CCME

2023 External Quality Review

MOLINA HEALTHCARE OF SOUTH CAROLINA

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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 2023 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Molina Healthcare of South Carolina (Molina) since the 2022 Annual Review.

The goals and objectives of the review are to:

- Determine if Molina is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2022 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

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

Summary and Overall Findings

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

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

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

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

Administration:

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

All Molina departments review policies and procedures annually, with recommendations and revisions approved by the Administrative and Policy (A&P) Committee. Policy changes are documented within the A&P committee meeting minutes. The Compliance department is responsible for educating and distributing information to employees via announcements, newsletters, and the iLearn virtual portal.

Molina's resources were found to be sufficient to ensure that all health care products and services required by the State are provided to members. The Organizational Chart and 2023 Companion Matrix clearly identified key personnel positions, lines of oversight, and operational relationships.

The Compliance Program is described in the 2022-2023 Compliance Plan. Molina's Code of Business Conduct and Ethics applies to all employees and as a condition of employment, employees are required to acknowledge receipt and understanding of the Code of Conduct upon hire and annually, thereafter.

Roles and responsibilities of the Compliance Officer and Compliance Committee are outlined in the SC Regulatory Compliance Committee Charter. The Compliance Committee oversees Molina's Medicaid, Medicare-Medicaid, and Marketplace compliance programs, meets quarterly, and reports to the Board of Directors.

Molina's 2023 Fraud, Waste, and Abuse (FWA) Plan outlines the requirements for compliance training. New employees are required to complete the training within 30 calendar days of employment and annually thereafter.

Confidentiality is addressed in the FWA Plan and included as part of the training materials for new employees. Existing employees are expected to complete the training annually. The expectation for adherence to processes to ensure member confidentiality

and the protection of health information is consistently documented in policy and supplemental documents.

Molina's Information Systems Capabilities Assessment (ISCA) documentation indicates the MCO has policies and procedures in place to meet the State's contract requirements. Molina has several self-assessment measures in place to ensure data, systems, and processes are functioning properly and securely.

Provider Services:

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

Molina's Professional Review Committee (PRC) uses a peer review process to make credentialing decisions and is chaired by a Molina Medical Director. The committee meets monthly and reports to the Quality Improvement Committee (QIC). Current voting members of the PRC include two OBGYN providers, one psychiatrist, three pediatricians, one nurse practitioner, and one physician assistant. Molina continues its efforts, initially reported during the previous (2022) EQR, to recruit a general surgeon for PRC membership. CCME encouraged Molina to also consider recruiting one or more adult general medicine providers for PRC membership.

Processes and requirements for initial and ongoing credentialing of practitioners and organizational providers are documented in policies and procedures, with related addenda that include South Carolina specific requirements. The sample of initial practitioner credentialing files and organizational provider initial credentialing and recredentialing files revealed no issues. Two practitioner recredentialing files did not include evidence that hospital admitting privileges/arrangements were verified. Molina staff explained that they have been directed by SCDHHS that this is no longer a required element of credentialing and recredentialing; however, the documentation Molina submitted to support this directive was not from SCDHHS. Also, Molina's Credentialing and Recredentialing Practitioners procedure (Procedure CR01) requires practitioner hospital privileges to be verified at both initial credentialing and recredentialing. Therefore, Molina is out of compliance with this Procedure.

Molina contracts with all required Status 1 provider types and routinely evaluates the geographic adequacy of its provider network using appropriate access standards. Geographic access goals for PCPs and hospitals were met for all counties in 2022. For specialists, gaps were noted for psychology (one county) and OBGYN (one county). Molina reported interventions to address these gaps.

Appointment access standards for PCPs were correctly listed in all documents reviewed. For specialty provider appointments, the documentation was incomplete and specialty appointment information was included under the heading for PCPs, which may result in

confusion. Molina conducts annual telephonic surveys to evaluate provider compliance with appointment access standards and re-educates and re-surveys providers who do not meet the standards.

CCME conducted a telephonic provider access study on a sample of PCPs from a list provided by Molina. Calls were successfully answered 62% of the time when omitting calls answered by voicemail messaging services. This represents a statistically significant improvement from last year's rate of 43%. The majority of unsuccessful calls were because the physician was no longer practicing at the location.

Initial and ongoing provider education is conducted to ensure providers understand health plan operations, programs, and requirements. This education is provided through orientation sessions, routine provider site visits, regional provider training sessions, and periodic communications such as face-to-face presentations, faxes, electronic communications, provider newsletters, webinars, and the website.

Molina educates providers about medical record documentation, maintenance, and confidentiality requirements and routinely assesses provider compliance with the requirements. The 2022 medical record audit was conducted on a sample of 150 medical records from 30 providers. 100% of the records received a passing score, and the results were reported to the QIC in September 2022.

Various activities are conducted to ensure Molina's network can meet the cultural and linguistic needs of its membership. The Provider Manual includes information about cultural competency, and Molina's website includes cultural competency training resources.

Member Services:

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

Molina's Member Bill of Rights and Responsibilities outlines all required member rights and responsibilities, which are reflected consistently in the Member Handbook and on the website.

Policy ME-01, New Medicaid Member Outreach and Education, states new members will receive the welcome packet within 14 calendar days from the date their eligibility file is received. A benefit grid in the Member Handbook and on Molina's website describes core benefits, covered services, and extra benefits provided by Molina. Prior approval is not required for family planning services, emergency visits, or behavioral health services. Changes are made in writing in the NCQH Mailer notification.

The Member Handbook and website provide contact numbers for a variety of member needs. The Nurse Advice Line number is listed on the Member ID Card and is available 24

hours a day. The Member Handbook and Molina's website describe and define behavioral health and physical health emergency services and provide clear and specific information about appropriate use of urgent and emergent services. The Member Handbook informs members that interpreter services are available by contacting the Member Services call center.

Policy MHSC-ME-02, Advanced Directives, provides information about a member's right to implement an advance directive, including a description of applicable state laws. This is addressed in the Member Handbook, as well.

The Member Handbook provides information about the steps to select a Primary Care Provider (PCP). The Provider Directory lists available in-network doctors and specialists. More information and assistance may be accessed by calling Member Services.

During the onsite discussion, it was shared that the l member newsletter, My Health My Life digital newsletter and the "Handle on Health" program provides bicycles and helmets to eight-, nine-, and ten-year-old children who are current on their health assessments. Digital campaigns have been enhanced to make members aware of the SC Facebook page.

Molina contracts with SPH Analytics, a certified 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 245 responses out of 1687 surveys, a 14.5% response rate, which is a decline from the previous response rate of 18.1%. Benchmarks (66.7th Quality Compass (QC) percentile) were met for seven out of 10 measures. For the Child survey, there were 353 responses out of 3640 surveys for a response rate of 9.7%. This is a decline from the previous year's rate of 13.1%. The benchmark rate (66.7th QC benchmark) was met for three out of nine measures. For the Child with CCC survey, there were 237 completed surveys out of a total of 2397, for a response rate of 9.9%. This is a decline from the previous year's rate of 12.7%. The benchmark (66.7th QC percentile) was met for five out of nine measures.

The results have been presented to the QIC and providers. The analysis and implementation of interventions to improve member satisfaction is discussed with the QIC.

Molina has policies and procedures in place describing the grievance process consistent with *SCDHHS Contract* language. Policy and Procedure MHSC-MRT-001, Grievance Disposition Process, the Member Handbook, and website consistently define a grievance as "an expression of dissatisfaction about any matter other than an adverse benefit determination." Grievances may be filed verbally in person or by telephone, and in writing, by fax, or electronically. An authorized representative may file or assist members with the grievance filing process.

The current EQR found, based on a review of randomly selected grievance files, that all timeliness standards were met.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

Molina has designed a Quality Improvement (QI) Program to ensure all medically necessary covered services are available and accessible to all members and that all covered services are provided in a culturally and linguistically appropriate manner. Molina submitted the Molina Healthcare of South Carolina, Inc. Quality Improvement Program Description 2022. This program description included the program's goals, structure, scope, and methodology used to monitor and improve the services delivered to members.

Molina develops a work plan to guide and track specific QI activities. The 2022 and 2023 Quality Improvement and Health Equity Transformation Work Plan was submitted for review. It was noted that the 2023 QI work plan included the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. CCME recommended labeling the columns for the applicable year (example: Y1=2023, Y2=2024, etc.). Also noted in the 2023 work plan were a few typos in the Program Structure section.

Molina's QIC is responsible for the implementation and monitoring of the QI Program. This committee meets at least quarterly, and membership includes the Chief Medical Officer (chairman), senior leaders from the health plan, and external network providers.

Annually, Molina conducts a formal evaluation of the QI Program. The evaluation identifies program outcomes, a description of limitations, and interventions to overcome those limitations. Molina provided the Quality Improvement Program 2021 Annual Evaluation. This evaluation included a summary of the results for each of the quality improvement activities, any barriers identified, and interventions underway. For the 2022 EQR, Molina had not included the outcome for all QI activities. This deficiency was addressed with a quality improvement plan. CCME found Molina had corrected this deficiency.

Performance Measure Validation: CCME conducted a validation review of HEDIS measures following the CMS protocol for validating performance measures. This process assessed the production of these measures by the health plan to confirm the 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 were compared for the current review year (MY 2021) to the previous year (MY 2020) and the changes from 2020 to 2021 are reported in the Quality Improvement section of this report. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the changes in the HEDIS measures. A substantial increase or decrease is a change in rate greater than 10%.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Controlling High Blood Pressure (cbp)	46.96%	59.85%	12.89%
Pharmacotherapy for Opioid Use Disorder (pod)			
Total	24.39%	52.55%	28.16%
Substantial Decrease in Rate (>10% decrease)			
Childhood Immunization Status (cis)			
Pneumococcal Conjugate	77.62%	67.4%	-10.22%
Combination #3	71.05%	58.88%	-12.17%
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	82.56%	71.59%	-10.97%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	56.23%	34.48%	-21.75%
Continuation and Maintenance (C&M) Phase	66.34%	45.5%	-20.84%

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

Molina submitted three PIPs for validation. Topics included: Improving Encounters Acceptance Rates, Well Care, and Immunizations for Adolescents. All three PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions are included.

Table 2: Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates	
The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from remeasurement one at 96.9% to remeasurement two at 97.3% (the refreshed rate shows 98.82%). The goal is 100%. The 837P rejection rate declined from 2.82% to 1.35% which demonstrated improvement. The goal for this measure is 2%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
Interventions	
The interventions included a provider crosswalk, review of QNXT claims setup, logic checks, review of rejected encounters, and logic adjustment focusing on billing NPI.	

Table 3: Immunizations for Adolescents PIP

Immunizations for Adolescents Program	
The Immunizations for Adolescents PIP examines adolescents, 13 years of age, with one dose of meningococcal vaccine, one tetanus, Tdap, and HPV by their 13th birthday. Molina chose this PIP to target rural and urban areas across SC to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV related cancers. The baseline rate was 28.95% with a slight decline in the administrative rate of 28.35%. The annual improvement goal for this PIP is 31.19%.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members.	

Table 4: Child and Adolescent Well-Care Visits PIP

Child and Adolescent Well-Care Visits	
The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% at the remeasurement one. The goal is 44.29% for the annual improvement.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Utilization Management:

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

Molina's Utilization Management (UM) Program Description outlines the staff responsibilities and the scope and objectives for physical health and behavioral health services. The Pharmacy Program Description outlines the program objectives and standard operations of the Pharmacy Program. The Chief Medical Officer, Behavioral Health Medical Director, and Pharmacy Director provide clinical oversight and daily operational management over their respective programs.

The UM Reviewers are health practitioners that hold a current licensure in their respective health care profession. When making clinical coverage determinations, UM Reviewers utilize external and internal guidelines such as Milliman Clinical Guidelines (MCG), Official Disability Guidelines (ODG), Hayes Technology Assessments, Inpatient Hospital Services Coverage Requirements, and State Guidelines. However, one procedure continues to reference InterQual as evidenced based criteria utilized in making clinical determinations. This was an issue identified during the previous EQR. Molina's UM Program Description and policies provide an overview of the timeliness requirements for processing UM decisions. During this EQR, there were some discrepancies identified in the

UM and Pharmacy Program Descriptions regarding the timeliness standards for processing pharmacy authorizations.

Annually, Molina conducts Inter-Rater Reliability (IRR) testing for physicians, pharmacists, and clinical reviewers. Based upon the IRR results, the Prior Authorization Clinicians, Pharmacy Reviewers, and Medical Directors received passing scores. However, the Inpatient Clinician Reviewers scored below the targeted goal level of 90% and received remediation training. Also, there was a discrepancy identified in reference to the goals for Pharmacy Reviewers and Medical Directors within the policies and the Health Care Services Annual Evaluation.

Molina's Provider Manual, various policies, and the Member Handbook outline Molina's appeal process. Requirements for filing an appeal are documented in the policies and procedures, UM Program Description, and Member Handbook. However, the UM Program Description and two letter templates continue to reference the requirement that a written appeal request must be submitted after a verbal request. This issue was addressed in the previous EQR. The review of a sample of appeal files confirmed the files were processed according to contractual standards.

A descriptive overview of Molina's approach to managing care management activities and care transitions programs are outlined in the UM Program Description and numerous policies. Care transition activities were described within Molina's policy and in the UM Program Description; however, there was no mention of how continuity of care is provided while a member is in the appeals process.

A sample of Molina's care management files was submitted for review. The files indicate that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and submitted additional information post onsite, there were several identified issues in reference to date of creation of members' Individualized Care Plan and a follow up schedule conducting an ongoing assessment of the members' progress.

Delegation:

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

Molina has implemented delegation agreements with 14 entities for activities including case management, claims processing, call center functions, credentialing, and credentialing verification.

The Delegation Oversight Committee (DOC) oversees and is accountable for all functions and responsibilities that are delegated to external entities. Processes and requirements for delegation of health plan functions and activities to external entities are found in policies and procedures. These policies and procedures address pre-delegation

assessment, annual oversight, ongoing monitoring, sub-delegation, and delegation termination. A minor issue was noted in that Policy MHSC-DO-001, Pre-Assessment Audits, included an outdated reference to the Excluded Parties Lists System (EPLS), which has been replaced by the System for Award Management (SAM).

Molina executes written delegation agreements with each delegate at the time of delegation approval. The agreements detail the activities and functions being delegated, delegate reporting requirements, annual and ongoing monitoring activities, and consequences that may result from substandard or noncompliant performance.

Documentation of annual delegate oversight was reviewed and reflected timely evaluations and use of comprehensive tools to ensure compliance with standards and requirements for the delegated activities. Results of annual and ongoing oversight activities and the status of any corrective actions implemented for the delegates are reported to the DOC.

State Mandated Services:

42 CFR § Part 441, Subpart B

Molina educates members and providers about the EPSDT program and recommended immunizations and encourages members to obtain recommended services. Monitoring mechanisms to ensure timely provision of required EPSDT services and immunizations include monitoring related HEDIS® measures and conducting medical record reviews. The Provider Services Team supplies gap in care reports to providers and informs providers of member incentives that can be shared with members upon completion of well-care screenings and services.

Molina provides all contractually required core benefits.

Quality Improvement Plans from 2022 EQR

During the previous EQR, there were four standards scored as “Partially Met” and one standard scored as “Not Met. The following is a high-level summary of those deficiencies:

- There was a statistically significant decline in the successfully answered calls from the Telephone Provider Access Study conducted by CCME.
- The 2020 QI Program Evaluation was incomplete and did not include all the activities underway or completed in 2019.
- The Preferred Drug List changes posted on Molina’s website did not include the approval dates for the changes and when those changes were published on the website as required by the *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3*.

- Molina was still requiring a written appeal request when a verbal request is received even though this requirement was removed from the *SCDHHS Contract* and the Federal Regulations.

- Some of the appeal files reviewed were untimely and the physician who made the appeal decision was not of the same or similar specialty as the ordering physician.

After the 2022 EQR, Molina addressed these deficiencies and submitted a Quality Improvement Plan (QIP) on June 16, 2022, and on July 1, 2022. CCME reviewed and accepted this plan on July 5, 2022. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies. Findings of the current EQR revealed Molina did not correct a previously identified issue related to the process for filing an appeal.

Conclusions

Overall, four of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330* were not met. *Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Molina's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

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

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	8	7	88%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	8	89%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	13	93%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	39	100%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and	20	19	95%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
	Utilization Management, Section V. C			
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	11	11	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	14	14	100%

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

As noted in the table above:

- For Availability of Services and Assurances of Adequate Capacity and Services, one standard was not met due to incomplete documentation of appointment access standards for specialty providers.
- One standard was not met for Care Coordination and Continuity of care related to the Case Management file review.
- Molina had a policy that contained incorrect information for the Coverage and Authorization of Services area.
- For Grievances and Appeals, Molina had an uncorrected deficiency in the Appeals section regarding verbal requests for an appeal.

Table 6, Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2022 review. For 2023, 210 out of 215 standards received a score of "Met." There were four standards scored as "Partially Met" and one standard related to an uncorrected deficiency that received a "Not Met" score.

Table 6: Scoring Overview

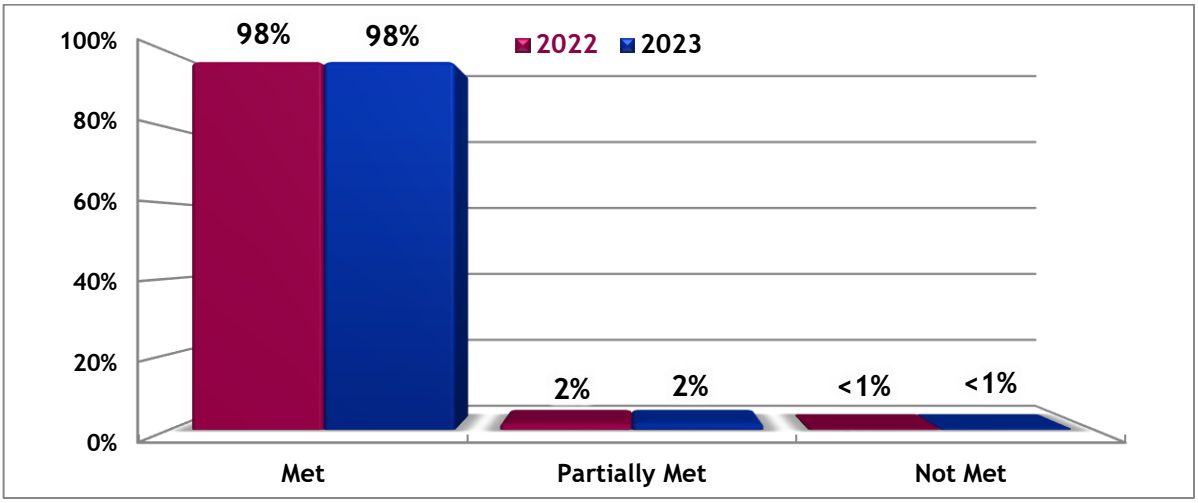
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	40	0	0	0	0	40	100%
2023	40	0	0	0	0	40	100%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Provider Services							
2022	75	0	1	0	0	76	99%
2023	75	1	0	0	0	76	99%
Member Services							
2022	33	0	0	0	0	31	100%
2023	33	0	0	0	0	33	100%
Quality Improvement							
2022	13	1	0	0	0	14	93%
2023	14	0	0	0	0	14	100%
Utilization							
2022	43	2	0	0	0	45	93%
2023	43	3	0	0	0	46	93%
Delegation							
2022	2	0	0	0	0	2	100%
2023	2	0	0	0	0	2	100%
State Mandated Services							
2022	4	0	0	0	0	4	100%
2023	3	0	1	0	0	4	75%
Totals							
2022	**209**	**4**	**1**	**0**	**0**	**214**	**98%**
2023	**210**	**4**	**1**	**0**	**0**	**215**	**98%**

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

The 2023 Annual EQR shows that Molina achieved "Met" scores for 97.67% of the standards reviewed. As the following chart indicates, 1.86% of the standards were scored as "Partially Met," and 0.47% were scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2022 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number.

Recommendations and Opportunities for Improvements

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

Table 7: Evaluation of Quality

Strengths Related to Quality
• Staffing levels appear adequate, and all key positions are filled. • Compliance and confidentiality training are covered for all current and new employees. The iLearn platform is used to distribute new and annual training, and to ensure attestation for required training. • Molina has disaster recovery and business continuity plans that are capable of restoring services within the organization's recovery objectives. • Initial credentialing files for practitioners and initial and recredentialing files for organizational providers were fully compliant with all credentialing requirements. • Ongoing provider sanction monitoring processes are addressed in various policies and are compliant with all applicable state, federal, and contractual requirements. • The Performance Measures were compliant with the HEDIS technical specifications for rate calculations. • All Performance Improvement Projects received validation scores within the High Confidence range. • In addition to IRR, Molina conducts monthly audits of UM decisions to ensure consistency in clinical criteria application for quality assurance. • Policies and procedures appropriately document processes and requirements for delegation of health plan activities to external entities. • Pre-delegation assessments are conducted to ensure potential delegates meet all contractual, federal, and state requirements for the activities being delegated.

Strengths Related to Quality
• Documentation confirms that an annual assessment is conducted, and audit tools are comprehensive and include appropriate elements for the specific activities that are delegated. • Reports of delegation activities, annual assessment results, and status of corrective action plans are provided to the Delegation Oversight Committee.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Procedure CR02, Assessment and Re-assessment of Organizational Providers, does not address whether providers can appeal non-administrative denials or terminations. Onsite discussion confirmed that no appeal process is available.	• Recommendation: Revise Procedure CR02 to indicate that appeals are not allowed for non-administrative denials or terminations.
• The voting membership of the Professional Review Committee includes no adult general medicine providers. Additionally, Molina reported that efforts to recruit a general surgeon have been unsuccessful.	• Recommendation: Continue efforts to recruit an additional specialty provider for membership on the Professional Review Committee. In addition, consider recruiting an adult general medicine provider, such as a family practitioner or internal medicine practitioner, for PRC membership.
• Policy MHI-QUAL-003, Standards of Medical Record Documentation, indicates the Standard Medical Record Documentation Audit Tool is included as an attachment, but this attachment was not found.	• Recommendation: Revise Policy MHI-QUAL-003, Standards of Medical Record Documentation, to include the Standard Medical Record Documentation Audit Tool.
• Policy MHI-QUAL-003, Standards of Medical Record Documentation, does not provide information about any additional actions taken for results below the 90% threshold for medical record audit scores	• Recommendation: Revise Policy MHI-QUAL-003, Standards of Medical Record Documentation, to include additional actions taken to reeducate providers who do not meet the 90% scoring threshold for medical record review.
• The 2023 Work Plan appeared to contain a few typos in the Program Structure section regarding the timeline for completing the QI Program Description, Work Plan, and the QI Evaluation.	• Recommendation: Correct the timeline for completing the 2023 QI Program Description, Workplan, and the QI Program Evaluation in the Program Structure section of the 2023 QI Work Plan.
• The UM Program Description describes the medical necessity criteria used by Molina and indicates that MCG criteria is used to conduct inpatient reviews. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, continues to indicate that Molina utilizes InterQual in performing clinical determinations.	• Quality Improvement Plan: Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, to remove the reference to InterQual Criteria.
• A discrepancy was identified in the IRR goals for Pharmacy Reviewers and for the Medical Directors. The Health Care Services Annual Program Evaluation listed the goal as 80% for the Pharmacy Reviewers and the Medical Directors. However, Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in	• Recommendation: Update Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria, to reflect the correct IRR goal for Pharmacy Reviewers and Medical Directors, and ensure it is consistent with the Health Care Services Annual Evaluation.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
Application of Medical Necessity Criteria, noted the goal as 90%.	
• Page 50 of Molina's UM Program Description indicates that a standard request for an appeal received verbally must be followed by a written request in 30 days. This was an issue identified in the previous EQR and not corrected. • Two of Molina's letter templates incorrectly state that a written request for an appeal is needed after an oral request is received.	• Quality Improvement Plan: Update all documents related to the process for filing an appeal to remove the requirement that a standard request for an appeal received verbally must be followed by a written request.
• The following issues were identified in Molina's care management files: ○ For seven files, there was no identified note or date provided on the creation of the Individualized Care Plan (ICP). ○ Two files did not have ongoing documentation of notes that entail a follow up schedule or an assessment of the member's progress that were receiving Level III Complex CM services.	• Quality Improvement Plan: In Individualized Care Plan development, please ensure to accurately document the date the plan was developed. Also, include notes that entail a follow up schedule or assessment of the member's progress.
• Policy MHSC-DO-001, Pre-Assessment Audits, references checking the GSA Excluded Parties Lists System (EPLS); however, the EPLS has been replaced by the System for Award Management (SAM).	• Recommendation: Revise Policy MHSC-DO-001 to correct the outdated reference to the EPLS.
• The current review confirmed that Molina did not correct an identified deficiency from the previous EQR related to documentation that states a verbal appeal request must be followed by a written appeal request.	• Quality Improvement Plan: Implement actions to address and correct all deficiencies identified during the EQR.

Table 8: Evaluation of Timeliness

Strengths Related to Timeliness
• Grievance files reviewed, all met the acknowledgment and resolution timeliness standards. • Utilization Management approval files were completed in a timely manner and reviewers utilized appropriate clinical criteria. • Appeal files were processed timely, and an appropriate physician specialist conducted the review of cases.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
• The timeframe for processing pharmacy decisions was incorrect in the UM Program Description.	• Recommendation: Update the UM Program Description to reflect the correct timeframe for processing pharmacy decisions.

Table 9: Evaluation of Access to Care

Strengths Related to Access to Care
• Routine monitoring activities are conducted to ensure the geographic access adequacy of the provider network. Geographic access is measured on a county by county basis using appropriate parameters. • Molina reported a current initiative is in place to recruit every South Carolina primary care provider into the Molina network. Molina also reported planned initiatives to improve the Provider Directories. • The successful contact rate for the Provider Access Study conducted by CCME was 62%, an improvement from the previous year's rate of 43%. • The Member Handbook presents all the required member information and is written in an easily understood manner. • Molina uses a variety of methods to keep members informed about adult preventive health screenings and well-child visits conducted at appropriate intervals. • Enhanced and expanded programs and member resources specific to chronic disease management are provided for all members. • Denial files utilized appropriate physician consultations and adverse benefit decisions were clear in documenting the reasoning for the decision. • Molina works to increase participation in the EPSDT program, including immunizations, by educating members and providers, and conducts monitoring and evaluation activities to assess provider compliance with provision of required EPSDT services and immunizations. Gaps in care reports are disseminated to providers and incentives are in place to encourage participation in recommended care. • Findings of this EQR reflect that Molina provides all contractually required core benefits.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Two practitioner recredentialing files did not provide evidence that hospital admitting privileges/arrangements were verified at recredentialing. Molina staff reported that they had received documentation via email from SCDHHS that this is no longer a required element of credentialing and recredentialing. However, the copy of the email that Molina referenced did not originate from SCDHHS. Also, Molina's Credentialing and Recredentialing Practitioners procedure (Procedure CR01) requires practitioners hospital privileges to be verified at both initial credentialing and recredentialing.	• Recommendation: Ensure all practitioner credentialing and recredentialing files include evidence that hospital admitting privileges/arrangements have been verified.
• For specialty providers, Policy MHSC-PS-005 does not include the requirements for emergent visits immediately upon referral and urgent medical condition care appointments within 48 hours of referral or notification of the PCP. The Provider Manual, pages 68-69, and the Member Handbook, page 29, include requirements for emergent visits and urgent medical condition care appointments; however, the information is found in a table with a heading of "PCPs," so it isn't clear that the information applies to specialist appointments. Also, the Provider Manual and Member Handbook define	• Quality Improvement Plan: Revise Policy MHSC-PS-005, the Provider Manual, and the Member Handbook to clearly state the requirements for specialty appointments. Ensure the information is compliant with the standards defined in the *SCDHHS Contract, Section 6.2.3.1.5.*

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
the requirement for routine specialist appointments as 12 weeks, however this is incomplete.	
• Policy MHSC-HCS-UM-331, Continuity of Care Policy, and Molina's UM Program Description do not address continuity of care while a member is in the appeals process.	• Recommendation: Consider adding additional information in Policy MHSC-HCS-UM-331, Continuity of Care Policy or in Molina's UM Program Description regarding the member's ability to continue to receive transition of care services while in the appeals process.

METHODOLOGY

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

On February 13, 2023, CCME sent notification to Molina that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Molina to ask questions regarding the EQR process and the requested desk materials.

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

The second segment was a virtual onsite review originally scheduled for April 19, 2023, and April 20, 2023. Due to a change in CCME's EQR contract, the onsite was conducted on May 17th and 18th. 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's policies and procedures are reviewed on an annual basis. Policy and Procedure MHSC-AD-02, Annual Policy Review details the process for the annual review. Updates to

the policies and procedures are taken to the Administrative and Policy Committee for approval. Staff have access to policies through a SharePoint site.

Molina's Organizational Chart and the Companion Matrix clearly identified key personnel and operational relationships. Dora Wilson, Molina's Plan President, is responsible for the health plan's day-to-day business activities. All contractually required positions are filled and staffing is sufficient for all departments. The Chief Medical Officer, Richard Shrouds, MD. oversees and is responsible for the appropriate provision of covered Benefits to Medicaid Managed Care Program members.

Molina's Code of Business Conduct and Ethics applies to all employees. Employees are required to acknowledge receipt and understanding of the Code of Conduct upon hire and annually, thereafter. Compliance with applicable laws, rules, contract requirements, and ethical business and professional practices is clearly described for employees.

The purpose the roles and responsibilities of the Compliance Officer and Compliance Committee are outlined in the SC Regulatory Compliance Committee Charter. The Compliance Committee oversees Molina's Medicaid, Medicare-Medicaid, and Marketplace Compliance Programs. This committee meets at least quarterly and reports to the Board of Directors. Committee minutes clearly document voting and non-voting attendees, actions, and the establishment of a quorum.

The 2023 Fraud, Waste, and Abuse (FWA) Plan and Molina's Compliance Plan outlines compliance training that takes place. In accordance with Anti-Fraud and Deficit Reduction Act policies, new employees are required to receive training within 30 calendar days of employment. Existing employees receive training on an annual basis. Employees must complete anti-fraud training delivered through the internal Molina education/training tracking system. The anti-fraud training reinforces and expands upon the fraud, waste, and abuse training provided to new employees during orientation. The iLearn platform is used to distribute new and annual training, and to ensure attestation for required training.

Policy PHARM 07-01, Pharmacy Lock-in Program, provides details regarding processes in place to monitor for potential over-utilization of prescription-controlled substances and medical services to promote patient safety, coordination of care, and quality of care.

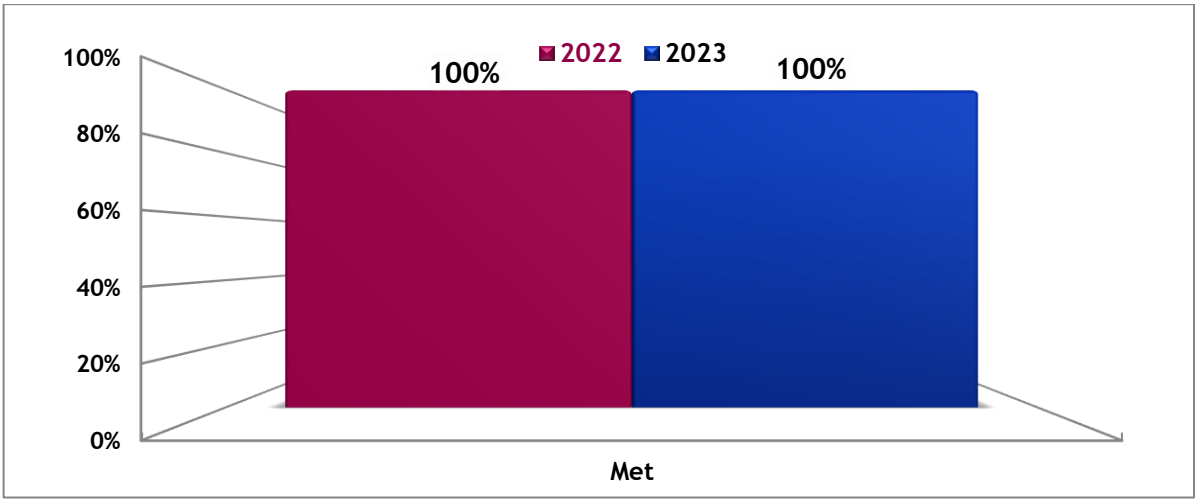
Confidentiality is addressed in the FWA Plan and included as part of the staff training materials for all employees. Policy MHSC HP-03, Privacy and Confidentiality Of PHI, details processes to protect members' privacy and maintain the confidentiality of protected health information in accordance with state and federal laws and contractual requirements.

Information Management Systems

Molina's Information Systems Capabilities Assessment (ISCA) documentation indicates the MCO has the policies and procedures in place to meet the State's contract requirements. The organization regularly reviews and updates these documents. Molina has several self-assessment measures in place to ensure data, systems, and processes are functioning properly and securely. In addition to self-assessment, Molina's documentation indicates that the organization regularly works with third parties to audit its systems. The results of those third-party audits indicate the organization almost always meets the audit requirements. Molina implemented corrective measures for one audit item that did not meet the requirements.

In the Administration section of the review, Molina received "Met" scores for 100% of the standards reviewed, as illustrated in *Figure 2: Administration Findings*.

Figure 2: Administration Findings



Strengths

- Staffing levels appear adequate, and all key positions are filled.
- Compliance and confidentiality training are covered for all current and new employees. The iLearn platform is used to distribute new and annual training, and to ensure attestation for required training.
- Molina has disaster recovery and business continuity plans that are capable of restoring services within the organization's recovery objectives.

B. Provider Services

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

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

Provider Credentialing and Selection

Molina's Professional Review Committee (PRC) uses a peer review process to make credentialing decisions. The PRC is chaired by a Molina Medical Director, meets at least monthly, and reports to the Quality Improvement Committee (QIC). The roles, responsibilities, functions, and composition of the PRC are detailed in policies and procedures, which also define the requirements for a quorum.

As noted in the 2022 Credentialing and Professional Review Committee Matrix, the voting membership of the PRC includes two OBGYN providers, one psychiatrist, three pediatricians, one nurse practitioner, and one physician assistant. During the previous (2022) EQR, Molina reported attempts to recruit a general surgeon for PRC membership; onsite discussion during the current EQR revealed a general surgeon has not yet been successfully recruited, but that these efforts continue. CCME identified that there are no adult general medicine providers included in the committee's membership and encouraged Molina to consider recruiting at least one adult general medicine provider.

Molina's processes for initial credentialing and recredentialing of practitioners and organizational providers are documented in policies and procedures, with South Carolina specific requirements in related addenda. Credentialing and recredentialing processes comply with state and federal requirements as well as National Committee for Quality Assurance (NCQA) standards. Onsite discussion confirmed that organizational providers may not appeal any credentialing denials, but Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, only addresses administrative denials and terminations. It does not address whether providers can appeal non-administrative denials or terminations.

The sample of initial practitioner credentialing files and organizational provider initial credentialing and recredentialing files revealed no issues. Two practitioner recredentialing files did not include evidence that hospital admitting privileges or admitting arrangements were verified. Molina staff explained that the health plan was directed by SCDHHS that this is no longer a requirement for credentialing and recredentialing. Molina provided a copy of an email reported to contain this instruction; however, the email was received from the South Carolina Alliance of Health Plans, Inc, which does not have the ability to waive health plan requirements. Also, Procedure CR01, Credentialing and Recredentialing Practitioners requires verification of practitioner hospital privileges at both initial credentialing and recredentialing. Therefore, Molina is

out of compliance with the requirement for verifying hospital admitting privileges or admitting arrangement.

Availability of Services

Standards for the number and geographic distribution of primary care providers (PCPs), specialists, and hospitals and activities to monitor compliance with those standards are appropriately defined in policies and procedures. Network Reports confirmed the use of correct parameters to evaluate geographic access to providers, indicated access is measured by county, and indicated that the health plan contracts with all required Status 1 provider types. Geographic access goals for PCPs and hospitals were met for all counties in 2022. For specialists, gaps were noted for psychology in Allendale County and OB/GYN in Barnwell County. Onsite discussion confirmed interventions are in place to address these gaps. In addition to monitoring geographic access to providers, Molina also monitors the number of PCPs who are accepting new members, evaluates this against internal targets, and takes action to address any identified issues.

Policy MHSC-PS-005, Provider Availability Standards, the Provider Manual, and the Member Handbook appropriately define appointment access standards for PCPs. For specialty providers, issues with documentation of appointment access standards were noted. Policy MHSC-PS-005 does not include the appointment access standard for emergent visits and urgent medical condition care appointments. The Provider Manual and Member Handbook include the standards for specialty emergent visits and urgent medical condition care appointments, but the information may be confusing for the reader because it is included under the heading for PCPs. Also, the Provider Manual and Member Handbook incompletely define the requirement for routine specialist appointments. Molina conducts annual provider availability and after hours telephonic surveys to evaluate provider compliance with appointment access standards and re-educates and re-surveys providers who do not meet the standards.

Molina conducts various activities to ensure its network can meet the cultural and linguistic needs of its membership. The Provider Manual includes information about cultural competency and Molina's website includes cultural competency training resources that address the Americans with Disabilities Act and providing services for members with disabilities, who are blind or have visual limitations, and who use service animals. Additional tools provided on the website include: "A Physician's Practical Guide to Culturally Competent Care" and "Industry Collaborative Effort (ICE) - Better Communication, Better Care."

Review of the printed and online versions of the Provider Directory confirmed all required elements are included, and Molina discussed several upcoming initiatives to improve information in the Provider Directories.

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 focusing on PCPs. Molina provided CCME with a list of 2,233 current providers. From that list, a random sample of 144 PCPs was selected for the study. Attempts were made to contact the sample of providers to ask a series of questions regarding access that members have with the providers.

For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 62% of the time (86 of 138) when omitting six calls answered by personal or general voicemail messaging services. This represents a statistically significant improvement from last year's rate of 43%.

Table 10 displays the success rate for the previous and current review years.

Table 10: Telephonic Access Study Answer Rate Comparison

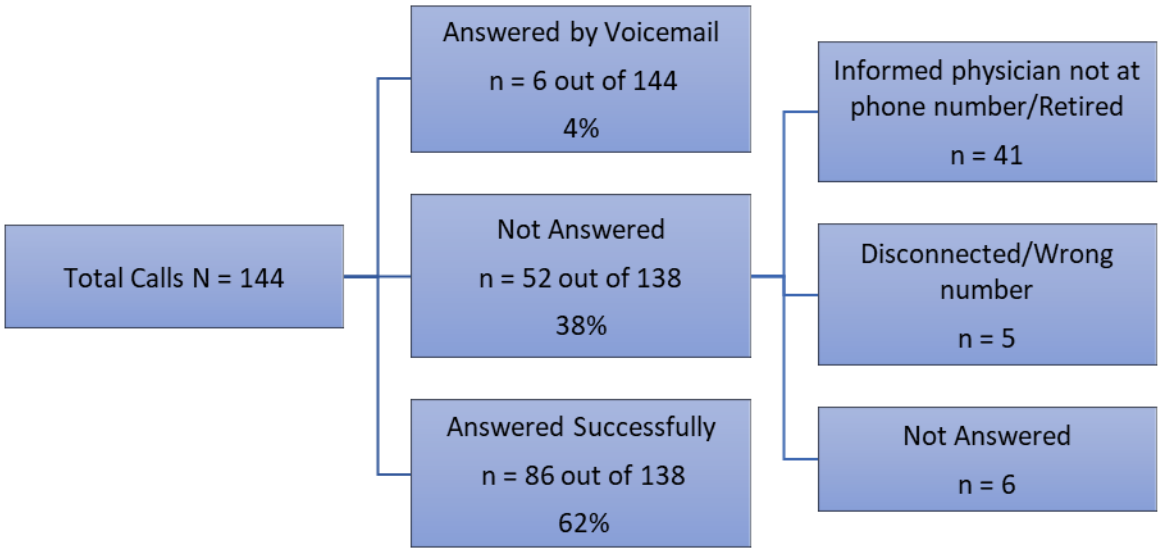
Review Year	Sample Size	Answer Rate	p-value
2022 Review	118	43%	.022
2023 Review	144	62%	

A total of 144 calls were completed and six were answered by voicemail. The voicemail calls were omitted from the success rate, resulting in a denominator of 138. For those not successfully answered (n = 52 of 138 calls), the majority (n = 41, 79%) were because the physician was no longer practicing at the location.

For 86 out of 138 calls, the practitioner was actively practicing at the location and considered successful (62%). Of the 86 providers, 74 (86%) indicated that they accept Molina. Of the 74 that accept Molina, 46 (62%) were accepting new patients. The 46 providers that were accepting new patients were asked if a screening process was in place for new patients. Eight (17%) required prescreening and 38 (83%) did not require prescreening. Of the eight who required prescreening, seven (88%) indicated that an application must be filled out and one (12%) required a medical record review. 30 of 46 providers (65%) had appointment availability within contractual requirements for a new patient routine appointment.

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

Figure 3: Telephonic Provider Access Study Results



As noted in *Table 11: Previous Provider Access and Availability Study QIP Items*, for the call study conducted for the previous (2022) EQR, Molina had a decline in the rate of successfully answered calls. Specific information regarding last year's findings and Molina's response are included in the table. CCME found Molina's successful call rate improved for this year's study.

Table 11: Previous Provider Access and Availability Study QIP Items

Standard	EQR Comments
Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time (51 out of 105) when omitting 13 calls answered by personal or general voicemail messaging services. This is a statistically significant decline from last year's rate of 63%. For calls not answered successfully (n= 54 out of 105 calls), the majority (n = 40, 74%) were because the physician was no longer practicing at the location. *Quality Improvement Plan: Provide documentation of specific processes in development or recently initiated to improve accuracy of provider contact information and status/location.*

Standard	EQR Comments
Molina Response: Molina is committed to maintaining an accurate, up to date provider directory. We will follow up with our delegated provider groups to ensure they are notifying us timely of any updates or terminations to reduce the chances that members will be viewing outdated information. For our non-delegated groups, we will continue to utilize CAQH to obtain the most up to date information that has been attested by the providers. In addition, we will include information in our provider newsletters and fax blasts, and post reminders on the provider section of the Molina website noting that providers must send updates 30 days in advance of any changes, when possible. Please see Access Study file submitted that includes feedback from Molina regarding the providers included in the access study. Molina Response: • Based upon the findings from our follow-up review of Providers previously called by CCME during the plan review and since a majority of Molina's network is delegated, the Delegation Oversight Team has been engaged to identify internal procedures that can be implemented to raise awareness of delegated entities and their need to validate provider data and update provider practice detail prior to submission of rosters. A meeting is scheduled for 7/8/22 with Molina Delegation Oversight leadership to clearly define the needs related to more intensive quality oversight of provider rosters and to explore methodologies that can be implemented for more timely updates particularly as it relates to providers who have changed practice location or exited practices altogether. • Following suit with the analysis activities completed on the survey list and submitted with our QIP, Molina is in process of developing a provider data audit process to be completed at a minimum twice/contract year. The process will be developed by end of current quarter and implemented by 10/01/22. At the point of any provider meetings, Provider Services Staff will stress the importance of providing updated practice data and inquire if there are any changes in medical staff that need to be reported. This will be implemented in July.	

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Initial provider orientation activities and an overview of topics included in orientation are included in Policy and Procedure MHSC-PS-010, Provider and Practitioner Education Processes. Educational resources disseminated to new providers include the 2023 Medicaid Provider Orientation presentation, which provides an overview of many topics to enhance new provider understanding of health plan operations and requirements, and the Provider Manual, which includes comprehensive information about health operations, programs, and requirements.

Ongoing provider education is conducted by Provider Services staff during routine provider site visits, as needed, and upon request. In addition, Molina conducts Provider Office Manager Meetings and regional provider training sessions. Additional information and updates are disseminated via periodic communications such as face-to-face presentations, faxes, electronic communications, provider newsletters, webinars, and the website.

Molina, through the National Quality Improvement Committee and the health plan's Quality Improvement Committee, adopts preventive health guidelines (PHGs) and clinical practice guidelines (CPGs). The guidelines are specific to the health care and service needs of members and give providers up-to-date information about treatment and diagnostic information and expected standards of practice. The PHGs and CPGs are disseminated to providers through provider orientation materials and training, the Provider Manual, newsletters, etc. The guidelines are also available on the health plan's website and printed copies are provided upon request.

Molina educates providers about medical record documentation, maintenance, and confidentiality requirements and conducts annual medical record reviews to assess compliance with the requirements. Processes for medical record review are documented in Policy and Procedure MHI-QUAL-003, Standards of Medical Record Documentation. The policy indicates that a copy of the Standard Medical Record Documentation Audit Tool is included in Attachment A; however, there were no attachments identified. The policy and procedure describe the scoring process, scoring threshold, and state that final scores of less than 90% prompt a re-audit, but the policy did not address any additional activities conducted, such as provider re-education about the requirements. The 2022 medical record audit was conducted on a sample of 150 medical records from 30 providers. 100% of the records received a passing score, and the results were reported to the QIC in September 2022.

As noted in *Figure 4: Provider Services Findings*, 99% of the standards in the Provider Services section were scored as "Met." One standard related to appointment access standards was scored as "Partially Met."

Figure 4: Provider Services Findings

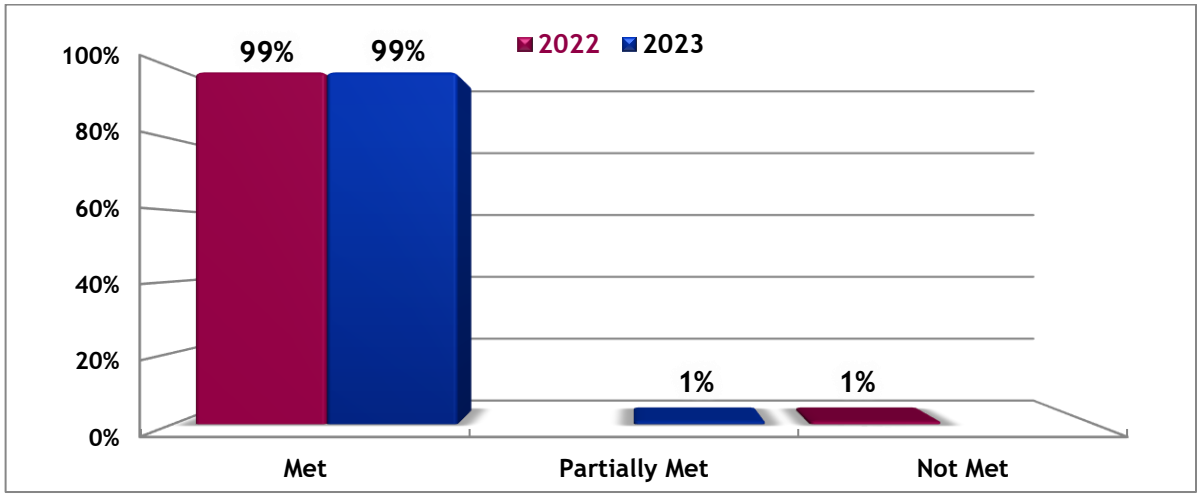


Table 12: Provider Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Adequacy of the Provider Network	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	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- Initial credentialing files for practitioners and initial and recredentialing files for organizational providers were fully compliant with all credentialing requirements.
- Ongoing provider sanction monitoring processes are addressed in various policies and are compliant with all applicable state, federal, and contractual requirements.
- Routine monitoring activities are conducted to ensure the geographic access adequacy of the provider network. Geographic access is measured on a county by county basis using appropriate parameters.
- Molina reported a current initiative is in place to recruit every primary care provider into the Molina network. Molina also reported planned initiatives to improve the Provider Directories.
- The successful contact rate for the Provider Access Study conducted by CCME was 62%, an improvement from the previous year's rate of 43%.

Weaknesses

- Procedure CR02, Assessment and Re-assessment of Organizational Providers, addresses appeals related to administrative denials and terminations, but does not address whether providers can appeal non-administrative denials or terminations. Onsite discussion confirmed that no appeal process is available.
- The voting membership of the Professional Review Committee includes no adult general medicine providers. Additionally, Molina reported that efforts to recruit a general surgeon have been unsuccessful.
- Two practitioner recredentialing files did not provide evidence that hospital admitting privileges/arrangements were verified at recredentialing. Molina staff reported that, per an email from SCDHHS, this is no longer a required element of credentialing and

recredentialing. However, the copy of the email that Molina referenced did not originate from SCDHHS. Also, Procedure CR01, Credentialing and Recredentialing Practitioners, requires practitioners' hospital privileges to be verified at both initial credentialing and recredentialing.

- For specialty providers, Policy MHSC-PS-005 does not include the requirements for emergent visits immediately upon referral and urgent medical condition care appointments within 48 hours of referral or notification of the PCP. The Provider Manual, pages 68-69, and the Member Handbook, page 29, include requirements for emergent visits and urgent medical condition care appointments; however, the information is found in a table with a heading of "PCPs," so it is not clear that the information applies to specialist appointments. Also, the Provider Manual and Member Handbook incompletely define the requirement for routine specialist appointments.
- Policy MHI-QUAL-003, Standards of Medical Record Documentation, indicates the Standard Medical Record Documentation Audit Tool is included as an attachment, but this attachment was not found.
- Policy MHI-QUAL-003, Standards of Medical Record Documentation, does not provide information about any additional actions taken for results below the 90% threshold for medical record audit scores.

Quality Improvement Plans

- Revise Policy MHSC-PS-005, the Provider Manual, and the Member Handbook to clearly state the requirements for specialty appointments. Ensure the information is compliant with the standards defined in the *SCDHHS Contract, Section 6.2.3.1.5.*

Recommendations

- Revise Procedure CR02 to indicate that appeals are not allowed for non-administrative denials or terminations.
- Continue efforts to recruit an additional specialty provider for membership on the Professional Review Committee. In addition, consider recruiting an adult general medicine provider, such as a family practitioner or internal medicine practitioner, for PRC membership.
- Ensure all practitioner credentialing and recredentialing files include evidence that hospital admitting privileges/arrangements have been verified.
- Revise Policy MHI-QUAL-003, Standards of Medical Record Documentation, to include the Standard Medical Record Documentation Audit Tool.
- Revise Policy MHI-QUAL-003, Standards of Medical Record Documentation, to include additional actions taken to reeducate providers who do not meet the 90% scoring threshold for medical record review.

C. Member Services

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

The review of Member Services included a review of all policies, procedures, member rights, member education, and processes for handling grievances, disenrollment, and requests for practitioner changes.

Members are informed of their rights and responsibilities in the Member Handbook. The Member and Provider Contact Center are also informed of member rights and responsibilities in Policy MHSC-ME-04, Member Bill of Rights and Responsibilities.

Policy ME-01, New Medicaid Member Outreach and Education, states new members will receive a welcome packet within 14 calendar days from the date their eligibility file is received. A benefit grid is provided in the Member Handbook and on Molina's website. It describes core benefits, covered services, and extra benefits provided by Molina. Prior approval is not required for family planning services, emergency visits, or behavioral health services. Changes are made in writing within the NCQH Mailer notification.

The Member Handbook and website provide contact numbers for a variety of member needs. The Nurse Advice Line number is listed on the Member ID Card and is available 24 hours a day. The Member Handbook and Molina's website describe and define behavioral health and physical health emergency services and provide clear and specific information about appropriate use of urgent and emergent services. The Member Handbook describes processes for obtaining interpreter services through the Member Services Department.

Policy MHSC-ME-02, Advanced Directives, provides information about a member's right to implement an advance directive, including a description of applicable state laws. The Member Handbook includes a section on Advanced Directives as well as information regarding Living Wills, Do Not Resuscitate Orders, Durable Power of Attorney, etc.

Procedure MHSC-ME-05, Medicaid Member Disenrollment, describes processes for member disenrollment. Disenrollment steps are also provided in the Member Handbook.

During the onsite discussion, it was shared that the "Handle on Health" program provides bicycles and helmets to eight-, nine-, and ten-year-old children who are current on their health assessments. Digital campaigns have been enhanced to make members aware of the SC Facebook page for information and resources.

Member Satisfaction Survey

Molina contracts with SPH Analytics, a certified 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 245 responses out of 1687 surveys, a 14.5% response rate, which is a decline from the previous response rate of 18.1%. Benchmarks (66.7th QC percentile) were met for seven out of ten measures. For the Child survey, there were 353 responses out of 3640 surveys for a response rate of 9.7%. This is a decline from the previous year's rate of 13.1%. The benchmark rate (66.7th QC benchmark) was met for three out of nine measures. For the Child with CCC survey, there 237 surveys out of 2397 were completed, for a response rate of 9.9%. This is a decline from the previous year's rate of 12.7%. The benchmark (66.7th QC percentile) was met for five out of nine measures.

The results have been presented to the QIC and providers. The analysis and implementation of interventions to improve member satisfaction is discussed with the QIC.

Grievances

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

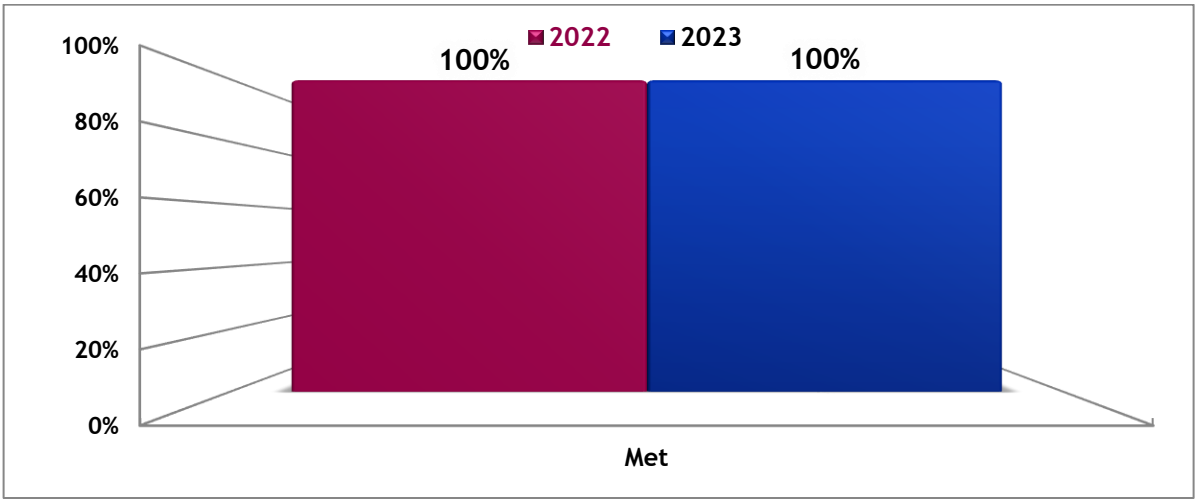
Policy MHSC-MRT-001, Grievance Disposition Process, the Member Handbook, and website consistently define a grievance as "An expression of dissatisfaction about any matter other than an adverse benefit determination." Examples of grievances are provided to members for reference following the definition. Grievances may be filed verbally in person or by telephone, in writing, by fax, or electronically. An authorized representative may file or assist members with the grievance filing process.

Members are notified of the grievance resolution in writing no later than 90 calendar days from the date Molina received the grievance. Timeframes for resolution may be extended up to 14 calendar days if the member requests the extension or Molina is able to demonstrate there is need for additional information and how the delay is in the member's interest. For a grievance received in writing, a written acknowledgment is sent to the member or member's representative within five business days from receipt of the written grievance.

The grievance files randomly selected for this EQR reflected that grievance processing and handling activities comply with policy and contract standards and timeliness requirements.

All of the standards in the Member Services section received a "Met" score as noted in the *Figure 5: Member Services Findings*.

Figure 5: Member Services Findings



Strengths

- The Member Handbook presents all the required member information and is written in an easily understood manner.
- Molina uses a variety of methods to keep members informed about adult preventive health screenings and well-child visits conducted at appropriate intervals.
- Enhanced and expanded programs and member resources specific to chronic disease management are provided for all members.
- Grievance files reviewed, all met the acknowledgment and resolution timeliness standards.

D. Quality Improvement

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

Molina has designed a Quality Improvement Program to ensure all medically necessary covered services are available and accessible to members and all covered services are provided in a culturally and linguistically appropriate manner. Molina submitted the Molina Healthcare of South Carolina, Inc. Quality Improvement Program Description 2022. This program description included the program's goals, structure, scope, and methodology used to monitor and improve the services delivered to members.

As part of the scope of QI program activities, Molina reviews potential over-and under-utilization statistics at least yearly using cross-functional teams and collaboration with the provider network.

Molina develops a work plan to guide and keep track of specific QI activities. The 2022 and 2023 Quality Improvement and Health Equity Transformation Work Plan was submitted for review. It was noted that the 2023 QI work plan included the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. CCME had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted for year one. CCME recommended labeling the columns for the applicable year (example: Y1= 2023, Y2=2024 etc.). Also noted in the 2023 work plan were a few typos in the Program Structure section. Those included:

- The objective states "Complete the 2023 QI Program Description and QI Workplan" and the timeline for completion is listed as "By the end of Q1 2023." However, the Action Plan description indicates review and approval will be completed by Q4.
- The timeline for completing the 2023 QI Program Evaluation was listed as "By the End of Q2 2023." This objective should read Complete the 2022 QI Program Evaluation instead of the 2023 QI Program Evaluation.

Molina's QIC is responsible for the implementation and monitoring of the QI Program. This committee recommends policy decisions, analyzes, and evaluates the progress and results of all QI activities. The Quality Improvement Committee meets at least quarterly. Committee minutes submitted for review demonstrated the meeting occurred at regular quarterly intervals. Documents provided also demonstrated electronic votes were obtained from committee members on two occasions. Membership for this committee includes the Chief Medical Officer (chairman), senior leaders from the health plan, and external network providers.

Network providers participate in the QI activities by serving on clinical and quality committees. Through these committees, participating providers review and provide feedback on proposed guidelines, clinical programs, quality projects, action plans, and interventions needed to improve levels of care and service.

Annually, Molina conducts a formal evaluation of the QI Program. The evaluation identifies program outcomes, a description of limitations and barriers, and interventions to overcome those barriers. Molina provided the Quality Improvement Program 2021 Annual Evaluation, which included a summary of the results for each of the quality improvement activities, any barriers identified, and interventions underway. The evaluation also included recommendations or areas of focus for 2022.

For the 2022 EQR, Molina had not included the outcome for all QI activities. This deficiency was addressed with a quality improvement plan. *Table 13: Previous*

Deficiency of Molina's Annual Evaluation of the QI Program provides a summary of the deficiency and Molina's response. CCME found Molina had corrected this deficiency.

Table 13: Previous Deficiency of Molina's Annual Evaluation of the QI Program

Standard	EQR Comments
Annual Evaluation of the Quality Improvement Program	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	Molina evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors and the QIC. The Quality Improvement Program 2020 Medicaid Annual Evaluation was provided. The program evaluation included the Executive Summary and several appendices. Most of the results of the activities conducted in 2019 were included in the program evaluation. Activities related to the availability of practitioners (section 5.0 of the work plan), the continuity and coordination of care (section 9.0 and 10 of the work plan), and the provider directory analysis (section 11 of the work plan) were not included. The section in the Executive Summary regarding the focus for the upcoming year incorrectly included the focus for 2022 instead of 2021. These errors and omissions were discussed during the onsite. Molina indicated those activities omitted from the program evaluation were conducted and provided copies of some of the reports after the onsite. However, these activities were not considered when the 2020 QI Program Evaluation was conducted. *Quality Improvement Plan: When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.*
Molina Response: Please see the expanded Table of Contents for CY2021 Program Evaluation with highlighted titles of reports reviewed and approved through the Quality Improvement Committee (see QIP Item 2). The Table of Contents is consistent with the Medicaid Quality Improvement Work Plan and ensures all Quality Improvement Committee approved reports are included in the Medicaid Annual Program Evaluation.	

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Molina was fully

compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures for the current measure year (2021), as well as the previous measure year (2020), and the change from 2020 to 2021 are reported in *Table 14: HEDIS Performance Measure Results*. The rate changes shown in green indicate a substantial (>10%) improvement and the rates shown in red indicate a substantial (>10%) decline.

Table 14: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	73.24%	70.56%	-2.68%
Counseling for Nutrition	61.07%	58.88%	-2.19%
Counseling for Physical Activity	56.69%	56.2%	-0.49%
Childhood Immunization Status (cis)			
DTaP	74.45%	64.96%	-9.49%
IPV	87.83%	82.73%	-5.10%
MMR	89.05%	82.97%	-6.08%
HiB	81.75%	76.4%	-5.35%
Hepatitis B	83.94%	80.78%	-3.16%
VZV	87.83%	80.29%	-7.54%
Pneumococcal Conjugate	77.62%	67.4%	-10.22%
Hepatitis A	86.13%	79.81%	-6.32%
Rotavirus	76.89%	69.34%	-7.55%
Influenza	40.63%	35.28%	-5.35%
Combination #3	71.05%	58.88%	-12.17%
Combination #7	62.77%	53.28%	-9.49%
Combination #10	32.12%	25.79%	-6.33%
Immunizations for Adolescents (ima)			
Meningococcal	74.45%	66.67%	-7.78%
Tdap/Td	82.48%	77.37%	-5.11%
HPV	33.33%	29.44%	-3.89%
Combination #1	73.48%	66.42%	-7.06%
Combination #2	32.6%	28.95%	-3.65%
Lead Screening in Children (lsc)	70.33%	67.4%	-2.93%
Breast Cancer Screening (bcs)	57.08%	52.36%	-4.72%
Cervical Cancer Screening (ccs)	58.15%	62.53%	4.38%

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Chlamydia Screening in Women (chl)			
Total	59.16%	57.78%	-1.38%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	82.56%	71.59%	-10.97%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.19%	25.66%	-0.53%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	71.09%	65.36%	-5.73%
Bronchodilator	83.18%	78.01%	-5.17%
Asthma Medication Ratio (amr)			
Total	64.5%	63.15%	-1.35%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	46.96%	59.85%	12.89%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	77.14%	68.18%	-8.96%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - Total	79.96%	82.21%	2.25%
Statin Adherence 80% - Total	61.67%	54.53%	-7.14%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	2.43%	2.65%	0.22%
Cardiac Rehabilitation - Engagement1 (Total)	2.91%	5.31%	2.40%
Cardiac Rehabilitation - Engagement2 (Total)	1.94%	4.87%	2.93%
Cardiac Rehabilitation - Achievement (Total)	0%	3.1%	3.10%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	87.35%	88.08%	0.73%
HbA1c Poor Control (>9.0%)	49.39%	45.5%	-3.89%
HbA1c Control (<8.0%)	41.85%	46.72%	4.87%
Eye Exam (Retinal) Performed	52.55%	51.58%	-0.97%
Blood Pressure Control (<140/90 mm Hg)	55.23%	61.31%	6.08%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (Total)	22.76%	24.79%	2.03%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	64.29%	64.14%	-0.15%
Statin Adherence 80%	58.33%	49.73%	-8.60%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Effective Acute Phase Treatment	51.88%	47.18%	-4.70%
Effective Continuation Phase Treatment	34.8%	30.82%	-3.98%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	56.23%	34.48%	-21.75%
Continuation and Maintenance (C&M) Phase	66.34%	45.5%	-20.84%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total - 30-Day Follow-Up	61.75%	59.68%	-2.07%
Total - 7-Day Follow-Up	39.77%	38.22%	-1.55%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Total - 30-Day Follow-Up	54.19%	57.95%	3.76%
Total - 7-Day Follow-Up	38.92%	42.19%	3.27%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	42.86%	36%	-6.86%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	29.06%	25.2%	-3.86%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	16.24%	16.25%	0.01%
Total - 7-Day Follow-Up	11.11%	11.31%	0.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	74.31%	79.97%	5.66%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	66.16%	66.82%	0.66%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA*	93.75%	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
Total	24.39%	52.55%	28.16%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	72.39%	64.03%	-8.36%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - Total	45.83%	51.21%	5.38%
Cholesterol Testing - Total	27.7%	28.64%	0.94%
Blood glucose and Cholesterol Testing - Total	25.98%	26.94%	0.96%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.64%	0.57%	-0.07%
Appropriate Treatment for Children With URI (uri)			
Total	85.5%	88.28%	2.78%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	48.28%	50.62%	2.34%

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Use of Imaging Studies for Low Back Pain (lbp)	68.74%	68.69%	-0.05%
Use of Opioids at High Dosage (hdo)	2.51%	1.74%	-0.77%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	20.44%	23.24%	2.80%
Multiple Pharmacies	4.14%	1.96%	-2.18%
Multiple Prescribers and Multiple Pharmacies	2.42%	1.39%	-1.03%
Risk of Continued Opioid Use (cou)			
Total - >=15 Days covered	4.79%	4.1%	-0.69%
Total - >=31 Days covered	3.13%	2.6%	-0.53%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
Total	80.24%	79.16%	-1.08%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.81%	40.02%	-1.79%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.87%	6.62%	-0.25%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	58.09%	57.21%	-0.88%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	33.16%	36.14%	2.98%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	43.3%	40.01%	-3.29%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	8.77%	8.89%	0.12%
Initiation of AOD Treatment: Total	44.01%	41.83%	-2.18%
Engagement of AOD Treatment: Total	11.85%	12.27%	0.42%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	92.7%	87.83%	-4.87%
Postpartum Care	74.45%	75.67%	1.22%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	60.43%	54.5%	-5.93%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	57.0%	57.31%	0.31%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	72.56%	69.27%	-3.29%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	44.03%	44.11%	0.08%

Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator

Molina uses a certified software organization for calculation of HEDIS rates. Substantial improvement of 10% or more was noted for Controlling High Blood Pressure (cbp), which

improved 12.89%, and Pharmacotherapy for Opioid Use Disorder (pod) had a 28.16% increase in the rate. Substantial declines occurred for Pneumococcal Conjugate and Combination #3 immunizations, as well as Appropriate Testing for Children with Pharyngitis – Total, and Follow-Up Care for Children Prescribed ADHD Medication for both initiation and continuation/maintenance rates. The table that follows provides an overview of the HEDIS measures with substantial increase or a decrease in the rate from measure year 2020 to measure year 2021.

Table 15: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Controlling High Blood Pressure (cbp)	46.96%	59.85%	12.89%
Pharmacotherapy for Opioid Use Disorder (pod)			
Total	24.39%	52.55%	28.16%
Substantial Decrease in Rate (>10% decrease)			
Childhood Immunization Status (cis)			
Pneumococcal Conjugate	77.62%	67.4%	-10.22%
Combination #3	71.05%	58.88%	-12.17%
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	82.56%	71.59%	-10.97%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	56.23%	34.48%	-21.75%
Continuation and Maintenance (C&M) Phase	66.34%	45.5%	-20.84%

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

Molina submitted three PIPs for validation. Topics included Improving Encounters Acceptance Rates, Child and Adolescent Well-Care Visits and Immunizations for Adolescents. All three PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions are included.

Table 16: Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates	
The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from remeasurement one at 96.9% to remeasurement two at 97.3% (the refreshed rate shows 98.82%). The goal is 100%. The 837P rejection rate declined from 2.82% to 1.35%, which demonstrated improvement. The goal for this measure is 2%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
Interventions	
The interventions included a provider crosswalk, review of QNXT claims setup, logic checks, review of rejected encounters, and logic adjustment focusing on billing NPI.	

Table 17: Immunizations for Adolescents PIP

Immunizations for Adolescents Program	
The Immunizations for Adolescents PIP examines adolescents, 13 years of age, with one dose of meningococcal vaccine, one tetanus, Tdap, and HPV by their 13th birthday. Molina chose this PIP to target rural and urban areas across SC to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV related cancers. The baseline rate was 28.95% with a slight decline in the administrative rate of 28.35%. The annual improvement goal for this PIP is 31.19%.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	

Immunizations for Adolescents Program
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members.

Table 18: Child and Adolescent Well-Care Visits PIP

Child and Adolescent Well-Care Visits	
The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% at the remeasurement one. The goal is 44.29% for the annual improvement.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Table 19 lists the recommendations CCME provided for the Immunizations for Adolescents and the Child and Adolescent Well-Care Visits PIPs.

Table 19: PIP Recommendations

Project	Section	Reason	Recommendation
Immunizations for Adolescents	Was there any documented, quantitative improvement in processes or outcomes of care?	The baseline rate was 28.95% with a slight decline in the administrative rate to 28.35%.	Additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers
Child and Adolescent Well-Care Visits	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate showed a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% at the remeasurement one.	Continue to assess interventions to determine the impact on the final measure rate that will be available in mid-2023.

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

For this EQR, Molina met all the requirements in the Quality Improvement section of the review as noted in *Figure 5*.

Figure 5: Quality Improvement Findings

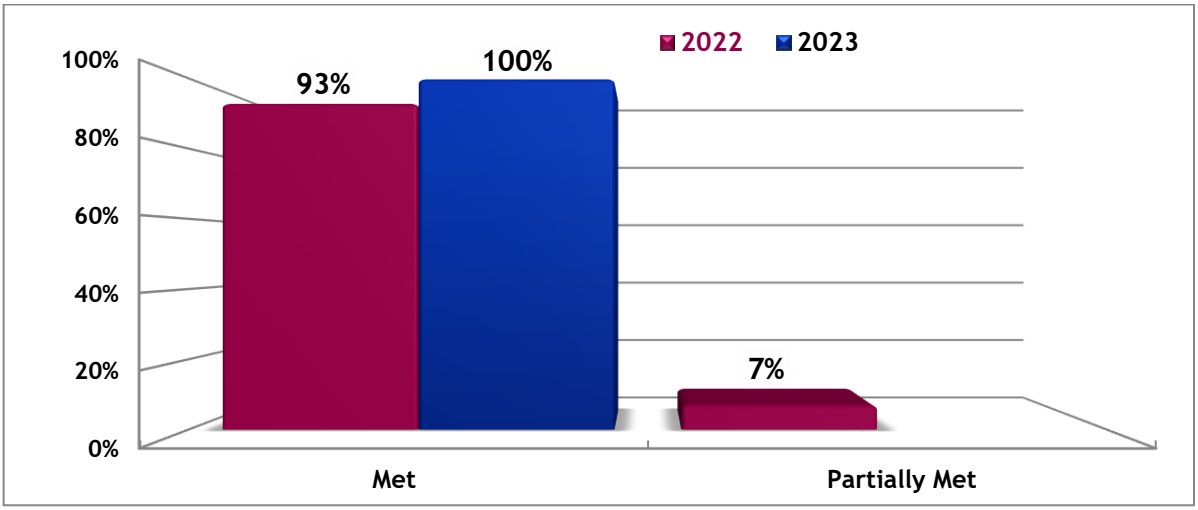


Table 20: Quality Improvement Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
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 2022 to 2023.

Strengths

- The Performance Measures were compliant with the HEDIS technical specifications for rate calculations.
- All Performance Improvement Projects received validation scores within the High Confidence range.

Weaknesses

- The 2023 Work Plan appeared to contain a few typos in the Program Structure section regarding the timeline for completing the QI Program Description, Work Plan, and the QI Evaluation.

Recommendations:

- Correct the timeline for completing the 2023 QI Program Description, Workplan, and the QI Program Evaluation in the Program Structure section of the 2023 QI Work Plan.

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)

For this EQR, CCME conducted a review of Molina's Utilization Management (UM) Program Description, policies, and a sample of UM, Appeal, and Case Management files. The Program Description outlines staff responsibilities and the scope and objectives for physical health and behavioral health services. The Pharmacy Program Description outlines the program objectives and standard operations of the Pharmacy Program.

The Chief Medical Officer provides overall clinical oversight of the UM Program and responsibilities entail clinical supervision, training, case review, second level review, committee participation, etc. The Behavioral Health Medical Director specializes in clinical oversight of the Behavioral Health UM activities. Likewise, the Pharmacy Director

provides oversight and responsibility over the clinical, administrative, and financial management of corporate pharmacy services.

Coverage and Authorization of Services

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228

The UM Reviewers are health practitioners that hold a current licensure in their respective health care professions. The professional staff do not receive direct or indirect incentives in relation to making clinical determinations. When making clinical coverage determinations, UM Reviewers utilize external and internal guidelines such as Milliman Clinical Guidelines (MCG), Official Disability Guidelines (ODG), Hayes Technology Assessments, Inpatient Hospital Services Coverage Requirements, and State Guidelines. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, continues to reference InterQual as an evidenced based criteria utilized in clinical determinations. This was an issue identified in the previous EQR. During onsite discussion, Molina responded that they have updated and removed the reference to InterQual Criteria in this stated procedure and are awaiting committee approval.

Molina's UM Program Description and Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, provides an overview of the timeliness standards for processing UM authorization requests. The timeframe for processing standard authorizations is listed as 14 calendar days for standard authorization requests and 72 hours for expedited authorization requests. There were inconsistencies identified in the UM and Pharmacy Program Descriptions regarding the timeframe for processing prior authorization requests for pharmacy services. Molina's UM Program Description indicated the timeframe for pharmacy decisions were 72 hours for expedited requests and 14 calendar days for standard requests. However, the Pharmacy Program Description indicated pharmacy decisions are made within 24 hours. During the onsite discussion, Molina confirmed the timeframe for processing pharmacy authorizations was within 24 hours.

Annually, Molina conducts Inter-Rater Reliability (IRR) testing for physicians, pharmacists, and clinical reviewers. The purpose of the audit is to ensure consistency in the application of clinical criteria. Based upon the IRR results, the Prior Authorization Clinicians, Pharmacy Reviewers, and Medical Directors received passing scores of over 90%. However, the Inpatient Clinician Reviewers scored 88%, below the targeted goal of 90%, and received remediation training. During onsite discussion, it was shared that the remediation activities that occurred were clinical criteria retraining and increased supervision. Molina shared that the Clinician Inpatient reviewers received a passing score after retesting.

There was a discrepancy identified with the IRR goals for the Pharmacy Reviewers and the Medical Directors within the Health Care Services Annual Program Evaluation and policies. The Health Care Services Program Evaluation described the target goal for

Pharmacy Reviewers as 80% and Medical Directors as 85%. However, Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria, stated that the overall targeted goal was 90%. The health plan clarified that the targeted goal for Pharmacy Reviewers and Medical Directors was 85%, which is not consistent with the policies and the Health Care Services Annual Evaluation.

The Pharmacy Program Description and various policies provide an overview and structure of Molina's Pharmacy Program. The Preferred Drug List (PDL) identifies formulary restrictions by indicating medications requiring prior approval, limitations, and/or step therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL. Changes to the PDL are posted on the website, and the change document includes the date the notice was posted and the effective date for the change, as required by the *SCDHHS Contract, Section 4.2.21.2.3*. For the previous EQR, CCME found Molina did not meet this requirement. Molina addressed this deficiency by updating the template for posting PDL changes to the website. The current EQR confirmed that Molina met SCDHHS' requirement for posting negative PDL changes. The table that follows is an overview of the previous deficiency and Molina's response.

Table 21: Previous Deficiency Regarding PDL Changes and Molina's Response

Standard	EQR Comments
Medical Necessity Determinations	
Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Molina's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. There was no information regarding when those changes were approved by the Pharmacy and Therapeutics Committee and when the negative PDL changes were published on the website. The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3*, requires the health plan's Pharmacy & Therapeutics Committee to approve the PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plan's website at least 30 days prior to implementation. Molina's changes posted on the website did not appear to meet this requirement. *Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Molina's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*

Standard	EQR Comments
Molina Response: Molina Pharmacy has updated internal procedures to ensure that all regulations for the Preferred Drug List (PDL) as outlined in sections 4.2.21.1 and 4.2.21.3 of the MCO Contract between MHSC and the South Carolina Department of Health and Human Services (SCDHHS) are met. Updated processes include instructions for posting and documenting when formulary changes are approved by the Pharmacy and Therapeutics Committee and documenting when negative PDL changes are published on the Molina website. MHSC has already implemented these processes and the current documents posted on our website are in compliance. Please see latest PDL update notification via the URL provided below. https://www.molinahealthcare.com/members/sc/en-US/mem/medicaid/overvw/coverd/~/media/Molina/PublicWebsite/PDF/members/sc/en-US/Medicaid/Recent-PDL-updates.pdf	

Review of the approval files reflected that the UM reviewers utilize appropriate clinical criteria when making UM determinations. The clinical reviewers utilized physician clinical consultations appropriately and individual member's circumstances were considered when making UM determinations. Review of the denial decisions demonstrated that the adverse benefit determinations were promptly communicated to the provider and member.

Appeals

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

Molina's Provider Manual, various policies, and the Member Handbook outline the health plan's appeals process. The process and guidelines for processing standard and expedited appeals were also described. Members can file an appeal verbally or submit a written request.

During the 2022 EQR, Molina had issues with the processing and management of verbal appeals. Molina's UM Program Description, policies, Member Handbook, and Provider Manual indicated a standard request for a verbal appeal must be followed up with a written request within 30 days. The table that follows provides an overview of this deficiency and Molina's response.

Table 22: 2022 EQR Deficiency Regarding Appeals and Molina's Response

Standard	EQR Comments
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	Requirements for filing an appeal are documented in policies and procedures. Policy and Procedure MHSC-MRT-002, Standard Appeal Process, the UM Program Description, the Guidelines for Appealing a Medical Denial, the Member Handbook, the Provider Manual, and the website indicate a standard request for an

Standard	EQR Comments
by the MCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal	appeal received verbally must be followed by a written request within 30 days. This requirement was removed from the *SCDHHS Contract* and the *Federal Regulation*. *Quality Improvement Plan: Revise all documents related to the process for filing an appeal and remove the requirement that indicates a standard request for an appeal received verbally must be followed by a written request.*
Molina Response: All A&G policy and procedure documents have been updated and the language regarding a requirement for a verbal appeal to be followed up in writing within 30 days has been removed. Red-lined documents were reviewed and approved by our policy committee on 4/28/22 and submitted to the State on 5/11/22 for approval. See submitted redlined policies in QIP response Item 4. An email was sent to A&G staff notifying them of the update on 4/12/22. Updates to the Molina web site, the member handbook and the provider manual were sent to the communications team on 5/19/22. The updates to the web site were submitted to the State for approval on 6/6/22. Edits to the Appeals Form that accompanies denial (NOABD) letters, as well as the related denial letters have been redlined and will be submitted to the State for approval on 6/16. See redlined copies in QIP Item 4. Once approvals are secured, updated letters will be forwarded to Information Technology for programming into Molina's Letter Management System for use when services are denied.	

For this EQR, CCME found Molina's UM Program Description was not corrected. Page 50 indicates that a standard request for an appeal received verbally must be followed by a written request within 30 days. During onsite discussion, Molina shared that this verbiage has been removed from the UM Program Description and committee approval is pending.

In addition, two letter templates incorrectly referenced requirements for a written appeal to follow a verbal appeal request. These included the letter template for acknowledging a standard appeal (MHSC-MIRR-014MbrStanAppAckWrittenRequ) states and the letter template used to inform a member that an appeal was closed (MHSC-MIRR-016-MbrStanAppClosed). The health plan shared that neither of these letters are currently being utilized.

During the 2022 EQR review, there were issues identified with the sample of appeal files review. Please see Table 23 for an overview of the deficiency and Molina's response.

Table 23: Previous Deficiency with Processing Appeal Requests and Molina's Response

Standard	EQR Comments
Appeals	
2. The MCO applies the appeal policies and procedures as formulated.	A sample of appeal files were reviewed. There were three files that were untimely and four files where the physician who made the appeal decision was not of the same or similar specialty as the ordering physician. Two of those cases were pediatric cases reviewed by a physician who specializes in internal medicine and two plastic surgery cases also reviewed by a physician who specializes in internal medicine. According to staff, the physicians' reviewing appeal requests are directed to use criteria and matching specialty was not necessary. Molina was cautioned regarding allowing physician reviewers to only utilize criteria when making medical necessity decisions on appeals. *Quality Improvement Plan: For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate physician reviewers regarding only utilizing review criteria and not considering individual medical conditions when making appeal determinations.*
Molina Response: REVIEWER SPECIALTY: Board certified physicians review each member's unique clinical notes that are submitted for medical necessity review against evidence-based criteria specific to the condition and procedure. Physician reviewers use their clinical experience in coordination with the nationally recognized evidence-based standard to make a determination for a medical appeal. Industry standard as well as customary practice in South Carolina is for board certified physicians with a general medical specialty to review cases for medical necessity. Having physicians with the same specialty review all appeals is cost-prohibitive and likely not reasonable. Molina does retain an outside vendor that includes unique specialists that can be accessed and used if, and when, our Medical Directors feel that they need assistance for complex requests or with a particular specialty. FILES FOLLOW UP: Appeal File 8 Appeal ID A0003141931: Feedback was that case was resolved late. Resolution due date was 5/1/2021. Per clerk notes: Overturned resolution letter to member and faxed to provider on 04-28-21. On the resolution letter that was mailed to the member, the specialist wrote that the date of the letter was August 28, 2021 and not April 28, 2021. Resolution letter does state the approved date range: The approved authorization is 2105700093APL and is valid April 28, 2021 and is valid July 27, 2021. We will authorize the services and inform your provider of the approval. This was a human error, case was resolved in compliance. Appeal File 20 Appeal ID MEM-81451: Feedback was case was resolved late. Resolution due date was 8/25/21. Per clerk notation Mailed certified 7003 2260 0006 4659 4765 denial Overturned resolution letter to member on 08-20-21. Pega shows that letter was printed by the clerk in house on 08/20/2021 04:31:36 PM EDT. This is showing in PEGA as in compliance. I believe this is the auditor not reading our system correctly. Molina's response and additional Information: Molina Healthcare of SC (MHSC) appreciates the recommendations from CCME and the reminder of the importance of ensuring all medical and clinical decisions appeal decisions are rendered by Health Care	

Standard	EQR Comments
Professionals who have the appropriate and clinical expertise, as determined by the State, in treating the Medicaid Managed Care Member's condition or disease. As previously indicated, MHSC does retain an outside vendor that includes unique specialists that can be accessed and used if and when our Medical Directors feel that they need assistance for complex requests or with a particular specialty. MHSC will re-educate the UM physician reviewers regarding the need for incorporating individual medical conditions/clinical information in the decision-making process in addition to utilization review criteria. A meeting of the MHSC medical directors is scheduled for 7/12/22 when all are present/available based upon current leave schedules where this agenda item will be covered along with the reminder of the external available if and when cases that require more specialized care can be submitted on behalf of the SC Medicaid Managed Care members.	

CCME found that Molina adequately addressed this issue during this review. The sample of appeal files reviewed during this EQR confirmed the appeals processed according to contractual standards. There were no identified patterns or trends.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

A descriptive overview of Molina's approach to handling care management activities and care transitions programs is outlined in the UM Program Description and numerous policies. Molina members are referred for case management services through various sources such as practitioner referrals, self-referrals, claims, etc. Also, monthly data is received from Molina's predictive modeling tool, Optum IPro, that analyzes multiple sources to aid in referral initiation and risk stratification. Health assessment tools are also completed to aid in further identification of the member's care needs.

Policy MHSC-HCS-UM-331, Continuity of Care Policy, and Molina's UM Program Description provide an overview of continuity of care requirements for newly enrolled members, pregnant members, etc. However, there is no mention of continuity of care while a member is in the appeals process.

A sample of care management files was submitted for review. The files indicate that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted after the onsite visit, the following issues were identified:

- For seven files, there was no identified note or date provided on the creation of the Individualized Care Plan (ICP).
- Two files did not have ongoing documentation of notes that entail a follow up schedule or an assessment of the member's progress that were receiving Level III Complex CM services.

Figure 6 and Table 24 provide a comparison of the scores in the Utilization Management section.

Figure 6: Utilization Management Findings

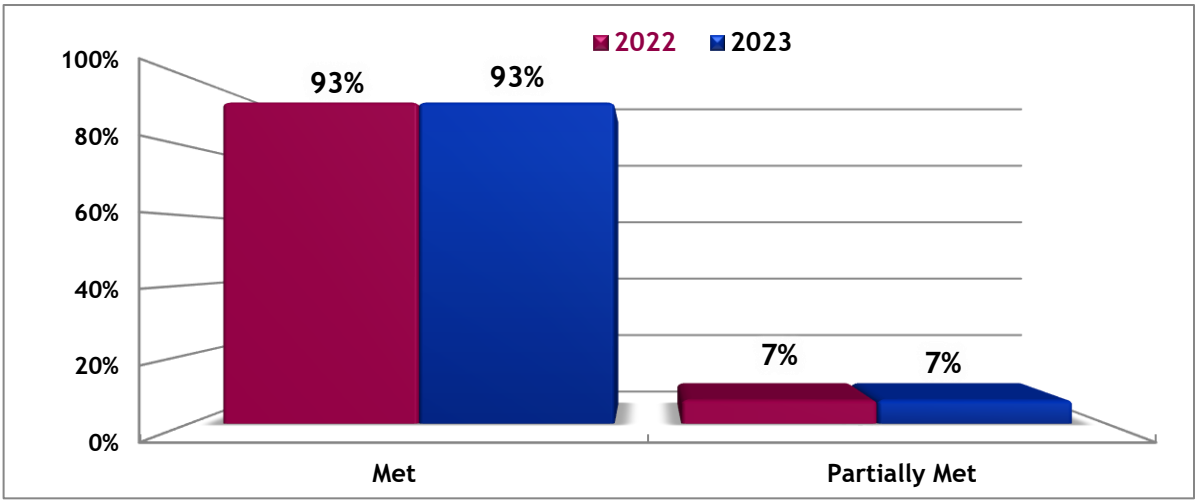


TABLE 24: Utilization Management Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Medical Necessity Determinations	Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Partially Met
Pharmacy Requirements	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Partially Met	Met
Appeals	The MCO applies the appeal policies and procedures as formulated	Partially Met	Met
Care Management and Coordination	Care management and coordination activities are conducted as required	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- In addition to IRR, Molina conducts monthly audits of UM decisions to ensure consistency in clinical criteria application for quality assurance.
- Approval files were completed in a timely manner and reviewers utilized appropriate clinical criteria.

- Denial files utilized appropriate physician consultations and adverse benefit decisions were clear in documenting the reasoning for the decision.
- Appeal files were processed timely, and an appropriate physician specialist conducted the review of cases.

Weaknesses

- The UM Program Description describes the medical necessity criteria used by Molina and indicates that MCG criteria is used to conduct inpatient reviews. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, continues to indicate that Molina utilizes InterQual in performing clinical determinations.
- A discrepancy was identified in the IRR goals for Pharmacy Reviewers and for the Medical Directors. The Health Care Services Annual Program Evaluation listed the goal as 80% for the Pharmacy Reviewers and the Medical Directors. However, Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria, noted the goal as 90%.
- The timeframe for processing pharmacy decisions was incorrect in the UM Program Description.
- Page 50 of Molina's UM Program Description indicates that a standard request for an appeal received verbally must be followed by a written request in 30 days. This was an issue identified in the previous EQR and not corrected.
- Two of Molina's letter templates incorrectly state that a written request for an appeal is needed after an oral request is received.
- Policy MHSC-HCS-UM-331, Continuity of Care Policy, and Molina's UM Program Description do not address continuity of care while a member is in the appeals process.
- The following issues were identified in Molina's care management files:
    - For seven files, there was no identified note or date provided on the creation of the Individualized Care Plan (ICP).
    - Two files did not have ongoing documentation of notes that entail a follow up schedule or an assessment of the member's progress that were receiving Level III Complex CM services.

Quality Improvement Plans

- Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, to remove the reference to InterQual Criteria.

- Update Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria, to reflect the correct IRR goal for Pharmacy Reviewers and Medical Directors, and ensure it is consistent with the Health Care Services Annual Evaluation.
- Update all documents related to the process for filing an appeal to remove the requirement that a standard request for an appeal received verbally must be followed by a written request.
- In Individualized Care Plan development, please ensure to accurately document the date the plan was developed. Also, include notes that entail a follow up schedule or assessment of the member's progress.

Recommendation

- Update the UM Program Description to reflect the correct timeframe for processing pharmacy decisions.
- Consider adding additional information in Policy MHSC-HCS-UM-331, Continuity of Care Policy or in Molina's UM Program Description regarding the member's ability to continue to receive transition of care services while in the appeals process.

F. Delegation

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

Table 24: Delegated Entities and Services lists the entities for which Molina has implemented delegation agreements.

Table 25: Delegated Entities and Services

Delegated Entities	Delegated Services
Accordant Care Rare (CVS)	Case Management
Aperture	Credentialing Verification
March Vision Care	Credentialing, Claims, Call Center
AnMed Health Regional Health Partners Medical University of South Carolina Prisma Midlands Prisma Upstate Augusta University Medical Center Managed Health Resources Bon Secours St. Francis Roper St. Francis	Credentialing

Delegated Entities	Delegated Services
Lexington Medical Center Tenet Physicians	

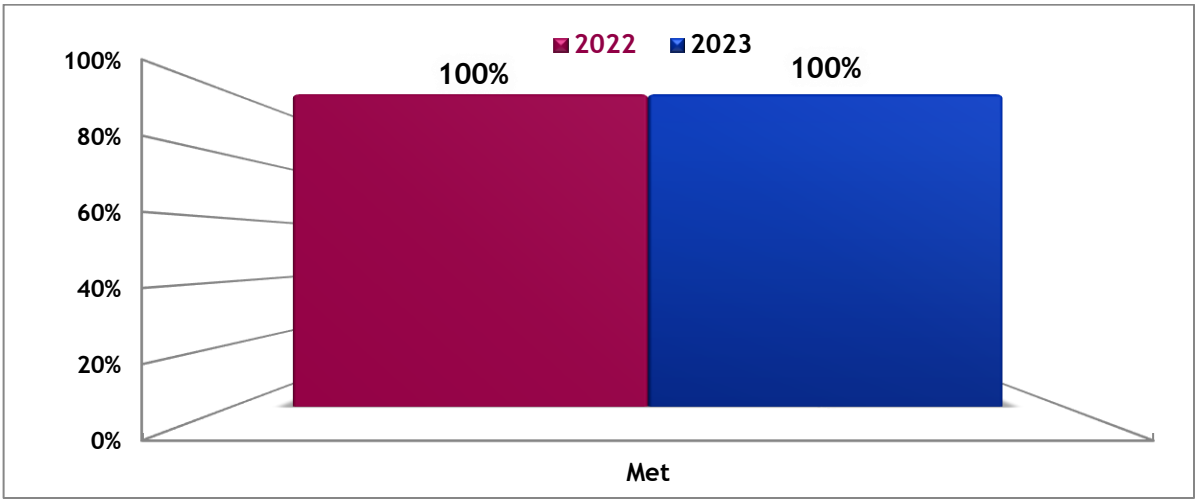
The Delegation Oversight Committee (DOC) is accountable for all functions and responsibilities that are delegated. Policies and procedures describe processes and requirements related to delegation of health plan functions and activities to external entities. The policies and procedures address pre-delegation assessment, annual oversight, ongoing monitoring, sub-delegation, and delegation termination. As detailed in the policies, the pre-delegation assessment and ongoing monitoring include determining the exclusion status of each entity. CCME noted that Policy MHSC-DO-001 included an outdated reference to the Excluded Parties Lists System (EPLS), which has been replaced by the System for Award Management (SAM).

Written delegation agreements, executed with each delegate at the time of delegation approval, specify the delegated activities and functions, reporting requirements, additional terms and conditions for delegation, annual and ongoing monitoring activities, and consequences of substandard or noncompliant performance.

Documentation of delegate oversight provided by Molina confirmed the health plan conducts annual oversight of all delegates using comprehensive tools to ensure compliance with standards and requirements for the delegated activities. Results of oversight activities are reported to the DOC. Minutes of the DOC meetings confirmed the reporting of annual and ongoing monitoring activities, as well as the status of any corrective actions implemented for the delegates.

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

Figure 7: Delegation Findings



Strengths

- Policies and procedures detail processes and requirements for delegating health plan functions and activities to external entities, including pre-delegation assessments, annual oversight, ongoing monitoring, sub-delegation, and delegation termination.
- Pre-delegation assessments are conducted to ensure potential delegates meet all contractual, federal, and state requirements for the activities being delegated.
- Documentation confirms that an annual assessment is conducted, and audit tools are comprehensive and include appropriate elements for the specific activities that are delegated.
- Reports of delegation activities, annual assessment results, and status of corrective action plans are provided to the Delegation Oversight Committee.

Weakness

- Policy MHSC-DO-001, Pre-Assessment Audits, references checking the GSA Excluded Parties Lists System (EPLS); however, the EPLS has been replaced by the System for Award Management (SAM).

Recommendation

- Revise Policy MHSC-DO-001 to correct the outdated reference to the EPLS.

G. State Mandated Services

42 CFR Part 441, Subpart B

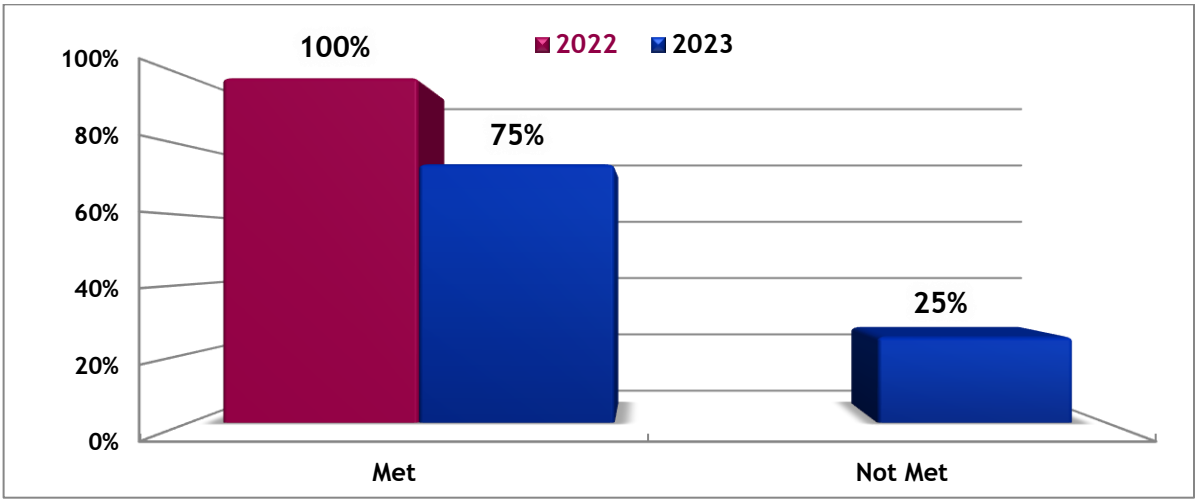
Molina works to increase participation in the EPSDT program, including immunizations, by educating members and providers, and encouraging members and their families to obtain

recommended services. Monitoring mechanisms to ensure timely provision of required EPSDT services and immunizations include monitoring related HEDIS® measures and conducting medical record reviews. The Provider Services Team supplies gap in care reports to providers and informs providers of member incentives to share with their assigned members. These incentives include gift cards providers can hand out to members upon completion of well-care screenings and services.

Findings of this EQR reflect that Molina provides all contractually required core benefits.

The current review confirmed that Molina did not correct an identified deficiency from the previous EQR related to documentation that a verbal appeal request must be followed by a written appeal request.

Figure 8: State Mandated Services



Strengths

- Molina works to increase participation in the EPSDT program, including immunizations, by educating members and providers and conducts monitoring and evaluation activities to assess provider compliance with provision of required EPSDT services and immunizations. Gaps in care reports are disseminated to providers and incentives are in place to encourage participation in recommended care.
- Findings of this EQR reflect that Molina provides all contractually required core benefits.

Weaknesses

- The current review confirmed that Molina did not correct an identified deficiency from the previous EQR related to documentation that states a verbal appeal request must be followed by a written appeal request.

Quality Improvement Plans

- Implement actions to address and correct all deficiencies identified during the EQR.

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

February 13, 2023

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 2023 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 two day onsite will be conducted virtually on **April 19th and April 20th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **February 27, 2023.**

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

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2022/2023

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. Please provide a list of all current employees, the employees title, and credentials.

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 **that serve as a PCP** 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, Population Health Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2022 and 2023.

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 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 (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all 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. Please provide the over and underutilization summary report(s) and the quarterly or monthly monitoring reports.

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 2022 through January 2023. 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 (i.e., CAHPS and ECHO), 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 2022 through January 2023.

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 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. **Provide a listing of all delegates** conducting delegated activities. Please include both local health plan delegates and corporate delegates that conduct activities for South Carolina using the following format:

Date of initial Delegation	Name of Delegated Entity	Functions Delegated	Methods of Oversight

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 point value, and index scores for the SCDHHS withhold measures.

36. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of February 2022 through January 2023. Include any medical information and physician review documentation used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of February 2022 through January 2023, 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: Appeal, Grievance, 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 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

(HEALTHY CONNECTIONS AND HEALTHY CONNECTIONS PRIME)

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

2. Credentials for all Key Personnel.

3. Please provide an update on any changes that have occurred since the desk materials were uploaded (2/27/23). Example, any policies that have changed or updated, staff changes, etc.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Topic was based on analysis of immunizations rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Aims of study are reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of clinical information.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	Relevant populations 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 not conducted for latest reported rate. Administrative rates were reported.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not conducted for latest reported rate. Administrative rates were reported.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not conducted for latest reported rate. Administrative rates were reported.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators 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**	Indicators measure changes in processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources of data were clearly identified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Project has a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	PIP involves qualified personnel.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data were analyzed per plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and one remeasurement period 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 follow up interventions are noted.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions align with barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The baseline rate was 28.95% with a slight decline in the administrative rate as of 1/20/23 to 28.35%. The goal is 31.19% for the annual improvement goal. ***Recommendation:*** *Additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not evaluated as rate did not improve in the most recent remeasurement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis not able to be conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	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 Healthcare of SC**
Name of PIP:	**IMPROVING ENCOUNTERS ACCEPTANCE RATES**
Reporting Year:	**2022**
Review Performed:	**2023**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Topic was based on analysis of encounters acceptance and rejection rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Aims of study were reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of non-clinical information.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	Relevant populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling 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 not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators were defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators measured changes in systematic processes.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources of data were clearly identified.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Project has a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	PIP involves qualified personnel.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data were analyzed annually.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and year 1 remeasurements 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 improvement and follow up interventions were noted.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions aligned with barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	For the acceptance rate, there was improvement from remeasurement 1 at 96.9% to remeasurement 2 at 97.3% (the refreshed rate shows 98.82%). The goal is 100%. The 837P rejection rate declined from 2.82% to 1.35% which is an improvement. The goal is 2%.
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**	Not evaluated due to lack of improvement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
High Confidence in Reported Results

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina Healthcare of SC**
Name of PIP:	**CHILD AND ADOLESCENT WELL CARE VISITS**
Reporting Year:	**2022**
Review Performed:	**2023**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Topic was based on analysis of well child visit adherence rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Aims of study were reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addressed key aspects of clinical information.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	Relevant populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used. Administrative rate reported.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used. Administrative rate reported.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used. Administrative rate reported.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicator was defined (WCV).
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicator measured changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources of data were clearly identified.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Project has a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	PIP involves qualified personnel.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data were analyzed according to the plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and remeasurement 1 were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of follow up interventions were noted.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions align with barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	There was a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% at the remeasurement #1 using the administrative rate as of 1/20/23. The goal is 44.29% for the annual improvement. ***Recommendation**: Continue to assess interventions to determine the impact on the final measure rate that will be available in mid-2023.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not evaluated due to no improvement in rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis was not able to be conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	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 PM Validation Worksheet

Plan Name:	**Molina Healthcare**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2022 (MY 2021)**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY 2021/RY 2022

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			Submitted measures were prepared according to measure specifications and present fairly.

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 of South Carolina**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	**2022**
Review Performed	**2023**

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 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

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 2022
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 2022
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 2022
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 2022
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 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022

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 2022
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 2022

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 2022

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 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
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 2022

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 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Adult survey had 245 responses out of 1687 surveys, a 14.5% response rate, which is a decline from the previous response rate of 18.1%. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022 **Recommendation:** Continue innovative methods to improve response rates and achieve a representative sample of the populations surveyed.
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 2022
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 2022

CCME EQR Survey Validation Worksheet

Plan Name	**Molina Healthcare of South Carolina**
Survey Validated	**CAHPS MEMBER SATISFACTION- Child CCC**
Validation Period	**2022**
Review Performed	**2023**

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 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience was identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

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 2022
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 2022
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 2022
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 2022
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 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
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 2022

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 2022

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 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
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 2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For Child with CCC: There were 237 out of 2397 completed, for a response rate of 9.9% which is a decline from the previous year's rate of 12.7%. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022 ***Recommendation:*** *Continue innovative methods to improve response rates and achieve a representative sample of the populations surveyed.*
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 2022
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 2022

CCME EQR Survey Validation Worksheet

Plan Name	**Molina Healthcare of South Carolina**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	**2022**
Review Performed	**2023**

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 2022
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 2022
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 2022

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 2022
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 2022

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 2022
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 2022
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 2022
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 2022
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 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
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 2022

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 2022

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 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
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 2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	There were 353 responses out of 3640 surveys for a response rate of 9.7%. This is a decline from the previous year's rate of 13.1%. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022 **Recommendation:** Continue innovative methods to improve response rates and achieve a representative sample of the populations surveyed.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
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 2022

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	**Molina Healthcare of SC**
Collection Date:	**2023**

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					Molina's policies are reviewed annually. Policy MHSC-AD-02, Annual Policy Review, and Procedure MHSC-AD-02, Annual Policy Review, detail the process for the annual review. Updates to the policies and procedures are taken to the Administrative and Policy Committee for approval.
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					Dora Wilson is Molina's Plan President .
1.2 Chief Financial Officer (CFO);	X					
1.3 * Contract Account Manager;	X					The Associate Vice President of Government Contracts is Bryan Amick.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Oversight of claims is performed by Heather Eddins, Director of Health Plan Operations. Oversight of encounters is performed by Jay Anderson, Sr. Program Manager of Encounters.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Vice President of Healthcare Services is Tena Kelly, RN, BSN.
1.5.1 Pharmacy Director,	X					Barnard Wilson is the Pharmacy Services Manager.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					Case Management staff are located in South Carolina and consist of a team of twelve with one vacancy identified.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Quality Director 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					The Provider Services Manager is Tyler Stalvey.
1.7.1 Provider Services Staff,	X					
1.8 *Member Services Manager;	X					The Member Services Manager is GG Garcia and Jennifer Marze is the AVP, Health Plan Engagement.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					The Chief Medical Officer is Richard Shrouds, MD.
1.10 *Compliance Officer;	X					Niurka Adorno-Davies is Molina's Associate Vice President of Compliance.
1.10.1 *Program Integrity Coordinator;	X					
1.10.2 Compliance/ Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					LaDawn Simmons is the Director of Government Contracts.
1.12 Legal Staff;	X					Molina's Associate General Council is Nicole Vega-Verdejo.
1.13 *Behavioral Health Director;	X					Dr. Nikitas Thomarios, a board-certified psychiatrist, is the Behavioral Health Medical Director.
1.14 *Program Integrity FWA Investigative/Review Staff.	X					Molina's SC FWA/Investigative Review staff includes: one nurse investigator, one

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						investigator, and 1 additional investigator, all domiciled/dedicated to SC Medicaid.
2. Operational relationships of MCO staff are clearly delineated.	X					Molina's Organizational Chart and Companion Matrix clearly identified key personnel positions and operational relationships.
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					For a particular month of incurred claims, inpatient facility claims are approximately 89% complete and all other claims would be about 94% complete after three months of runout. These percentages fall below the South Carolina timeliness requirements. Molina stated post-onsite that the claims completeness calculation is based on a lag model that includes all claims (paid and incurred). This considers claims that have not been received yet. For this methodology, the timeliness reported above may vary a few percentage points across a few months, but the range reported is accurate. This statistic is not one and the same as claims adjudication timeliness for clean claims. Molina meets the 90% within 30 days and 99% in 90 days requirement for processing clean claims.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Molina's reported statistics indicate the MCO processes 99% of transactions electronically and only 1% on paper. An EDI system handles Molina's electronic transactions, and that system has

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						mechanisms to ensure transaction data is HIPAA compliant. Transaction data that is not HIPAA compliant is rejected and sent back to the submitter with details as to why it was rejected.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Molina's HEDIS software is capable of capturing demographic data and linking it to other systems. The HEDIS software also identifies and rejects duplicate records based on the key fields for each input file. If a duplicate is detected, only one record would be loaded based on the key field and the rest of the records are rejected.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Molina uses NCQA-certified HEDIS software (Claim Sphere) to generate HEDIS and HEDIS-like reports from the MCO's consolidated data repository. Molina's ISCA documentation states that staff review reports to identify potential issues with reporting programs based on the results.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Molina has the necessary policies and procedures in place to address the State's data security requirements. To ensure adequate controls are in place, Molina performs a regular security risk assessment. In the most recent assessment, almost all controls met the organization's security requirements; the one item that did not is being addressed and remediated.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Molina's has the necessary policies and procedures in place to address the State's system, information security, and access

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						management requirements. The MCO recently had Ernst and Young assess the organization's systems and organizational controls (SOC). The assessment only found one item in need of attention and Molina has addressed that item.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Molina has disaster recovery and business continuity plans in place that adhere to industry best practices. Additionally, the MCO has tests in place to verify the effectiveness of those plans. Molina's most recent tests were successful and met the organization's recovery time and recovery point objectives.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Molina's Code of Business Conduct and Ethics applies to all employees, and as a condition of employment, employees are required to acknowledge receipt and understanding of the Code of Conduct upon hire and annually, thereafter.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						Compliance training and education are listed in the new employee training material. . The iLearn portal is used to disburse new and annual training to new employees and annually, thereafter.
2.6 Lines of communication;						
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						
2.9 Response to offenses and corrective action;						The Compliance Plan describes responsibilities of the Compliance Officer, including responding to, investigating, and assisting management with enforcement and discipline for instances of non-compliance.
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Committee oversees Molina's Medicaid, Medicare-Medicaid, and Marketplace compliance programs, including compliance with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the requirements of contracts with respect to lines of business.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Procedure PHARM 07-01, Pharmacy Lock-In Program, describes processes for monitoring potential over-utilization of prescription-controlled substances and medical services to promote patient safety, coordination of care, and quality of care.
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 Protected Health Information, describes processes taken by Molina to protect privacy and maintain the confidentiality of members' protected health information in accordance with state and federal laws and contractual requirements.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Processes for initial credentialing and recredentialing of practitioners and organizational providers have been developed in accordance with state and federal requirements as well as National Committee for Quality Assurance (NCQA) standards, are documented in policies and procedures, including: •Policy and Procedure CR01, Credentialing and Recredentialing Practitioners •Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers Related addenda document South Carolina specific requirements. Procedure CR02 states, “Providers who are administratively denied or administratively terminated, do not have the right to submit an appeal.” However, the procedure does not address whether providers can appeal non-administrative denials or terminations. Onsite

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussion confirmed that no appeal process is available. *Recommendation: Revise Procedure CR02 to indicate that appeals are not allowed for non-administrative denials or terminations.*
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					Procedure CR01, Credentialing and Recredentialing Practitioners, provides an overview of the roles, responsibilities, functions, and composition of the Professional Review Committee (PRC). The PRC is chaired by a Molina Medical Director, meets at least monthly, and reports to the Quality Improvement Committee (QIC). Using a peer review process, the PRC makes recommendations for credentialing decisions. Only licensed practitioner/clinician members of the PRC have voting privileges. A quorum is established with the presence of four voting practitioners, two of whom must be participating network practitioners. The 2022 Credentialing and Professional Review Committee Matrix indicates the voting membership of the PRC includes two OBGYNs, one psychiatrist, three pediatricians, one nurse practitioner, and one physician assistant. During the previous EQR, Molina reported attempts to recruit a general surgeon for PRC membership. Molina reported that they have not successfully

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recruited a general surgeon to participate on the committee, but that efforts continue. CCME noted that there are no adult general medicine providers included in the committee's membership. *Recommendation: Continue efforts to recruit an additional specialty provider for membership on the PRC. In addition, consider recruiting an adult general medicine provider, such as a family practitioner or internal medicine practitioner, for PRC membership.*
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:						No issues were identified in the sample of initial credentialing files reviewed.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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:						
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The sample provider files did not include documentation of re-querying the System for Award Management; however, Molina submitted documentation after the onsite that demonstrated the query was conducted 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					The sample provider files included documentation of checking the SCDHHS Providers Terminated for Cause list, but they did include documentation of querying the SCDHHS Excluded Providers Report. Molina submitted documentation after the onsite that demonstrated EPStaffCheck™ conducted the query.
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					The sample provider files did not include documentation of re-querying the Office of Inspecter General (OIG) List of Excluded Individuals and Entities (LEIE). Molina submitted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation after the onsite that demonstrated the query was conducted by EPStaffCheck™.
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					Two files did not provide evidence that hospital admitting privileges/arrangements were verified at recredentialing. During onsite discussion of this issue, Molina staff reported that they had received documentation via email from SCDHHS that this is no longer a required element of credentialing and recredentialing. Staff reported that the health plan does not contract with providers who do not have admitting privileges or an established admitting arrangement with another provider. Molina provided CCME with a copy of the email referenced above; however, it did not originate from SCDHHS. It was received from a staff person at the South Carolina Alliance of Health Plans, Inc. This body does not have the ability to waive health plan requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Also, Procedure CR01, Credentialing and Recredentialing Practitioners, states, "The practitioner's hospital privileges are verified by their attestation on the credentialing application stating the practitioner has current hospital privileges." It further states the verification is conducted at both initial credentialing and recredentialing. Therefore, Molina is out of compliance with this Procedure. *Recommendation: Ensure all practitioner credentialing and recredentialing files include evidence that hospital admitting privileges/arrangements have been verified.*
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					
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Ongoing provider sanction monitoring processes are addressed in various policies and procedures, including Procedure CR02, Assessment and Reassessment of Organizational Providers, Policy CR-04, Ongoing Monitoring Policy, and Procedure CR04-01-OGM, Sanctions Monitoring Procedure.
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)*						
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					Standards for the number and geographic distribution of primary care providers (PCPs) and activities to monitor compliance with those standards are defined in Policy and Procedure PC-011, Availability of Health Care. For PCPs, the standard is that 90% of members have access within 30 miles/45 minutes. Network Reports confirmed appropriate parameters are used to evaluate geographic access to PCPs and indicated access is measured by county. Goals were met for all counties in 2022. Policy and Procedure MHSC-PC-004, Provider Panel Closure, states Provider Contracting staff monitor the number of PCPs who are accepting new members and evaluates this against internal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						targets for the number of PCPs that are accepting new members by county and provider. If PCP availability falls below the standard or if access issues are identified through the member grievance process, action will be taken to contract with additional PCPs or to outreach to current PCPs to ensure an adequate number of providers are accepting new members.
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					As stated in Policy and Procedure PC-011, Availability of Health Care, Molina sets standards for the number and geographic distribution of specialists, behavioral health practitioners, acute care facilities, and skilled nursing facilities, and monitors compliance with those standards. Network Reports confirmed that access is measured for all required Status 1 provider types. In the most recent Network Report provided by Molina (November 2022), goals for Hospitals were met for all counties. Gaps were noted for Psychology in Allendale County and OB/GYN in Barnwell County. Onsite discussion confirmed interventions taken to address these gaps.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Procedure MHI-QUAL-011, Practitioner Network Cultural Responsiveness, describes processes for ensuring the network can meet membership cultural and linguistic needs. These activities include, but are not limited to: ○Requesting, tracking, and comparing member and practitioner race, ethnicity, and language data, and language services offered by practices. ○Analyzing grievances related to member cultural and linguistic needs. ○Offering interpreter services through the Contact Center and qualified language service providers. Information about cultural competency is included in the Provider Manual. Molina's website includes cultural competency training resources and information about accessing interpreter services. Information on the website addresses the Americans with Disabilities Act, and providing services for members with disabilities, who are blind or have visual limitations, and members with service animals. Additional tools provided on the website include: "A Physician's Practical Guide to Culturally Competent Care" and "Industry Collaborative Effort (ICE) - Better Communication, Better Care."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements.	X					The printed and online versions of the Provider Directory incorporate all required elements. During onsite discussion, Molina staff reported upcoming initiatives to improve information in the Provider Directories.
3. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MHSC-PS-005, Provider Availability Standards, the Provider Manual, and the Member Handbook appropriately define appointment access standards for PCPs. Requirements for specialty care appointments are found in the *SCDHHS Contract, Section 6.2.3.1.5*. For specialty providers, Policy MHSC-PS-005 does not include the requirements for emergent visits immediately upon referral and urgent medical condition care appointments within 48 hours of referral or notification of the PCP. The Provider Manual, pages 68-69, and the Member Handbook, page 29, include requirements for emergent visits and urgent medical condition care appointments; however,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the information is found in table with a heading of "PCPs," so it is not clear that the information applies to specialist appointments. Also, the Provider Manual and Member Handbook define the requirement for routine specialist appointments as 12 weeks; however, this is incomplete. As stated in Procedure MHSC-PS-005, Molina conducts annual provider availability and after hours telephonic surveys of PCP, specialty, and behavioral health providers to evaluate compliance with appointment access standards. Providers who do not meet the standards are re-educated and resurveyed within 3-6 months. *Quality Improvement Plan: Revise Policy MHSC-PS-005, the Provider Manual, and the Member Handbook to clearly state the requirements for specialty appointments. Ensure the information is compliant with the standards defined in the SCDHHS Contract, Section 6.2.3.1.5.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					For the Telephonic Provider Access Study conducted by CCME, Molina submitted a Provider File containing a population of 2,233 providers. A random sample of 144 PCPs was selected and attempts were made to contact these providers to ask a series of questions regarding the access that members have with the providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The calls were successfully answered 62% of the time (86 out of 138) when omitting six calls answered by voicemail messaging services. This is a statistically significant improvement from last year's rate of 43%. For calls not answered successfully (n= 52 of 138 calls), the majority (n = 41, 79%) were because the physician was no longer practicing at the location. Out of 138 calls (omitting voicemail), 86 providers were actively practicing at the location called. ○Of those 86 providers, 74 (86%) indicated that they accept Molina. ○Of the 74 that accept Molina, 46 (62%) are accepting new patients. ○Of the 46 providers that are accepting new patients, 38 (83%) do not require a prescreening and 8 (17%) do require a prescreening. □Of the 8 that require a prescreening, 7 (88%) indicated that an application must be filled out and 1 (12%) required a review of medical records.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						30 of 46 providers (65%) had appointment availability within contract requirements for a new patient routine appointment.
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					Processes and topics for initial provider orientation are detailed in Policy and Procedure MHSC-PS-010, Provider and Practitioner Education. The 2023 Medicaid Provider Orientation presentation document covers many topics providers need to understand health plan operations and requirements, and includes links for various functions such as signing up for provider bulletins, the online provider directory, the provider portal, the preferred drug list, etc. The Provider Manual includes a comprehensive overview of health operations, programs, and requirements.
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provided under fee-for-service payment by SCDHHS;						
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention, and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
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					Ongoing provider education is conducted by Provider Services staff during routine provider site visits, as needed, and upon request. Additional information and updates are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						disseminated via periodic communications such as face-to-face presentations, facsimiles, e-communications, mailing of provider newsletters, webinars, and the website. In addition, Molina conducts quarterly regional provider trainings and annual provider office manager meetings. In developing ongoing provider training, staff evaluate the provider education and training program and collaborate with other internal departments and external entities as needed to identify additional training topics needed. These processes are found in Policy and Procedure MHSC-PS-010, Provider and Practitioner Education.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Molina adopts Preventive Health Guidelines (PHGs) that are specific to the health care and service needs of members to provide up-to-date information about expected standards of practice. The National Quality Improvement Committee (NQIC) selects, reviews, and approves the PHGs, and informs the local plans of the selected guidelines. The health plan's Quality

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Improvement Committee reviews and approves the PHGs for adoption by the MCO.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					PHGs are disseminated to providers through provider orientation materials and training, the Provider Manual, newsletters, other mailings, fax blasts, etc. Molina sends written notification that the guidelines are available on the web, 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					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Molina adopts Clinical Practice Guidelines (CPGs) to provide up-to-date treatment and diagnostic information about important clinical topics. The National Quality Improvement Committee (NQIC) selects, reviews, and approves the CPGs, and informs the market plans of the selected guidelines. The health plan's Quality Improvement Committee reviews and approves the CPGs for adoption by the MCO.
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					CPGs are disseminated to providers through provider orientation materials and training, the Provider Manual, newsletters, other mailings, fax blasts, etc. Molina sends written notification that the guidelines are available on the web, 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 PCPs and other providers.	X					Molina monitors continuity and coordination of care between practitioners and across the network at least annually by collecting and analyzing data from claims, encounters, utilization management and case management information, HEDIS data, etc. This assists in identifying and prioritizing opportunities for improvement. These processes are described in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHI-QUAL-004, Monitoring Continuity of Care. As described in MHI-QUAL-003, Standards of Medical Record Documentation, Molina's annual medical record review also aids the health plan in assessing continuity and coordination of care between providers. Molina's Continuity and Coordination of Care Analysis: 2022 Report was completed in June 2022 based on analysis of 2021 data. The report included data, a summary of the analysis, identified priorities, and interventions for the priorities.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy and Procedure MHI-QUAL-003, Standards of Medical Record Documentation, lists documentation standards for member medical records maintained by network providers as well as requirements for medical record storage and confidentiality. It also describes processes for the annual assessment of compliance with the medical record documentation standards.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy MHI-QUAL-003, Standards of Medical Record Documentation, page 29 (the SC State Specific Policy and Procedure) states the Standard Medical Record Documentation Audit Tool is included in Attachment A. However, Attachment A was not identified in the document. For the medical record audit, scores of 90% or higher are passing scores. Scores below 90% require an over read, and scores below 90% on over read prompt a re-audit in approximately 6 months. Medical record audit results are reported to the QIC and SCDHHS annually. Policy MHI-QUAL-003 does not provide information about any additional actions taken for results below the 90% threshold. Onsite discussion confirmed that additional education activities are conducted for these providers. The 2022 medical record audit was conducted on a sample of 150 medical records from 30 providers. 100% of the records received a passing score. Scores ranged from a high of 100% to a low of 90.70%. Molina staff reported that the audit

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						results were reported to the QIC in September 2022. *Recommendation: Revise Policy MHI-QUAL-003, Standards of Medical Record Documentation, to include the Standard Medical Record Documentation Audit Tool. Revise Policy MHI-QUAL-003, Standards of Medical Record Documentation, to include additional actions taken to reeducate providers who do not meet the 90% scoring threshold for medical record review.*
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 and Procedure MHSC-ME-04, Member Bill of Rights and Responsibilities, outlines member's rights and responsibilities. Molina informs members of their rights and responsibilities via the Member Handbook and Molina's website.
2. Member rights include, but are not limited to, the right:	X					All rights are defined in Procedure MHSC-ME-04, Member Bill of Rights and Responsibilities, and in the Member Handbook.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Procedure MHSC-ME-01, New Medicaid Member Outreach and Education, indicates new members will receive a welcome packet within 14 calendar days from the date their eligibility file is received. The Welcome packet includes directions to access or request a Member Handbook and Provider Directory, and a Notice or Privacy Practices.
1.1 Benefits and services included and excluded in coverage;						A benefit grid is provided in the Member Handbook and on Molina's website. It describes

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						core benefits, covered services, and extra benefits provided by Molina.
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.						Page 47 of the Member Handbook informs members of their right to a second opinion. Molina provides this service at no cost to the member. Prior approval is required if the member chooses to go to an out-of-network provider.
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The Member Handbook and website detail services that require prior authorization. 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;						The Member Handbook and website provide contact numbers for a variety of member needs. The Nurse Advice Line is available 24 hours a day, seven days a week. The Member Handbook and Molina's website describe and define behavioral health and physical health emergency services and provide clear and specific information about appropriate use of urgent and emergent services.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Handbook and Molina's website include the toll-free number to reach the Member Services department. Other phone numbers are also included for different services such as scheduling transportation and accessing the Nurse-Advice Line.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						Members are informed of their right to implement an advance directive. The Member Handbook includes a section on Advanced Directives as well as information regarding Living Wills, Do Not Resuscitate Orders, Durable Power of Attorney, etc..
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					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Molina's Member Handbook outlines the steps and available assistance to select a Primary Care Provider (PCP) or specialist.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Procedure MHSC-ME-05, Medicaid Member Disenrollment, describes processes for member disenrollment. Disenrollment steps are also provided in the Member Handbook.
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					
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					SPH summarizes and details all results from both surveys. It was noted the response rates were below the NCQA target of 40%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Adult survey had 245 responses out of 1687 surveys, a 14.5% response rate, which is a decline from the previous response rate of 18.1%. The benchmark was met for 7 out of 10 measures. For the Child survey, there were 353 responses out of 3640 surveys for a response rate of 9.7%. This is a decline from the previous year's rate of 13.1%. The benchmark rate was met for 3 out of 9 measures. For the Child with CCC Survey, there were 237 out of 2397 completed, for a response rate of 9.9%. This was a decline from the previous year's rate of 12.7%. The benchmark was met for 5 out of 9 measures. *Recommendation: Continue innovative methods to improve response rates and achieve a representative sample of the populations surveyed.*
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Results of the Member Satisfaction surveys are presented to the Quality Improvement Committee. Action plans are initiated to address problematic measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The 2022 Quarter Three Palmetto Partners Provider Newsletter provided the results of the member satisfaction survey to network providers.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Molina has policies and procedures in place describing the grievance process consistent with *SCDHHS Contract* language.
1.1 The definition of a grievance and who may file a grievance;	X					Procedure MHSC-MRT-001 Grievance Disposition Process, the Member Handbook, and Molina's website consistently define a grievance as, "An expression of dissatisfaction about any matter other than an adverse benefit determination."
1.2 Procedures for filing and handling a grievance;	X					Policy MHSC-MRT-001, Grievance Disposition Process, indicates that grievances may be filed verbally in person, by telephone, in writing, by fax, or electronically. An authorized representative may file or assist members with the filing of grievances.
1.3 Timeliness guidelines for resolution of a grievance;	X					Members are notified of the grievance resolution in writing no later than 90 calendar days from the date Molina received the grievance. Timeframes for resolution may be extended up to 14 calendar days if the member requests the extension or Molina is able to demonstrate there is need for additional information and how the delay is in the member's interest.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Grievances are logged, tracked, analyzed, and reported per Policy MHSC-MRT-001, Grievance Disposition Process.
2. The MCO applies grievance policies and procedures as formulated.	X					Molina resolves grievances and provides verbal or written notification of the findings and steps taken to resolve the grievance within 90 calendar days. Timeliness standards were met for all grievance files reviewed. Molina documents most of the calls and contacts made during resolution in the file.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					Of the randomly selected grievance files reviewed, no issues were identified.

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 designed a Quality Improvement Program to ensure all medically necessary covered services are available and accessible to all members and that services are provided in a culturally and linguistically appropriate manner. Molina submitted the Molina Healthcare of South Carolina; Inc. Quality Improvement Program Description 2022. This program description included the program's goals, structure, scope, and methodology used to monitor and improve the services delivered to members.
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					As part of the scope of QI program activities, Molina reviews potential over- and under-utilization statistics at least yearly using cross-functional teams and collaboration with the provider network.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Molina develops a work plan to guide and keep track of specific QI activities. The 2022 and 2023 Quality Improvement and Health Equity Transformation Work Plan was submitted for review. It was noted that the 2023 QI work plan included the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						year 2023 will be considered the first year for this trending activity. CCME had concerns with this new format related to how new activities added during the five-year period would be displayed or denoted for year one. CCME recommended labeling the columns for the applicable year (example: Y1= 2023, Y2=2024 etc.). The 2023 work plan appeared to contain a few typos. Those included: In the Program Structure section, • The objective states "Complete the 2023 QI Program Description and QI Workplan" and the timeline for completion is listed as "By the end of Q1 2023." However, the Action Plan description indicates review and approval will be completed by Q4. • The timeline for completing the 2023 QI Program Evaluation was listed as "By the End of Q2 2023." This objective should read Complete the 2022 QI Program Evaluation instead of the 2023 QI Program Evaluation. *Recommendation: Correct the timeline for completing the 2023 QI Program Description, Workplan, and the QI Program Evaluation in the Program Structure section of the 2023 QI Work Plan.*
IV B. Quality Improvement Committee						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Molina's Quality Improvement Committee (QIC) is responsible for the implementation and monitoring of the QI Program. This committee recommends policy decisions, analyzes, and evaluates the progress and results of all QI activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership for this committee include the Chief Medical Officer (chairman), senior leaders from the health plan, and external network providers.
3. The QI Committee meets at regular quarterly intervals.	X					The Quality Improvement Committee meets at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Committee minutes submitted for review demonstrated the meeting occurred at regular quarterly intervals. Documents provided also demonstrated electronic votes were obtained from committee members on two occasions.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Molina was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*. Molina uses a certified software organization for calculation of HEDIS rates. Substantial improvement of 10% or more was noted for two measures. The Controlling High Blood Pressure (cbp)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						improved 12.89% and Pharmacotherapy for Opioid Use Disorder (pod) had a 28.16% increase in the rate. Substantial declines occurred for Pneumococcal Conjugate and Combination #3 immunizations, as well as Appropriate Testing for Children with Pharyngitis - Total, and Follow-Up Care for Children Prescribed ADHD Medication for both initiation and continuation/maintenance rates.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Molina submitted three PIPs for validation. Topics included Improving Encounters Acceptance Rates, Child and Adolescent Well-Care Visits, and Immunizations for Adolescents.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					All three PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Network providers participate in the QI activities by serving on clinical and quality committees. Through these committees, participating providers review and provide feedback on proposed guidelines, clinical programs, quality projects, action plans, and interventions needed to improve levels of care and service.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Molina provided an example of the Quality Report generated for network providers. This report included Member data profiles, ED Visit Utilization, HEDIS Gaps in Care, and HEDIS Trending Graphics.
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. The evaluation identifies program outcomes, a description of limitations and barriers, and interventions to overcome those limitations. Molina provided the Quality Improvement Program 2021 Annual Evaluation. This evaluation included a summary of the results for each of the quality improvement activities, any barriers identified and interventions underway. The evaluation also included recommendations or areas of focus for 2022.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					The 2021 QI Program Evaluation was presented to the QIC in September 2022 and to the Board of Directors in December 2022.

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 Utilization Management (UM) Program Description outlines staff responsibilities as well as the scope and objectives for physical health and behavioral health services. The Pharmacy Program Description outlines the program objectives and standard operations of the pharmacy program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					Molina's UM program Description and Policy MHSC-HCS-UM-365, Clinical Criteria Utilization Management Decision Making, describe that health practitioners utilize external and internal guidelines such as Milliman Clinical Guidelines (MCG), Official Disability Guidelines (ODG), Hayes Technology Assessments, Inpatient Hospital Services Coverage Requirements, and State Guidelines to make clinical coverage decisions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Molina's UM Program Description, Pharmacy Program Description, and Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, provide an overview of the timeliness standards for processing UM decisions. The timeframe for processing standard authorizations is listed as 14 calendar days and 72 hours for expedited authorizations. There were inconsistencies identified in the UM and Pharmacy Program Descriptions regarding the timeframes for processing prior authorization requests for pharmacy services. Molina's UM Program Description indicated the timeframe for pharmacy decisions was 72 hours for expedited requests and 14 calendar days for standard requests. However, the Pharmacy Program Description indicated pharmacy decisions are made within 24 hours. During the onsite discussion, Molina confirmed the timeframe for processing pharmacy authorizations was within 24 hours. *Recommendation: Update the UM Program Description to reflect the correct timeframe for processing pharmacy decisions.*
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Molina's UM Program Description states that the professional staff do not directly or indirectly receive incentives in relation to clinical determinations and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						this is communicated annually to providers, practitioners, members, and Molina staff.
1.7 the mechanism to provide for a preferred provider program.	X					As described in Molina's UM Program Description, Molina's Star Provider Program measures several metrics such has low incidence of UM medical necessity denial decisions, emergency department utilization, HEDIS metrics, etc. to evaluate provider eligibility for participation in their preferred provider program. The providers approved for participation are subject to a bi-annual analysis of quality and UM performance for continued eligibility and participation. During onsite discussion, it was reported that there are currently eight providers in the program and that Molina is seeking to expand the program in the future.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Molina's UM Program Description and Policy MHSC-HCS-UM-364, Appropriate Professionals Making UM Decisions, provide a descriptive overview of the role and responsibility of the Medical Director, such as clinical supervision, training, case review, second level review, etc. Additionally, the Chief Medical Officer chairs and serves on various committees such as the HealthCare Services Committee and the Pharmacy and Therapeutics Committee. The Behavioral Health Medical Director specializes in clinical oversight of the Behavioral Health UM activities. Likewise, the Pharmacy Director provides

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						oversight and responsibility over the clinical, administrative, and financial management of corporate pharmacy services, including but not limited to serving as chair on various committees, conducting second level reviews, consultations, and participating in the evaluation of new technology applicable to pharmacy services.
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					
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				Molina's UM Program Description and Policy MHSC-HCS-UM-365, Clinical Criteria Utilization Management Decision Making, describe that health practitioners utilize external and internal guidelines such Milliman Clinical Guidelines (MCG), Official Disability Guidelines (ODG), Hayes Technology Assessments, Inpatient Hospital Services Coverage Requirements, and State Guidelines to make clinical coverage decisions. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, continues to identify InterQual as an evidenced based criteria utilized in clinical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determinations. This was an issue identified in the previous EQR. During onsite discussion, Molina responded that they have removed the reference to InterQual Criteria to the stated policy and committee approval is pending. After the onsite, the health plan submitted an updated draft policy. *Quality Improvement Plan: Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making and remove the reference to InterQual Criteria.*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of the approval files reflected that the UM reviewers utilize appropriate clinical criteria when making UM determinations.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					In review of the approval files the clinical reviewers utilized physician clinical consultations appropriately and individualized member's circumstances were assessed.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Annually, Molina conducts Inter-Rater Reliability (IRR) testing for physicians, pharmacists, and clinical reviewers. The purpose of the audit is to ensure consistency in the application of clinical criteria. Based upon the IRR results, the Prior Authorization Clinicians, Pharmacy Reviewers, and Medical Directors received a passing score of over 90%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, the Inpatient Clinician Reviewers scored 88%, below the targeted goal of 90%, and received remediation training. During onsite discussion, it was shared that the remediation activities that occurred were clinical criteria retraining and increased supervision. Molina shared that the reviewers received a passing score after retesting. A discrepancy was identified with the IRR goals for the Pharmacy Reviewers and Medical Directors. The Health Care Services Annual Evaluation for IRR described the target goal for Pharmacy Reviewers as 80% and Medical Directors as 85%. However, Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria, stated that the overall goal was 90%. The health plan clarified that the goal for Pharmacy Reviewers and Medical Directors was 85%, which is not consistent with the policies and the Health Care Services Annual Evaluation. *Recommendation: Update Policy MHSC HCS-UM-376, Molina Way Inter-rater Reliability Documentation Guidelines, and Policy MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria, to reflect the correct IRR goals for Pharmacy Reviewers and Medical Directors and ensure that it is consistent with the Health Care Services Annual Evaluation.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Members can receive specialty pharmacy medications from a local pharmacy when there is a need for immediate access to prescribed medications. Also, a 72-hour emergency supply of medications may be obtained prior to an authorization if deemed necessary. However, successive supplies for a single prescription are not permitted.
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					As described in the UM Program Description, Provider Manual, and Denial Letter template, clinical guidelines are available upon request.
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Approval files reflect that the approval decisions were communicated within 14 days for standard authorization requests and 72 hours for expedited requests.
11. Denials						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					UM denial files reflect that the adverse benefit determinations were issued by an appropriate physician specialist.
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 the denial decisions demonstrated that the adverse benefit determinations were promptly communicated to the provider and member.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;		X				Requirements for filing an appeal are documented in Molina's UM Program Description, policies, and procedures. However, page 50 of Molina's UM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Description indicates that a standard request for an appeal received verbally must be followed by a written request within 30 days. This was an issue identified in the previous EQR. During onsite discussion, Molina shared that this verbiage has been removed from the UM Program Description and committee approval is pending. Also, the letter template for acknowledging a standard appeal incorrectly informs the member that a written request is needed after an oral request. Lastly, the letter template used to inform a member that an appeal was closed also mentions a written appeal was not received after an oral request. The health plan shared that neither of these letters is currently being utilized. *Quality Improvement Plan: Update all documents related to the process for filing an appeal and remove the requirement that a standard request for an appeal received verbally must be followed by a written request.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Molina has an established policy and procedure (Policy MHSC-MRT-003, Expedited Appeal Process) that describe the guidelines and procedures for managing expedited appeals.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Review of sample appeal files yielded that the files were processed according to contractual standards. For the appeal files that were filed by a provider on behalf of the member that did not include a member consent for the provider to appeal, Molina submitted Policy MHSC-MRT-002, Standard Appeals Process, that indicated that a member's consent for treatment serves as consent for the provider to file an appeal on the member's behalf.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MHS-MRT-002, Standard Appeal Process, states a quarterly summary of member appeals is reported to the Quality of Services Committee. Meeting minutes for March 3, 2022, June 6, 2022, and September 1, 2022, confirm review and approval of the summary and analysis of appeals. These

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performance metrics aid in discussion of barriers, strengths, and opportunities for improvement.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					A descriptive overview of Molina's approach to managing care management activities and care transitions programs is outlined in the UM Program Description and numerous policies.
2. The MCO has processes to identify members who may benefit from care management.	X					Molina members are referred for case management services through various sources such as practitioner referrals, self-referrals, claims, and many other referral sources. Also, monthly data is received from Molina's predictive modeling tool, Optum IPro, that analyzes multiple sources to aid in referral initiation and risk stratification. Health assessment tools are also completed to aid in further identification of the member's care needs.
3. The MCO provides care management activities based on the member's risk stratification.	X					Molina's care management activities are provided to members based upon their stratification level which are as follows: • Level I - Health Management that focuses on disease prevention. • Level II - Care Management is designed to improve member's health status and reduce the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						burden of disease through education and assistance with care coordination. • Level III - Complex Case Management is offered for members who have experienced a critical event or diagnosis and members with multiple complex medical or behavioral conditions that require extensive use of resources and support in navigating through the healthcare system. • Level IV - Intensive Need focuses on members with multiple complex conditions who are at the end stage of treatment or palliative care that necessitates more intensive services. Also, there is a special community-based waiver program for members with long term needs and special populations such as persons with HIV/AIDs, elderly or disabled, individuals with intellectual disability needs, complex medical needs, or who have sustained head or spinal cord injuries.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					
6. Care Transitions activities include all contractually required components.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy MHSC-HCS-UM-331, Continuity of Care Policy, and Molina's UM Program Description provide an overview of when continuity of care is provided for the members entering the health plan, pregnant, etc. However, there is no mention of continuity of care while a member is in the appeals process. *Recommendation: Consider adding additional information in Policy MHSC-HCS-UM-331, Continuity of Care Policy or in Molina's UM Program Description regarding the member's ability to continue to receive transition of care services while in the appeals process.*
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					
8. Care management and coordination activities are conducted as required.		X				A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, the following issues were identified:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• For seven files, there was no identified note or date provided on the creation of the Individualized Care Plan (ICP). • Two files did not have ongoing documentation of notes that entail a follow up schedule or an assessment of the member's progress that were receiving Level III Complex CM services. *Quality Improvement Plan: In Individualized Care Plan development, please ensure to obtain and accurately document the date of the signed acknowledgement and receipt with the member, and that a follow up schedule with documentation of the members' process is appropriately documented.*
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

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					Policy MHSC-DO-001, Pre-Assessment Audits, and Procedure MHSC-DO-005, Credentialing Delegation Requirements, describe processes for conducting pre-delegation assessments for potential delegates to ensure the potential delegate meets all applicable state, federal, and accreditation requirements. The pre-delegation assessment includes checking the entity to determine any exclusion status. Policy MHSC-DO-001, page two, references checking the GSA Excluded Parties Lists System (EPLS); however, the EPLS has been replaced by the System for Award Management (SAM). Written delegation agreements, executed with each delegate at the time of delegation approval, specify the delegated activities and functions, reporting requirements, additional terms and conditions, annual and ongoing monitoring, and consequences of substandard or noncompliant performance. *Recommendation: Revise Policy MHSC-DO-001 to correct the outdated reference to the EPLS.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Documentation provided by Molina confirmed the health plan conducts annual oversight of all delegates using comprehensive tools to ensure compliance with standards and requirements for the delegated activities. Results of oversight activities are reported to the Delegation Oversight Committee (DOC). Minutes of the DOC meetings confirmed the reporting of annual and ongoing monitoring activities and the status of any corrective actions implemented for the delegates.

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 works to increase participation in the EPSDT program, including immunizations, by educating

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members and providers, and encouraging members and their families to obtain recommended services. Monitoring mechanisms to ensure timely provision of required EPSDT services and immunizations include monitoring related HEDIS® measures and conducting medical record reviews. Molina's Provider Services Team supplies gap in care reports to providers.
1.2 performing EPSDTs/Well Care.	X					As noted in Policy MHSC-AD-03, EPSDT Notification, Tracking and Follow-up, Molina works to increase participation in the EPSDT program by educating and encouraging members and their families about EPSDT services and requirements. Monitoring mechanisms to ensure timely provision of required EPSDT services and immunizations include monitoring related HEDIS® measures and conducting medical record reviews. Molina's Provider Services Team supplies gap in care reports to providers and informs providers of member incentives to share with their assigned members, including gift cards the provider can hand out to members that complete a well-care screenings and services. Molina also offers PCPs an enhanced fee for completing comprehensive well-care visits for members 3 to 21 years old.
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			The current review confirmed that Molina did not correct an identified deficiency from the previous EQR related to documentation that states a verbal appeal request must be followed by a written appeal request. *Quality Improvement Plan: Ensure that all deficiencies are addressed by taking action to correct the deficiency.*