2021 External Quality Review

MOLINA HEALTHCARE OF SOUTH CAROLINA

Submitted: May 20, 2021

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 Molina Healthcare of South Carolina (Molina) 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 since the 2020 Annual Review.

The goals 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 2020 annual EQR 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, and validation of performance improvement projects, performance measures, and 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 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 access Molina's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration:

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

Molina has policies and procedures in place to guide staff in conducting day to day activities of the health plan. The organizational structure, staffing, lines of communication, and oversight are clearly defined. The prevention and detection of suspected fraud, waste, and abuse is conducted by the Compliance Officer, Compliance Committee, and the Special Investigation Unit. Training and education about general policies and compliance issues is a collaborative effort between Human Resources and the Compliance Department.

The Information System Capabilities Assessment (ISCA) documentation provided by Molina indicates the provider is capable of satisfying the requirements of the *SCDHHS Contract*. Specifically, Molina has a robust business continuity plan that details the activities required to limit system and service interruption. Molina's Disaster Recovery (DR) documentation indicates the organization performed system recovery operations to a separate data center. Performing a DR test in this manner is resource-intensive but tends to be more thorough than a "tabletop" exercise.

Auditing and monitoring are used to identify areas of compliance deficiency; to respond to reports of suspected non-compliance; to assess continuing compliance; and to assess the effectiveness of corrective measures implemented to address previously identified compliance deficiencies. Corrective Action Plans (CAPs) are issued once non-compliance from either internal or external sources has been identified. The Special Investigation Unit (SIU) may identify overpayments and issue sanctions after an audit or investigation. In all areas of business operations, Molina protects the privacy and maintains the confidentiality of members' Protected Health Information (PHI) in accordance with state and federal laws and contractual requirements.

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

Processes and requirements for initial credentialing and recredentialing of independent and organizational providers are documented in policies. Molina's follows state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA) for credentialing and recredentialing. The Professional Review Committee, chaired by the Medical Director, makes recommendations for credentialing decisions through a peer review process. The committee's membership includes Molina network providers with varying specialties. The meeting minutes reflected review of Level I providers approved by the Medical Director and appropriate review and discussion of providers requiring Level II review.

CCME reviewed a sample of credentialing and recredentialing files for independent practitioners and organizational providers. No issues were identified in the initial credentialing files but, due to Molina's process for completing the Recredentialing Checklist, CCME could not determine that the required sanctions monitoring was conducted for most independent and organizational providers at recredentialing. Molina staff explained its process, and CCME offered a recommendation to improve this process.

Ongoing sanction and exclusion monitoring of providers is conducted by a vendor, and appropriate processes are in place to notify internal departments when a match is confirmed to both terminate the provider's contract and configure the claims system to prevent future claims and authorizations for the provider.

Processes are in place to evaluate Molina's network against required standards for primary care providers (PCPs), specialists, and organizational providers. Time/distance requirements for PCPs, specialists, and hospitals are defined in policy. The Geo Access report for Q4 of 2020 did not provide evidence that access was measured for psychologists. Along with network availability, Molina monitors provider compliance with appointment access standards through annual provider availability and after-hours telephonic surveys. The Provider Availability Standards procedure (MHSC-PS-005) does not include the standards for specialist emergent visits and urgent appointments. Also, the timeframe for routine specialty appointments is incomplete in this procedure and in the Provider Manual. CCME noted the Provider Directory does not include all required elements.

Appropriate processes are in place for provider education and review and adoption of clinical practice and preventive health guidelines. PCPs are evaluated for coordination

and continuity of care, as well as compliance with medical record documentation standards, through annual medical record documentation audits.

As part of the annual EQR process for Molina, CCME conducted a provider access study focused on PCPs. It was noted that Molina had a statistically significant decrease in the number of successfully answered calls from the previous year's results.

Member Services:

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

Molina has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New members receive a Welcome Packet that includes a Quick Start Guide with instructions for contacting Member Services, accessing the Member Handbook and Molina's website, and initiating services. All members have access to information and resources in the Member Handbook, on the website, and in member newsletters that assists members to utilize their benefits. The website includes preventive health services, available case management programs, and instructions to obtain educational support.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continue to be conducted annually by a third-party vendor, SPH Analytics. The 2020 survey response rates fell below the NCQA target response rate of 40%.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

Molina has a Quality Improvement (QI) Program with specific goals and objectives outlined in the Medicaid Quality Improvement Program Description 2020 and in the QI Work Plan. Molina presented the draft 2020 and 2021 Medicaid Quality Improvement Work Plans for review. Both are updated, as needed, and presented to the Quality Improvement Committee on a quarterly basis for approval. During the previous EQR, several errors related to the goals and benchmarks being measured were noted in the 2020 work plan. Molina corrected those errors; however, the dates in the column labeled "Timeline" were not updated. Molina indicated the work plan was in draft form and the timeline dates would be updated.

Molina's Quality Improvement Committee (QIC) continues to be responsible for the implementation, oversight, and ongoing monitoring of the QI Program. The Quality Improvement Committee is co-chaired by the Chief Medical Officer (CMO) and the Quality Lead. Members include key staff from functional areas of the health plan and contracted network providers specializing in Pediatrics, OB/GYN, Family Medicine, and Cardiology.

Molina also has a designated Behavioral Health practitioner who advises Molina in QI activities related to behavioral health. The committee meets at least quarterly.

Annually, Molina conducts a formal evaluation of the QI Program to assess the effectiveness of the program's activities and determine actions needed. It was noted during the previous EQR that the 2018 QI Program Evaluation did not include all the quality improvement activities. Molina addressed those missing activities in their Quality Improvement Plan submitted following last year's EQR. The Quality Improvement Program 2019 Medicaid Annual Evaluation was provided and found that Molina included summaries and analyses of all activities. Section 14, Areas of Focus/Recommendations for Next Year, was not included. However, this was provided during the onsite.

Performance Measure Validation

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 (HEDIS 2020), the previous year (HEDIS 2019), and the change from 2019 to 2020 can be found in the Quality Improvement section of this report.

As shown in *Table 1: HEDIS Measures with Substantial Changes*, the comparison from the 2019 rates to the 2020 rates revealed a substantial increase (>10%) in the prenatal care and postpartum care measures. The measures with a substantial decrease (>10%) include persistence of beta-blocker treatments after heart attack.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	Change from MY 2018 to MY 2019
Substantial Increase in Rate (>10% improvement)			
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	86.37%	99.76%	**13.39%**
Postpartum Care	69.83%	83.21%	**13.38%**
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.92%	64.29%	**-12.63%**

Quality Withhold Measures

Molina reported 12 quality clinical withhold measures reported for MY 2019. The 2019 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Diabetes measure rates generated the highest index score, followed by Women's Health, and then Pediatric Preventive Care. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020).

Table 2: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.77%	90	6	5.05
HbA1c Control (< =9)	47.49%	25	3	
Eye Exam (Retinal) Performed	61.87%	90	6	
Medical Attention for Nephropathy	93.41%	75	5	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	99.76%	90	6	4.35
Breast Cancer Screen	57.26%	25	3	
Cervical Cancer Screen	64.72%	50	4	
Chlamydia Screen in Women (Total)	60.82%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	73.45%	75	5	3.75
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.57%	25	3	
Adolescent Well-Care Visits	57.91%	50	4	
Weight Assessment/Adolescents: BMI % Total	78.52%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	58.76	90	6	3.75
Antidepressant Medication Management Effective Continuation Phase Treatment	29.13%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	66.87%	75	5	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	26.92%	10	2	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	35.67%	50	4	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	42.57%	50	4	

Performance Improvement Project Validation

Molina submitted three projects for validation: Breast Cancer Screening, Well-Care Program, and Correlation Between Member Assignment and Engagement. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

TABLE 3: Performance Improvement Project Validation Scores

Project	2019 Validation Score	2020 Validation Score
Breast Cancer Screening (Clinical)	91/91=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Well-Care Program(Clinical)	111/111=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Correlation Between Member Assignment and Engagement (Non-Clinical)	Not Submitted or Validated	63/74=85% Confidence in Reported Results

For the Breast Cancer Screening Performance Improvement Project (PIP), the rate decreased in the most recent remeasurement from 58.83% to 57.26%. Several interventions have been initiated for this PIP including member outreach through postcard mailing and call campaigns, community engagement team calls, member incentives, and transportation assistance. The provider-related interventions included provider education through provider quality reports, HEDIS tip sheets and scorecards, and a quality engagement team (QET). This PIP has been ongoing for several years and has shown little or no improvements on the breast cancer rates even with all the incentives and initiatives. It seems the QET appears to have a stronger impact on the rates than gift card incentives. Molina should consider continuing the effective interventions, monitor the breast cancer screening rate, and replace this PIP with another project focusing on a different priority population to continue improving the quality of care.

For the Well-Care Program PIP, most of the measures improved, except for the Adults' Access to Preventive/Ambulatory Health Services measure. The interventions for this PIP are focused on incentives for the members including gift cards, outreach via telephone, transportation assistance, reminder calls, and member education. The provider interventions include incentives, education via HEDIS scorecards and the QET partnership, as well as education related to clinical and coding practices. Several measures in this PIP are being replaced or are retired (e.g., Children and Adolescents' Access to Primary Care

Practitioners measure). Molina indicated the health plan would document the changes and consider using new measures.

The Member Assignment and Engagement PIP documentation reported system limitations and data issues that are affecting accuracy of reported rates and member assignments. This PIP had baseline and one remeasurement displayed in the report. 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 this indicator. The interventions that align with specific data barriers were not presented in the PIP report, although it is evident from the analyses that the primary intervention is addressing data management and reporting.

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)

CCME's assessment of utilization management (UM) includes reviews of the Healthcare Services, Pharmacy, and Quality Program Descriptions, program evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. The Healthcare Services Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Policies and procedures are well-written and clearly define how services are implemented and provided to members.

Molina's CMO and Behavioral Health Medical Director provide oversight and expertise for UM activities. Appropriate reviewers conduct service authorizations using InterQual guidelines or other established criteria. Molina has policies defining processes for handling appeals of adverse benefit determinations. The Care Management policies appropriately document care management processes and services provided. Care Management files indicate care gaps are identified and addressed consistently and services are provided for various risk levels.

Overall, the review of UM approval, appeals, and denial files provided evidence that appropriate processes are followed, and no major issues were identified with review of the UM Program.

Delegation:

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

Policies and procedures define delegation processes and requirements. The Delegation Oversight Committee oversees and is accountable for delegated activities. For all

delegated entities, Molina implements written agreements that specify the delegated activities as well as requirements for assessments and ongoing monitoring, sub-delegation, reporting requirements, performance expectations, and actions that may be taken for unsatisfactory performance. Review of delegation oversight documentation confirmed Molina conducts ongoing monitoring and annual oversight of delegates. Molina implemented appropriate corrective action and follow-up for delegates who were not performing satisfactorily.

State Mandated Services:

42 CFR § Part 441, Subpart B

Molina's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program follows the Bright Futures Periodicity Schedule for required screenings and health treatments. Provider compliance with provision of EPSDT services and required immunizations is monitored through HEDIS requirements and medical record reviews conducted by the Quality Department. The Quality Improvement 2019 Medicaid Program Evaluation identified Well-Child Visits in the third, fourth, fifth and sixth Years of Life below the tenth percentile benchmark.

Molina provides all core benefits specified by the *SCDHHS Contract* and offers extra benefits and services at no cost to eligible members.

Quality Improvement Plans from Previous EQR

During the previous EQR, there were three standards scored as "Partially Met" and two standards scored as "Not Met." Following the 2020 EQR, Molina submitted a Quality Improvement Plan to address any deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on July 21, 2020. The following is a high-level summary of those deficiencies:

- For grievances referred to Provider Services, the grievance files contained no documentation of investigation or resolution of the issues about which the member voiced dissatisfaction. This was a previously identified as an issue in the 2019 EQR.
- There were several issues identified in the Quality Improvement Work Plan regarding benchmarks and goals listed.
- The Quality Improvement Program Evaluation did not include the results of all QI activities conducted during the year. Practitioner availability and accessibility, patient safety initiatives, medical record review activities, delegation monitoring, and performance improvement project results were not included.

- A deficiency from the previous EQR related to closing member grievances prior to investigation and providing inadequate information in the member's notification of grievance resolution was not corrected.
- Members are not notified of their right to have access to their appeal case files, and the address for submitting the appeal request was incorrect in several documents.

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 Plan was implemented and the deficiencies were corrected.

Table 4, Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. 210 of 214 standards received a score of "Met." There were three standards scored as "Partially Met" and one standard related to the Telephone Provider Access Study that received a "Not Met" score.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2020	40	0	0	0	0	40	100%
2021	40	0	0	0	0	40	100%
Provider Services							
2020	79	0	0	0	0	79	100%
2021	73	2	1	0	0	76	96%
Member Services							
2020	32	0	1	0	0	33	97%
2021	33	0	0	0	0	33	100%
Quality Improvement							
2020	12	2	0	0	0	14	86%
2021	13	1	0	0	0	14	93%
Utilization							
2020	44	1	0	0	0	45	98%
2021	45	0	0	0	0	45	100%
Delegation							
2020	2	0	0	0	0	2	100%
2021	2	0	0	0	0	2	100%

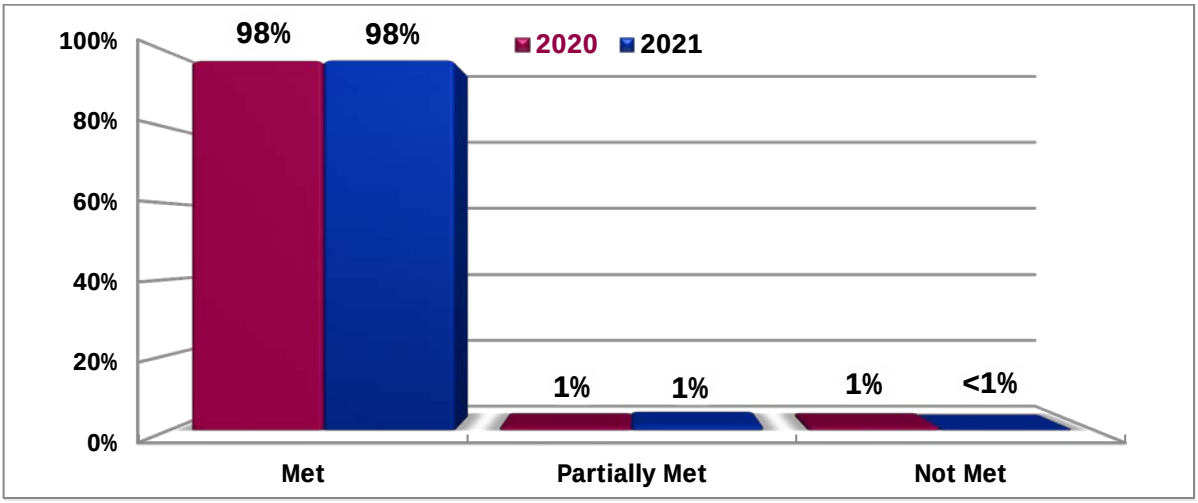
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
State Mandated Services							
2020	3	0	1	0	0	4	75%
2021	4	0	0	0	0	4	100%
Totals							
2020	**212**	**3**	**2**	**0**	**0**	**216**	**98%**
2021	**210**	**3**	**1**	**0**	**0**	**214**	**98%**

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

Conclusions

Overall, Molina met the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. The 2021 Annual EQR shows that Molina has achieved a "Met" score for 98% of the standards reviewed. 1% of the standards were scored as "Partially Met" and 0.47% of the standards scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2020 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

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

- It was difficult to determine in most recredentialing files for individual practitioners and organizational providers that sanctions and exclusions were checked at recredentialing.
- The Q4 2020 Geo Access report did not include all required Status 1 providers.
- The Provider Directory did not include all required elements.
- Molina's Provider Availability Standards procedure does not include standards for specialty emergent visits or urgent medical condition care appointments, and the timeframe for routine specialty appointments was incomplete.
- For the Provider Access Study conducted by CCME, Molina was noted to have a statistically significant decrease in the number of successfully answered calls when comparing the previous year's results.
- Network providers receive monthly Quality Reports that contain provider specific data regarding assigned members.
- Documentation issues in the Correlation Between Member Assignment and Engagement PIP caused a lower validation score.
- The Breast Cancer Screening PIP has shown little or no improvement in the screening rate.
- Information on available health services and programs is not clearly identified or accessible on the website, and the newsletter, "A Guide to Accessing Quality Care," is heavily focused on "quality" issues and does not provide general health care topics and information.
- Response rates for each of the CAHPS surveys were below the NCQA target of 40%.
- Members are completely educated on the requirements and expectations for co-payments.
- As a convenience to members, the "Medical Appeal Request Form" and "Guidelines for Appealing a Medical Denial" instructions are enclosed with Adverse Benefit Determination notices.
- Molina conducts appropriate ongoing monitoring and annual oversight of delegated entities and takes appropriate action when delegates do not perform satisfactorily.
- Molina offers several extra services at no cost to members.

Recommendations and Opportunities for Improvements

Areas needing corrections and recommendations include:

- Include complete information about sanction and exclusion queries on the Recredentialing Checklist.

- Ensure all required Status 1 providers are included in Geo Access reports.
- Revise the Provider Directory to include all required elements.
- Update the Provider Availability Standards procedure to include standards for specialty emergent visits, urgent medical condition care appointments, and the complete timeframe for routine specialty appointments.
- Implement interventions to improve provider contact information.
- Display the specific data and system issues in the Correlation Between Member Assignment and Engagement PIP and aligned interventions to address those issues in the PIP report.
- Reevaluate the Breast Cancer Screening PIP and consider replacing this PIP with another project focusing on a different priority population to continue improving the quality of care.
- Edit the member website to clearly identify where information on preventive health and disease management services are located and consider adding healthcare topics and information on the website.
- Continue working with SPH Analytics to increase response rates for CAHPS surveys.

METHODOLOGY

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

On February 8, 2021, CCME sent notification to Molina that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for 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 22, 2021 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. A review of credentialing, grievance, utilization, case management, and appeal files was also included in the desk review.

The second segment was a virtual onsite review conducted on April 21 and 22, 2021. 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

Molina has policies and procedures in place to guide staff in conducting day to day activities of the health plan. The organizational structure, staffing, lines of communication, and oversight are clearly defined. The prevention and detection of suspected fraud, waste, and abuse is conducted by the Compliance Officer, Compliance

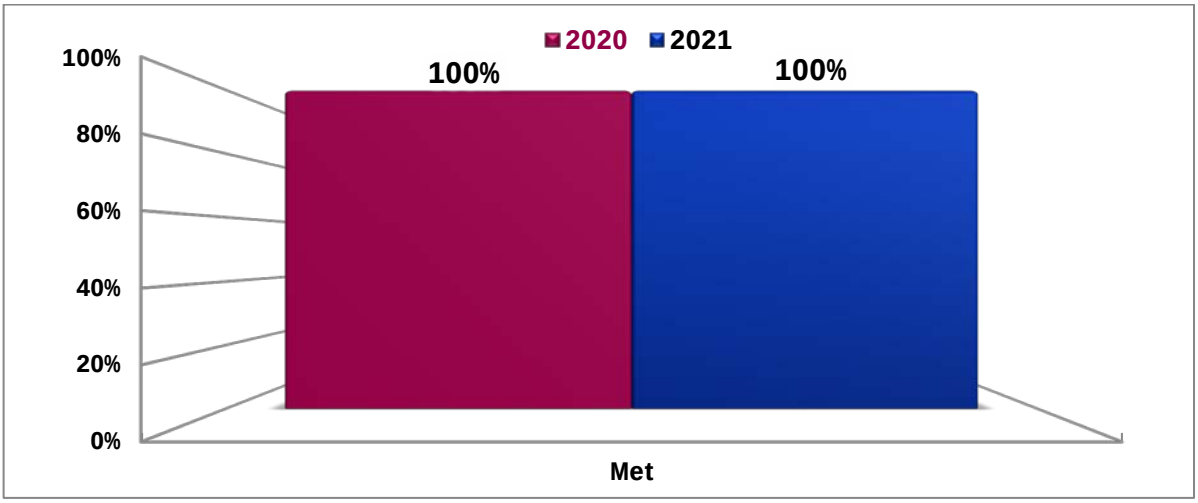
Committee, and the Special Investigation Unit. Training and education about general policies and compliance issues is a collaborative effort between Human Resources and the Compliance Department.

The ISCA documentation provided by Molina indicates the health plan can satisfy the requirements of the *SCDHHS Contract*. Specifically, Molina has a robust business continuity plan that details the activities required to limit system and service interruption. Molina's Disaster Recovery (DR) documentation indicates the organization performed system recovery operations in a separate data center. Performing a DR test in this manner is resource intensive but tends to be more thorough than a "tabletop" exercise. Molina's DR test efforts should be commended. Molina's average time for paying claims was found to be 95.9% paid within 30 days and 100% paid within 90 days.

Auditing and monitoring are used to identify areas of compliance deficiency, respond to reports of suspected non-compliance, and to assess continuing compliance and the effectiveness of corrective measures implemented to address previously identified compliance deficiencies. Corrective Action Plans (CAPs) are issued once non-compliance from either internal or external sources has been identified. The Special Investigation Unit (SIU) may identify overpayments and issue sanctions after an audit or investigation. In all areas of business operations, Molina protects the privacy and maintains the confidentiality of its members' Protected Health Information, in accordance with state and federal laws and contractual requirements.

The 2021 EQR review resulted in a 100% "Met" scores for the Administration standards.

Figure 2: Administration Findings



Strengths

- Molina frequently reviews and revises policies to address state and federal guidelines.

- Business recovery testing exercises that recover IT resources are conducted at a different data center.

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 file review, network adequacy, provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical records.

Provider Credentialing and Selection

Initial provider credentialing and recredentialing processes and requirements are documented in Policy CR 01, Credentialing Program Policy. Requirements and processes for organizational providers are addressed in Policy CR 02, Assessment of Organizational Providers. Molina's Credentialing Program follows state and federal requirements and the standards of the NCQA. Non-discriminatory credentialing and recredentialing practices are employed. The Professional Review Committee (PRC) reports to the Quality Improvement Committee (QIC) and is designated to make recommendations for credentialing decisions through a peer review process. The Medical Director chairs the PRC and appoints committee members, who must be Molina network providers. The PRC meeting minutes confirmed the committee meets frequently and membership includes an array of provider specialties from within the network. The meeting minutes reflected review of Level I providers approved by the Medical Director and appropriate review and discussion of providers requiring Level II review.

CCME reviewed a sample of credentialing and recredentialing files for independent practitioners and organizational providers. Overall, the files were in good order. However, due to Molina's process for completing the Recredentialing Checklist, CCME could not determine that the required sanctions monitoring was conducted for most independent and organizational providers at recredentialing. Molina staff explained the process, and CCME offered a recommendation to improve this process.

Ongoing monitoring of providers for sanctions and exclusions is conducted by a vendor, EPStaffCheck. Appropriate processes are in place to notify applicable internal departments when a match is confirmed. Molina immediately terminates the practitioner's contract across all states for all lines of business, effective the date the sanction was implemented, and the claims system is configured to prevent future claims and authorizations by the provider.

Availability of Services

Processes have been established to evaluate Molina's network against required standards for PCPs, specialists, and organizational providers. Time/distance requirements for PCPs, specialists, and hospitals are defined in policy. Geo Access reports are run quarterly, and network reporting is provided to SCDHHS twice yearly. The Provider Contracting Department develops a provider availability evaluation and plan annually. CCME noted the Geo Access report for Q4 of 2020 did not provide evidence that access was measured for psychologists.

Standards for appointment access for PCPs and specialists are defined in the Provider Availability Standards procedure (MHSC-PS-005). Appointment standards for PCPs are appropriately documented, but standards for specialty appointments do not include the standards for emergent visits or urgent medical condition care appointments. Also, the timeframe for routine care (non-symptomatic) specialty appointments is incomplete. This incomplete timeframe is also noted in the Provider Manual. Molina's process for measuring and ensuring availability of primary, urgent, and emergency care services includes annual provider availability and after-hours telephonic surveys of network providers.

To monitor and assess the network's ability to meet the needs of members with special language and cultural needs, Molina requests practitioner race/ethnicity and language information from network providers at initial credentialing and annually, on a voluntary basis. Molina also gathers information about language services offered by providers. The web-based Provider Directory includes provider gender and languages spoken. Various data sources are monitored to assess language and cultural needs of Molina's membership, including prevalent language and cultural groups. Provider Contracting staff use the data to align the network to meet the various member needs. Molina supports providers by training them on available language services and providing language assistance resources for in-person, video, and telephonic interpretation services.

The *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR §438.10 (h) (vii)* define elements that must be included in the Provider Directory. CCME's review of the Molina's Provider Directory revealed a few of the required elements are not included. The missing elements are provider website addresses, whether the provider has completed cultural competency training, and whether the provider can accommodate physical disabilities.

The Provider Services Manager/Supervisor or Provider Services Representatives conduct provider training. Initial provider training and orientation are conducted at the initiation of the provider's contract with Molina. Ongoing provider education is conducted during monthly or quarterly provider site visits, as needed, and upon request. Education is provided in a variety of ways, including through face-to-face presentations, fax

communications, electronic communications, newsletters, webinars, the Molina website, etc. Provider Office Manager Meetings are held at least annually, and regional provider training sessions are held throughout the year.

Upon recommendation from the National Quality Improvement Committee, Molina reviews and adopts Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) to provide up to date treatment and diagnostic information about important clinical and preventive health topics to Molina providers. The CPGs and PHGs define expected standards of practice, are specific to Molina's membership, and may serve as the basis for health/disease management programs, benefit interpretation, or quality measures. CPGs and PHGs are distributed to providers through various avenues, including provider orientation materials, Provider Manuals, newsletters and other mailings, the website, and fax blasts.

Primary care providers are evaluated for coordination and continuity of care, as well as compliance with medical record documentation standards, through annual medical record documentation audits. A review score of 90% or above is considered passing score. For final review scores of <90%, a re-audit is required.

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, CCME conducted a Provider Access Study focused on PCPs. From a list of current Molina network providers, a population of 2,459 unique PCPs was found. A sample of 180 providers was randomly selected from this population for the Access Study. Attempts were made to contact the 180 providers to ask a series of questions regarding member access to the providers.

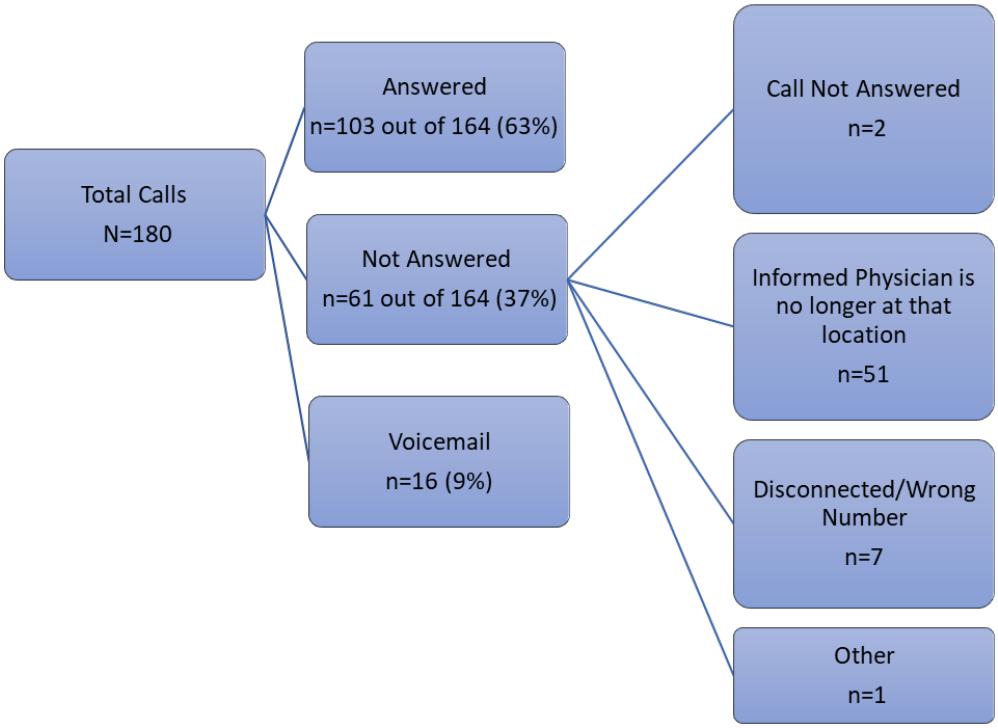
Calls were successfully answered 63% of the time (103 of 164) when omitting 16 calls answered by personal or general voicemail messaging services. When compared to last year's result of 74%, this year had a decrease in successful calls at 63% (p=.0275), as shown in *Table 5: Telephonic Access Study Answer Rate Comparison*. This is a statistically significant decline from the previous year's rate.

Table 5: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2020 Review	207	74%	.0275
2021 Review	180	63%	

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

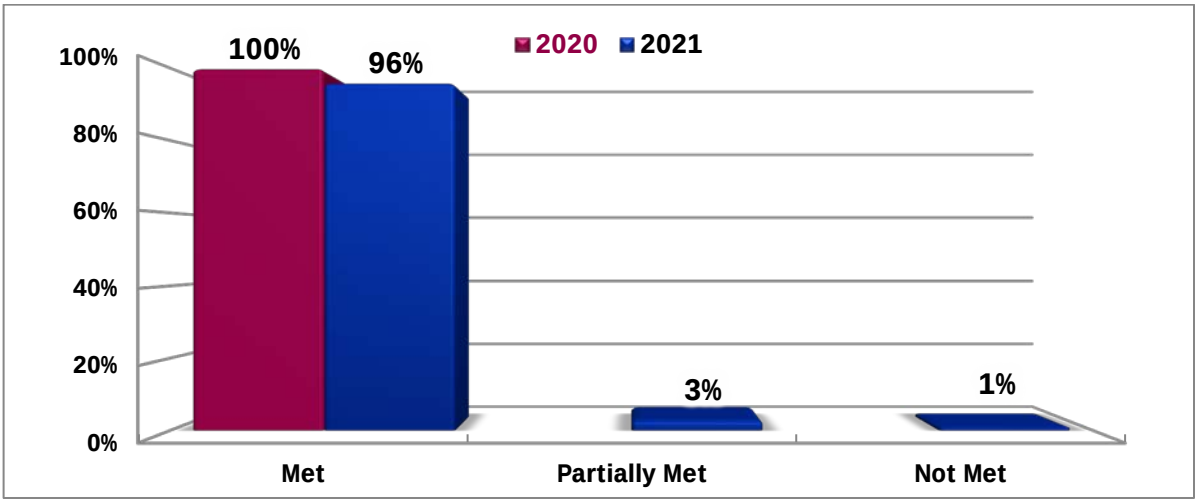
Figure 3: Telephonic Provider Access Study Results



A total of 103 of 164 calls (63%) were considered successful. For the 61 calls not answered successfully, the majority (n = 51, 84%) were because the physician was no longer practicing at the location. Of the 103 successful calls, 94 (91%) of the providers indicated they accept Molina and 78 (83%) of the 94 indicated they accept new patients. For the 78 providers that accept new patients, 30 (39%) do not require a prescreening and 48 (61%) do require a prescreening. Of those 48, three (6.3%) indicated an application must be filled out; six (12.5%) require a review of medical records; and 32 (67%) require both an application and a medical record review. Seven of the 48 (14.5%) required a referral.

Figure 4: Provider Services Findings shows 96% of the standards in Provider Services received a "Met" score. *Table 6: Provider Services Comparative Data* highlights changes in scores from 2020 to 2021.

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 6: Provider Services Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Adequacy of the Provider Network	The MCO maintains a provider directory that includes all requirements outlined in the contract	Met	Partially 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	Met	Partially Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- The Professional Review Committee meets more frequently than required by policy. Committee minutes reflect thorough review and discussion of providers under consideration.
- Comprehensive provider education is provided through a variety of methods. The Provider Manual and Molina website are additional resources of information for providers.

Weaknesses

- Due to the process Molina follows for completing the Recredentialing Checklist, it was difficult to determine in most recredentialing files for individual practitioners and organizational providers that sanctions and exclusions were checked at recredentialing.
- The Q4 2020 Geo Access report did not include psychologists, defined as Status 1 providers in the *Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*
- 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 has completed cultural competency training
  - 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 when comparing the previous year's results (74%) to current results of 63%.
- Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, page 2, item E (1) states the Medical Record Audit Tool is included in Attachment A of the document but was not located as an attachment to the procedure.
- Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, describes processes for the annual medical record review and scoring methodology. However, the procedure does not describe the re-audit process or timeframe for providers who do not meet the 90% scoring threshold.

Quality Improvement Plans

- 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)*.
- 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*.

- 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.

Recommendations

- To clearly convey that the required sanction/exclusion monitoring is conducted for all providers at recredentialing, complete the Sanctions/Exclusions section of the Recredentialing Checklist to indicate verification is conducted by EPStaffCheck, the date of the verification, and who reviewed the report provided by EPStaffCheck.
- Ensure all Status 1 providers are included in Geo Access reporting.
- Include the Medical Record Audit Tool as an attachment to Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation.
- Revise Procedure MHSC QI 120.000 to document the process and timeframe for reaudits of providers who do not achieve a passing score for the initial medical record audit.

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

CCME's review of Member Services focused on areas such as member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures. Molina has policies and procedures that define and describe Member Services activities and provide guidance to staff for performing said activities.

Members are informed of their rights and responsibilities in the Member Handbook, annual newsletters, and on Molina's website. Staff are trained on member rights and responsibilities during new employee orientation and reinforcement is provided during on-going trainings. Providers are notified of member rights and responsibilities in the Provider Manual and during the onboarding process.

New members are provided a Welcome Packet within 14 days of Molina receiving the member's enrollment data from SCDHHS. The packet includes the member ID card, directions for accessing or requesting a Member Handbook and a Provider Directory, and the Notice of Privacy Practices. During the onsite, Molina staff explained that a Quick Start Guide was recently developed and has been added to the Welcome Packet. Scripts are being created to implement welcome calls.

The Member Handbook provides useful information and is written at an appropriate reading level to be easily understood. It is available in Spanish and alternate formats including large font, audio, and Braille. The Member Handbook educates members about their rights and responsibilities, preventive health and appointment guidelines, and how to access benefits. It also provides key contact information.

In addition to the Member Handbook, members can access the website for information on available case management and disease management programs, and educational support for medical, behavioral health, and pharmaceutical services. Molina publishes one member newsletter, "A Guide to Accessing Quality Care," that is available on the website annually and focuses on "quality" related healthcare topics. Although members are instructed to contact Member Services or their providers for information, CCME did not identify information or materials on general health/wellness topics and care tips, such as healthy eating, the importance of handwashing, and COVID related precautions on the website or in the newsletter.

Member Services staff are available per contract requirements via a toll-free number, which routes calls to Interactive Voice Response menus that allow callers to reach staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Standard Time, Monday through Friday. The Nurse Advice Line is available 24 hours a day.

Molina contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, to conduct both the Child and Adult surveys. The response rates were below the NCQA target of 40%. The Adult survey had 337 responses, and the response rate of 20% is lower than the 2019 rate (29%). For Child Surveys, the required sample of 411 was not met (n=236), and response rates decreased from 23.9% in 2019 to 14.5% in 2020. The minimum required sample of 411 was not met (n=351) with a response rate of 19.6% in 2019 for the Children with Chronic Conditions (CCC) survey. Results of the CAHPS survey are distributed to providers and presented to the Quality Improvement Committee.

Grievances

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

Requirements and processes for handling member grievances and complaints are correctly documented in policies and associated procedures, and information is provided in the Member Handbook, Provider Manual, and on the website. Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff. It was noted that Member Service Representatives frequently offered apologies for the member's negative experience.

Additionally, grievance files indicate that Molina addressed corrective actions identified from the 2020 EQR, as evidenced by files having clear documentation of grievance investigations and staff conducting appropriate follow-up with other departments when monitoring the grievance status. Actions taken to resolve issues were clearly noted and resolutions directly addressed the member's grievance.

Overall, the review of Member Services indicates that Molina guarantees members their rights, informs members of all benefits and services, and is available and accessible to answer questions, address concerns, and offer assistance when needed.

As noted in *Figure 5: Member Services Findings*, 100% of the standards for Member Services are scored as "Met."

Figure 5: Member Services Findings

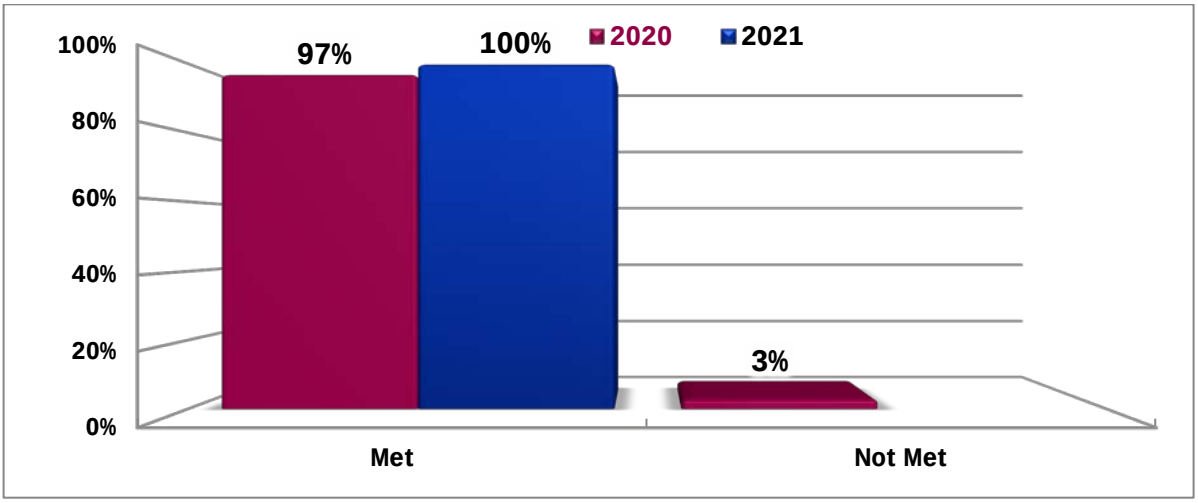


Table 7: Member Services Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Grievances	The MCO applies grievance policies and procedures as formulated	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- Grievance files reflect that Member Service Representatives frequently offered apologies for the member's negative experience.

- Examples are provided when defining and describing the term "grievance."

Weaknesses

- Information or materials on general health and wellness topics and care tips are not available on the website or in the member newsletter.
- Response rates for each of the CAHPS surveys were below the NCQA target of 40%.

Recommendations

- Consider adding care tips and health and wellness information or downloadable materials on topics such as healthy eating, the importance of handwashing, COVID related precautions, weight management, etc. to the website or member newsletter.
- Continue working with SPH Analytics to increase response rates for CAHPS surveys.

D. Quality Improvement

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

Molina has a Quality Improvement (QI) Program with specific goals and objectives outlined in the Medicaid Quality Improvement Program Description, 2020 and in the QI Work Plan. Information regarding Molina's QI program information is available to members and providers on the website and upon request. The QI Program Description is reviewed and modified as needed and formally updated at least once a year.

Molina presented the draft 2020 and 2021 QI Work Plans for review. Both are updated as needed and presented to the Quality Improvement Committee quarterly for approval. During the previous EQR, several errors related to measuring goals and benchmarks were noted in the 2020 work plan. Molina corrected those errors; however, the dates in the column labeled "Timeline" were not updated. Molina indicated the work plan was in draft and the timeline dates would be updated.

Molina's Quality Improvement Committee (QIC) continues to be responsible for the implementation, oversight, and ongoing monitoring of the QI Program. The QIC is co-chaired by the Chief Medical Officer and the Quality Lead. Members include key staff from functional areas of the health plan and contracted network providers specializing in Pediatrics, OB/GYN, Family Medicine, and Cardiology. Molina also has a designated Behavioral Health practitioner who advises Molina in QI activities related to behavioral health. The committee meets at least quarterly. Any actions or decisions needed between meetings are conducted via E-Vote. A quorum of at least 51% of the committee members with no less than half of network provider participants is needed to enact or implement decisions. A quorum was met for all meetings except one E-Vote meeting.

There were only two network providers that participated in the E-Vote dated March 11, 2020. At least three network providers are needed for a quorum.

Annually, Molina conducts a formal evaluation of the QI Program to assess the effectiveness of the program's activities and determine actions needed. It was noted during the previous EQR that the 2018 QI Program Evaluation did not include all the QI activities. Molina addressed those missing activities in the Quality Improvement Plan submitted following last year's EQR. The Quality Improvement Program 2019 Medicaid Annual Evaluation was provided and found that Molina included summaries and analysis of all activities. Section 14, Areas of Focus/Recommendations for Next Year was not included. However, this was provided during the onsite.

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)*.

Table 8: HEDIS Performance Measure Results reports all relevant HEDIS performance measures for the current review year (HEDIS 2020), the previous year (HEDIS 2019), and the change from 2019 to 2020. A change in rates displayed in green indicates a substantial (>10%) improvement. A change noted in red indicates a substantial (>10%) decrease in the rate.

Table 8: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	90.27%	93.08%	2.81%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	73.24%	78.52%	5.28%
Counseling for Nutrition	62.04%	66.17%	4.13%
Counseling for Physical Activity	56.20%	61.48%	5.28%
Childhood Immunization Status (cis)			
DTaP	74.94%	74.94%	R
IPV	84.18%	84.18%	R

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
MMR	88.08%	88.08%	R
HiB	83.70%	83.70%	R
Hepatitis B	84.91%	84.91%	R
VZV	87.59%	87.59%	R
Pneumococcal Conjugate	77.13%	77.13%	R
Hepatitis A	82.97%	82.97%	R
Rotavirus	70.07%	70.07%	R
Influenza	37.96%	37.96%	R
Combination #2	70.32%	70.32%	R
Combination #3	68.86%	68.86%	R
Combination #4	66.67%	66.67%	R
Combination #5	58.64%	58.64%	R
Combination #6	32.60%	32.60%	R
Combination #7	57.18%	57.18%	R
Combination #8	32.60%	32.60%	R
Combination #9	28.71%	28.71%	R
Combination #10	28.71%	28.71%	R
Immunizations for Adolescents (ima)			
Meningococcal	77.13%	77.13%	R
Tdap/Td	87.10%	87.10%	R
HPV	32.12%	32.12%	R
Combination #1	76.40%	76.40%	R
Combination #2	31.87%	31.87%	R
Lead Screening in Children (lsc)	69.34%	69.34%	R
Breast Cancer Screening (bcs)	58.83%	57.26%	-1.57%
Cervical Cancer Screening (ccs)	58.15%	64.72%	6.57%
Chlamydia Screening in Women (chl)			
16-20 Years	57.16%	57.87%	0.71%
21-24 Years	68.35%	68.95%	0.60%
Total	60.04%	60.82%	0.78%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	81.59%	86.02%	4.43%
18-64 years	NA	72.71%	NA
65+years	NA	NA	NA
Total	NA	83.23%	NA
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.46%	31.62%	5.16%

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	68.76%	64.12%	-4.64%
Bronchodilator	78.10%	76.91%	-1.19%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	57.39%	59.15%	1.76%
5-11 Years - Medication Compliance 75%	28.35%	31.62%	3.27%
12-18 Years - Medication Compliance 50%	56.25%	58.05%	1.80%
12-18 Years - Medication Compliance 75%	27.29%	29.03%	1.74%
19-50 Years - Medication Compliance 50%	57.53%	63.13%	5.60%
19-50 Years - Medication Compliance 75%	31.51%	33.75%	2.24%
51-64 Years - Medication Compliance 50%	72.22%	67.27%	-4.95%
51-64 Years - Medication Compliance 75%	42.59%	47.27%	4.68%
Total - Medication Compliance 50%	57.61%	59.56%	1.95%
Total - Medication Compliance 75%	28.92%	31.54%	2.62%
Asthma Medication Ratio (amr)			
5-11 Years	79.71%	77.35%	-2.36%
12-18 Years	72.03%	69.80%	-2.23%
19-50 Years	54.37%	53.33%	-1.04%
51-64 Years	48.78%	47.87%	-0.91%
Total	71.49%	68.94%	-2.55%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	50.12%	57.18%	7.06%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.92%	64.29%	**-12.63%**
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	79.08%	73.57%	-5.51%
Statin Adherence 80% - 21-75 years (Male)	52.26%	47.31%	-4.95%
Received Statin Therapy - 40-75 years (Female)	71.43%	73.20%	1.77%
Statin Adherence 80% - 40-75 years (Female)	53.08%	48.59%	-4.49%
Received Statin Therapy - Total	75.40%	73.40%	-2.00%
Statin Adherence 80% - Total	52.63%	47.90%	-4.73%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	89.77%	89.77%	R
HbA1c Poor Control (>9.0%)	47.49%	47.49%	R
HbA1c Control (<8.0%)	44.19%	44.19%	R
Eye Exam (Retinal) Performed	61.87%	61.87%	R

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
Medical Attention for Nephropathy	93.41%	93.41%	R
Blood Pressure Control (<140/90 mm Hg)	55.46%	55.46%	R
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	62.22%	64.37%	2.15%
Statin Adherence 80%	45.24%	47.06%	1.82%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	39.50%	44.36%	4.86%
Effective Continuation Phase Treatment	25.16%	29.13%	3.97%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	60.05%	58.76%	-1.29%
Continuation and Maintenance (C&M) Phase	76.74%	70.05%	-6.69%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	72.15%	75.86%	3.71%
6-17 years - 7-Day Follow-Up	50.00%	50.19%	0.19%
18-64 years - 30-Day Follow-Up	54.46%	54.28%	-0.18%
18-64 years - 7-Day Follow-Up	26.98%	28.62%	1.64%
65+ years - 30-Day Follow-Up	NA*	NA*	NA*
65+ years - 7-Day Follow-Up	NA*	NA*	NA*
30-Day Follow-Up	59.43%	61.33%	1.90%
7-Day Follow-Up	33.45%	35.67%	2.22%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	66.56%	71.52%	4.96%
6-17 years - 7-Day Follow-Up	43.65%	52.12%	8.47%
18-64 years - 30-Day Follow-Up	51.25%	52.89%	1.64%
18-64 years - 7-Day Follow-Up	36.88%	36.89%	0.01%
65+ years - 30-Day Follow-Up	NA*	NA*	NA*
65+ years - 7-Day Follow-Up	NA*	NA*	NA*
30-Day Follow-Up	57.41%	60.77%	3.36%
7-Day Follow-Up	39.60%	43.33%	3.73%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	NR	42.86%	NA
13-17 years - 7-Day Follow-Up	NR	28.57%	NA
18-64 years - 30-Day Follow-Up	NR	53.81%	NA
18-64 years - 7-Day Follow-Up	NR	43.65%	NA
65+ years - 30-Day Follow-Up	NR	NA*	NA
65+ years - 7-Day Follow-Up	NR	NA*	NA
Total - 30-Day Follow-Up	NR	53.43%	NA

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
Total - 7-Day Follow-Up	NR	43.14%	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
*30-Day Follow-Up: 13-17 Years**	NA	NA	NA
*7-Day Follow-Up: 13-17 Years**	NA	NA	NA
30-Day Follow-Up: 18+ Years	17.77%	14.25%	-3.52%
7-Day Follow-Up: 18+ Years	12.18%	9.90%	-2.28%
30-Day Follow-Up: Total	18.33%	14.61%	-3.72%
7-Day Follow-Up: Total	12.38%	10.05%	-2.33%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	79.82%	78.83%	-0.99%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	74.21%	72.09%	-2.12%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	NA	NA*	NA*
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	72.34%	72.47%	0.13%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	NR	32.26%	NA
65+ years	NR	NA*	NA
Total	NR	32.26%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	NR	33.03%	NA
Cholesterol Testing - 1-11 Years	NR	25.69%	NA
Blood glucose and Cholesterol Testing - 1-11 Years	NR	22.02%	NA
Blood glucose testing - 12-17 Years	NR	54.80%	NA
Cholesterol Testing - 12-17 Years	NR	31.32%	NA
Blood glucose and Cholesterol Testing - 12-17 Years	NR	28.83%	NA
Blood glucose testing - Total	NR	48.72%	NA
Cholesterol Testing - Total	NR	29.74%	NA
Blood glucose and Cholesterol Testing - Total	NR	26.92%	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.92%	0.93%	0.01%
Appropriate Treatment for Children With URI (uri)			
3months-17 Years	NR	88.10%	NA
18-64 Years	NR	66.01%	NA
65+ Years	NR	NA*	NA*
Total	NR	85.12%	NA

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	NR	54.83%	NA
18-64 Years	NR	30.41%	NA
65+ Years	NR	NA*	NA*
Total	NR	45.49%	NA
Use of Imaging Studies for Low Back Pain (lbp)	63.34%	70.69%	7.35%
Use of Opioids at High Dosage (hdo)	2.44%	2.25%	-0.19%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	25.40%	24.11%	-1.29%
Multiple Pharmacies	9.35%	6.08%	-3.27%
Multiple Prescribers and Multiple Pharmacies	4.46%	3.02%	-1.44%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	5.51%	4.68%	-0.83%
18-64 years - >=31 Days covered	2.60%	3.00%	0.40%
65+ years - >=15 Days covered	NA*	NA*	NA
65+ years - >=31 Days covered	NA*	NA*	NA
Total - >=15 Days covered	5.51%	4.68%	-0.83%
Total - >=31 Days covered	2.60%	3.00%	0.40%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	79.69%	79.59%	-0.10%
45-64 Years	89.17%	89.09%	-0.08%
*65+ Years**	NA*	NA*	NA
Total	82.97%	82.75%	-0.22%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.73%	96.71%	-0.02%
25 Months - 6 Years	86.11%	86.86%	0.75%
7-11 Years	89.88%	90.20%	0.32%
12-19 Years	89.48%	90.05%	0.57%
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

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	40.54%	38.73%	-1.81%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	25.23%	21.83%	-3.40%
Initiation of AOD Treatment: 13-17 Years	39.67%	38.26%	-1.41%
Engagement of AOD Treatment: 13-17 Years	23.97%	20.81%	-3.16%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	40.92%	41.92%	1.00%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	7.38%	8.08%	0.70%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	50.59%	57.74%	7.15%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	22.78%	27.30%	4.52%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	37.96%	39.55%	1.59%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.41%	8.59%	-0.82%
Initiation of AOD Treatment: 18+ Years	39.74%	42.89%	3.15%
Engagement of AOD Treatment: 18+ Years	10.70%	11.05%	0.35%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	40.96%	41.80%	0.84%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7.77%	8.02%	0.25%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	50.29%	57.44%	7.15%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	22.65%	27.15%	4.50%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	38.22%	39.46%	1.24%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	11.01%	10.04%	-0.97%
Initiation of AOD Treatment: Total	39.74%	42.57%	2.83%
Engagement of AOD Treatment: Total	11.57%	11.72%	0.15%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	86.37%	99.76%	**13.39%**
Postpartum Care	69.83%	83.21%	**13.38%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	NR	60.00%	NA
12-17 Years	NR	69.49%	NA
Total	NR	66.87%	NA
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.73%	0.85%	0.12%
1 Visit	0.49%	0.56%	0.07%

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	PERCENTAGE POINT DIFFERENCE
2 Visits	2.19%	2.82%	0.63%
3 Visits	4.14%	1.69%	-2.45%
4 Visits	8.52%	5.65%	-2.87%
5 Visits	14.84%	14.97%	0.13%
6+ Visits	69.10%	73.45%	4.35%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	60.83%	65.57%	4.74%
Adolescent Well-Care Visits (awc)	51.58%	57.91%	6.33%

Note: NR= not reported; NA= not applicable due to missing data or small denominator; R = rotated per NCQA allowance

Molina uses Inovalon, a certified software organization, for calculation of HEDIS rates. For measures reported using only the hybrid methodology, NCQA allowed organizations to report their audited HEDIS 2019 (MY 2018) hybrid rates if they were better than their HEDIS 2020 (MY 2019) hybrid rates. Molina chose to rotate a subset of hybrid measure with HEDIS 2019 results for the following:

- Comprehensive Diabetes Care
- Childhood Immunizations
- Immunizations for Adolescents
- Lead Screening

The comparison from the 2019 rates to the 2020 rates revealed a substantial increase (>10%) in the prenatal care and postpartum care measures. The measures with a substantial decrease (>10%) include persistence of beta-blocker treatments after heart attack. *Table 9* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 9: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	Change from MY 2018 to MY 2019
Substantial Increase in Rate (>10% improvement)			
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	86.37%	99.76%	**13.39%**
Postpartum Care	69.83%	83.21%	**13.38%**

MEASURE/DATA ELEMENT	Measure Year 2018 (HEDIS 2019)	Measure Year 2019 (HEDIS 2020)	Change from MY 2018 to MY 2019
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.92%	64.29%	**-12.63%**

Quality Withhold Measures

As required by SCDHHS, there were 12 quality clinical withhold measures reported for MY 2019. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020). As per the Medicaid Playbook and Policy and Procedure Guide for Managed Care Organizations, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 percentile = 1 point; 10-24 percentile = 2 points; 25-49 percentile = 3 points; 50-74 percentile = 4 points; 75-90 percentile = 5 points; >90 percentile = 6 points). Points attained for each measure are multiplied by the weight of an individual measure then summed to obtain the quality index score. *Table 10: Quality Withhold Measures* shows the 2019 rate, percentile, point value, and index score. The Diabetes measure rates generated the highest index score, followed by Women's Health, and then Pediatric Preventive Care.

Table 10: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.77%	90	6	5.05
HbA1c Control (< =9)	47.49%	25	3	
Eye Exam (Retinal) Performed	61.87%	90	6	
Medical Attention for Nephropathy	93.41%	75	5	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	99.76%	90	6	4.35
Breast Cancer Screen	57.26%	25	3	
Cervical Cancer Screen	64.72%	50	4	
Chlamydia Screen in Women (Total)	60.82%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	73.45%	75	5	3.75

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
Well Child Visits in 3rd,4th,5th&6th Years of Life	65.57%	25	3	
Adolescent Well-Care Visits	57.91%	50	4	
Weight Assessment/Adolescents: BMI % Total	78.52%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	58.76	90	6	3.75
Antidepressant Medication Management Effective Continuation Phase Treatment	29.13%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	66.87%	75	5	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	26.92%	10	2	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	35.67%	50	4	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	42.57%	50	4	

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

Molina submitted three projects for validation: Breast Cancer Screening, Well-Care Program, and Correlation Between Member Assignment and Engagement. *Table 11: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

TABLE 11: Performance Improvement Project Validation Scores

Project	2019 Validation Score	2020 Validation Score
Breast Cancer Screening (Clinical)	91/91=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Well-Care Program (Clinical)	111/111=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Correlation Between Member Assignment and Engagement (Non-Clinical)	Not Submitted or Validated	63/74=85% Confidence in Reported Results

This year, the Well-Care Program and Breast Cancer Screening PIPs received a validation score within the High Confidence range. A new PIP, Correlation Between Member Assignment and Engagement, was validated and received a score within the Confidence range.

For the Breast Cancer Screening PIP, the rate decreased in the most recent remeasurement from 58.83% to 57.26%. Several interventions have been initiated for this PIP, including member outreach through postcard mailing and call campaigns, community engagement team calls, member incentives, and transportation assistance. The provider-related interventions included provider education through provider quality reports, HEDIS tip sheets and scorecards, and a quality engagement team (QET) that offer tool kits to educate providers. This PIP has been ongoing for several years and has shown little or no improvements on the breast cancer rates even with all the incentives and initiatives. It seems the QET appears to have a stronger impact on the rates than gift card incentives. Molina should consider continuing the effective interventions, monitoring the breast cancer screening rate, and replacing this PIP with another project focusing on a different priority population to continue improving the quality of care. *Table 12: Performance Improvement Project Recommendations,* provides an overview of the recommendations.

TABLE 12: Performance Improvement Project Recommendation

Project	Section	Reason	Recommendation
Breast Cancer Screening	Was there any documented, quantitative improvement in processes or outcomes of care?	Screening rate for annual measurement decreased from 57.26% in 2019 to 56.01% in 2020 (using admin rate). The 2018 rate was 58.83%, so	Continue incentive and QET initiatives. The QET appears to have a stronger impact on BCS rates.

Project	Section	Reason	Recommendation
		there was a decline from 2018 to 2019 using completed HEDIS calculated rates.	

For the Well-Care Program PIP, most of the measures improved, except for the Adults Access to Preventive/Ambulatory Health Services measure. The interventions for this PIP are focused on incentives for the members including gift cards, outreach via telephone, transportation assistance, reminder calls, and member education. The provider interventions include incentives, education via HEDIS scorecards and the QET partnership, as well as education related to clinical and coding practices. Several measures in this PIP are being replaced or are retired (e.g., Children and Adolescents' Access to Primary Care Practitioners measure). Molina indicated the health plan would document the changes and consider using new measures.

The Member Assignment and Engagement PIP documentation reported system limitations and data issues that are affecting accuracy of reported rates and member assignments. This PIP had baseline and one remeasurement displayed in the report. 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. The interventions that align with specific data barriers were not presented in the PIP report, although it is evident from the analyses that the primary intervention is addressing data management and reporting. The table that follows outlines the errors requiring corrections.

TABLE 13: Performance Improvement Project Corrections Needed

Project	Section	Reason	Quality Improvement Plan
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.	Display the specific data and system issues and aligned interventions to address those issues in the PIP report.

Project	Section	Reason	Quality Improvement Plan
	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.	Add interventions that are related to each indicator's barriers/data issues in efforts to improve rates.

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

Molina showed improvements in their scores in the Quality Improvement section of the review as noted in *Figure 6.*

Figure 6: Quality Improvement Findings

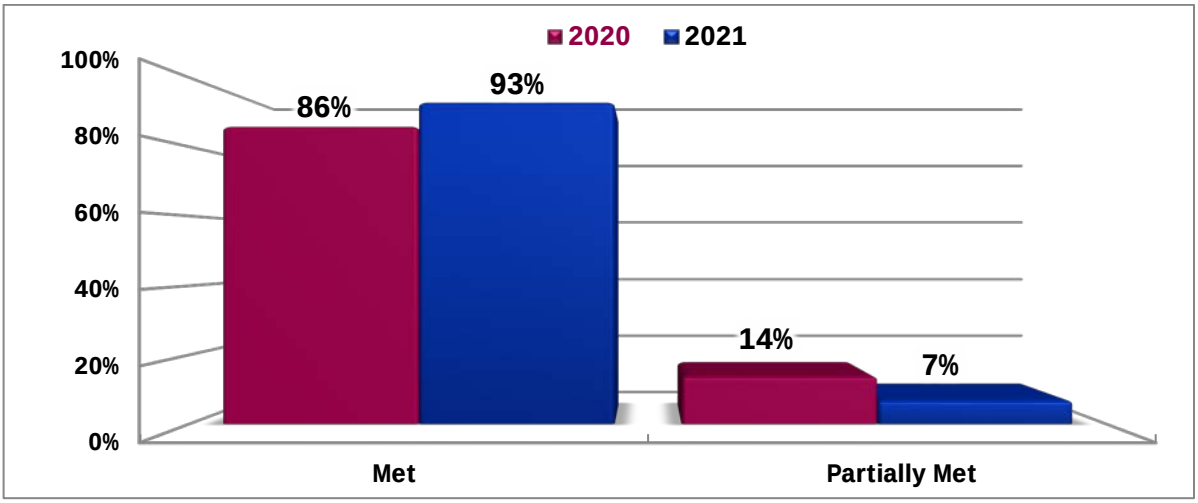


Table 14: Quality Improvement Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
The Quality Improvement (QI) Program	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Partially Met	Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Partially 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	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- Molina uses certified software for HEDIS calculations.
- Network providers receive monthly Quality Reports that contain provider specific data regarding assigned members.

Weaknesses

- In the 2021 QI work plan, the dates in the column labeled "Timeline" were not updated. The dates reflected 2020 instead of 2021.
- Documentation issues in the Correlation Between Member Assignment and Engagement PIP caused a lower validation score.
- The Breast Cancer Screening PIP has shown little or no improvement in the screening rate.

Quality Improvement Plan

- Display the specific data and system issues in the Correlation Between Member Assignment and Engagement PIP and aligned interventions to address those issues in the PIP report.

Recommendations

- Update the timeline dates in the 2021 QI work plan.
- Reevaluate the Breast Cancer Screening PIP and consider replacing this PIP with another project focusing on a different priority population to continue improving the quality of care.

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)

CCME's assessment of Molina's Utilization Management (UM) Program includes the program description, medical necessity determination processes, pharmacy requirements, the Care Management Program, and a review of approval, denial, appeal, and care management files. The UM Program is incorporated into the Health Care Services (HCS) Program and Molina's CMO and Behavioral Health Medical Director provide oversight and expertise for UM activities.

The HCS Program Description, along with policies and associated procedures, provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in South Carolina.

Processes for reviewing service authorization requests are conducted utilizing InterQual guidelines, internal clinical criteria, or other established criteria. Molina assesses consistency in criteria application and decision-making through annual inter-rater reliability testing and monthly chart quality audits for physician reviewers, clinical reviewers, behavioral health staff, and pharmacy staff. All reviewers received passing scores at or above the established benchmarks.

The review of approval and denial files reflected timely and consistent decision-making and notification. Approval notices were faxed to the provider and contained all required information. Adverse Benefit Decision notices were clearly written with the "Medical Appeal Request Form" and "Guidelines for Appealing a Medical Denial" instructions enclosed.

The Pharmacy Services Program uses the most current version of the preferred drug list (PDL) to fulfill pharmacy requirements, maintains the PDL, and the PDL Updates list on the website. The timeliness standard for authorizations includes an automatic fax acknowledgement sent to the provider within 24 hours, standard determinations made within 14 days, and expedited determinations made within 72 hours.

Molina analyzed and monitored utilization data for several services, such as emergency room utilization and behavioral health admissions, and reported results during the HCS Committee meetings. Onsite discussion revealed readmission rates were higher than established benchmarks. Molina recently hired an associate to assist in reducing readmissions and improving utilization rates.

Following standards of the Case Management Society of America, the Care Management (CM) Program focuses on prevention, continuity and coordination of care, and management of chronic medical conditions. Molina has documented methods for identifying and referring members to the CM Program to ensure comprehensive, coordinated care for all members stratified into one of the four risk levels. Additionally, processes are in place to address the requirements of Transition Care Management according to the *SCDHHS Contract, Section 5.6.* CM files indicate care management activities are conducted as required and HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed.

The UM Program is evaluated at least annually to assess its strengths and effectiveness. Results are reported to the QIC and HCS Committee, and interventions are established for areas requiring improvement. Additionally, CCME identified that Molina has implemented several recommendations made from the 2020 EQR.

Appeals

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

Molina has established policies describing processes for handling appeals of adverse benefit determinations. The processes are consistent with requirements in the *SCDHHS Contract* and Federal Regulations. Definitions of an adverse benefit determination, an appeal, and who may file an appeal are correctly documented. Procedures for filling an appeal are clearly provided and consistently documented in policies, the Member Handbook, Provider Manual, and on the website. The review of appeal files reflected timely acknowledgement, resolution, and notification of determination. Determination letters are written in language that is easily understood by a layperson, and instructions for State Fair Hearings are provided.

Molina has addressed the corrective actions from the 2020 EQR related to appeals procedures. Documents such as the Member Handbook and Adverse Benefit Determination notices were updated to include information that members can have access to their appeal case file and to documents related to the appeal in advance of the resolution timeframe. Additionally, the address for submitting an appeal was corrected in the Member Handbook and across other member materials.

Even though isolated instances of staff not following UM guidelines were discussed during the onsite, CCME did not identify trends or patterns of noncompliance. Overall, no major issues were identified, and UM services are provided according to established processes and SCDHHS requirements.

As illustrated in *Figure 7: Utilization Management Findings*, 100% of the standards in the UM section are "Met."

Figure 7: Utilization Management Findings

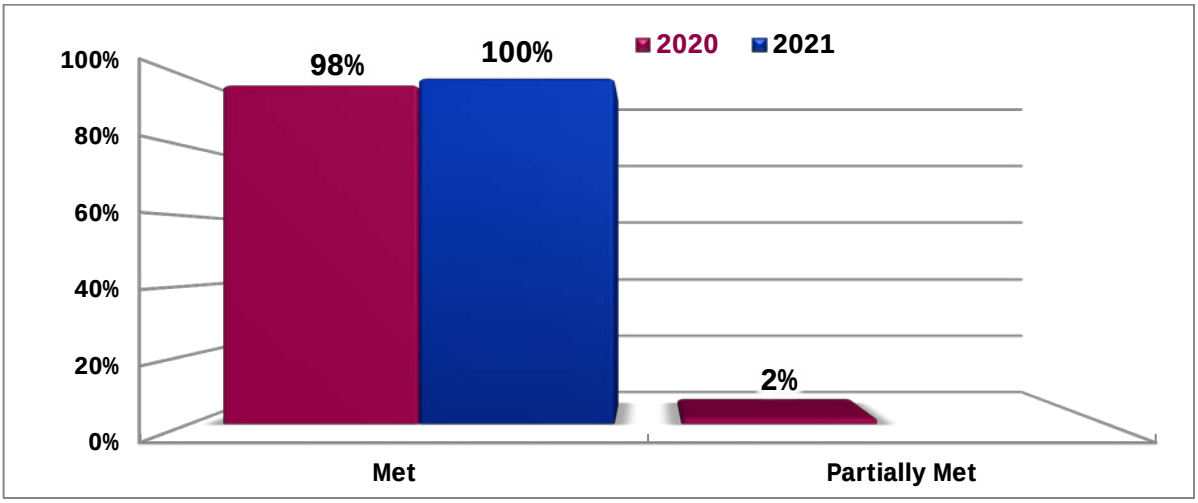


TABLE 15: Utilization Management Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
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	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- Members are completely educated on the requirements and expectations for copayments.

- As a convenience to members, the "Medical Appeal Request Form" and "Guidelines for Appealing a Medical Denial" instructions are enclosed with Adverse Benefit Determination notices.

F. Delegation

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

Molina enters into written agreements with all entities performing delegated functions. The delegated services are defined in *Table 16: Delegated Entities and Services*.

Table 16: Delegated Entities and Services

Delegated Entities	Delegated Services
Aperture AnMed Health Augusta Medical Bon Secours St. Francis Medical University of South Carolina Prisma Midlands Prisma Upstate Regional Health Plus Roper UniPhy	Credentialing
March Vision Care	Vision Benefit Management
MedXM	In-Home Assessments
Teladoc	Telemedicine

Policies and procedures are established to define delegation processes and requirements. The Delegation Oversight Committee oversees and is accountable for all activities delegated by the MCO.

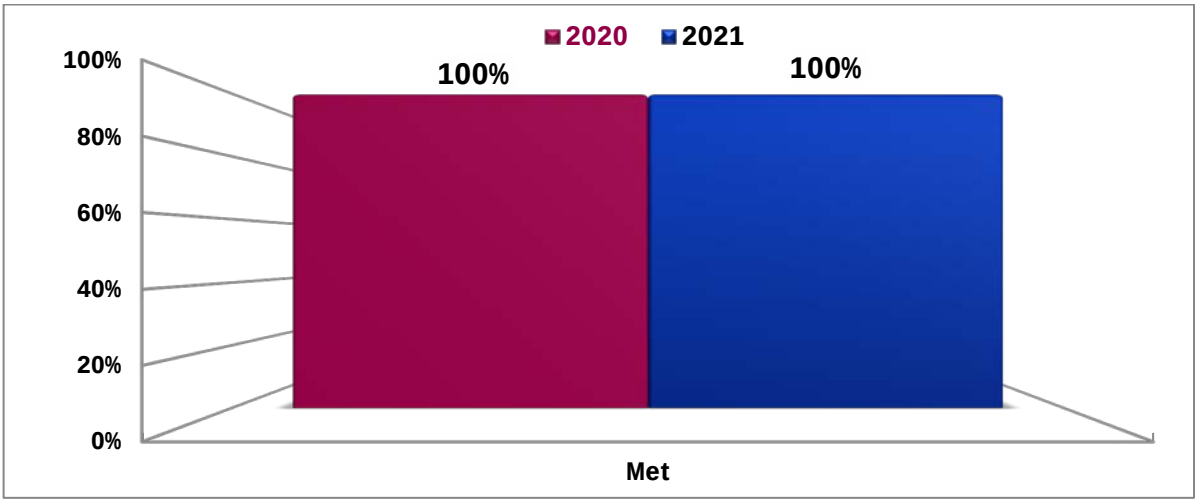
Molina implements written agreements with all delegated entities. The written agreements include the activities to be delegated and information about pre-delegation assessments, ongoing monitoring, sub-delegation, reporting requirements, and performance expectations. The agreements also specify actions that may be taken for unsatisfactory performance.

Review of delegation oversight documentation confirmed Molina conducts ongoing monitoring and annual oversight of delegates. Molina implemented corrective action for

delegates who were not performing satisfactorily, and onsite discussion revealed Molina has terminated the delegation agreements with two entities due to poor performance and/or lack of response to the correction action.

As noted in *Figure 8: Delegation Findings*, 100% of the Delegation standards were scored as "Met."

Figure 8: Delegation Findings



Strengths

- Molina conducts appropriate ongoing monitoring and annual oversight of delegated entities.
- Action is taken when delegated entities do not perform satisfactorily.

G. State Mandated Services

42 CFR Part 441, Subpart B

Molina continuously monitors immunization and Early and Periodic Screening Diagnostic, and Treatment (EPSDT) compliance through frequent review of HEDIS metrics and during provider performance on annual medical record reviews. The health plan has several processes and provider engagement activities in place to educate, notify, and remind providers and members of needed EPSDT services.

Molina provides all core benefits according to requirements in the *SCDHHS Contract* and ensures members receive medically necessary care to meet their physical and behavioral health needs. Additionally, Molina offer extra benefits and services at no cost to eligible members, such as access to virtual doctor visits, electric breast pumps for pregnant members, car seats, and gift cards.

As noted in *Figure 9: State Mandated Services Findings*, Molina received scores of "Met" for 100% of the standards.

Figure 9: State Mandated Services

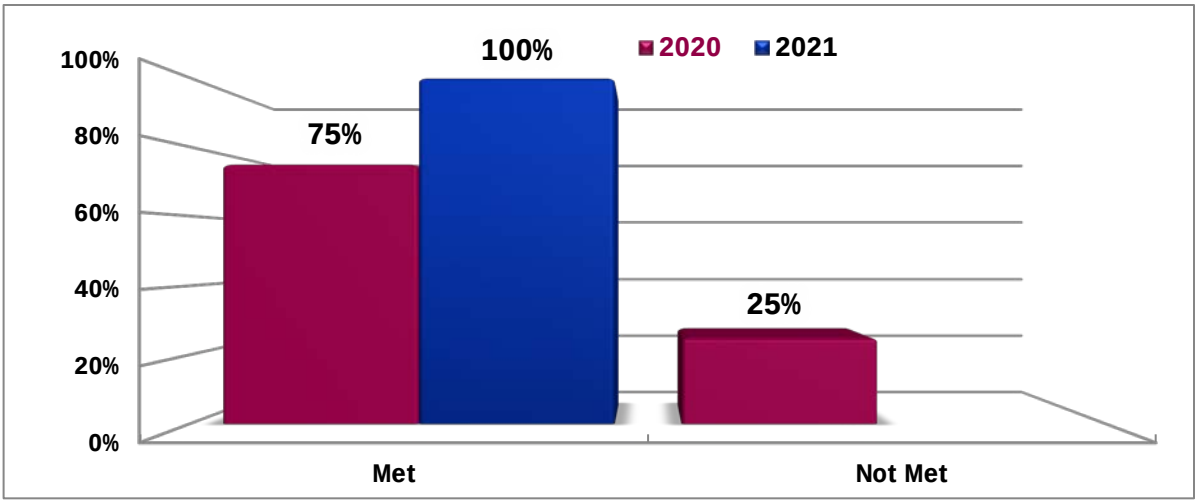


TABLE 17: State Mandated Comparative Data

Section	Standard	2020 Review	2021 Review
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews.	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- In addition to providing all core benefits according to requirements in the *SCDHHS Contract*, Molina offers several extra services at no cost to members.

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 8, 2021

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 2021 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. The CCME EQR team plans to conduct the onsite visit on **April 21st and 22nd.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **February 22, 2021.**

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 2021

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 2020 and 2021.

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 2020 through January 2021. 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 2020 through January 2021.

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.
i. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, 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 (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, 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 2020 through January 2021. 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 2020 through January 2021, 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 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copy of the updated (4th quarter results) 2020 QI Work Plan.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**BREAST CANCER SCREENING**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling 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**	Measure is defined on page 11.
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**	Measure is focused on 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 is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed on page 16.

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**	Data collection uses programming logic queries.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are clearly presented.
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 remeasurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
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 are directly related to barriers identified.
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**	Screening rate for annual measurement decreased from 57.26% in 2019 to 56.01% in 2020 (using admin rate). The 2018 rate was 58.83%, so there was a decline from 2018 to 2019 using completed HEDIS calculated rates. *Recommendation: Continue incentive and QET initiatives. The QET appears to have a stronger impact on BCS rates.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement did not occur.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis presented for sub-evaluations, though not validated as overall rate did not improve.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Rate has not met target goal.

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 EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**CORRELATION BETWEEN MEMBER ASSIGNMENT AND ENGAGEMENT**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling 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**	Measures are 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**	Measures are focused on 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 is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed in the report.

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**	Data collection uses programming logic queries.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are clearly presented.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement is 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 data is included in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions are not clearly documented in the report. *Corrective Action: Display the specific data and system issues and aligned interventions to address those issues in the PIP report.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALLY MET**	Indicator #1 remained the same at 32%. Indicator #2 declined from 72% to 66%, and the goal is to increase that rate. Indicator #3 decreased from 85% to 47% and this is improvement, as the goal is to decrease indicator #3. *Corrective Action: Add interventions that are related to each indicator's barriers/data issues in efforts to improve rates.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement did not occur for 2 of the 3 indicators.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis not presented (not required unless sampling is used).

Component / Standard (Total Points)	Score	Comments
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge- only baseline and one remeasurement; goal rates only met for one indicator.

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	0
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**63**
Project Possible Score	**74**
Validation Findings	**85%**

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**WELL-CARE PROGRAM**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim of project was appropriate and documented.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling 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**	Measures are 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**	Measures are focused on 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 is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed in the report.

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**	Data collection uses programming logic queries.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are clearly presented.
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 remeasurements are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
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 are directly related to barriers identified.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	All measures except one improved from the most recent measurement. AWC improved from 51.58 to 57.91% (replacing this measure); W34 improved 60.83 to 65.57 (replacing this measure); W15 improved from 69.10 to 73.45 (replacing this measure); AAP is 82.97 reduced to 82.75; CAP improved from 89.27 to 89.75 (retired measure).
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the member and provider incentives and member outreach and transportation interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis presented for rate evaluations.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Rate has not been sustained at goal rate- unable 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	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**Molina Healthcare**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2020 ***(Note: Due to COVID allowances, hybrid rates for HEDIS2020 were the same as RY2019/HEDIS 2019)***

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 Quality Spectrum Insight™ from Inovalon. Audit report noted compliance 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	2019-2020
Review Performed	2021

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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

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 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Adult survey had 337 responses out of 1681 for a 20% response rate. This is a 9% decline from the 2019 response rate of 29%. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 **Recommendation:** Monitor the new initiative to determine if response rates improve; work on provider reminders, website reminders, and call script reminders to increase member participation
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020

CCME EQR Survey Validation Worksheet

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

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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

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 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For the Child survey, there were 236 responses out of 1,627 responses for a 14.5% response rate. This is a 9.4% decline from the 2019 response rate of 23.9%. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 **Recommendation:** Monitor the new initiative to determine if response rates improve; work on provider reminders, website reminders, and call script reminders to increase member participation
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2020

CCME EQR Survey Validation Worksheet

Plan Name	**Molina Healthcare**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2019-2020
Review Performed	2021

Review Instructions

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

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020

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 2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	There were 351 surveys. The response rate was 14.8% (351 out of 2,379) which is a 4.8% decline from the 2019 rates of 19.6%. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 **Recommendation*:*** Monitor the new initiative to determine if response rates improve; work on provider reminders, website reminders, and call script reminders to increase member participation.
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 CCC 2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	Molina Healthcare of South Carolina
Collection Date:	2021

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, establishes that all policies and procedures are required to be reviewed and revised annually by individual departments. Policies are stored on a shared drive and Molina's intranet. Emails are sent out when major policy changes occur.
I B. Organizational Chart / Staffing						
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:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					The Molina Plan President is Dora Wilson.
1.2 Chief Financial Officer (CFO);	X					Edward Mohr is the Regional Chief Financial Officer.
1.3 * Contract Account Manager;	X					The Associate Vice President, Government Contracts is Beverly Hamilton.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					The AVP of Health Plan Operations is John Segars.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					Diana Michalic is the Encounters Manager.
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Vice President, Healthcare Services is Debra Enigl.
1.5.1 Pharmacy Director,	X					John Sivori, Senior Vice President of Pharmacy as an interim Director until the recruitment process has been completed.
1.5.2 Utilization Review Staff,	X					Onsite discussion indicated that the Molina UM department consists of 33 employees located in SC.
1.5.3 *Case Management Staff,	X					Lisa Kromer is the Manager of Healthcare Services and Care Management. Amber Turner is the Medicaid Case Manager.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Quality Manager is Wilson Huang.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Heather Eddins is the Provider Services Manager.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Emilio (Juan) Bellizzia Arriaga is the Director of Member Services (Corporate Support).
1.8.1 Member Services Staff,	X					Jennifer Marze is the AVP of Health Plan Engagement.
1.9 *Medical Director;	X					Richard Shrouds, MD is the Molina Chief Medical Officer.
1.10 *Compliance Officer;	x					Niurka Adorno is the Director of Compliance.
1.10.1 Program Integrity Coordinator;	X					
1.10.2 Compliance /Program Integrity Staff;	X					Onsite discussion indicated that the Program Integrity and Special Investigation Unit (SIU) are separately operated from the Compliance department. The Compliance Department is located in SC and reports to the Board of Directors and the Regional Compliance Officer.
1.11 * Interagency Liaison;	X					Brandon Hulko is the Director Government Contracts.
1.12 Legal Staff;	X					Liz Stone is the Assistant General Counsel for Molina.
1.13 Board Certified Psychiatrist or Psychologist;	X					Nikitas Thomarios, D.O. is the Medical Director for Behavioral Health.

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 ISCA documentation indicates that 95.9% of claims are paid within 30 days and 100% are paid within 90 days. Additionally, it was noted that Molina monitors performance and tracks activity in its Encounter Key Performance Indicator (KPI) reports.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Molina's systems are capable of handling electronic transactions and protecting those transactions in a HIPAA compliant manner.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Molina updates eligibility files and enrollment data daily. Additionally, the MCO's systems track member demographics and are capable of deduplicating records if multiples are found. Finally, Molina's systems leverage multiple enrollee attributes to track an enrollee across multiple systems.
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's systems run NCQA-certified software which is used to generate reports and calculate HEDIS data. Additionally, the MCO noted that it upgrades the software as the vendor releases updates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Molina's documentation indicates that the organization follows best practices in managing physical and electronic data security. Additionally, Molina stated that the organization performs regular audits to ensure access controls are operating correctly.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Molina has policies, procedures, and processes in place to address IT security and access control. Additionally, Molina reviews its IT security policies at least once a year to ensure they are up to date.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Molina's ISCA documentation included the organization's business continuity plan which was most recently updated on October 20th, 2020. The business continuity plan details the resources to protect and the processes to recover them. Molina performed recovery testing exercises on February 1, 2020. The test resulted in the successful restoration of resources ahead of the organization's recovery time objectives.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Molina 2020 Compliance Plan provides a description of the Compliance Program, which is commitment to upholding both the internal and external laws governing its activities.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					Policy MHSC COM 02, Anti-Fraud Plan, outlines procedures for training all Molina employees on the Compliance Plan and Anti-Fraud Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Training will be conducted within 60 days of employee's date of hire and then annually.
2.1 Standards of conduct;						Molina has adopted a Code of Conduct and Ethics Code that applies to all employees, officers, directors, and subcontractors of the Company. Molina's expectation is that business will be conducted in accordance with applicable laws, rules, and contract requirements as well as ethical business and professional practices.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The Compliance Committee advises, supports, and carries out the directives of the Compliance Officer, reaffirming Molina's commitment to abide by and uphold the internal and external laws that govern Molina and its activities.
2.5 Compliance training and education;						Education, training, and retraining about compliance matters are conducted to make compliance a regular aspect of work activities and a routine of the company. Education and training sessions are mandatory for all employees, and attendance is documented by use of attendance sign-in logs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Lines of communication;						The Compliance orientation for new employees includes information about the responsibility to report any suspected compliance issues, available reporting options, and Molina's policy of non-retaliation. All reporting options are on Molina's Compliance SharePoint site.
2.7 Enforcement and accessibility;						Instances of non-compliance may subject those involved to discipline, up to and including termination. The Compliance Officer, in conjunction with the Compliance Committee, develops policies setting forth various degrees of disciplinary action that may be imposed to ensure meaningful, effective, and consistent disciplinary action in all instances of non-compliance.
2.8 Internal monitoring and auditing;						Policy MHSC COM 13, Internal Audit Process, states the Molina Healthcare Inc. Internal Auditing Team conducts periodic audits of operations aimed at ensuring adherence with applicable plan policies and federal & state laws to strengthen governance, accountability, and risk management. The Compliance Plan outlines auditing and monitoring conducted for each line of business. Auditing and monitoring are used to identify areas of compliance deficiency, respond to reports of suspected non-compliance, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						assess continuing compliance and the effectiveness of corrective measures implemented to address previously identified compliance deficiencies.
2.9 Response to offenses and corrective action;						Upon identification of non-compliance from either internal or external sources notifies the Molina Healthcare Inc. Compliance CAP Management Team of a need for corrective action based upon the confirmed instance of non-compliance. The team facilitates the issuance of the CAP to and collection from the applicable business units to formally document and track the implementation, remediation, and validation of the CAP.
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					The 2020-2021 Molina Fraud, Waste, and Abuse Plan indicates that the Special Investigation Unit works with Molina's Compliance Officer to prevent, detect, and investigate all reported or suspected fraud, waste, and abuse.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Policy P-MHI-SIU-101, Administrative Actions, outlines the role and responsibility of the SIU to notify providers of identified overpayments resulting from a SIU investigation and/or audit. Providers are required to repay identified

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						overpayments to avoid culpability under the federal or applicable state False Claims Acts and in compliance with program integrity requirements.
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					Policy MHSC-PHARM-03, Pharmacy Lock-In Program, describes processes to evaluate and follow members for potential inclusion in the South Carolina Medicaid Pharmacy Lock-In Program.
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 the privacy and maintain the confidentiality of members' PHI, 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 related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Policy CR 01, Credentialing Program Policy, defines credentialing and recredentialing processes and requirements, and confirms the Credentialing Program follows state and federal requirements and the standards of the NCQA. Molina's Credentialing Program is reviewed annually, revised, and updated as needed.
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) is designated to make recommendations for credentialing decisions through a peer review process. The Medical Director chairs the PRC and appoints committee members who must be Molina network providers. The PRC reports to the Quality Improvement Committee (QIC). CCME's review of PRC meeting minutes revealed the committee meets frequently, usually monthly; membership includes an array of provider specialties; the quorum was met for each of the meetings; and attendance was satisfactory. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meeting minutes reflected review of Level I providers approved by the Medical Director and appropriate review and discussion of providers requiring Level II review.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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:						Any issues identified are addressed in standards 4.2.1 through 4.3.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Most recredentialing files for individual practitioners indicated "No sanctions check data exists for this provider" on the Recredentialing Checklist section labeled "Sanctions/Exclusions." This was discussed during the onsite and Molina staff responded that monthly monitoring is conducted by an exclusion, sanction, and license monitoring vendor, EPStaffCheck. It was explained that the vendor conducts the required queries and sends a report to Molina, which is reviewed for potential matches. Logs are kept of all reports received from EPStaffCheck. The statement that

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						no sanctions check data exists for the provider indicates no matches were found. *Recommendation: To clearly convey that the required sanctions monitoring is conducted for providers at recredentialing, complete the Sanctions/Exclusions section of the Recredentialing Checklist to indicate verification is conducted by EPStaffCheck, the date of the verification, and who reviewed the report provided by EPStaffCheck.*
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					Refer to standard 4.2.7 above.
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					Refer to standard 4.2.7 above.
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					Refer to standard 4.2.7 above.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					Refer to standard 4.2.7 above.
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					
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					Policy CR-01, Credentialing Program Policy, lists provider findings that require a Level II review by the PRC and processes followed for provider termination. Terminated providers are notified in writing of the description of the action being taken and the reason for termination via certified mail within 10 calendar days of the PRC's decision.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					As with the recredentialing files for individual practitioners, CCME could not identify clear evidence of sanction/exclusion checks in the recredentialing files for organizational providers. Molina responded that, as with the individual practitioners, EPStaffCheck conducts the monthly monitoring of the SAM, State exclusions lists, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the LEIE, and sends a report to Molina. Logs are kept of all reports received from EPStaffCheck. *Recommendation: To clearly convey that the required sanctions monitoring is conducted for organizational providers at recredentialing, complete the Sanctions/Exclusions section of the Recredentialing Checklist to indicate verification is conducted by EPStaffCheck, the date of the verification, and who reviewed the report provided by EPStaffCheck.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Policy CR-01 states Molina queries every provider in its claims payment system against updates to the OIG LEIE and SCDHHS Program Integrity lists within 30 calendar days of release of updates to identify any potential matches. Monthly queries are conducted of the SAM. The Credentialing Department determines the validity of potential matches and notifies applicable departments when a match is confirmed. Molina immediately terminates the practitioner's contract across all states for all lines of business, effective the date the sanction was implemented, and the claims system is configured to prevent future claims and authorizations by the provider.
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					Time/distance requirements for PCPs are defined in Policy and Procedure PC-011, Availability of Health Care, as 90% of the population with access to a PCP with 30 miles/45 minutes. Geo access documentation by Quest Analytics for Q1, Q2, and Q4 of 2020 indicate appropriate parameters were used to measure access to PCPs. The Provider Contracting Department develops a provider availability evaluation and plan annually.
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 MHSC-PC-011, Availability of Health Care, defines appropriate parameters for access to specialists. Geo access documentation by Quest Analytics for Q1 and Q2 of 2020 indicate appropriate parameters were used to measure access to required specialists; however, the Q4 2020 Geo access report did not include psychologists. This was discussed with Molina staff during the onsite, and they noted that this may be a result of recent software or systems updates by Quest Analytics. The plan will work with Quest to ensure all required Status 1 providers are included in future reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy and Procedure MHSC-PC-011, Availability of Health Care, defines appropriate parameters for access to hospitals. Geo access documentation by Quest Analytics for Q1, Q2, and Q4 of 2020 indicate appropriate parameters were used to measure access to hospitals. *Recommendation: Ensure all Status 1 providers are included in Geo access reporting.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Quarterly availability reports are generated that include analysis of the number and geographic analysis of PCPs, specialists, behavioral health practitioners, and hospitals. A provider availability evaluation and plan are developed annually.
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 Policy MHSC QI 011, Practitioner Network Cultural Responsiveness, Molina requests, on a voluntary basis, practitioner race/ethnicity and language information from network providers at initial credentialing and annually. Molina also gathers information about language services offered by providers. The web-based Provider Directory includes provider gender and languages spoken. Various data sources are monitored to assess language and cultural needs of Molina's membership, including prevalent language and cultural groups. Provider Contracting staff use the data to align the network to meet the various member needs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina supports providers by training providers on available language services, providing language assistance resources, and providing in-person, video, and telephonic interpretation services.
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 outlined in the contract.		X				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. *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).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				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. Molina's process for measuring and ensuring availability of primary, urgent, and emergency care services includes annual provider availability and after-hours telephonic surveys of network providers. *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	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			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 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.*
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					Policy MHSC-PS-010, Provider and Practitioner Education, and its associated procedure describes process for initial and ongoing provider education. Providers receive training at the initiation of their contract, during monthly/quarterly provider site

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						visits, as needed, and/or upon request. Education can also be provided through periodic communications such as face-to-face presentations, fax communications, electronic communications, newsletters, webinars, website, etc. Provider Office Manager Meetings are held at least annually. Regional provider training sessions are also held throughout the state.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Molina adopts preventive health guidelines (PHGs) to provide up to date treatment and diagnostic information about important preventive health topics to Molina providers. The PHGs are specific to the member population.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The guidelines are selected based on scientific evidence and recommendations made by national clinically based organizations. PHGs focus on age- and condition-specific recommendations relevant to Molina's population. The guidelines are reviewed and updated at least every 2 years.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					The PHGs are distributed to providers through various avenues including provider orientation materials, Provider Manuals, newsletters and other mailings, the website, and fax blasts. The Quality Improvement Department is responsible for the distribution of new and revised PHGs. All practitioners are notified of the availability of the PHGs on the website and 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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 of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Molina adopts clinical practice guidelines (CPGs) to provide up to date treatment and diagnostic information about important clinical topics to Molina providers. The CPGs define an expected standard of practice for providers that are specific to the demographics, health care, and service needs of members. The CPGs are selected based on scientific evidence and recommendations made by national clinically- based organizations and may serve as the basis for a health management programs, benefit interpretation, and quality measures. The guidelines are reviewed and updated at least every 2 years.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation	X					The CPGs are distributed to providers through various avenues including provider orientation materials, Provider Manuals, newsletters and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
that they will be followed for MCO members to providers.						other mailings, the website, and fax blasts. The Quality Improvement Department is responsible for the distribution of new and revised CPGs. All practitioners are notified of the availability of the CPGs on the website and paper copies are provided upon request.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Procedure MHSC-HCS-CM-PLCY-081, Continuity of Care and Coordination, addresses continuity of care for members newly enrolling in Molina's plan, newly enrolled pregnant members, members whose provider terminates, members disenrolling from Molina, etc. Molina staff facilitate communication between specialists and PCPs. Policy MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, indicates continuity and coordination of care between PCPs and other 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 the member medical records maintained by primary care physicians.	X					According to Policy MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, Molina conducts annual medical record documentation audits on a sample of PCPs to assess compliance with medical record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation standards for maintaining medical records, preventive care that supports HEDIS® requirements, and continuity and coordination of care. The associated procedure defines the medical record documentation standards and the roles, responsibilities, and process for the annual assessment of PCP compliance with the documentation standards.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, page 2, item E (1) states the Medical Record Audit Tool is included in Attachment A of the document but was not located. Molina staff provided a copy of the tool after the onsite. *Recommendation: Include the Medical Record Audit Tool as an attachment to Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation.*
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					Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, states the review scores for each independently graded set of member medical records from the PCP are averaged, resulting in the PCP's final review score. A final review score of 90% or above is considered passing score. A final review score of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<90% requires an over-read. If the over-read score is <90%, a re-audit is required. However, the procedure does not describe the re-audit process or timeframe. Onsite discussion revealed the reaudit is conducted within six months and follows the same process as the initial audit. *Recommendation: Revise Procedure MHSC QI 120.000 to document the process and timeframe for reaudits of providers who do not achieve a passing score for the initial medical record audit.*
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					Policy MHSC-ME-04, Member Bill of Rights and Responsibilities, and the associated procedure describe Molina's process for ensuring and informing members of their rights and responsibilities according to requirements in the *SCDHHS Contract, Section 3.16*. Primarily, members are informed of their rights and responsibilities through the Member Handbook, annual newsletters, and the Molina website. Member Service representatives and other staff are trained on the Member's Bill of Rights and Responsibilities during new employee orientation and during on-going trainings.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in the Member Handbook, Provider Manual, and on the website.
2.1 To be treated with respect and with due consideration for dignity and privacy;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
2.5 To be able to request and receive a copy of the member's medical records and request that they 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)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy and Procedure MHSC-ME-01, New Medicaid Member Outreach and Education, state members are provided a Welcome Packet within 14 days of Molina receiving the member's enrollment data from SCDHHS. The packet includes the member's ID card along with directions to access the Member Handbook and Provider Directory, and the Notice of Privacy Practices. During the virtual onsite, Molina staff explained that a Quick Start Guide was recently developed and has been added to the Welcome Packet. The Quick Start Guide gives instructions on important information such as accessing the Member Handbook, Provider Directory and member rights and responsibilities from the Molina website. Additionally, Molina is in the process of creating scripts to implement welcome calls for new members.
1.1 Benefits and services included and excluded in coverage;						Benefit information is noted throughout the Member Handbook and on the website. Members can also contact Member Services to obtain this information. The Member Handbook includes a table that appropriately lists and describes core benefits, covered services, and Molina Extra Benefits, and it notes 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;						A table listing copayments and limits of coverage are listed in the Member Handbook and on the website. Molina informs members that copays do not apply to well-child/well-baby visits or vaccines for children under 19 years old, members who are pregnant, and members of other identified populations.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual. 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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Members are informed that in addition to their PCP, the Nurse Advice Line is available 24 hours a day, seven days a week. Members are instructed to call 911 or go to the nearest hospital if they are experiencing what they consider to be an emergency. The Member Handbook and the Molina website describe and define behavioral health and physical health emergency services and provide clear and specific information instructing members on the appropriate level of care for routine, urgent, or emergent healthcare needs.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and to find participating pharmacies or to contact Member Services to obtain this information. A copayment of $3.40 is applied to prescription medications for members 19 years and older, except for select populations.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						Procedure MHSC-ME-07, Changes in Benefits, describes Molina's process for notifying members affected by changes in benefits and services. Molina will provide written notice 30 days before the expected change of benefit. Molina will also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						notify members within 15 days if a provider is terminated from the network.
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The Member Handbook and the website give instructions for managing PCP selections and scheduling appointments. Members can call Member Services for assistance or log into their secured online account.
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						Information and instructions for filing grievances, appeals, and State Fair Hearings are correctly noted in the Member Handbook and on the website.
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						The Member Handbook has sample pictures of the ID Card and describes the importance of presenting it at the time of service.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Handbook and website provide the hours of operation, toll-free number, and mailing address for Member Services. Additionally, they were updated to include the fax number and email address as recommended from the previous EQR.
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;						The Member Handbook defines and describes EPSDT preventive services to adequately educate members on the requirements and recommended schedule for services. Additionally, detailed information on EPSDT services is posted on the website, including a link to the American Academy of Pediatrics (AAP) and Bright Futures Periodicity Schedule.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Molina notifies members of their right to request a copy of the Provider Directory and Member Handbook annually as noted in Procedure MHSC-COMM-03, Member Collateral Materials, and on the member website under the "Annual Notice" tab. During the onsite, Molina staff explained that an annual mailer is sent to every head of household informing them that annual information is available for viewing on the website.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Procedure MHSC-ME-07, Changes in Benefits, describes Molina's process for notifying members in writing within 15 days after a receipt of a provider's termination from the network and at least 30 days before the effective date of a change in benefits.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policies such as Policy MHSC QI 010, Access and Availability of Language Services, MHSC-COMM-03, Member Collateral Materials, and the associated procedure documents describe

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina's approach to ensuring member materials are clear, understandable, and meet requirements of the *SCDHHS Contract, Section 3.15.*
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					The Member Services Call Center is staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of normal business hours, the Interactive Voice Response system instructs callers to call 911 or go to the nearest emergency room for life-threatening emergencies. Callers are given the option to leave a message to which a response is provided within one business day. Interpreter and translation services are provided to members who have limited English proficiency or other communication barriers free of charge as described in the Member Handbook and the website. Molina addresses staffing, personnel, hours of operation, access and response standards, and monitoring of calls in Policy MHSC-MS-11, Member & Provider Contact Center Staffing Levels, and Policy MHSC-MS-01, Contact Center Performance, along with associated procedures. Molina monitors the Member Call Center's performance to ensure compliance with the performance and response standards. The Quality Improvement Program 2019 Medicaid Annual

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Evaluation indicates that the Call Center Performance access standards for service level, average speed of answer, and abandonment rate, met all goals in 2019 even though overall performance was lower than the previous year.
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					Molina must submit a detailed written request for member disenrollment to SCDHHS, according to processes described in Procedure MHSC-ME-05, Medicaid 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					Members can access the website or Member Handbook for information on available case management and disease management programs and instructions to obtain educational support for medical, behavioral health, and pharmaceutical services. The annual newsletter, "A Guide to Accessing Quality Care," is on the website. The newsletter provides a brief description of, and the contact information for, various health services and programs in which eligible members may participate. Additionally, the guide gives an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						overview of Molina's Quality Improvement Plan and Quality Program. Information and materials on general health and wellness topics and care tips, such as healthy eating, the importance of handwashing, and COVID related precautions, were not identified on the website or in the member newsletter. Molina staff explained that the annual newsletter has content required by NCQA and confirmed that no other member newsletter is provided. *Recommendation: Consider adding care tips and health and wellness information or downloadable materials on topics such as, but not limited to, healthy eating, the importance of handwashing, COVID related precautions, and weight management to the website or member newsletter.*
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					Molina ensures EPSDT services for members through the month of their 21st birthday, as described in Policy and Procedure MHSC-AD-03, EPSDT Notification, Tracking and Follow-up. The policy describes processes and methods for notification, tracking, and follow-up of the EPSDT program and addresses barriers of low utilization by creating interventions to encourage members to use the services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					The "Guide to Accessing Quality Health Care," Member Newsletter provides a variety of information regarding healthcare quality activities and it serves as a resource guide. Onsite discussion revealed Molina conducts and participates in community events with established community partners to provide health and wellness information to members and the public. However, due to COVID restrictions, events were not conducted in-person during 2020. Instead, the Community Engagement staff participated in other remote activities, such as conducting COVID wellness calls.
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					Policy MHSC-HCS-CM-002, High Risk Pregnancy–Screening and Triage to Disease Management/Case Management and the Member Handbook inform members about the Maternity Education Program. Additionally, Molina tracks timeliness of prenatal care through HEDIS monitoring of pregnant members.
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 the Adult and Child surveys.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					The Adult survey had 337 responses out of 1681 for a 20% response rate. This is a 9% decline from the 2019 response rate of 29%. For the Child survey, there were 236 responses out of 1,627 for a 14.5% response rate. This is a 9.4% decline from the 2019 response rate of 23.9%. For the Child with CCC survey, there were 351 responses, resulting in a response rate of 14.8% (351 of 2,379), which is a 4.8% decline from the 2019 rate of 19.6%. *Recommendation: Monitor new initiatives to determine if response rates improve; work on provider reminders, website reminders, and call script reminders to increase member participation.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					An article of "Patient Experience Improvement Tips" was featured in the 2020 Q4 Palmetto Partners Provider Newsletter sent out on December 21, 2020. The article contains the link to the CAHPS results on the Molina Healthcare of SC website.
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. QIC Meeting Minutes from November 2020 indicate Molina implemented an employee centered CAHPS initiative, "Every Member Counts," to address low rates.
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					Policy MHSC-MRT-001, Grievance Disposition Process, and the associated procedure describe and outline Molina's grievance processes. Additionally, grievance information is provided in the Member Handbook, Provider Manual, and on the website.
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 indicates that anyone may file an oral or written grievance any time and authorized representatives must have a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member's written consent to file on the member's behalf.
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;	X					Policy MHSC-MRT-01, Grievance Disposition Procedures, the Provider Manual, and the Member Handbook state grievances are resolved within 90 calendar days, with the potential for an extension of 14 days.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					Policy MHSC-MRT-0,1 Grievance Disposition Procedures, states grievance staff are trained to identify grievances requiring special handling by the Medical Director.
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.	X					Grievance files reflect timely acknowledgement, investigation, and notice of resolution. Grievance acknowledgements and resolutions are provided orally. As a follow up to the deficiencies identified during the 2020 EQR, files have clear documentation of grievance investigations and of staff conducting appropriate follow-up with other departments when monitoring the grievance status. Actions taken to resolve issues were clearly noted and resolutions directly addressed the member's grievance issue.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Member grievances are reviewed by the Quality Improvement Committee to identify trends and opportunities for improvement. Molina tracks and monitors member grievance data quarterly with a goal of <5 grievances/1000 members. Results and analysis are presented and discussed during Quality Improvement Committee meetings and are reflected in committee minutes. Results in the Quality Improvement Program Medicaid Annual Evaluation indicate the top three grievance categories during Q4 2018 through Q3 2019 were Access and Availability (2,944), Billing and Financial (2,794), and Attitude/Service (410), and between Q4 2018 and Q3 2019, all categories decreased in total and per thousand volume.
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					Molina has a Quality Improvement Program with specific goals and objectives outlined in the Medicaid Quality Improvement Program Description, 2020 and in the QI Work Plan. Information regarding Molina's QI Program is available to members and provider on the website and upon request. The QI Program Description is reviewed and modified as needed and formally updated at least once a year.
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					The scope of program activities is covered in the QI Program Description. Program activities focuses on the members' entire health care experience using various sources of data including utilization data. Molina uses QNXT, a health information technology system, and a web-based member centric health management software application for data collection and storage.
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 presented the draft 2020 and 2021 QI Work Plans for review. Both are updated as needed and presented to the Quality Improvement Committee quarterly for approval. During the previous EQR, several errors related to the goals and benchmarks being measured were noted in the 2020 Work Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina corrected those errors, however; the dates in the column labeled "Timeline" were not updated. Molina indicated the work plan was in draft and the timeline dates would be updated. *Recommendation: Update the timeline dates in the 2021 QI work plan.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Molina's Quality Improvement Committee continues to be responsible for the implementation, oversight, and ongoing monitoring of the QI Program.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Quality Improvement Committee is co-chaired by the Chief Medical Officer and the Quality Lead. Members include key staff from functional areas of the health plan and contracted network providers specializing in Pediatrics, OB/GYN, Family Medicine, and Cardiology. Molina also has a designated Behavioral Health practitioner who advises Molina in QI activities related to behavioral health. A quorum of at least 51% of the committee members with no less than half of network provider participants needed to enact or implement decisions.
3. The QI Committee meets at regular quarterly intervals.	X					Meetings are scheduled quarterly.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					A meeting coordinator records and drafts minutes for each 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					Molina uses Inovalon, a certified software organization, for calculation of HEDIS rates. For measures reported using only the hybrid methodology, NCQA allowed organizations to report their audited HEDIS 2019 (MY 2018) hybrid rates if they were better than their HEDIS 2020 (MY 2019) hybrid rates. Molina chose to rotate a subset of hybrid measure with HEDIS 2019 results in IDSS for the following submissions: •Comprehensive Diabetes Care •Childhood Immunizations •Immunizations for Adolescents •Lead Screening The comparison from the 2019 rates to the 2020 rates revealed a substantial increase (>10%) in the Prenatal Care and Postpartum Care measures. The measures with a substantial decrease (>10%) include Persistence of Beta-Blocker Treatments After Heart Attack and Comprehensive Diabetes Care Eye exam, Medical Attention for Nephropathy, and Blood Pressure Control. CCME found the measures met all requirements. Details of the validation of the performance measures

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						can be found in the *CCME EQR Validation Worksheets, Attachment 3.*
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					Molina submitted three projects for validation: Breast Cancer Screening, Well Care-Program, and Correlation Between Member Assignment and Engagement.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				For the Breast Cancer Screening Performance Improvement Project (PIP), the rate decreased in the most recent remeasurement from 58.83% to 57.26%. This PIP has been ongoing for several years and has shown little or no improvements on the breast cancer rates even with all the incentives and initiatives. Molina should consider continuing the effective interventions, monitoring the breast cancer screening rate, and replacing this PIP with another project focusing on a different priority population to continue improving the quality of care. *Recommendation: Reevaluate the Breast Cancer Screening PIP and consider replacing this PIP with another project focusing on a different priority population to continue improving the quality of care.* For the Well-Care Program PIP, most of the measures improved except for the Adults' Access to Preventive/Ambulatory Health Services measure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Several measures in this PIP are being replaced or are retired (e.g., Children and Adolescents' Access to Primary Care Practitioners measure). Molina indicated the health plan would document the changes and consider using new measures. The Member Assignment and Engagement PIP documentation reported system limitations and data issues that are affecting accuracy of reported rates and member assignments. This PIP had baseline and one remeasurement displayed in the report. 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. The interventions that align with specific data barriers were not presented in the PIP report, although it is evident from the analyses that the primary intervention is addressing data management and reporting. Documentation issues caused a lower validation score. Details of the validation of the PIPs are found in the *CCME EQR Validation Worksheets, Attachment 3.* *Quality Improvement Plan: Display the specific data and system issues in the Correlation Between Member Assignment and Engagement PIP and aligned interventions to address those issues in the PIP report.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Molina includes contracted medical and behavioral health providers in planning and carrying out of the QI Program activities. Practitioners serve on clinical committees including the Quality Improvement Committee, Healthcare Services Committee, Pharmacy and Therapeutics Committee, and the Professional Review Committee.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Molina provided a sample of the Quality Reports that contains provider specific data regarding assigned members. This report also shows emergency room utilization and any gaps in care the member(s) may have. The reports are available to providers at least monthly.
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					Annually, Molina conducts a formal evaluation of the QI Program to assess the effectiveness of the program's activities and determine actions needed. It was noted during the previous EQR that the Quality Improvement Program 2018 Medicaid Annual Evaluation did not include all the QI activities. Molina addressed those missing activities in the Quality Improvement Plan submitted following last year's EQR. The Quality Improvement Program 2019 Medicaid Annual Evaluation was provided and found that Molina

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						included summaries and analyses of all activities. Section 14, "Areas of Focus/Recommendations for Next Year" was not included. However, this was provided during the onsite.
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's UM Program is incorporated within the Healthcare Services (HCS) Program. The HCS Program Description, along with policies and associated procedures, describe and define UM activities and functions, such as service authorizations, care management, behavioral health management, and appeals. The HCS Program Description outlines the program's structure and defines the goals, scope, and staff roles for physical and behavioral health services for members in South Carolina. The program description was last reviewed and approved by the Health Care Services Committee on September 20, 2020.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for service authorization timeframes are correctly documented in Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, and the HCS Program Description. Additionally, requirements are documented in the Member Handbook, Provider Manual, and on the website.
1.5 consideration of new technology;	X					Consideration of new technology or new uses of existing technologies is addressed in Policy and Procedure MHSC-HCS-UM-323, Authorization of New Medical Technologies, and in the HCS Program Description.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Discussion during the onsite revealed activities related to the Provider Profiling Program were put on hold due to changes in service authorization processes and the impact on healthcare resulting from the COVID-19 pandemic.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The role of Molina's CMO is described in the HCS Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, and chairing committees. The Behavioral

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Health Medical Director provides oversight and expertise within behavioral health service areas.
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					Procedure MHSC-HCS-UM-363, Continuity of Use of Clinical Utilization Criteria by Molina Health Plans, indicates clinical criteria are reviewed annually with participation of physician members of the HCS Committee, and updated as needed. The UM Program is reviewed, evaluated, and updated annually, and results and recommendations are presented to the HCS and Quality Improvement Committees for review and approval. The HCS Committee is a subcommittee of the Quality Improvement Committee and provides meeting minutes and reports on UM activities. The 2020 HCS Program Description and the 2019 HCS Program Evaluation were approved by the HCS Committee on September 14, 2020.
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					UM standards and criteria are documented in Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, and the HCS Program Description. Molina uses several review criteria, such as InterQual Criteria™,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Medicaid Coverage Guidelines, and internal clinical policies to determine medical necessity. Individual member circumstances and the local delivery system are considered when determining medical necessity.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of approval files reflects that reviewers follow processes described in UM policies such as Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, and Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, to determine service authorization requests. Use of appropriate criteria, consideration of individual member's needs, and requests to obtain additional information were noted.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Processes for covering hysterectomies, sterilizations, and abortions are described in Policy SC.UM.45, Sterilization and Hysterectomies, and Policy SC.UM.33, Abortions. The criteria for utilization are communicated in the Member Handbook, the Provider Manual, and on the website. In addition to the Abortion Statement on the provider tab under "Frequently Used Forms," the Surgical Justification Review For Hysterectomy form has been added as recommended from the 2020 EQR. A link on the website and in the electronic version of the Provider Manual redirects

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the reader to the SCDHHS website page where all required forms are located.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy CC.UM.02, Clinical Decision Criteria and Application, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. A physician reviewer can approve requested services when criteria is not met, and clinical evidence supports the decision. Files reflect individual member needs are considered and additional information is requested when applicable.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy and Procedure MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff, describe Molina's process for conducting inter-rater reliability testing. HCS departments and the pharmacy department conduct inter-rater reliability testing annually and chart quality audits monthly to assess the consistency with which staff apply decision-making criteria. Remediation and coaching are given to reviewers scoring below the established benchmark. All HCS and pharmacy reviewers achieved passing scores.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Pharmacy benefit information is available in the Pharmacy Services Program Description, Procedure MHSC- PHARM-02, Pharmacy Prior Authorization

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Requests, the Member Handbook, on the website, and in the Provider Manual. The Preferred Drug List provides formulary restrictions indicating medications that require prior authorization, limitations, or step therapy. The timeframes for authorizations include an automatic fax acknowledgement sent to the provider within 24 hours, a standard determination made within 14 days, and an expedited determination within 72 hours.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Procedure MHSC-PHARM-02, Pharmacy Prior Authorization Requests, and Procedure MHSC-PHARM-03, Pharmacy Lock-in Program, describe Molina's process for approving medications while a prior authorization request is pending. Molina allows a 3-day emergency supply of prescription drugs when a prior authorization is pending, as noted in the Pharmacy Program Description.
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					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Molina ensures UM decisions are rendered by appropriate staff as described in Policy MHSC-HCS-UM-364, Appropriate Professionals Making UM Decisions. Non-licensed staff collect structured clinical data and approve services with clear

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						criteria without interpretation of clinical information. Level 1 reviews are conducted by a licensed nurse. Only physicians or other appropriately licensed health care professionals render adverse benefit determinations. Reviewed files with adverse benefit determinations reflect decisions are made by appropriate physician specialists.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with Policy SC.UM.05, Timeliness of UM Decisions and Notifications, the HCS Program Description, and *SCDHHS Contract* requirements. Molina provides written or electronic notification to the requesting provider and member within 14 calendar days for standard authorization requests, within 72 hours for urgent and concurrent requests, and within 30 days for retrospective requests.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Denial files reflect attempts from the reviewer to obtain additional clinical information when needed prior to rendering an adverse benefit determination. During the onsite, Molina explained that reviewers have access to electronic medical records at certain facilities which allows them to obtain the most curtain clinical information without having to interrupt the requesting provider. This was evident in one denial file reviewed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Adverse Benefit Determination files reflect decisions are made by the Medical Director or other appropriately licensed health care professional as outlined in Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making.
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					Review of denial files revealed decisions were timely and notice to the requesting provider and member were communicated according to processes described in Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification. Adverse Benefit Determination notices are written in language that is clear, without medical jargon, and easily understood by a layperson. Member and provider notices include contractually required information, such as the action taken by the plan, the member's right to file an appeal with Molina, and to request a State Fair Hearing. An Appeal Form and Authorized Representative Form were enclosed.
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	X					Molina's appeals processes are described and outlined in policies such as Policy MHSC-MRT-002, Standard Appeal Process, Policy MHSC-MRT-003, Expedited Appeal Process, Policy MHSC MS-20,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
benefit determination by the MCO in a manner consistent with contract requirements, including:						Member Appeals, and in associated procedures. Additionally, appeal information is provided in the Member Handbook, Provider Manual, and on the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Definitions of the terms "appeal" and "adverse benefit determination," and a description of who may file an appeal, are correctly documented in policies according to requirements in the *SCDHHS Contract, Section 9*. Molina defines and provides examples of people who can be an authorized representative acting on the member's behalf. Additionally, the Member Handbook and Provider Manual include the statement that, "a provider can appeal on a member's behalf if the member has agreed to treatment; Molina has received medical records from the provider; and/or there is a history of paid claims for services from the provider." This inclusion was as a recommendation from the previous EQR.
1.2 The procedure for filing an appeal;	X					Requirements for filing an appeal are documented in policies and procedures and in denial and acknowledgement letter templates. Members are instructed to submit a signed appeal request within 30 days from the oral appeal request, unless an expedited appeal is requested. Members can provide evidence and review the appeal case file prior to a resolution. The "Medical Appeal Request

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Form" and "Guidelines for Appealing a Medical Denial" instructions are enclosed with adverse benefit determination notices. As a follow up to the corrective action from the 2020 EQR, Molina updated documents, such as the Member Handbook and adverse benefit determination letters, to include information that members can have access to their appeal case file and documents related to the appeal in advance of the resolution timeframe. Also, the address for submitting appeals is correctly noted in the Member Handbook and across documents.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Molina's process for handling expedited appeal requests is described in Policy MHSC-MRT-003, Expedited Appeal Process and in the associated procedure.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Timeframes for resolving appeals are documented according to requirements in the *SCDHHS Contract, Section 9.* Molina resolves standard appeals and gives notice within 30 calendar days of receipt and expedited appeals within 72 hours of receipt. If a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						request for an expedited appeal is denied, the member is notified, and the appeal is processed within the standard timeframe of 30 days.
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					The review of appeal files reflected Molina staff processed standard and expedited appeal requests according to guidelines in Procedure MHSC-MRT-002, Standard Appeal Process, Procedure MHSC-MRT-003, Expedited Appeal Process, and associated policies. Appeal determinations were issued by appropriate physician reviewers, and acknowledgments and resolutions were completed timely.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy and Procedure MHSC-MRT-002, Standard Appeal Process, explains Molina's process for tracking, analyzing, and reporting appeals data. Appeals data is presented at QIC and submitted to SCDHHS quarterly. The 2019 MHSC Medicaid Executive Summary document indicates Molina achieved the established a goal of <5.0 appeals per 1000 members.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					Molina's Care Management Program is clearly defined, described, and outlined within the HCS Program Description. Policies such as MHSC-HCS-CM-047, Integrated Care Management Program and Complex Case Management, and Policy MHSC-HCS-CM-044, Case Management Clinical Guideline and Tools, and the respective procedure documents, describe processes and procedures Molina uses to ensure care management services and activities are provided according to *SCDHHS Contract* requirements.
2. The MCO has processes to identify members who may benefit from case management.	X					The HCS Program Description describes methods for identifying and referring members into the Care Management Program. In addition to performing an annual population assessment, members are also identified through claims data, laboratory and health risk assessment results, predictive modeling software, and internal and external referrals.
3. The MCO provides care management activities based on the member's risk stratification.	X					Molina's approach to risk stratification is outlined in Policy MHSC-HCS-CM-051, Risk Stratification. Members are initially stratified using pre-enrollment data are re-stratified based on results from the initial assessment and can be stratified using predictive modeling after enrolled in the program for 6 months. Procedure MHSC-HCS-CM-051, Risk Stratification provides detailed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						descriptions of CM services and activities provided in each stratification level.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
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					The "Transition of Care Reference Guide-Medicaid" addresses transition requirements according to the *SCDHHS Contract, Section 5.6*. Molina conducts appropriate referrals, monitoring, and follow-up to ensure continuity of the member's care.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					Policy and Procedure MHSC-HCS-CM-361, CM Audit Review, explains that HCS staff performance is evaluated during monthly case audits and "cases are reviewed and analyzed for clinical decision making based on Molina's model of care, care management principles, clinical guideposts, federal and state requirements and CMS standards." Remediation is given to staff who do not achieve

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the minimum passing score of 90% for two consecutive months. The HCS Program is evaluated annually and results from select metrics are analyzed for effectiveness and reported to the HCS Committee and QIC. Evaluation of the Care Management Program are based on the results from the Member Satisfaction/Experience Survey, HEDIS, and the Chronic Disease Self-Management Program (CDSMP) Assessment Tool.
7. Care management and coordination activities are conducted as required.	X					Care Management files indicate CM activities are conducted as required and Care Managers follow policies to conduct the appropriate level of service. CCME noted that HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed; Unable to Contact (UTC) letters and education materials are appropriately utilized; updated care plans are available to members' PCPs; and Health Risk Assessments were completed timely.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					Policy MHSC-HCS-UM-362, Monitoring to Ensure Appropriate Utilization, describes Molina's processes for monitoring and analyzing relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization which

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						may impact health care services, coordination of care, and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Health Care Services Committee meeting minutes and Utilization Reports reflect Molina analyzed and monitored utilization data for services such as ER utilization and behavioral health admissions. Recommendations were offered based on findings. Admissions continue to be a concern for the aged-blind-disabled population. Discussions during the onsite revealed the vacant staff role to assist in reducing readmissions and improving utilization rates was filled in March 2021. Given the position being filled and COVID-19 restrictions continuing to lessen, it was noted that the readmission rates will improve.

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					Molina delegates credentialing functions to: •Aperture •AnMed Health •Augusta Medical •Bon Secours St. Francis (BSSF) •Medical University of South Carolina •Prisma Midlands •Prisma Upstate •Regional Health Plus •Roper St. Francis •UniPhy Additional delegates include: •March Vision Care – vision benefit management •MedXM – in-home assessments •Teladoc - telemedicine Delegation agreements are implemented with each approved delegate. The delegation agreements include information about general delegation terms and conditions, pre-delegation assessments and ongoing monitoring, sub-delegation, reporting requirements, and performance expectations. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						agreements also specify actions that may be taken for unsatisfactory performance.
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-005, Credentialing Delegation Requirements, and its corresponding procedure include requirements for delegation of credentialing activities. The Delegation Oversight Committee oversees and is accountable for delegated credentialing and other activities delegated by the MCO. The procedure describes pre-assessment audit requirements and ongoing monitoring of credentialing delegates. A review of delegation oversight documentation revealed Molina conducts appropriate ongoing monitoring and annual oversight of delegates. Documentation confirmed Molina implemented corrective action for delegates who were not performing satisfactorily. Onsite discussion revealed Molina has terminated the delegation agreements with two entities due to poor performance and/or lack of response to correction action.

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					Molina tracks compliance with adolescent and pediatric immunizations by conducting annual medical record reviews and HEDIS collections, as described in Policy and Procedure MHSC-AD-03, EPSDT Notification, Tracking and Follow-up Procedure, and Policy and Procedure MHSC-QI-120, Standards of Medical Record Documentation. Additionally, the Quality Improvement Program 2019 Medicaid Annual Evaluation reflects that child and adolescent immunization compliance are evaluated for improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					Molina follows the EPSDT periodicity schedule according to the American Academy of Pediatrics (AAP). Methods such as annual medical record reviews are used to ensure EPSDT requirements are tracked, and providers are informed of impending or missed EPSDT services by receiving a member non-compliant list.
2. Core benefits provided by the MCO include all those specified by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					