Annual Evaluation was provided and included the Executive Summary and several appendices. Most of the results of the activities conducted in 2019 were included in the program evaluation. Activities related to the availability of practitioners (section 5.0 of the work plan), the continuity and coordination of care (section 9.0 and 10 of the work plan), and the provider directory analysis (section 11 of the work plan) were not included.

The section in the Executive Summary regarding the focus for upcoming year incorrectly included the focus for 2022 instead of 2021. These errors and omissions were discussed during the onsite. Molina indicated those activities omitted from the program evaluation

were conducted and provided copies of some of the reports after the onsite. However, these activities were not considered when the 2020 QI Program Evaluation was conducted.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Molina was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures for the current review year (2020), as well as the previous year (2019) and the change from 2019 to 2020 are reported in *Table 15: HEDIS Performance Measure Results*. A change in rate shown in green indicates a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 15: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	78.52%	73.24%	-5.28%
Counseling for Nutrition	66.17%	61.07%	-5.10%
Counseling for Physical Activity	61.48%	56.69%	-4.79%
Childhood Immunization Status (cis)			
DTaP	74.94%	74.45%	-0.49%
IPV	84.18%	87.83%	3.65%
MMR	88.08%	89.05%	0.97%
HiB	83.70%	81.75%	-1.95%
Hepatitis B	84.91%	83.94%	-0.97%
VZV	87.59%	87.83%	0.24%
Pneumococcal Conjugate	77.13%	77.62%	0.49%
Hepatitis A	82.97%	86.13%	3.16%
Rotavirus	70.07%	76.89%	6.82%
Influenza	37.96%	40.63%	2.67%
Combination #2	70.32%	72.26%	1.94%
Combination #3	68.86%	71.05%	2.19%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Combination #4	66.67%	70.07%	3.40%
Combination #5	58.64%	63.75%	5.11%
Combination #6	32.60%	35.04%	2.44%
Combination #7	57.18%	62.77%	5.59%
Combination #8	32.60%	34.31%	1.71%
Combination #9	28.71%	32.85%	4.14%
Combination #10	28.71%	32.12%	3.41%
Immunizations for Adolescents (ima)			
Meningococcal	77.13%	74.45%	-2.68%
Tdap/Td	87.10%	82.48%	-4.62%
HPV	32.12%	33.33%	1.21%
Combination #1	76.40%	73.48%	-2.92%
Combination #2	31.87%	32.6%	0.73%
Lead Screening in Children (lsc)	69.34%	70.33%	0.99%
Breast Cancer Screening (bcs)	57.26%	57.08%	-0.18%
Cervical Cancer Screening (ccs)	64.72%	58.15%	-6.57%
Chlamydia Screening in Women (chl)			
16-20 Years	57.87%	57%	-0.87%
21-24 Years	68.95%	63.4%	-5.55%
Total	60.82%	59.16%	-1.66%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	86.02%	85.81%	-0.21%
18-64	72.71%	72.36%	-0.35%
65+	NA*	NA*	NA
Total	83.23%	82.56%	-0.67%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	31.62%	26.19%	-5.43%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	64.12%	71.09%	6.97%
Bronchodilator	76.91%	83.18%	6.27%
Asthma Medication Ratio (amr)			
5-11 Years	77.35%	76.79%	-0.56%
12-18 Years	69.80%	65.81%	-3.99%
19-50 Years	53.33%	47.78%	-5.55%
51-64 Years	47.87%	48.09%	0.22%
Total	68.94%	64.5%	-4.44%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	57.18%	46.96%	-10.22%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	64.29%	77.14%	12.85%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	73.57%	79.31%	5.74%
Statin Adherence 80% - 21-75 years (Male)	47.31%	62.8%	15.49%
Received Statin Therapy - 40-75 years (Female)	73.20%	80.65%	7.45%
Statin Adherence 80% - 40-75 years (Female)	48.59%	60.5%	11.91%
Received Statin Therapy - Total	73.40%	79.96%	6.56%
Statin Adherence 80% - Total	47.90%	61.67%	13.77%
Effectiveness of Care: Diabetes			
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (18-64)	NR	2.43%	NA
Cardiac Rehabilitation - Engagement1 (18-64)	NR	2.91%	NA
Cardiac Rehabilitation - Engagement2 (18-64)	NR	1.94%	NA
Cardiac Rehabilitation - Achievement (18-64)	NR	0%	NA
Cardiac Rehabilitation - Initiation (65+)	NR	NR	NA
Cardiac Rehabilitation - Engagement1 (65+)	NR	NR	NA
Cardiac Rehabilitation - Engagement2 (65+)	NR	NR	NA
Cardiac Rehabilitation - Achievement (65+)	NR	NR	NA
Cardiac Rehabilitation - Initiation (Total)	NR	2.43%	NA
Cardiac Rehabilitation - Engagement1 (Total)	NR	2.91%	NA
Cardiac Rehabilitation - Engagement2 (Total)	NR	1.94%	NA
Cardiac Rehabilitation - Achievement (Total)	NR	0%	NA
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	89.77%	87.35%	-2.42%
HbA1c Poor Control (>9.0%)	47.49%	49.39%	1.90%
HbA1c Control (<8.0%)	44.19%	41.85%	-2.34%
Eye Exam (Retinal) Performed	61.87%	52.55%	-9.32%
Blood Pressure Control (<140/90 mm Hg)	55.46%	55.23%	-0.23%
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	NR	22.76%	NA
Kidney Health Evaluation for Patients With Diabetes (65-74)	NR	NR	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	NR	NR	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	NR	22.76%	NA
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	64.37%	64.29%	-0.08%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Statin Adherence 80%	47.06%	58.33%	11.27%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	44.36%	51.88%	7.52%
Effective Continuation Phase Treatment	29.13%	34.8%	5.67%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	58.76%	56.23%	-2.53%
Continuation and Maintenance (C&M) Phase	70.05%	66.34%	-3.71%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	75.86%	77.42%	1.56%
6-17 years - 7-Day Follow-Up	50.19%	57.26%	7.07%
18-64 years - 30-Day Follow-Up	54.28%	53.17%	-1.11%
18-64 years - 7-Day Follow-Up	28.62%	30.19%	1.57%
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
30-Day Follow-Up	61.33%	61.75%	0.42%
7-Day Follow-Up	35.67%	39.77%	4.10%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	71.52%	71.74%	0.22%
6-17 years - 7-Day Follow-Up	52.12%	56.52%	4.40%
18-64 years - 30-Day Follow-Up	52.89%	45.04%	-7.85%
18-64 years - 7-Day Follow-Up	36.89%	29.75%	-7.14%
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
30-Day Follow-Up	60.77%	54.19%	-6.58%
7-Day Follow-Up	43.33%	38.92%	-4.41%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	42.86%	33.33%	-9.53%
13-17 years - 7-Day Follow-Up	28.57%	20%	-8.57%
18-64 years - 30-Day Follow-Up	53.81%	43.62%	-10.19%
18-64 years - 7-Day Follow-Up	43.65%	29.79%	-13.86%
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
Total - 30-Day Follow-Up	53.43%	42.86%	-10.57%
Total - 7-Day Follow-Up	43.14%	29.06%	-14.08%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
13-17 years - 30-Day Follow-Up	NA	12.9%	NA
13-17 years - 7-Day Follow-Up	NA	9.68%	NA
18+ years - 30-Day Follow-Up	14.25%	16.48%	2.23%
18+ years - 7-Day Follow-Up	9.90%	11.21%	1.31%
Total - 30-Day Follow-Up	14.61%	16.24%	1.63%
Total - 7-Day Follow-Up	10.05%	11.11%	1.06%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	78.83%	74.31%	-4.52%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	72.09%	66.16%	-5.93%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	NA*	NA*	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	32.26%	24.26%	-8.00%
65+ years	NA*	NA*	NA
Total	32.26%	24.39%	-7.87%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	72.47%	72.39%	-0.08%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	33.03%	33.64%	0.61%
Cholesterol Testing - 1-11 Years	25.69%	24.55%	-1.14%
Blood glucose and Cholesterol Testing - 1-11 Years	22.02%	21.82%	-0.20%
Blood glucose testing - 12-17 Years	54.80%	50.34%	-4.46%
Cholesterol Testing - 12-17 Years	31.32%	28.86%	-2.46%
Blood glucose and Cholesterol Testing - 12-17 Years	28.83%	27.52%	-1.31%
Blood glucose testing - Total	48.72%	45.83%	-2.89%
Cholesterol Testing - Total	29.74%	27.7%	-2.04%
Blood glucose and Cholesterol Testing - Total	26.92%	25.98%	-0.94%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.93%	0.64%	-0.29%
Appropriate Treatment for Children With URI (uri)			
3months-17 Years	88.10%	88.42%	0.32%
18-64 Years	66.01%	69.3%	3.29%
65+ Years	NA*	NA*	NA
Total	85.12%	85.5%	0.38%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	54.83%	58.65%	3.82%
18-64 Years	30.41%	28.34%	-2.07%
65+ Years	NA*	NA*	NA
Total	45.49%	48.28%	2.79%
Use of Imaging Studies for Low Back Pain (lbp)	70.69%	68.74%	-1.95%
Use of Opioids at High Dosage (hdo)	2.25%	2.51%	0.26%
Use of Opioids From Multiple Providers (uop)			

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Multiple Prescribers	24.11%	20.44%	-3.67%
Multiple Pharmacies	6.08%	4.14%	-1.94%
Multiple Prescribers and Multiple Pharmacies	3.02%	2.42%	-0.60%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	4.68%	4.79%	0.11%
18-64 years - >=31 Days covered	3.00%	3.13%	0.13%
65+ years - >=15 Days covered	NA*	NA*	NA
65+ years - >=31 Days covered	NA*	NA*	NA
Total - >=15 Days covered	4.68%	4.79%	0.11%
Total - >=31 Days covered	3.00%	3.13%	0.13%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	79.59%	77.29%	-2.30%
45-64 Years	89.09%	87.21%	-1.88%
*65+ Years**	NA*	NA*	NA
Total	82.75%	80.24%	-2.51%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA*	NA*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	38.73%	48.44%	9.71%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	21.83%	16.41%	-5.42%
Initiation of AOD Treatment: 13-17 Years	38.26%	46.04%	7.78%
Engagement of AOD Treatment: 13-17 Years	20.81%	15.11%	-5.70%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	41.92%	41.44%	-0.48%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.08%	6.58%	-1.50%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	57.74%	57.87%	0.13%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	27.30%	33.33%	6.03%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	39.55%	42.72%	3.17%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.59%	7.9%	-0.69%
Initiation of AOD Treatment: 18+ Years	42.89%	43.86%	0.97%
Engagement of AOD Treatment: 18+ Years	11.05%	11.62%	0.57%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.80%	41.81%	0.01%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	8.02%	6.87%	-1.15%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	57.44%	58.09%	0.65%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	27.15%	33.16%	6.01%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	39.46%	43.3%	3.84%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	10.04%	8.77%	-1.27%
Initiation of AOD Treatment: Total	42.57%	44.01%	1.44%
Engagement of AOD Treatment: Total	11.72%	11.85%	0.13%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	99.76%	92.7%	-7.06%
Postpartum Care	83.21%	74.45%	-8.76%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	60.00%	56.41%	-3.59%
12-17 Years	69.49%	62%	-7.49%
Total	66.87%	60.43%	-6.44%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	NR	57%	NA
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	NR	72.56%	NA
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (3-11)	NR	48.49%	NA
Child and Adolescent Well-Care Visits (12-17)	NR	45.24%	NA
Child and Adolescent Well-Care Visits (18-21)	NR	22.63%	NA
Child and Adolescent Well-Care Visits (Total)	NR	44.03%	NA

NR = Not Reportable; NA* = Not reported due to small denominator; NA = Not Applicable due to missing data or small denominator

The comparison from the previous year to the current year revealed a substantial improvement (>10%) for Persistence of Beta-Blocker Treatment After a Heart Attack, which improved by 12.85%. Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%: 21-75 Years (Male) improved by 15.49%, Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%: 40-75 Years (Female) improved by 11.91%, Statin Therapy for Patients With Cardiovascular Disease-Statin Adherence 80%: Total improved by 13.77%, Statin Therapy for Patients With Diabetes Statin Adherence 80% improved by 11.27%. The measures with substantial decreases were Controlling High Blood Pressure which declined 10.22% and Follow-Up After High-Intensity Care for

Substance Use Disorder. The 18-64 had a 10% decline in 30 day follow up and a 14% decline in 7-day follow up. *Table 16* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 16: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Substantial Increase in Rate (>10% improvement)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	64.29%	77.14%	12.85%
Statin Therapy for Patients With Cardiovascular Disease (spc)Statin Adherence 80%: 21-75 Years (Male)	47.31%	62.8%	15.49%
Statin Therapy for Patients With Cardiovascular Disease (spc)Statin Adherence 80%: 40-75 Years (Female)	48.59%	60.5%	11.91%
Statin Therapy for Patients With Cardiovascular Disease (spc)Statin Adherence 80%: Total	47.90%	61.67%	13.77%
Statin Therapy for Patients With Diabetes (spd) Statin Adherence 80%	47.06%	58.33%	11.27%
Substantial Decrease in Rate (>10% decrease)			
Controlling High Blood Pressure (cbp)	57.18%	46.96%	-10.22%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
18-64 years - 30-Day Follow-Up	53.81%	43.62%	-10.19%
18-64 years - 7-Day Follow-Up	43.65%	29.79%	-13.86%
Total - 30-Day Follow-Up	53.43%	42.86%	-10.57%
Total - 7-Day Follow-Up	43.14%	29.06%	-14.08%

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

For the 2020 EQR, Molina submitted the Well Care Visits, Breast Cancer Screenings, and the Correlation for Member Assignment and Engagement PIPs. The Correlation for Member Assignment and Engagement PIP scored in the Confidence Range. The interventions that align with specific data barriers were not presented in the PIP report. Molina addressed those deficiencies and updated the PIP report. *Table 17: Previous Quality Improvement Project Deficiencies* provides an overview of the deficiencies and Molina's response.

Table 17: Previous Quality Improvement Project Deficiencies

Standard	EQR Comments
IV D. Quality Improvement Projects	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	
Performance Improvement Projects: Correlation between Member Assignment and Engagement	
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions are not clearly documented in the report. *Recommendation: Display the specific data and system issues and aligned interventions to address those issues in the PIP report.*
Molina Response: The PIP report has been updated to include the corrections as indicated.	
Was there any documented, quantitative improvement in processes or outcomes of care?	Indicator one remained the same at 32%. Indicator two declined from 72% to 66%, and the goal is to increase that rate. Indicator three decreased from 85% to 47% and this is improvement, as the goal is to decrease indicator three. *Recommendation: Add interventions that are related to each indicator's barriers/data issues in efforts to improve rates.*
Molina Response: The PIP report has been updated to include the corrections as indicated.	

For this EQR, Molina implemented two new PIPs (Improving Encounters Acceptance Rates and Immunizations for Adolescents) and modified the Child and Adolescent Well-Care Visits Program PIP with a new indicator and baseline data. The PIPs met the validation requirements and received scores within the "High Confidence Range." The tables that follow provide an overview of the previous validation scores with the current scores and a summary of interventions for each project.

Table 18: Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates (Non Clinical)	
The focus for this PIP is to improve the encounter acceptance rates for professional (837P) encounters. This PIP has two indicators. The initial acceptance rate was 97.5% at baseline and declined to 96.9% at year 1 with a goal of 100%. For the 837P taxonomy rejection rate, the baseline was 2.63% and increased to 2.82%. The target goal for this indicator was set at 2%. Both indicators did not show improvement.	
Previous Validation Score	Current Validation Score
Not Submitted	73/74=99% High Confidence in Reported Results
Interventions	
The interventions included a provider crosswalk, review of QNXT claims setup, logic checks, review of rejected encounters, and logic adjustment focusing on billing NPI.	

CCME provided the following recommendation for the Improving Encounters Acceptance Rates PIP listed in *Table 19*.

Table 19: Encounter Acceptance Rate Recommendations

Project	Section	Reason	Recommendation
Improving Encounters Acceptance Rates	Was there any documented, quantitative improvement in processes or outcomes of care?	The initial acceptance rate was 97.5% at baseline and declined to 96.9% at year 1. The goal is 100%. For the 837P taxonomy rejection rate, the baseline was 2.63% and increased to 2.82%. The goal is 2%. Both indicators did not show improvement.	Continue monitoring of indicator rates to determine if logic adjustment and rejected encounter reviews improve rates toward 100% for initial acceptance rate.

Table 20: Child and Adolescent Well-Care Visits Program PIP

Child and Adolescent Well-Care Visits Program (Clinical)	
Molina Healthcare of South Carolina (MHSC) is implementing the Child and Adolescent Well-Care Visits Program to offer eligible Members and Providers incentives for Members receiving a Well-Visit or Comprehensive Well-Visit (for Ages 3 to 21). The baseline measurement rate for this PIP was 43.16%. using the administrative data. The interventions included member and provider education and outreach, incentive programs, and transportation assistance.	
Previous Validation Score	Current Validation Score

Child and Adolescent Well-Care Visits Program (Clinical)	
80/80=100% High Confidence in Reported Results	72/72=100% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for Member Transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate Provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was Developed and Placed on the Provider Portal. • Calendar Year 2021 Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Table 21: Immunizations for Adolescent Program PIP

Immunizations for Adolescents Program (Clinical)	
Molina chose this PIP to target rural and urban areas across South Carolina to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV related cancers. The baseline rate for this PIP was reported as 27.98%.	
Previous Validation Score	**Current Validation Score**
Not Submitted	72/72=100% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for Member Transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate Provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was Developed and Placed on the Provider Portal. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members.	

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Molina met 93% of the standards in the Quality Improvement section as noted in *Figure 5*. The QI Program Evaluation did not meet all of the requirements.

Figure 5: Quality Improvement Findings

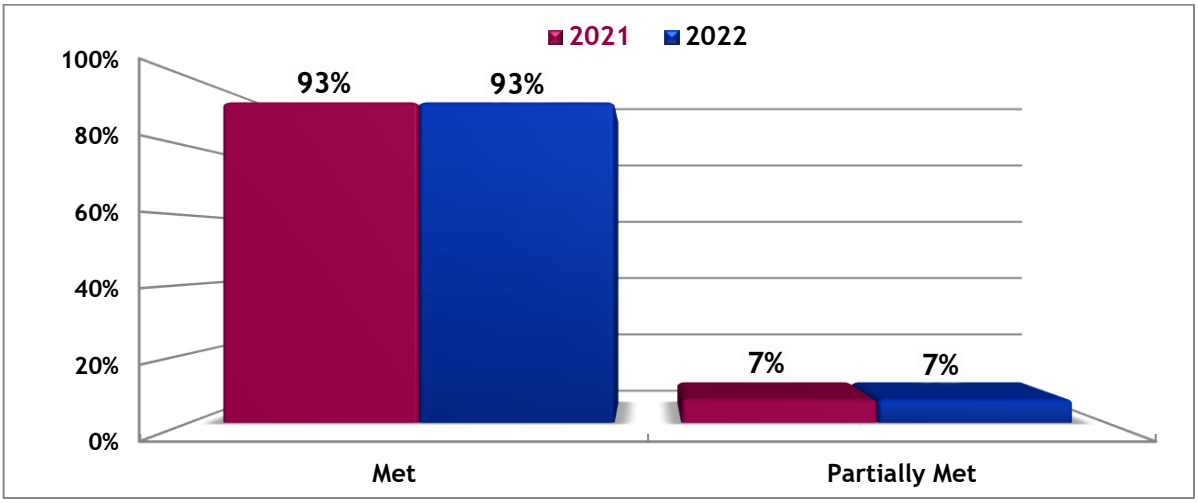


Table 22: Quality Improvement Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022

Strengths

- The performance improvement projects met the validation requirements and received scores within the "High Confidence Range."
- The Persistence of Beta-Blocker Treatment After a Heart Attack and the Statin Therapy for Patients with Cardiovascular Disease and for Patients with Diabetes rates showed improvement.
- Molina has several network providers that actively participate on the Quality Improvement Committee.

Weaknesses

- Follow-Up After High-Intensity Care for Substance Use Disorder and Controlling High Blood Pressure showed a decline in the reported rates.
- Molina offers network providers reports of their QI performance data and feedback. There was no documentation found regarding the process for how often the quality reports are generated and shared with providers. There was also no information found to inform network providers of the availability of these reports.
- The QI Program Evaluation did not include the analysis, results, and interventions for the availability of practitioners, the continuity and coordination of care, and the provider directory analysis.

Quality Improvement Plans

- When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.

Recommendations:

- Evaluate the cause for the decline in the Follow-Up After High-Intensity Care for Substance Use Disorder and Controlling High Blood Pressure rates and implement interventions to improve those rates.
- Include in a policy, program description and in the Provider Manual information regarding the process followed for sharing provider performance data and feedback.

E. Utilization Management

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

Molina has developed a program description and several policies and documents that guide staff in the implementation of utilization management functions. Molina's Utilization Management (UM) Program is incorporated within the Healthcare Services area of the organization. The Healthcare Services Program Description describes and defines Molina's Utilization Management (UM) service areas, such as service authorizations, retrospective reviews, care transitions, care management, appeals, and over- and under-utilization. The responsibilities for oversight have been delegated to the South Carolina Quality Improvement Committee. The Health Care Services Committee is a subcommittee of the Quality Improvement Committee and reports on UM activities. The Healthcare Services Program Description was last reviewed and approved by the Health Care Services Committee on October 14, 2021.

Molina's Preferred Provider Program is described in the UM Program Description, page 79. Practitioners who meet the specific indicators for participation are referred to the Star Provider Program. This designation makes them eligible for increased member assignment and reduction and simplification of the prior authorization process.

The UM Program Description addresses the medical necessity criteria used by Molina and indicates MCG criteria is utilized to conduct inpatient review except when InterQual is contractually required. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, indicates Molina utilizes InterQual. During the onsite discussion, staff indicated MCG criteria are currently being used for medical necessity determinations.

Results of the 2020 Inter-Rater Reliability (IRR) Analysis were reported in the 2020 Annual Healthcare Services Program Evaluation. The methodology described in the UM Program Evaluation was not consistent with the methodology in the IRR policy and procedures provided with the desk materials. This was discussed during the onsite, and staff indicated a SC-specific policy/procedure is used for IRR testing. A copy of policy and procedure HCS-366, Consistency in Application of Medical Necessity Criteria and Inter-Rater Reliability Documentation Guidelines, was provided. This policy outlines the process Molina conducts in SC and reported in the 2020 Annual Healthcare Services Program Evaluation.

Molina provides coverage for medications through their Pharmacy Benefit Manager. The Pharmacy and Therapeutics Committee is responsible for the development and updating of the pharmacy formulary or the preferred drug list. The committee's oversight also includes prior authorization criteria, pharmaceutical classes, step therapy, quantity limits, and restrictions. Providers may request a formulary exception to a prescribed medication not listed in the formulary. Molina's website contains information regarding covered prescriptions including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. There was no information regarding when those changes were approved by the Pharmacy and Therapeutics Committee and when the negative PDL changes were published on the website. The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3,* requires the health plan's Pharmacy & Therapeutics Committee approve the PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plan's website at least 30 days prior to implementation. Molina's changes posted on the website did not appear to meet this requirement.

As demonstrated in the denial files reviewed, Molina provides prompt notifications to members and providers of decisions to deny a requested service. The adverse benefit determination notices included the action Molina intended to take, the reason for the

action, and instructions for appealing the decision. Molina uses a standard Adverse Benefit Determination Notice template for all denial notices. In one file, it was noted the denial was issued for a non-covered service. The standard language in the notice stated, "You will have to meet all of the set rules before this can be approved." The notice further stated, "you or your doctor may ask for a copy of the criteria used for this review decision." This standard language did not appear appropriate in this case.

Appeals

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

Molina has several policies that describe how appeals are submitted and processed. Policy and procedure MHSC-MRT-002, Standard Appeal Process, and policy and procedure MHSC-MRT-003, Expedited Appeal Process, details Molina's appeal process. Appeal information is provided in the Member Handbook, Provider Manual, and on the website. The website also includes forms for members or providers to file the appeal.

Requirements for filing an appeal are documented in policies and procedures. Policy and procedure MHSC-MRT-002, Standard Appeal Process, the UM Program Description, the Guidelines for Appealing a Medical Denial, in the Member Handbook, the Provider Manual, and on the website indicate a standard request for an appeal received verbally must be followed up with a written request within 30 days. This requirement was removed from the *SCDHHS Contract* and *Federal Regulation*.

A sample of appeal files was reviewed. There were three files that were untimely and four files where the physician who made the appeal decision was not of the same or similar specialty as the ordering physician. Two of those cases were pediatric cases reviewed by a physician who specializes in internal medicine and two plastic surgery cases also reviewed by a physician who specializes in internal medicine. According to staff, the physicians reviewing appeal requests are directed to use criteria and matching specialty was not necessary. Molina was cautioned regarding allowing physician reviewers to only utilize criteria when making medical necessity decisions on appeals.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

The Molina Healthcare of South Carolina, Inc. Healthcare Services (HCS) Program Description includes information about the Care Management (CM) and Healthcare Transitions (TOC) Programs. A host of policies and procedures provide detailed information to guide staff conducting CM and TOC activities.

Risk stratification processes and risk levels are described in the HCS Program Description and in related policies and procedures. Risk stratification levels include Health/Disease Management (Level 1), Care Coordination (Level 2), Complex Case Management (Level 3),

and Intensive Needs Case Management (Level 4). Additional programs for members with specific needs, such as the Sickle Cell Disease Program, are in place. Policies and procedures did not provide clear documentation of when and for whom a comprehensive assessment is conducted and the frequency of routine outreach for the CM risk levels. Molina provided a copy of a quick reference guide that included this information.

Molina evaluates and updates the Care Management Program at least annually. Ongoing monitoring of the CM Program is conducted by monitoring program metrics and CM outcomes. When opportunities for improvement are noted, interventions are implemented, and the effectiveness of the interventions is assessed. A survey processes is used to evaluate member satisfaction with the CM Program. Member satisfaction is also measured by analyzing member complaints and inquiries related to the program.

No issues or concerns were identified in the sample of CM files reviewed. The files reflected consistent documentation of member consent for participation in CM activities, appropriate assessment and care plan development, routine member outreach attempts at appropriate frequencies, and use of "unable to contact" letters and appropriate case closure when members could not be contacted.

Evaluation of Over/ Underutilization

Policy MHSC-HCS-UM-362, Monitoring to Ensure Appropriate Utilization, addresses data monitoring and analysis to detect and correct patterns of actual or potential under- or over-utilization which may impact health care services, care coordination, and appropriate use of services and resources. Topics included in the monitoring include emergency room (ER) utilization, medical/surgical admissions, behavioral health admissions, and readmissions.

Documentation showed Temporary Assistance for Needy Families (TANF) medical/surgical admits at 19 per 1000, below the goal of 23; behavioral health admits at 6 per 1000, also below the goal of 10. Emergency room visits increased Q3 but were still below 660 per 1000. Readmission percentage declined to 7.8%, below the 10% goal, and behavioral health readmissions declined to 8%, also below the 10% goal. The Aged Blind or Disabled (ABD) population was above the readmission goal of 18% at 20.6% for Q3; however, all other measures met the goals.

Quarterly Health Care Services Committee meeting minutes reflected the data were analyzed and recommendations were offered based on the findings.

As noted in *Figure 6: Utilization Management Findings*, Molina achieved "Met" scores for 93% of the UM standards and 7% of the standards were scored as "Partially Met."

Figure 6: Utilization Management Findings

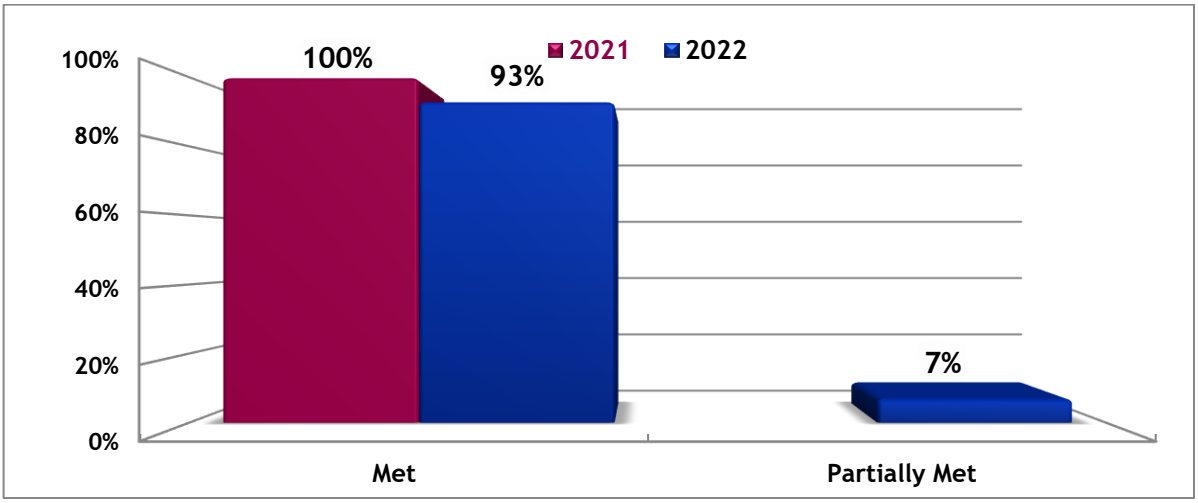


TABLE 23: Utilization Management Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Pharmacy Requirements	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Met	Partially Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: The procedure for filing an appeal	Met	Partially Met
	The MCO applies the appeal policies and procedures as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Utilization management decisions were timely, and members were notified of these decisions appropriately.
- UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
- Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-Rater Reliability testing.

- In addition to Care Management Programs, separate programs, such as the Sickle Cell Disease Program, for members with special, specific needs are in place.

Weaknesses

- Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, indicates Molina utilizes InterQual. During the onsite discussion, staff indicated MCG criteria is currently being used for medical necessity determinations.
- There was no documentation to indicate when the negative PDL changes were published on Molina's website as required by the *SCDHHS Contract, Section 4.2.21.2.1 and 4.2.21.3*.
- In one denial file, it was noted the denial was issued for a non-covered service. The standard language in the Adverse Benefit Notification template did not appear appropriate in this case.
- Molina's process for filing an appeal incorrectly indicates a standard request for an appeal received verbally must be followed by a written request within 30 days.
- A sample of appeal files were reviewed found three files were untimely and the physician who made the appeal decision in four files was not of the same or similar specialty as the ordering physician.

Quality Improvement Plans

- Ensure notices of negative PDL changes are posted on Molina's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3*.
- Revise all documents related to the process for filing an appeal and remove the requirement that indicates a standard request for an appeal received verbally must be followed up with a written request.
- For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate physician reviewers regarding inappropriately using only review criteria and not considering individual medical conditions when making appeal determinations.

Recommendations

- Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, and remove the reference to InterQual Criteria.
- Develop an Adverse Benefit Determination Notice template for denials issued for non-covered services.

F. Delegation

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

Molina has delegation agreements with the entities listed in *Table 24: Delegated Entities and Services.*

Table 24: Delegated Entities and Services

Delegated Entities		Delegated Services
Accordant		Disease Management
Aperture - CVO		Recredentialing
March Vision Care		Call Center Claims Processing Credentialing
AnMed AU Medical BSSF Lex Health MHR	MUSC Prisma Midlands Prisma Upstate RHP Roper	Credentialing

Policies and related procedures define processes and requirements for delegation of health plan activities to external entities. They address pre-delegation assessment, annual oversight and ongoing monitoring, sub-delegation, and delegation termination.

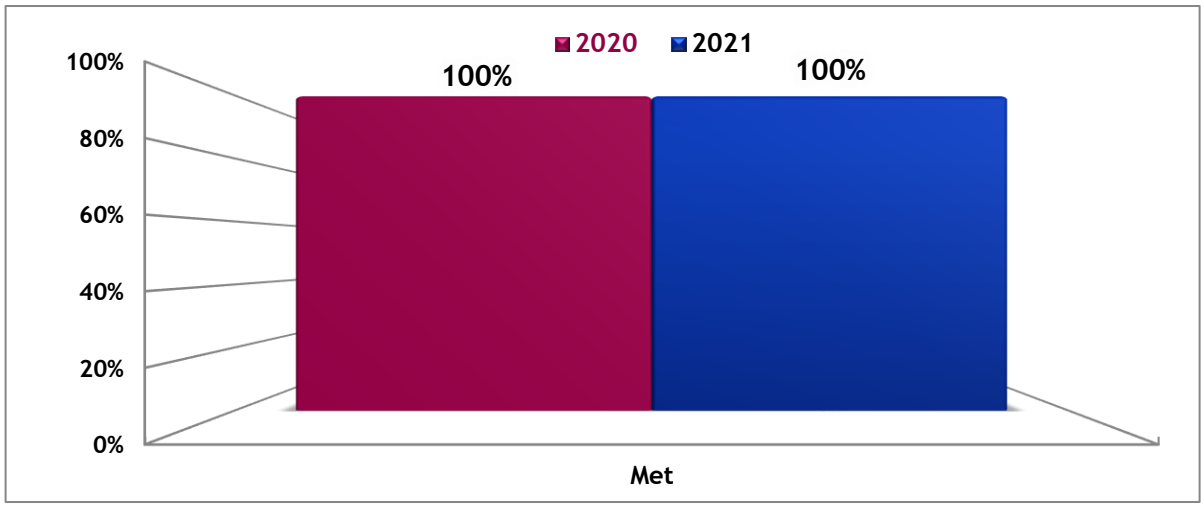
The Delegation Services Addendum (delegation agreement) document defines terminology related to delegation and includes activities to be delegated, general terms and conditions for delegation, and information about actions that may result from non-performance or non-compliance with the delegation agreement. Delegates are also informed about reporting requirements and ongoing and annual monitoring activities. Delegation agreements are implemented with each delegate after completion of pre-delegation evaluation and upon approval by the Delegation Oversight Committee.

Documentation of pre-delegation assessment and annual oversight was submitted for review. The documentation confirmed annual oversight is conducted for each delegate. Also, the documentation indicated Molina initiates corrective action when warranted and conducts appropriate follow-up of the corrective action.

It was noted that one delegate was terminated due to non-compliance with delegated credentialing requirements. Onsite discussion revealed two additional delegation agreements were terminated for delegates whose services were no longer needed.

As noted in *Figure 7: Delegation Findings*, 100% of the Delegation standards were scored as "Met."

Figure 7: Delegation Findings



Strengths

- Policies and procedures appropriately document processes and requirements for delegation of health plan activities to external entities.
- Delegation agreements define terminology and include activities to be delegated, general terms and conditions for delegation, and information about actions that may result from non-performance or non-compliance with the delegation agreement.
- Documentation of pre-delegation assessment and annual oversight confirmed annual oversight is conducted for each delegate, Molina initiates corrective action when warranted, and conducts appropriate follow-up of any corrective action.

G. State Mandated Services

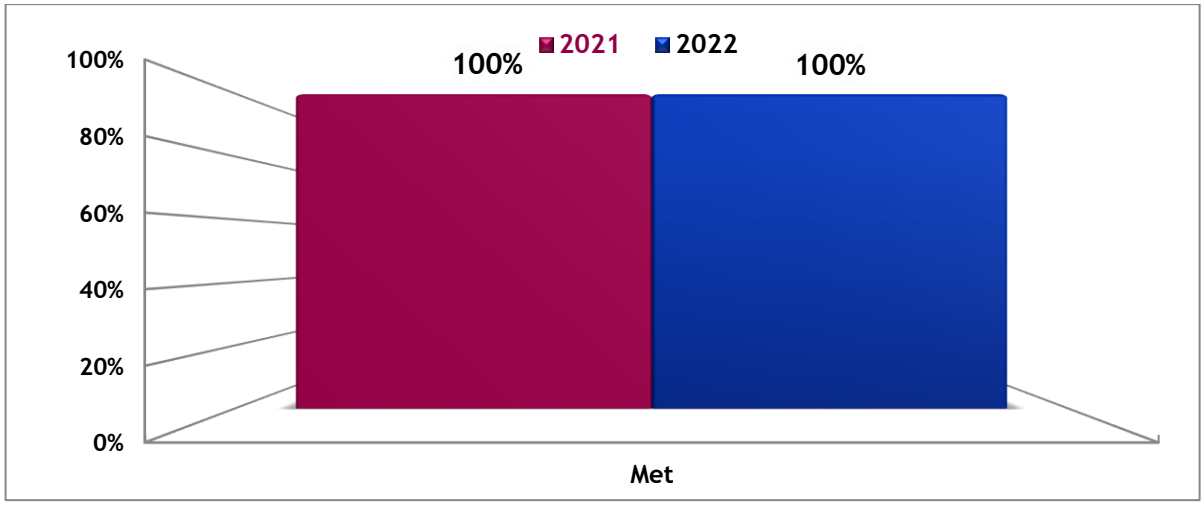
42 CFR Part 441, Subpart B

Molina has adopted the American Academy of Pediatrics (AAP) Children and Adolescents Preventive Health Guidelines and conducts monitoring to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including immunizations, are timely. The Quality Improvement Department tracks members that are non-compliant for EPSDT services/Well Care and required immunizations by monitoring HEDIS® data sets. Members are notified of services for which they are eligible, and staff make attempts to follow up with non-compliant members until identified gaps in care are closed. Quality Reports are run monthly and as needed and distributed to providers. The reports include detailed information about ER utilization and member-specific gaps in care.

The 2022 EQR confirms Molina provides all contractually required core benefits.

As indicated in *Figure 8: State Mandated Services*, 100% of the standards in the State Mandated Services section are scored as "Met."

Figure 8: State Mandated Services



Strengths

- Molina monitors member and provider compliance with EPSDT services and immunizations recommended by the Academy of Pediatrics Children and Adolescents Preventive Health Guidelines. Steps are taken to notify both members and providers of gaps in care.
- All contractually-required core benefits are covered. Molina also covers additional benefits outside of the required core benefits for members, such as non-ambulance transportation, limited dental services for adult members, and adult vision services.

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
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

February 14, 2022

Ms. Dora Wilson
Molina Healthcare of South Carolina
4105 Faber Place Drive, Suite 120
Charleston, SC 29405

Dear Ms. Wilson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2022 External Quality Review (EQR) of Molina Healthcare of South Carolina is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

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), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **April 6th and 7th.**
In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **February 28, 2022.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, 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.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. **The list should be submitted as an excel spreadsheet in the format listed in the table below.** Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

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

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2021 and 2022.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

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

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (i.e., 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 committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

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

16. Copies of the most recent physician profiling activities 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.

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

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

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

21. A report of findings from the most recent member and provider satisfaction survey, 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 other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of February 2021 through January 2022.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

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

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

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. 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 South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina 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 or Business Continuity 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 most recent data security audit, if completed.
    h. 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.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e., credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. 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.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey,

including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) for:
        i. Ten PCP's (Include two NP's acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of February 2021 through January 2022. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of February 2021 through January 2022, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan 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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

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

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**IMMUNIZATIONS FOR ADOLESCENTS**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Topic was based on analysis of immunizations rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Aims of study were reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addressed key aspects of clinical information.
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**	Relevant populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not conducted for baseline measurement- admin. Data only.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not conducted for baseline measurement- admin. Data only.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not conducted for baseline measurement- admin. Data only.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators were 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**	Indicators measured changes in processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources of data were clearly identified.
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**	Project had a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	PIP involves qualified personnel.
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 were analyzed per plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of follow up interventions were noted.
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 aligning with barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge as baseline rate only is reported.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not evaluated
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis was not able to be conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**72**
Project Possible Score	**72**
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 PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**IMPROVING ENCOUNTERS ACCEPTANCE RATES**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Topic was based on analysis of encounters acceptance and rejection rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Aims of study were reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addressed key aspects of non-clinical information.
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**	Relevant populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators were 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**	Indicators measured changes in systematic processes.
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 the report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources of data were clearly identified.

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**	Project had a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments used allowed for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	PIP involves qualified personnel.
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 were analyzed annually.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and Year 1 remeasurements 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 of improvement and follow up interventions were noted.
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 aligned with barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Initial acceptance rate declined and 837P rejection rate increased. Both of the indicators showed a lack of improvement. ***Recommendation:*** *Continue the monitoring of indicator rates to determine if logic adjustment and rejected encounter reviews improve rates toward 100% for initial acceptance rate.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not evaluated due to lack of improvement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
High Confidence in Reported Results

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

CCME PIP Validation Worksheet

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Topic was based on analysis of Well-Child visit adherence rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Aims of study were reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addressed key aspects of clinical information.
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**	Relevant populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used for baseline measurement calculation.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used for baseline measurement calculation.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used for baseline measurement calculation.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators were 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**	Indicators measured changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources of data were clearly identified.

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**	Project had systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	PIP involved qualified personnel.
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 were analyzed per plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of follow up interventions was noted.
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 aligning with barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge as baseline rate only was reported.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not evaluated
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis not able to be conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**72**
Project Possible Score	**72**
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 PM Validation Worksheet

Plan Name:	**Molina Healthcare**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2020**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2020/2021

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**	Data sources and programming logic were documented.

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**	Denominator sources were accurate.
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**	Calculation of rates adhered to denominator specifications.

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 sources were accurate.

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**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
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**	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall assessment			Plan uses NCQA certified software noted for HEDIS measures.

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 Survey Validation Worksheet

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

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021
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 2021
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 2021

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021
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 2021

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

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Adult survey had 306 responses out of 1701 for a 18.1% response rate. This is an 1.9% decline from the 2020 response rate of 20%. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021 ***Recommendation:*** *Assess the benefits of additional methods to improve response rates such as design of cover letter, mode of survey administration, survey administration timing, and member awareness campaigns.*
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 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021

CCME EQR Survey Validation Worksheet

Plan Name	**Molina Healthcare**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2021
Review Performed	2022

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2021
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 CCC 2021
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 CCC 2021

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2021
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 CCC 2021

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

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were used. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021
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 CCC 2021

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	There were 304 completed surveys out of 2409 for a response rate of 12.7%. This is a 2.1% decline from the 2020 response rate of 14.8%. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 ***Recommendation:*** *Assess the benefits of additional methods to improve response rates such as design of cover letter, mode of survey administration, survey administration timing, and member awareness campaigns.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2021
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 2021
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 2021

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2021
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 2021

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

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	There were 476 responses out of 3,663 responses for a 13.1% response rate. This is a 1.4% decline from the 2020 response rate of 14.5%. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 ***Recommendation:*** *Assess the benefits of additional methods to improve response rates such as design of cover letter, mode of survey administration, survey administration timing, and member awareness campaigns.*
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 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2021

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Molina Healthcare of SC
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy and Procedure MHSC-AD-02, Annual Policy Renewal, indicates that Molina reviews policies and procedure annually to ensure compliance with regulatory, SCDHHS contractual, and accreditation requirements and practices. The Administrative and Policy (A&P) Committee and other governing unit committees work collaboratively to review and revise policies as needed.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						A review of Molina's Organizational Chart and the 2022 Companion Matrix found that positions are staffed to ensure that health care services required by SCDHHS are fulfilled.
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Molina's Plan President and Chief Executive Officer is Dora Wilson.
1.2 Chief Financial Officer (CFO);	X					Edward Mohr is the Regional Financial Officer.
1.3 * Contract Account Manager;	X					The Vice President (VP) of Government Contracts is Beverly Hamilton.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					The Claims and Encounter Manager is Diana Michalic.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The VP of Healthcare Services is Debra Enigl, RN.
1.5.1 Pharmacy Director,	X					Barnard Wilson is the Pharmacy Services Manager.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Quality Manager is Wilson Huang.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Provider Services Director is Heather Eddins.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					The Member Services Manager is GG Garcia.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					The Chief Medical Director is Richard Shrouds, MD.
1.10 *Compliance Officer;	X					Niurka Adorno-Davies is Molina's Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					
1.10.2 Program Integrity FWA Investigative/Review Staff;	X					
1.11 * Interagency Liaison;	X					Brandon Hulko is the Director Government Contracts.
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					The Medical Director of Behavioral Health is Nikitas Thomarios, DO.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Molina's Information Systems Capabilities Assessment (ISCA) documentation indicates Molina complies with contractual timeliness requirements for claims and encounter processing. Specifically, it was noted that Molina uses an internal model to estimate "completion factors" that are then used to approximate the percent of a month's total incurred claims that have been paid to date.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					ISCA documentation indicates Molina's infrastructure can receive electronic files and once received, an Electronic Data Interchange process formats data into standard file formats. Additionally, systems are in place to electronically process paper submissions.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Documentation indicates Molina meets the requirements for updating eligibility/enrollment databases and handling 834 transactions. The organization processes membership files daily, and the files are checked via a detailed process that verifies the records and checks for duplicates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Molina uses the software, ClaimSphere®, to consolidate Medicaid claims/encounter data into a data repository. Molina also uses ClaimSphere to generate HEDIS and HEDIS-like reports from the consolidated data repository. Finally, it was noted that Molina performs validation testing to ensure the accuracy and completeness of data and the reports based on that data.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ISCA documentation indicates Molina practices the principles of least privilege when assigning access to systems and data. This is reflected in the organization's physical and logical information technology (IT) security policies. Additionally, Molina uses IT security and monitoring software to aid in monitoring data access and system activity.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Molina provided a number of IT security policies and procedures. The documents indicate Molina has designed its security around industry standards and best practices. To ensure the policies and procedures are being followed, regular security self-assessments are performed.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Molina has a comprehensive disaster recovery (DR) plan that is reviewed and updated regularly. The DR plan is tested annually. The most recent DR test was completed and validated on March 6, 2021. The DR test resulted in the successful recovery of data and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						applications within the recovery time objectives and recovery point objectives.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The 2021 Compliance Plan describes Molina's integrated internal controls, interventions, and activities dedicated to operational excellence and compliance with state and federal laws, regulations, and contract requirements, and summarizes compliance activities.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Compliance Plan contains Molina's Code of Conduct and Ethics Code, which describes the expectation that business is conducted in accordance with applicable laws, rules, contract requirements, and ethical business and professional practices.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Officer is identified on the Executive Organizational Chart.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The 2021 Compliance Committee Charter identifies the Compliance Committee as a senior management level entity overseeing the Molina

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Healthcare program and compliance with regulatory and contractual requirements.
2.5 Compliance training and education;						New employees receive compliance training within sixty days of hire, and all employees receive annual compliance training. Electronic reports are maintained of employee training completed via the iLearn system to track compliance with Molina's training requirements. Training materials were provided, and topics included privacy and confidentiality, Advanced Directives, fraud, waste, and abuse, etc.
2.6 Lines of communication;						Reporting options are addressed in employee training and are included in the Provider Manual, Member Handbook, and on Molina's website.
2.7 Enforcement and accessibility;						The 2021 Compliance Plan indicates that one of the responsibilities of the Compliance Committee is to carry out the protocols for consistent enforcement of appropriate disciplinary action, including termination, against persons who have engaged in acts or omissions constituting non-compliance.
2.8 Internal monitoring and auditing;						The Compliance Plan is informed by the results of an annual health plan Compliance Risk Assessment that reviews each business unit's performance on internal controls; internal or external threats; internal and external audits; compliance reports; incidents or notices of noncompliance; trends noted in ongoing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitoring; and known risks or anticipated program requirement amendments.
2.9 Response to offenses and corrective action;						The Compliance Plan describes responsibilities of the Compliance Officer, including responding to, investigating, and assisting management with enforcement and discipline for instances of non-compliance.
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MHSC HP-03, Privacy and Confidentiality Of PHI, indicates Molina will protect privacy and maintain the confidentiality of members' protected health information in accordance with state and federal laws and contractual requirements.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Credentialing and recredentialing processes are documented in the following: •Policy and Procedure CR01, Credentialing and Recredentialing Practitioners •State Addendum CR01, Credentialing and Recredentialing Practitioners

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•State Addendum CR02, Assessment of Organizational Providers
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Professional Review Committee (PRC) uses a peer-review process to make credentialing decisions. The PRC reports to the Quality Improvement Committee (QIC) and is chaired by a Molina Medical Director who appoints committee members. Committee members must be actively practicing network practitioners. Licensed Medical/Professional members of the PRC have voting privileges. PRC meetings are held at least quarterly, but usually every 4 to 6 weeks. A quorum is established with four voting practitioners in attendance. The Credentialing and Professional Review Committee Matrix (updated 2/10/21) lists the specialties of voting committee members as obstetrics and gynecology, psychiatry, pediatrics, cardiology, and a physician assistant. Attendance documentation of committee minutes showed one external member missed five of eight meetings, and another missed two of eight meetings. Molina reported that both are no longer members of the committee, as of 1/1/22, and Molina is currently recruiting a general surgeon to sit on the committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.3 Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Procedure MHSC QI 500.000, Potential Quality of Care Issues, details processes for identifying, stratifying, investigating, and resolving potential quality of care issues. Procedure CR01, Credentialing and Recredentialing Practitioners, outlines processes for actions that may be taken when provider performance issues are noted.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					One initial credentialing file for an ambulatory surgery center was missing verification of the Clinical Laboratory Improvement Amendments (CLIA) certificate. The provider's application section labeled "Additional Location Credentials" was incomplete. Review determined the provider does have a CLIA certification but there was no evidence in the file. *Recommendation: If the credentialing application is incomplete regarding laboratory services and/or CLIA certification, reach out to the provider and/or conduct independent verification of CLIA certification status.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy and Procedure PC-011, Availability of Health Care, lists the geographic access standards for PCPs. The listed standards are compliant with the contractual requirement. Geo Access reports submitted for review reflected Molina uses appropriate parameters to measure access to primary care providers.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy and Procedure PC-011, Availability of Health Care includes geographic access standards for specialty providers and hospitals. The listed standards are compliant with contractual requirements and submitted Geo Access reports confirm Molina uses appropriate parameters to measure access to these provider types. All required Status 1 provider types are included in the geographic access measurements.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					As noted in the Medicaid Quality Improvement Program Description 2021 and Procedure MHSC QI, Access and Availability of Language Services, Molina has developed a Cultural Competency Plan and conducts activities to ensure its network can

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meet special sensory, language, and cultural needs of the membership population. These activities include: •Analyzing membership demographics and identifying cultural and linguistic disparities. •Analyzing network practitioner demographics to evaluate for network gaps. •Providing translation and language services. •Developing member informational and educational materials to meet the cultural, linguistic, and special needs of the membership. •Educating staff and network providers about cultural competency. •Routinely evaluating the Culturally and Linguistically Appropriate Services (CLAS) Program for effectiveness and opportunities. The Provider Manual includes information about cultural competency and linguistic services. Molina's "Culturally and Linguistically Appropriate Resources / Disability Resources" website page includes a variety of tools and resources about cultural competency.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements.	X					A review of Molina's print and online Provider Directories confirmed the online directory

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						includes all required elements. However, the print version of the Provider Directory did not include practitioner website addresses. Onsite discussion of this finding revealed Molina is currently collecting website addresses from applicable providers and, due to the cost associated with producing the printed directory, will produce an updated Provider Directory later in 2022 when more provider website addresses have been obtained. The print version of the Provider Directory contains a footer notation that any provider site that is not ADA compliant is noted with an asterisk. However, no practitioner entries contained this indicator. Onsite discussion revealed 100% of providers credentialed by delegates are ADA compliant and that Molina is working to verify this information for remaining providers. Providers are informed of their responsibility to notify Molina if their practice sites are not ADA compliant/. Procedure MHSC-PNA-01, Provider Directory Validation lists elements that must be included in the Provider Directory but fails to include provider website addresses.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: To comply with requirements 42 CFR §438.10(h)(1) and SCDHHS Contract, Section 3.13.5.1.1, include practitioner website addresses in the print version of the Provider Directory. Revise Procedure MHSC-PNA-01, Provider Directory Validation, to include provider website addresses as a required element in the "Pertinent Demographic Attributes" section.
3.Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy MHSC-PS-005, Provider Availability Standards, outlines Molina's methods to measure the availability of primary care, urgent care, and emergency care services. Appointment access standards documented in the policy are compliant with contractual requirements. As noted in the associated procedure, Molina conducts annual provider availability and after-hours telephonic surveys to evaluate appointment availability for routine and urgent visits and average wait time. Survey results are evaluated to identify noncompliant providers, and an action plan is developed for provider education and re-survey within 3-6 months.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time (51 out of 105) when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						omitting 13 calls answered by personal or general voicemail messaging services. This is a statistically significant decline from last year's rate of 63%. For calls not answered successfully (n= 54 out of 105 calls), the majority (n = 40, 74%) were because the physician was no longer practicing at the location. *Quality Improvement Plan: Provide documentation of specific processes in development or recently initiated to improve accuracy of provider contact information and status/location.*
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					The process for initial provider orientation is found in Procedure MHSC-PS-010, Provider and Practitioner Education. Initial provider orientation is conducted at contract initiation, but the procedure and its associated policy do not specify the timeframe within which the initial orientation is conducted. Onsite discussion revealed it is conducted within 30 days. *Recommendation: Revise the Provider and Practitioner Education policy or procedure (MHSC-PS-010) to include the timeframe within which initial provider orientation is conducted.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					As noted in Procedure MHSC-PS-010, Provider and Practitioner Education, ongoing provider education is conducted during routine provider visits, as needed, and upon request. Education and updates may also be provided through electronic and mailed communications, webinars, and the website. Molina holds at least annual Provider Office Manager Meetings to provide education and updates to office staff/managers.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Molina, through its National Quality Improvement Committee (NQIC), which includes participation of physicians and other health professionals, selects, reviews, and approves preventive health guidelines (PHGs). The adopted guidelines are based on scientific evidence and recommendations of national clinical-based organizations and focus on the demographics and needs of Molina's membership. Local health plans are informed of the selected PHGs, and the plans then adopt the guidelines through the QIC. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines are reviewed and updated at least annually by Molina's QIC.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Molina distributes new and/or revised PHGs to providers in a variety of ways, including provider orientation materials, Provider Manuals, newsletters, mailings/faxes, Molina's website, etc. Paper copies are provided upon request.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services 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					Adopted clinical practice guidelines (CPGs) are based on scientific evidence and recommendations of national clinical-based organizations and focus on the demographics and general membership characteristics and high-risk, problem-prone, and/or high-cost population sub-sets. The guidelines are reviewed and updated at least annually by Molina's QIC.
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					Molina distributes new and/or revised CPGs to providers through the Provider Manual, newsletters, mailings/faxes, Molina's website, etc. Paper copies are provided upon request. The Provider Manual includes information about CPGs and a hyperlink to the guidelines on Molina's website.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Processes to ensure continuity of care for newly-enrolled members, members whose provider terminates, disenrolling members, etc. are addressed in Procedure MHSC-HCS-CM-PLCY-081, Continuity of Care and Coordination. Policy MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, indicates continuity and coordination of care between PCPs and other

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers is a component of annual medical record documentation audits.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					The Procedure titled "Assessing for Standards of Medical Record Documentation" associated with Policy MHSC QI 120.000, Standards of Medical Record Documentation, defines required medical record documentation elements and the process for evaluating PCP compliance with the documentation standards.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The "Assessing for Standards of Medical Record Documentation" procedure describes the process for annual assessment of provider compliance with medical record documentation standards. Final scores of ≥90% are considered passing, and scores <90% prompt an over-read. Over-read scores below 90% prompt a re-audit. The procedure does not define the timeframe for conducting the re-audit. Onsite discussion revealed re-audits are conducted within six months.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Medical record audit results are reported to the QIC and to SCDHHS annually. Results for Calendar Year 2020 were reported to the QIC in June 2021. Scores ranged from a low of 90.43% to high of 99.31% and no providers required re-audit. *Recommendation: Revise the procedure titled, "Assessing for Standards of Medical Record Documentation" to include the timeframe for re-audits for providers who do not successfully pass the initial audit and over-read.*
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					According to Policy and Procedure MHSC-ME-01, New Medicaid Member Outreach and Education, educational material is provided to new members within 14 calendar days from the date the eligibility file is received. Member ID cards are provided within 14 calendar days from the date the eligibility file is received or the date a PCP is selected, whichever is later.
1.1 Benefits and services included and excluded in coverage;						Information about member benefits is outlined in the Member Handbook and on Molina's website. A benefit grid in the Member Handbook lists and describes core benefits, covered services, and extra benefits provided by Molina, and any applicable limits or restrictions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services which require prior authorization are listed in the Member Handbook. Prior approval is not required for family planning services, emergency visits, or behavioral health services.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The Nurse Advice Line is available 24 hours a day, seven days a week. The Member Handbook and Molina's website describe and define behavioral health and physical health emergency services and provide clear and specific information about appropriate use of urgent and emergent services.
1.7 Policies and procedures for accessing specialty care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						Options for reporting fraud, wase, and abuse are outlined in the Member Handbook and on the Molina website.
1.22 Additional information as required by the contract and/or federal regulation;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Procedure MHSC-ME-05, Medicaid Member Disenrollment, describes processes for member disenrollment.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					Members are provided information and materials about general health and wellness topics. Onsite discussion indicated that the Communications Team adds new information to the website periodically, and information is also provided in the Member Newsletter.
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Molina contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct annual adult and child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					Response rates for the member satisfaction surveys were below the NCQA target of 40%: •The Adult survey had a response rate of 18.1% (306 responses out of 1701). This is a 1.9% decline from the 2020 response rate of 20%. •The Child survey had a response rate of 13.1% (476 responses out of 3,663). This is a 1.4% decline from the 2020 response rate of 14.5%. •The Child with Chronic Conditions response rate was 12.7% (304 responses out of 2409). This is a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						2.1% decline from the 2020 response rate of 14.8%. *Recommendation: Assess the benefits of additional methods to improve response rates such as design of cover letter, mode of survey administration, survey administration timing, and member awareness campaigns.*
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					SPH summarizes and details all results from both surveys. QI Evaluation displayed analysis of data and action steps to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Molina's QIC Committee presented results and initiated action plans to address problematic measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The results of the member satisfaction survey are made available to providers in the 2021 Q4 Palmetto Partners Provider Newsletter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The CAHPS Outcome report was presented to the QIC Committee and were found in the QIC Meeting Minutes 09 2021.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO 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					Policies and procedures are in place describing the grievance process consistent with *SCDHHS Contract* language.
1.1 The definition of a grievance and who may file a grievance;	X					Policy MHSC-MRT-001, Grievance Disposition Process, the Member Handbook, Provider Manual, and website correctly define a grievance and who can file a grievance. They indicate that anyone may file an oral or written grievance any time and authorized representatives must have a member's written consent to file on the member's behalf.
1.2 Procedures for filing and handling a grievance;	X					Policy MHSC-MRT-001, Grievance Disposition Process, indicates that grievances may be filed verbally in person, by telephone, in writing, by fax, or electronically. An authorized representative may file or assist members with the filing and processing of grievances.
1.3 Timeliness guidelines for resolution of a grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Grievances are logged, tracked, analyzed, and reported per Policy MHSC-MRT-001, Grievance Disposition Process.
2. The MCO applies grievance policies and procedures as formulated.	X					Of the grievance files randomly selected for review, processes were in place to demonstrate compliance with policy and contract standards.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO 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 2021 Medicaid Quality Improvement Program Description is updated annually and presented to the Board of Directors and the Quality Improvement Committee for approval. The QI Program Description clearly outlines the program's goals and objectives. Specific activities are identified to support the achievement of the program's goals. Molina's Provider Manual includes details regarding their Quality Management program and a copy of the QI program is available upon request. Molina's website contained information regarding the QI program for providers and for members. In the 2021 and 2022 QI Work Plans, Molina included an objective to include information about the QI Program and/or Progress Reports on the website and in the Member Handbook. However, there was no information found in the Member Handbook regarding the QI program. During the onsite, staff explained information regarding the QI Program is provide to members in a newsletter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. 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					
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Molina develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. Molina presented the 2020 and 2021 QI Work Plans for review. Under Section 6.0, Accessibility of Services: Primary Care and Member Services, the goals were missing for the Appointment Access Audit. Molina agreed the goals for this activity were missing and updated the work plan after the onsite.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QIC is responsible for oversight of the QI Program and the implementation, coordination, and integration of all QI activities.
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. Network practitioner participants include physicians specializing in pediatrics, OB/GYN, family medicine, and cardiology.
3. The QI Committee meets at regular quarterly intervals.	X					The committee meets at least quarterly. A quorum is defined as at least 51% of the committee members with no less than half of network provider participants. A review of the minutes provided found the quorum requirements were met for each meeting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes for each meeting are recorded and review during the next scheduled meeting.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Molina was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*. The comparison from the previous year to the current year revealed a substantial improvement (>10%) for five measures and a substantial decrease (>10%) for five measures. *Recommendation: Evaluate the cause for the decline in the Follow-Up After High-Intensity Care for Substance Use Disorder and Controlling High Blood Pressure rates and implement interventions to improve those rates.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					For this EQR, Molina implemented two new PIPs (Improving Encounters Acceptance Rates and Immunizations for Adolescents) and modified the Child

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Adolescent Well-Care Visits Program PIPs with a new indicator and baseline data.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					The PIPs met the validation requirements and received scores within the "High Confidence Range." Both indicators for the Improving Encounters Acceptance Rates PIP did not show improvements. *Recommendation: Continue monitoring of indicator rates to determine if logic adjustment and rejected encounter reviews improve rates toward 100% for initial acceptance rate.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Providers are advised that Molina requires their participation and compliance with the QI Program.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Molina provided two examples of the quality reports generated for providers. However, there was no documentation found regarding the process for how often these reports are generated and shared with providers. There was also no information found to inform network providers of the availability of these reports. *Recommendation: Include in a policy, program description, and Provider Manual, information*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						regarding the process followed for sharing provider performance data and feedback.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.		X				Molina evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors and the QIC. The Quality Improvement Program 2020 Medicaid Annual Evaluation was provided. The program evaluation included the Executive Summary and several appendices. Most of the results of the activities conducted in 2019 were included in the program evaluation. Activities related to the availability of practitioners (section 5.0 of the work plan), the continuity and coordination of care (section 9.0 and 10 of the work plan), and the provider directory analysis (section 11 of the work plan) were not included. The section in the Executive Summary regarding the focus for the upcoming year incorrectly included the focus for 2022 instead of 2021. These errors and omissions were discussed during the onsite. Molina indicated those activities omitted from the program evaluation were conducted and provided copies of some of the reports after the onsite. However, these activities were not considered when the 2020 QI Program Evaluation was conducted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Molina has developed a program description and several policies and documents that guide staff in the implementation of utilization management functions. Molina's Utilization Management (UM) Program is incorporated within the Healthcare Services area of the organization. The Healthcare Services Program Description describes and defines Molina's UM service

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						areas, such as service authorizations, retrospective reviews, care transitions, care management, appeals, and over- and under-utilization. The responsibilities for oversight have delegated to the South Carolina QIC. The Health Care Services Committee is a subcommittee of the QIC and reports on UM activities. The Healthcare Services Program Description was last reviewed and approved by the Health Care Services Committee on October 14, 2021.
1.1 structure of the program and methodology used to evaluate the medical necessity;	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					Molina's policy, UM Program Description, Member Handbook, and Provider Manual document the guidelines Molina follows for making timely UM decisions.
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established 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	
1.7 the mechanism to provide for a preferred provider program.	X					Molina's Preferred Provider Program is described in the UM Program Description, page 79. Practitioners who meet the specific indicators for participation are referred to the Star Provider Program. This designation makes providers eligible for increased member assignment, as well as reduction and simplification of the prior authorization process.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description describes the Chief Medical Officer's (CMO) role and responsibilities. The CMO oversees all aspects of the UM Program. The Behavioral Health Medical Director provides oversight and expertise for the behavioral health services area.
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, and modifications made as needed. The 2020 Healthcare Services Annual Evaluation was provided for review. The program evaluation was approved by the HCS Committee at the October 2021 meeting.
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					The UM Program Description describes the medical necessity criteria used by Molina and indicates that MCG criteria is used to conduct inpatient review except when InterQual is contractually required. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, indicates Molina utilizes InterQual. During the onsite

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussion, staff indicated MCG criteria is currently being used for medical necessity determinations. For psychiatric inpatient reviews, American Society of Addiction Medicine (ASAM) and appropriate National and Local Coverage Determination (NCD/LCD) may be used. The medical necessity criteria is reviewed, modified, and adopted by the Healthcare Services (HCS) Committee at least annually. *Recommendation: Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making and remove the reference to InterQual Criteria.*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					The UM Program Description and Procedure MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, describe the process Molina uses to evaluate the quality and consistency of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						clinical decisions among reviewers. Procedure MHSC-HCS-UM-361, Quality Assessment Process, describes the process Molina uses to evaluate reviewer comprehension and consistent application of criteria and/or guidelines. Quality audits are conducted monthly and inter-rater reliability audits are conducted annually. Results of the 2020 Inter-Rater Reliability (IRR) Analysis were reported in the 2020 Annual Healthcare Services Program Evaluation. Per the program evaluation, each individual clinician reviewed the same eight outpatient or eight inpatient hypothetical case presentations to evaluate the accuracy of applying medical necessity criteria and resulting decisions. However, Procedure MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, indicates that Molina will use the NCQA 8/30 audit methodology, and 30 files are selected at random for review of each Healthcare Services Care Review Clinicians. This was discussed during the onsite, and staff indicated a SC specific policy/procedure is used for IRR testing. A copy of policy and procedure HCS-366, Consistency in Application of Medical Necessity Criteria and Inter-Rater Reliability Documentation Guidelines, was provided. This policy outlines the process Molina uses in SC and reported in the 2020 Annual Healthcare Services Program Evaluation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.		X				Molina provides coverage for medications through their Pharmacy Benefit Manager. The Pharmacy and Therapeutics Committee is responsible for developing and updating the pharmacy formulary or the preferred drug list. The committee's oversight also includes prior authorization criteria, pharmaceutical classes, step therapy, quantity limits, and restrictions. Providers may request a formulary exception to a prescribed medication not listed in the formulary. Molina's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. There was no information regarding when those changes were approved by the Pharmacy and Therapeutics Committee and when the negative PDL changes were published on the website. The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3,* requires the health plan's Pharmacy & Therapeutics Committee to approve the PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plan's website at least 30 days prior to implementation. Molina's changes posted on the website did not appear to meet this requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Molina's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					Molina's Adverse Benefit Determination Notice indicates the member or provider may request a copy of the criteria used for the review decision. Information regarding criteria was found in the Provider Manual.
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
information prior to making the decision to deny services.						
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 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					Molina provides prompt notifications to member and providers of their decisions to deny a requested services as demonstrated in the denial files reviewed. The adverse benefit determination notice included the actions Molina intended to take, the reason for those actions, and instructions for appealing the decision. Molina uses a standard Adverse Benefit Determination Notice template for all denial notices. In one file, it was noted the denial was issued for a non-covered service. The standard language in the Adverse Benefit Determination Notice template stated, "You will have to meet all of the set rules before this can be approved." The notice further stated, "you or your doctor may ask for a copy of the criteria used for this review decision." This standard language did not appear appropriate in this case. *Recommendation: Develop an Adverse Benefit Determination Notice template for denials issued for non-covered services.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Molina has several policies that describe how appeals are submitted and processed. Policy and procedure MHSC-MRT-002, Standard Appeal Process, and policy and procedure MHSC-MRT-003, Expedited Appeal Process, detail Molina's appeal process. Appeal information is provided in the Member Handbook, Provider Manual, and on the website. The website also includes forms for members or providers to file an appeal.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;		X				Requirements for filing an appeal are documented in policies and procedures. Policy and procedure MHSC-MRT-002, Standard Appeal Process, the UM Program Description, the Guidelines for Appealing a Medical Denial, the Member Handbook, the Provider Manual, and the website indicate a standard request for an appeal received verbally must be followed by a written request within 30 days. This requirement was removed from the *SCDHHS Contract* and the *Federal Regulation*. *Quality Improvement Plan: Revise all documents related to the process for filing an appeal and*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						remove the requirement that indicates a standard request for an appeal received verbally must be followed by a written request.
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					Per Molina's policy, once pertinent information related to the appeal is received, all information is forwarded to a physician for clinical review.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				A sample of appeal files were reviewed. There were three files that were untimely and four files where the physician who made the appeal decision was not of the same or similar specialty as the ordering physician. Two of those cases were pediatric cases reviewed by a physician who specializes in internal medicine and two plastic surgery cases also reviewed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by a physician who specializes in internal medicine. According to staff, the physicians' reviewing appeal requests are directed to use criteria and matching specialty was not necessary. Molina was cautioned regarding allowing physician reviewers to only utilize criteria when making medical necessity decisions on appeals. *Quality Improvement Plan: For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate physician reviewers regarding only utilizing review criteria and not considering individual medical conditions when making appeal determinations.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					The Molina Healthcare of South Carolina, Inc. Healthcare Services (HCS) Program Description includes information about the Care Management (CM) and Healthcare Transitions (TOC) Programs. A host of policies and procedures provide detailed information to guide staff conducting CM and TOC activities.
2. The MCO has processes to identify members who may benefit from care management.	X					The HCS Program Description addresses risk stratification processes and describes the risk levels. Members are stratified using methodologies such as eligibility data, the Molina Health Risk Assessment (HRA), condition-specific and comprehensive assessments, social determinants of health (SDOH), and referrals, along with clinical judgement. Risk stratification levels include: •Level 1—Health/Disease Management •Level 2—Care Coordination •Level 3—Complex Case Management •Level 4—Intensive Needs Case Management In addition, programs for members with special, specific needs, such as the Sickle Cell Disease Program, are in place. Procedure MHSC-HCS-CM-051, Risk Stratification, provides detailed information about risk stratification processes for new members and existing members. As noted in the procedure, the initial level of care may

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						change over time as the member's condition progresses or needs change.
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Procedure MHSC-HCS-CM-047, Integrated Care Management Program and Complex Case Management, does not provide a clear understanding of when and for whom a comprehensive assessment is conducted. Also, the procedure does not clearly identify the frequency of routine outreach for the CM risk levels. Molina reported that this information is included in a quick reference guide. A copy of QRG-CM-001, Case Management Outreach and Communication, was provided after the onsite. This document includes a table listing the outreach frequency and assessments conducted for each of the CM risk levels.
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Processes and activities for care coordination and care transition are found in Procedure MHSC-HCS-CM-PLCY-081, Continuity of Care and Coordination, and Procedure MHSC-HCS-CM-406, Transition to Other Care When Benefits End. The procedures address coordination and transition of care for new members,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						new pregnant members, members under the care of a provider whose contract terminates, etc.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					
6. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					The Healthcare Services Program, including the Care Management Program, is reviewed, evaluated, and updated annually. Molina also conducts ongoing monitoring and evaluation of CM Program by monitoring program metrics and CM outcomes. When opportunities for improvement are noted, interventions are implemented, and the effectiveness of the interventions is assessed. Procedure MHSC-HCS-CM-0473.14, Integrated Care Management Program and Complex Case Management, addresses processes for evaluating member satisfaction with the program using a survey process of members whose case has been closed and members who are active in CM and have received services for at least 60 days. Member satisfaction is also measured via an analysis of member complaints and inquiries related to the program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Care management and coordination activities are conducted as required.	X					No issues or concerns were identified in the sample of CM files reviewed. The files reflected: •Consistent documentation of member consent for participation in CM activities. •Appropriate assessment and care plan development •Routine member outreach attempts at appropriate frequencies. •Use of "unable to contact" letters and appropriate case closure when members could not be contacted after multiple attempts.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					Policy MHSC-HCS-UM-362, Monitoring to Ensure Appropriate Utilization, addresses monitoring and analysis of relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization which may impact health care services, coordination of care, and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for over- and under- utilization.	X					As noted in the 2021 Q2 and Q3 Utilization Reports and HCS Committee Minutes, Molina monitors data for: •ER Utilization •Medical/Surgical admissions •Behavioral Health admissions •Readmissions

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Documentation in the quarterly Health Care services committee meetings indicated Molina analyzed and monitored the data, and offered recommendations based on findings.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Delegation Services Addendum document and related documents define delegation terminology and include activities to be delegated, general terms and conditions for delegation, and information about actions that may result from non-performance or non-compliance with the delegation agreement. Delegates are also informed about reporting requirements and ongoing and annual monitoring activities. Delegation agreements are implemented with each approved delegate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHSC-DO-001, Pre-Assessment Audits, indicates delegation agreements are executed after completion of pre-delegation assessments and approval of the delegation by the Delegation Oversight Committee (DOC).
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Policy MHSC-DO-002, Continual Monitoring and Annual Audits of Delegation, and its associated procedure describe annual oversight and ongoing monitoring processes for delegated entities. Processes for revoking delegation or imposing sanctions/corrective actions for subpar performance are addressed in the established delegation policies. Documentation of pre-delegation assessment and annual oversight was submitted for review. The documentation confirmed annual oversight is conducted for each delegate. Also, the documentation indicated Molina initiates corrective action when warranted and conducts appropriate follow-up of the corrective action. It was noted that one delegate was terminated due to non-compliance with delegated credentialing requirements. Onsite discussion revealed two additional delegation agreements were terminated for delegates whose services were no longer needed.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Policy MHSC-AD-03, EPSDT Notification, Tracking and Follow-up, states Molina has adopted the American Academy of Pediatrics (AAP) Children and Adolescents Preventive Health Guidelines and conducts monitoring to ensure all required EPSDT services (including immunizations) are timely according to required guidelines. The corresponding Procedure MHSC-AD-03, EPSDT Notification, Tracking and Follow-up Procedure, states the Quality Improvement Department tracks members that are non-compliant for Well-Child care by monitoring HEDIS® data sets. Members are notified of services for which they are eligible, and staff make attempts to follow up with non-compliant members until the care gaps are closed. Quality Reports are run monthly and as needed and distributed to providers. The reports include detailed information about ER utilization and member-specific gaps in care.
1.2 performing EPSDTs/Well Care.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Core benefits provided by the MCO include all those specified by the contract.	X					All contractually-required core benefits are covered.
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					