CCME

2017 External Quality Review

MOLINA HEALTHCARE OF SOUTH CAROLINA

Submitted: March 30, 2017

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

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCO) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. The purpose of this review was to determine the level of performance demonstrated by Molina Healthcare of South Carolina (Molina) since the 2016 Annual Review. This report contains a description of the process and the results of the 2017 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

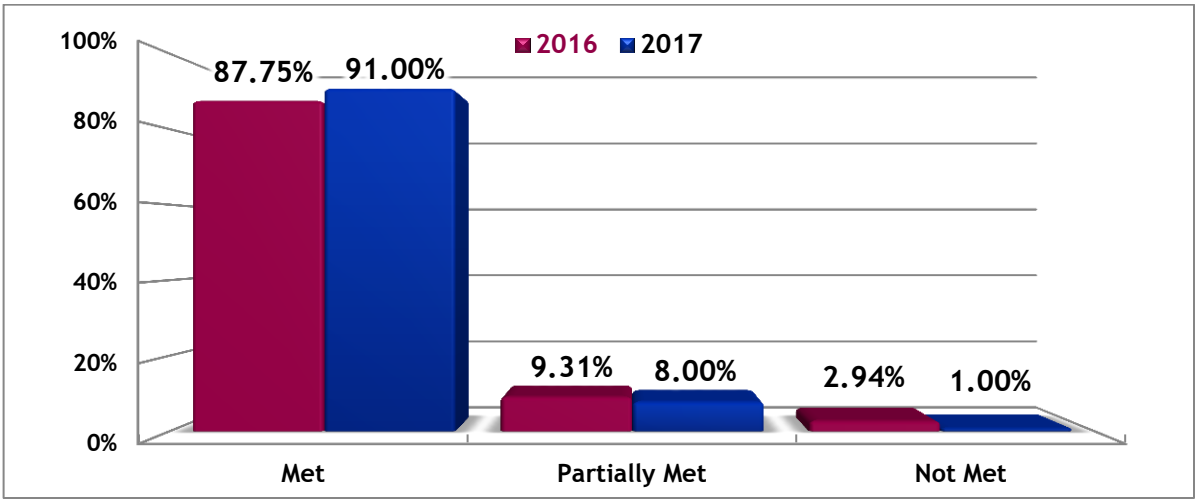
- determine if Molina was in compliance with service delivery as mandated in the Managed Care Organization (MCO) contract with SCDHHS;
- evaluate the status of deficiencies identified during the 2015 Annual Review and any ongoing corrective action taken to remedy those deficiencies;
- provide feedback for potential areas of further improvement; and
- assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of Medicaid Managed Care Organizations. The review included a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects, and validation of performance improvement measures.

Overall Findings

The 2017 annual EQR review shows Molina has achieved a “Met” score in 91% of the standards reviewed. As the following chart indicates, 8% of the standards were scored as “Partially Met,” and 1% of the standards scored as “Not Met.” The chart that follows provides a comparison of Molina’s current review results to the 2016 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review, as well as specific strengths, weaknesses, any applicable corrective action items and recommendations can be found further in the narrative of this report.

Administration:

Molina has an experienced and qualified executive leadership team in place. The only weakness is in behavioral health because Molina does not yet have a South Carolina board certified psychiatrist on staff and the position for Behavioral Health Coordinator is vacant. Policies and procedures are reviewed on an annual basis and the line of business to which they apply is clearly documented. The Compliance and Fraud, Waste, and Abuse Plans, along with multiple policies and a Code of Conduct define the processes used to enforce, audit, investigate, and report compliance issues. Molina has a training plan in place for staff and providers, along with well-publicized hotline numbers. Molina is capable of meeting contract requirements for claims and receiving enrollment and eligibility files securely. Molina did not submit documentation regarding the results of required biennial audits, the required security audit, or the results of testing the disaster recovery plan.

Provider Services:

Molina's credentialing program is comprehensive and was developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). A review of credentialing and recredentialing files showed the established program is being followed and files contained appropriate documentation.

Molina received "Partially Met' Scores in the areas of provider network adequacy, provider education, and practitioner medical record due to updates that need to be made to policies and/or the *Provider Manual*.

Results of the CCME-conducted *Telephonic Provider Access Study* did not show improvement from the previous year's review. The successful answer rate was 44% for the current year and 48% for the previous year.

Member Services:

The Member Services review demonstrated Molina provides thorough information in the *Member Handbook* to guide members on covered services and how to obtain health care services. All member rights and responsibilities are included in the *Member Handbook*. The call center (Contact Center) consistently meets or surpasses goals for abandonment rate, speed of answer, and answer within 30 seconds. Recently, Molina has been providing additional education to this staff about grievance categories and the distinction between a grievance and an appeal. Molina reports grievances related to access and availability continue to reflect the highest percentage of grievances. Grievances are managed in a timely fashion for acknowledgement and resolution, with appropriate member letters. There is a lack of detail provided in the policies regarding which staff is responsible for deciding grievances of a clinical nature.

Quality Improvement:

Molina has procedures and process in place for measuring and improving the care and services received by its members and providers. The HEDIS performance measure rates were compared to the 2015 HEDIS rates, with one rate having a noticeable decline in score (more than a 10% decrease), which was 30-day Follow Up after Hospitalization for Mental Illness. Molina submitted three projects for validation. Two of the projects scored within the "High Confidence" range and one project scored within the "Confidence" range. The lower scores in the projects were due to errors found in the documentation of project results.

Utilization Management:

Molina's Healthcare Services (HCS) Program is comprised of Care Access and Monitoring, the Transitions Program, and the Case Management Program. The *Healthcare Services Program Description*, policies, and procedures define requirements and processes, which serve as resources for staff in the performance of functions. Issues were noted in documentation of utilization management and appeal processes and requirements in policies, the *Member Handbook*, and the *Provider Manual*. However, review of approval, denial, appeal, and case management files reflected these functions are handled appropriately.

Molina implemented a process to review and edit appeal resolution letters for appropriate language prior to mailing to providers and members. Since several initial notice of action letters contained acronyms and/or abbreviations that members may not understand, CCME encourages Molina to adopt a similar process to review initial notice of action letters prior to mailing.

Molina has developed a Preferred Provider Program to meet the requirements of the *SCDHHS Contract, Section 8.4.2.7*. However, currently no providers have received Preferred Provider status due to the large number of procedures performed by PCPs in their offices which require no prior authorization. When a provider does achieve the Preferred Provider designation, a process is in place to conduct continued monitoring of quality and UM performance metrics at defined intervals to determine the provider's eligibility to continue in the program.

Delegation:

Molina delegates credentialing and recredentialing functions to various entities. Primary source verification for credentialing/recredentialing is delegated to Aperture, an accredited credentialing verification organization. Appropriate processes are in place for delegation initiation and oversight.

State Mandated Services:

Molina provides members with all core benefits required by the *SCDHHS Contract*. Provider compliance with provisions of required Early and Periodic Screening, Diagnostic and Treatment services, including immunizations, are routinely monitored via medical record audits.

A deficiency related to the required biennial security audit, its reports, and corresponding corrective action plan from the previous external quality review was not addressed.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2016 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2016	30	2	1	0	0	33
2017	30	2	1	0	0	33

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Provider Services						
2016	65	6	4	0	0	75
2017	69	5	1	0	0	75
Member Services						
2016	31	6	0	0	0	37
2017	35	2	0	0	0	37
Quality Improvement						
2016	13	2	0	0	0	15
2017	13	2	0	0	0	15
Utilization						
2016	35	3	0	0	0	38
2017	33	5	0	0	0	38
Delegation						
2016	2	0	0	0	0	2
2017	2	0	0	0	0	2
State Mandated Services						
2016	3	0	1	0	0	4
2017	3	0	1	0	0	4

METHODOLOGY

The process used by CCME for the EQR activities was based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) 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 January 9, 2017, CCME sent notification to Molina advising the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Molina to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on January 23, 2017 and reviewed in the offices of CCME (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 an onsite review conducted on March 2, 2017 and March 3, 2017 at Molina's office in Charleston, SC. 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 findings of the EQR are summarized below and are based on the regulations set forth in *title 42 of the Code of Federal Regulations (CFR), part 438*, 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 in the tabular spreadsheet (Attachment 4).

A. Administration

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance, and confidentiality (HIPAA Privacy Practices).

Molina South Carolina is part of Molina Healthcare, Inc. based in Long Beach, California, and has the support of the parent company for various functions. Tom Lindquist is the Plan President and oversees day-to-day business activities. He reports to the Board of Directors and Regional Senior Vice-President. The Chief Medical Officer and Vice-President of Medical Affairs is Dr. Cheryl Shafer, Internal Medicine. She is supported by two other Medical Directors, Dr. Delores Baker, Ob-Gyn, and Dr. Richard Shroud, Pediatrician. The organization chart also includes Dr. Nikitas Thomarios who is a licensed psychiatrist in the states of Minnesota and North Carolina. He applied for his South Carolina license, but it was not in effect at the time of this review. The position for Behavioral Health Director was filled following our previous review. However, it has been vacant again since November 2016. Leadership in the area of behavioral health remains a weakness for Molina.

The Compliance Department is led by Compliance Director, Ms. Jamilah Deans-Muhammad, who is responsible for verifying Molina complies with all federal and state requirements for Program Integrity. Her responsibilities include, but are not limited to, conducting initial and annual training in compliance, fraud, waste, and abuse, HIPAA training, chairing the Compliance Committee, confirming access for members and employees to report without fear of retaliation, promoting open communication, and managing the monitoring, audits, inquiries, and investigations of compliance matters. The Compliance Committee meets no less than quarterly and a quorum is defined in the committee charter. There were some discrepancies noted in documentation regarding the number of members and composition of the Compliance Committee.

Molina has systems and processes in place to make certain appropriate claims payment functions occur. Molina demonstrated 91% of claims are processed within 30 days and 99.46% of claims are processed within 90 days. Molina is capable of meeting the requirements of updating the eligibility/enrollment databases and handling 834 transactions. Molina meets the formats and methods specified by HIPAA and SCDHHS.

ISCA documentation demonstrates Molina's ability to provide the required reports and meet contractual obligations. However, evidence of the required biennial audit, resulting reports, and corresponding corrective action plan was not submitted. No evidence of the required security audit prior to June 30, 2016 was provided. This remains an uncorrected finding from the previous EQR.

Molina provided documentation of a detailed disaster/business continuity plan stating, "Molina performs disaster recovery testing at least once each year to ensure the current DR process is up to date and is working as expected. Any anomalies are remediated and retested if appropriate to ensure success." However, no documentation was presented describing testing of the plan, testing results, or any revisions made to the plan based on testing.

As indicated in Figure 2, for the Administration findings, 91% of the standards were scored as "Met". Scores of "Partially Met" are related to lack of documentation in the disaster recovery plan testing along with inconsistent Compliance Committee membership. Scores of "Not Met" were related to conducting required biennial audits.

Figure 2: Administration Findings

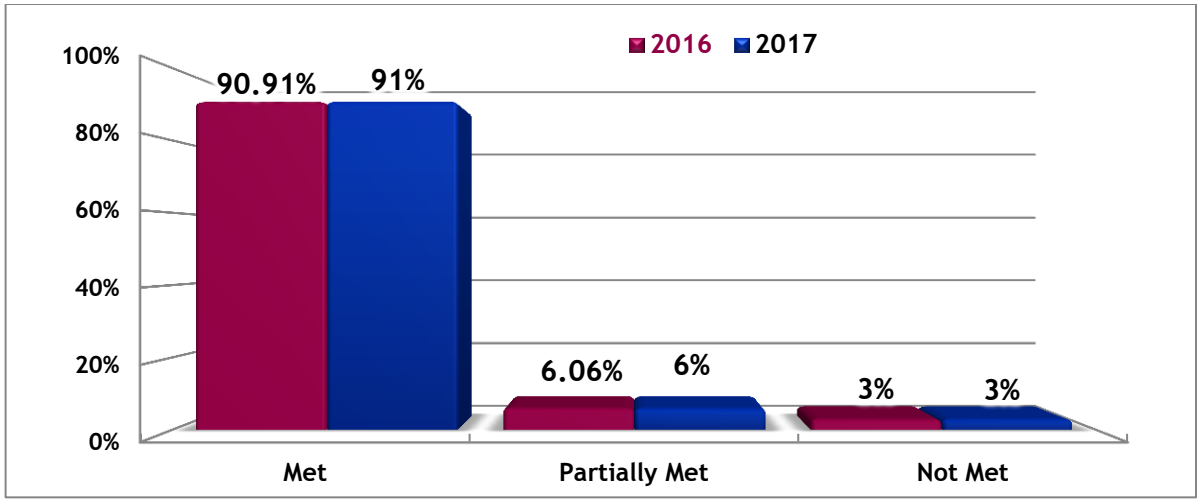


Table 2: Administration Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Organizational Chart / Staffing	Behavioral Health Coordinator	Partially Met	Met
Management Information Systems	The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met	Partially Met
	The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	Met	Partially Met
Compliance/ Program Integrity	The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Compliance and Fraud, Waste, and Abuse Plans are updated and strengthened as contract changes are implemented.

- Executive leadership and staffing levels are sufficient for the provision of care and services required by Molina's contract with SCDHHS.
- Molina's ISCA documentation demonstrates the ability to provide the required reports and meet its contractual obligations.

Weaknesses

- The position for Behavioral Health Director is vacant at this time.
- Dr. Nickitas Thomarios, Psychiatrist, is in the process of obtaining his South Carolina license. He is a licensed as a Psychiatrist in Minnesota and North Carolina. The *SCDHHS Contract Section 2.2, Exhibit 1*, states "the Contractor shall have a board certified psychiatrist in the State of South Carolina who has at least 3 years combined experience in mental health and substance abuse services."
- Molina has not supplied evidence of the required biennial audit, its reports, or corresponding corrective action plan.
- No documentation is presented describing testing of the disaster recovery plan, the results of the testing, and any revisions made to the plan based on testing.
- The Compliance Plan includes the plan is reviewed periodically, however, Policy MHSC COM – 09, Review of Compliance Program, states the plan is reviewed annually.
- The membership listings and numbers of members on the Compliance Committee was inconsistent in following documents:
  - 2016 Medicaid QI Program Description, Appendix B
  - The Compliance Plan, page 10
  - The Compliance Committee Membership Matrix

Quality Improvement Plans

- A security audit needs to be performed by an independent third party as required. The resulting audit report and corrective action plan will need to be submitted. Schedule biennial security audits going forward.
- Testing and resulting documentation of the Disaster Recovery plan is to be provided.
- Update the following documents with consistent information on Compliance Committee membership and the number of members on the committee:
  - 2016 Medicaid QI Program Description, Appendix B
  - The Compliance Plan, page 10
  - The Compliance Committee Membership Matrix

Recommendations

- Fill the position for the Behavioral Health Director as soon as possible.
- Make certain Dr. Thomarios obtains his South Carolina State licensure.
- Confirm the timeframe for regular review of the Compliance Plan is consistent in the Program Description and Policy COM - 09, Review of Compliance Program.

B. Provider Services

A review of all policies, the provider agreement, provider training and educational materials, the provider network information, credentialing files, and practice guidelines was conducted for Provider Services.

The Peer Review & Credentialing Committee (PRC) is the oversight committee for the provider credentialing program. The PRC also provides peer review for certain quality of care concerns. The PRC is chaired by the Medical Director, Dr. Delores Baker, with Chief Medical Officer, Cheryl Shafer, serving as back up to the committee chair. Additional voting members include Medical Director, Dr. Nickitas Thomarios, and four network providers. Specialties represented on the committee include OB/GYN, internal medicine, pediatrics, cardiology, and psychiatry. Additional non-voting employees of Molina attend the meetings as well. The PRC Charter states a quorum is met with the presence of three network physician members and a review of committee minutes showed that a quorum was met at all the meetings reviewed.

The credentialing and recredentialing program is defined in Policy MHSC CR-01, Credentialing Program Policy. The credentialing program was developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The credentialing program is reviewed annually and updated, as needed. A review of credentialing and recredentialing files showed the established program is being followed and files contained appropriate documentation.

A few updates to policies and the *Provider Manual* were identified and are discussed in the “Weaknesses” section.

Provider Access and Availability Study

As a part of the annual EQR process for Molina, a *Telephonic Provider Access Study* was performed focusing on primary care providers. A list of current providers was given to CCME by Molina, from which a sample of 305 providers was randomly selected for the access study. Attempts were made to contact these providers to ask a series of questions regarding access members have with the contracted providers.

Calls were successfully answered 44% of the time (135 out of the 305 providers), which estimates between 39% and 49% for the entire population. When compared to last year's results of 48%, this year's study proportion decreased from the previous measure, but was statistically unchanged.

Of the 170 calls not answered successfully (n= 170),

- 82 (48%) said the physician was not at the phone number listed or are no longer at the practice.
- 26 (15%) of the calls, a voicemail message answered the call requesting the caller to leave a message.
- 20 (12%) of the calls, the caller was informed this was the wrong phone number or the caller was transferred to the wrong phone number.
- 12 (7%) of the calls, the phone was disconnected or not in service.

Out of the successful calls (n=135), 107 (79%) of the providers indicated they specifically accept Molina as a health plan. Of those indicating they accept the plan (n=107), 72 (67%) of the providers responded they are accepting new Medicaid patients.

When asked about any screening process for new patients, 36 (50%) of the 72 providers accepting new patients indicated an application or prescreen was necessary. Four (11%) of those with a prescreening process require both an application and review of the medical record before accepting the patient. When the office was asked about the next available routine appointment, 58 of the 135 providers (43%) indicated appointments met contract requirements. It is recommended Molina look for barriers in the update process so that having up-to-date provider contact information for members is not an issue.

Figure 3, Provider Services Findings, shows that 92% of the standards in Provider Services were scored as "Met". *Table 3, Provider Services Comparative Data,* highlights standards showing a change in score from 2016 to 2017.

Figure 3: Provider Services Findings

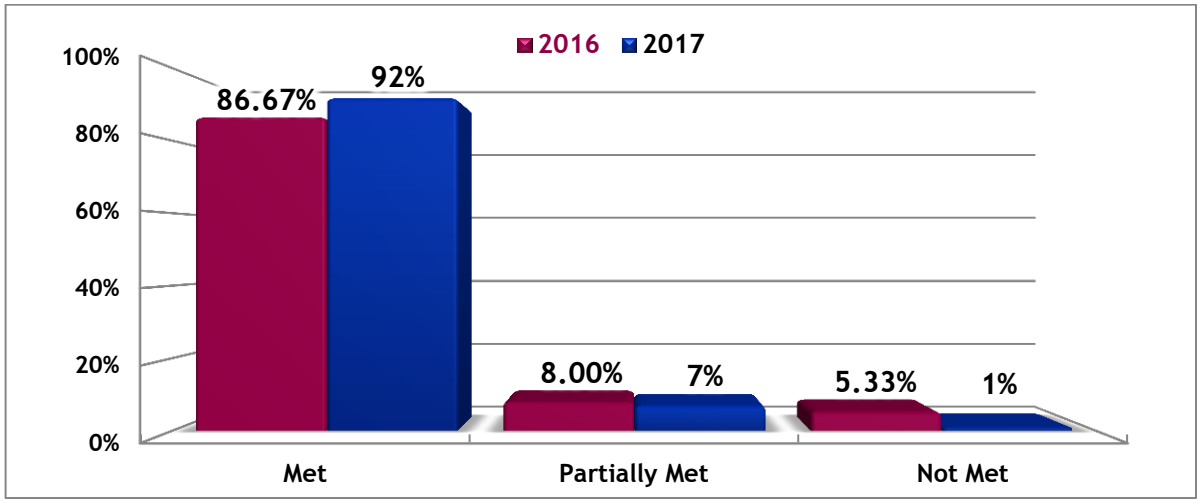


Table 3: Provider Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	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	Partially Met	Met
	Ownership Disclosure form	Partially Met	Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Partially Met	Met
Adequacy of the Provider Network	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	Met	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Adequacy of the Provider Network	The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met	Met
	Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Partially Met
	The MCO maintains a provider directory that includes all requirements outlined in the contract	Partially Met	Met
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met
Primary and Secondary Preventive Health Guidelines	The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Not Met	Met
	The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	Not Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data	Not Met	Met
Practitioner Medical Records	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	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Overall, the credentialing program is well-established and the credentialing/ recredentialing files were in good order and contained appropriate information.
- New provider education includes an orientation with comprehensive materials conducted by provider services representatives. In addition, the Molina website provider portal contains good resource information for navigating the plan.

Weaknesses

- Policy MHSC-PC-011, Availability of Health Care, does not include the member-to-provider ratios for behavioral health providers as addressed in the *Practitioner Availability and Network Adequacy Analysis* (report date 10/6/16).
- The *Provider Manual*, page 41, mentions the *Cultural Competency Plan* and states providers may use links on the Molina website to obtain the full *Cultural Competency Plan*. However, the information could not be found.
- Policy MHSC-PS-005 has the follow issues:
  - It does not address the availability standards for behavioral health or for specialists.
  - It does not explain the process for how Molina assesses provider availability and after hour's standards (i.e. phone calls, paper survey, etc.).
- The *Medicaid Provider Orientation* does not mention standards for specialists; and lists the office wait time as "not to exceed 30 minutes" when Policy MHSC-PS-005 and the *Provider Manual* state the wait time as "not to exceed 45 minutes".
- The *Provider Manual* does not mention the HEDIS measure for behavioral health, "Follow up of an acute BH hospitalization with a BH provider who can prescribe medications within 7 days post discharge" that is listed on slide 31 of the *Medicaid Provider Orientation*.
- For appointments, the *Provider Manual*, page 28, shows the routine specialty care standard as "within 12 weeks". However, the *Practitioner Availability and Network Adequacy Analysis* (report date 10/6/16), page 4, shows the specialty care standard as being measured "within 4 weeks".
- The *Telephonic Provider Access Study* conducted by CCME revealed a decrease compared to last year's results (from 48% previous review to 44% this review), but was, statistically, unchanged.
- The *Provider Manual* had the following issues:
  - Page 16 shows $3.40 copay for ambulatory surgical center
  - Page 17 shows $3.40 copay for durable medical equipment

- Page 17 shows $3.30 copay for home health services
- Page 19 for prescription drugs/pharmacy states, "Special Note- no copay for children under age 18 and pregnant women". However, it should state "age 19" instead of "age 18" because the coverage applies to age 18 and under.
- Page 19 does not show any coverage information for podiatry services
- Page 20 does not show specific coverage information for vision services/optometrists. The website states age 21+ glasses every two years; age 20 and under glasses every year if needed.

- Policy MHSC QI 120.000, Standards of Medical Record Documentation, states, "The Provider is responsible to retain their records for at least ten (10) years for adult patients and at least thirteen (13) years for minors." However, medical record retention requirements are not addressed in the *Provider Manual*.

Quality Improvement Plans

- Update Policy MHSC-PC-011, Availability of Health Care, to include the member-to-provider ratios for behavioral health providers addressed in the *Practitioner Availability and Network Adequacy Analysis* (report date 10/6/16).
- Ensure the full *Cultural Competency Plan* is listed on the website as stated in the *Provider Ma*nual, page 41.
- Update Policy MHSC-PS-005 to include the availability standards for behavioral health and for specialists. Also, explain the process for how Molina assesses provider availability and after hour's standards (i.e. phone calls, paper survey, etc.).
- Correct the discrepancy in the *Medicaid Provider Orientation* or Policy MHSC-PS-005 and the *Provider Manual* regarding office wait time.
- Update the *Provider Manual* to include the HEDIS measure for behavioral health, "Follow up of an acute BH hospitalization with a BH provider who can prescribe medications within 7 days post discharge" listed on slide 31 of the *Medicaid Provider Orientation*.
- Address the discrepancy between the *Provider Manual* and the *Practitioner Availability and Network Adequacy Analysis* (report date 10/6/16) regarding the timeframe for routine specialty care appointments.
- Regarding members' access to their providers, look for barriers in the update process so that having up-to-date provider contact information for members is not an issue.
- Correct the member benefit information in the *Provider Manual* for home health, DME, ambulatory surgical, and prescription drugs/pharmacy. Add additional information to podiatry and vision services/optometrists.

- Update the *Provider Manual* to address the medical record retention requirements defined in Policy MHSC QI 120.000, Standards of Medical Record Documentation.

Recommendations

- Ensure Policy MHSC CR-01 contains consistent information on pages 20 and 28 regarding disclosure of ownership.

C. Member Services

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. Molina mails a welcome packet with educational materials and ID card within 14 days from the date the eligibility file was received. The *Member Handbook* includes Member Rights and Responsibilities, the *Notice of Privacy Practices*, and a multilingual, non-discrimination document explaining translation services available. The *Member Handbook* is presented in an easily understood format and is available in Spanish or alternate formats upon request. The *Member Handbook* contains a thorough listing of covered services. Additionally, it provides detailed information on obtaining prescriptions and emergency/urgent care. The *Member Handbook* could be improved by adding additional information on the components of well-child/EPSDT services and how important adhering to the recommended schedule is for a child's health.

Call center (Contact Center) data meets or surpasses contract requirements for speed of answer, abandonment rate, and calls answered within 30 seconds. Members are provided toll-free phone numbers for access to Member Services, reporting fraud, waste, and abuse, care management, WIC, and SCDHHS.

A review of the grievance files show Molina provides assistance to members in filing, acknowledges grievances, and provides resolution within contract timeliness guidelines and Molina's policies. The method Molina uses to resolve quality of care or service grievances is of concern, particularly because the Medical Director was not involved in the resolution of a grievance involving care received from a provider where member safety could have been compromised. The policy does not address the circumstances when a medical director is consulted as part of the grievance resolution. The documentation of the steps taken to resolve grievances was documented in most files.

Figure 4: Member Services Findings demonstrates that 95% of the standards for Member Services were scored as "Met". Scores of "Partially Met" were related to information on EPSDT in the *Member Handbook* and grievance policies regarding the handling of quality of care grievances.

Figure 4: Member Services Findings

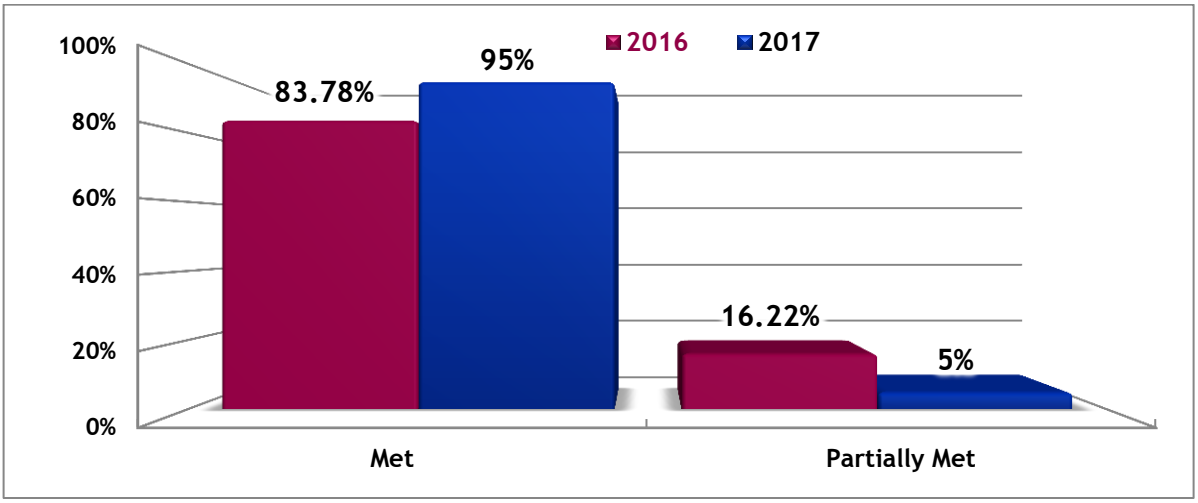


Table 4: Member Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Preventive Health and Chronic Disease Management Education	The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits	Partially Met	Met
	The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program	Partially Met	Met
Grievances	The procedure for filing and handling a grievance	Partially Met	Met
	Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	Met	Partially Met
	The MCO applies the grievance policy and procedure as formulated	Partially Met	Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Grievances	Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- The Molina Member Handbook includes nearly all the required information as defined in the *SCDHHS Contract*.
- Call Center data metrics meet or surpass both *SCDHHS Contract* requirements and Molina's goals.
- Molina identifies pregnant members, provides education through the Motherhood Matters® Pregnancy Program, and assesses for high-risk case management needs.

Weaknesses

- The *Member Handbook* does not inform parents about some of the components of a well-child exam including Psychosocial and Behavioral Assessments, Nutritional Assessment, Growth and development (weight, height, BMI, Blood Pressure), or oral health. Finally, it does not stress the importance of these visits or any incentives Molina offers for completion.
- Onsite discussion revealed that members calling the Member Services department after-hours or on weekends receive instructions to call a different number to reach the Nurse Advice Line or they can leave a message. The automated prompts do not include an option to talk directly to a nurse or clinician.
- Policy MHSC-MIRR-001, Grievance Disposition Process, does not define when a medical director is consulted as part of grievance resolution. For example, are grievances regarding clinical quality of care or service, grievances regarding the denial of an expedited appeal, or all grievances related to the delivery of medical care decided with input from a medical director?
- One quality of care concern regarding inappropriate behavior by a provider was not sent to the Medical Director for review and not handled in a timely fashion considering the possible risk to member safety.
- Molina's analysis indicates the majority of grievances are related to the Access and Availability category. Molina is analyzing specific access and availability components to help identify specific provider types that members are having difficulty accessing. This remains an ongoing issue.

Quality Improvement Plans

- Provide additional information in the *Member Handbook* about the components of Well-Child/EPSDT visits. Include any encouragement and any incentives Molina offers for the completion of Well-Child visits.
- Update Policy MHSC-MIRR-001, Grievance Disposition Process, or develop a new policy addressing grievances that would include when a medical director is consulted as part of the resolution.
- Develop a process to train staff handling grievances to identify grievances that require special handling by a medical director or attention sooner than contract requirements to ensure member safety.

Recommendations

- Consider including the capability for calls received in the call-center after-hours or on weekends to provide direct access to the Nurse-Advice line or licensed clinician without having to make a second call.
- Continue to drill into grievance data to identify areas of improvement and weaknesses in the network. Develop strategies to address these issues.

D. Quality Improvement

Molina's *2016 Medicaid Quality Improvement (QI) Program Description* outlines the processes in-place for measuring and improving the care and services received by its members and their providers. Molina monitors provider performance by measuring compliance with some of the adopted clinical and preventative health guidelines. The explanation provided in the *QI Program Description* implies the monitoring is conducted for each guideline. Molina's staff indicated the health plan had chosen specific guidelines to measure and indicated the measures chosen were listed in the *QI Work Plan*. The program description must be corrected to clearly indicate the process for monitoring provider compliance with the guidelines.

Dr. Cheryl Shafer provides support for the quality improvement program and chairs the Quality Improvement Committee. At least annually, the Quality Department is responsible for formally evaluating the effectiveness of the QI program. The program evaluation for 2016 was not received. According to the health plan, the evaluation had not been completed. It is expected to be completed and submitted to the QI Committee during first quarter 2017.

Performance Measure Validation

CCME conducted a validation review of the Health Effectiveness Data Information Set (HEDIS®) performance measures following CMS developed protocols. This process assesses the application of these measures by the health plan to confirm reported information is valid.

Molina uses Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements. The 2016 HEDIS performance measure rates were compared to the 2015 HEDIS rates. Only one rate had a noticeable decline in score (more than a 10% decrease), which was 30-day Follow Up after Hospitalization for Mental Illness. This rate decreased 14% from 66% to 52%. The WCC and CDC measures increased substantially. All relevant HEDIS performance measures are detailed in *Table 5: HEDIS Performance Measure Data*.

Table 5: HEDIS Performance Measure Data

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
PREVENTION AND SCREENING			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Members aged 20-44	78.23%	78.55%	0.33%
Members aged 45-64	88.61%	88.34%	-0.27%
Members aged 65 and older	100.00%	100.00%	0.00%
All members	81.91%	82.16%	0.24%
Adult BMI Assessment (ABA)	NR15	83.59%	N/A
WOMEN'S HEALTH			
Breast Cancer Screening (BCS)	NR15	NR16	N/A
Cervical Cancer Screening (CCS)	47.87%	59.37%	11.49%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	3.91%	3.19%	-0.72%
Chlamydia Screening in Women (CHL)			
Age 16 to 20	49.21%	46.44%	-2.77%
Age 21 to 24	63.99%	61.67%	-2.31%

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
Total	51.92%	49.49%	-2.43%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	15.26%	16.59%	1.33%
Frequency of Ongoing Prenatal Care (FPC)			
More than 81 percent of expected visits	72.00%	79.45%	7.45%
Prenatal and Postpartum Care (PPC)			
Timeliness of prenatal care	90.22%	83.14%	-7.08%
Postpartum care	60.89%	66.05%	5.16%
CHILDREN'S/ADOLESCENT HEALTH			
Adolescent Well-Care Visits (AWC)	33.55%	42.70%	9.15%
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Members 12 to 24 Months of Age	93.71%	97.48%	3.77%
Members 25 Months to 6 Years of Age	84.59%	86.10%	1.50%
Members 7 to 11 Years of Age	NR15	89.24%	N/A
Members 12 to 19 Years of Age	NR15	87.54%	N/A
Childhood Immunization Status (CIS)			
DTaP Immunizations	69.70%	66.89%	-2.81%
OPV/IPV Immunizations	80.13%	86.31%	6.18%
Measles Mumps and Rubella Immunizations	83.84%	83.66%	-0.17%
H Influenza Type B Immunizations	80.81%	79.91%	-0.90%
Hepatitis B Immunizations	76.77%	85.87%	9.10%
Chicken Pox Immunization	85.86%	86.09%	0.23%
Pneumococcal Conjugate	72.73%	70.64%	-2.09%
Hepatitis A Immunizations	82.49%	80.57%	-1.92%

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
Rotavirus Immunizations	68.01%	69.09%	1.08%
Influenza Immunizations	36.36%	34.22%	-2.15%
Combination 2 Immunizations	62.63%	62.03%	-0.60%
Combination 3 Immunizations	59.93%	59.60%	-0.33%
Combination 4 Immunizations	58.25%	57.62%	-0.63%
Combination 5 Immunizations	50.51%	50.77%	0.27%
Combination 6 Immunizations	29.29%	26.49%	-2.80%
Combination 7 Immunizations	49.49%	49.67%	0.17%
Combination 8 Immunizations	29.29%	26.27%	-3.02%
Combination 9 Immunizations	24.92%	22.96%	-1.96%
Combination 10 Immunizations	24.92%	22.96%	-1.96%
Lead Screening in Children (LSC)	54.88%	61.37%	6.49%
Immunizations for Adolescents (IMA)			
Meningococcal	62.69%	63.94%	1.24%
Tdap/Td	84.33%	81.64%	-2.69%
Combo 1	61.81%	62.17%	0.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Screening - 3 to 11	33.10%	59.41%	26.30%
BMI Screening - 12 to 17	47.24%	60.00%	12.76%
BMI Screening - Total	38.19%	59.60%	21.41%
Counseling on Nutrition - 3 to 11	40.34%	46.86%	6.52%
Counseling on Nutrition - 12 to 17	36.20%	48.00%	11.80%
Counseling on Nutrition - Total	38.85%	47.24%	8.39%

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
Counseling on Physical Activity - 3 to 11	32.41%	39.60%	7.19%
Counseling on Physical Activity - 12 to 17	33.13%	44.67%	11.54%
Counseling on Physical Activity - Total	32.67%	41.28%	8.61%
Well-Child Visits in the First 15 Months of Life (W15)			
Six or more well-child visits	NR15	58.50%	N/A
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	54.53%	56.89%	2.36%
RESPIRATORY CONDITIONS			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	21.84%	23.80%	1.96%
Appropriate Testing for Children With Pharyngitis (CWP)	74.83%	74.19%	-0.64%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	78.66%	81.50%	2.84%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	NR15	NR16	
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroids	57.19%	61.28%	4.09%
Bronchodilator	70.14%	74.41%	4.27%
Medication Management for People With Asthma (MMA)			
Age 5 to 11 50% Covered	NR15	51.64%	N/A
Age 5 to 11 75% Covered	NR15	22.18%	N/A
Age 12 to 18 50% Covered	NR15	47.32%	N/A
Age 12 to 18 75% Covered	NR15	18.58%	N/A
Age 19 to 50 50% Covered	NR15	52.53%	N/A
Age 19 to 50 75% Covered	NR15	34.34%	N/A
Age 51 to 64 50% Covered	NR15	69.23%	N/A

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
Age 51 to 64 75% Covered	NR15	51.28%	N/A
Total Population 50% Covered	NR15	50.66%	N/A
Total Population 75% Covered	NR15	22.49%	N/A
Asthma Medication Ratio (AMR)			
Age 5 to 11 Ratio > 50%	NR15	74.18%	N/A
Age 12 to 18 Ratio > 50%	NR15	61.42%	N/A
Age 19 to 50 Ratio > 50%	NR15	46.36%	N/A
Age 51 to 64 Ratio > 50%	NR15	46.67%	N/A
Total Population Ratio > 50%	NR15	66.38%	N/A
CARDIOVASCULAR CONDITIONS			
Controlling High Blood Pressure (CBP)	48.79%	48.88%	0.09%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NR15	81.82%	N/A
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
Adherence Males	NA	77.61%	N/A
Adherence Females	NA	72.36%	N/A
Statin Therapy Females	NA	73.21%	N/A
Statin Therapy Males	NA	65.69%	N/A
Total Adherence	NA	75.10%	N/A
Total Statin Therapy	NA	69.09%	N/A
MEDICATION MANAGEMENT			
Annual Monitoring for Patients on Persistent Medications (MPM)			
ACE or ARB	87.23%	89.19%	1.96%
Digoxin	46.67%	44.83%	-1.84%
Diuretics	87.72%	89.31%	1.59%

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
Total	87.09%	88.88%	1.79%
DIABETES			
Comprehensive Diabetes Care (CDC)			
HbA1c Testing	88.96%	90.95%	1.99%
HbA1c Poor Control (>9)	57.40%	43.49%	-13.91%
HbA1c Adequate Control (<8)	35.54%	46.80%	11.26%
Eye Exam	27.81%	50.33%	22.52%
Monitoring for Nephropathy	83.00%	93.82%	10.82%
Blood Pressure Control (<140/90)	47.02%	52.32%	5.30%
Statin Therapy for Patients With Diabetes (SPD)			
Statin Adherence	NA	47.43%	N/A
Received Statin Therapy	NA	55.96%	N/A
MUSCULOSKELETAL CONDITIONS			
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	64.04%	70.30%	6.25%
Use of Imaging Studies for Low Back Pain (LBP)	71.68%	71.49%	-0.19%
BEHAVIORAL HEALTH			
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	50.00%	40.56%	-9.44%
Effective Continuation Phase Treatment	31.37%	25.67%	-5.70%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	NR15	42.11%	N/A
Continuation Phase	NR15	55.72%	N/A
Follow-Up After Hospitalization for Mental Illness (FUH)			
30 Days	65.72%	52.02%	-13.70%

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
7 Days	42.81%	35.24%	-7.57%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	83.11%	81.27%	-1.85%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	66.30%	62.37%	-3.94%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NR15	72.73%	N/A
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	66.41%	58.89%	-7.51%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)			
Initiation (13 to 17)	36.63%	38.58%	1.95%
Initiation (18+)	35.58%	37.02%	1.44%
Initiation (Total)	35.72%	37.19%	1.47%
Engagement (13 to 17)	21.29%	17.77%	-3.52%
Engagement (18+)	7.12%	7.46%	0.34%
Engagement (Total)	8.98%	8.61%	-0.36%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)			
1-5 years	NR15	NR16	N/A
6-11 years	NR15	2.86%	N/A
12-17 years	8.00%	0.56%	-7.44%
Total	6.67%	1.41%	-5.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
1-5 years	NR15	NR16	N/A
6-11 years	18.33%	14.29%	-4.05%
12-17 years	20.46%	21.33%	0.87%
Total	19.47%	18.53%	-0.94%

MEASURE/SUBMEASURE	HEDIS 2015 Rates	HEDIS 2016 Rates	PERCENTAGE POINT DIFFERENCE
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1-5 years	NR15	NR16	N/A
6-11 years	50.00%	62.12%	12.12%
12-17 years	47.06%	60.22%	13.16%
Total	48.15%	61.49%	13.34%

Performance Improvement Project Validation

The validation of the performance improvement projects (PIPs) was done in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0*, September 2012. 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

Three projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. They included Breast Cancer Screening, Well Care Program, and Provider Data Management. *Table 6, Performance Improvement Project Validation Scores*, provides an overview of each projects' scores.

TABLE 6: Performance Improvement Project Validation Scores

PROJECT	2016 VALIDATION SCORE	2017 VALIDATION SCORE
Breast Cancer Screening (Mobile Mammography Program)	59/95=62% Low Confidence	96/96=100% High Confidence
Well Care Program	69/90=77% Confidence	125/131= 95% High Confidence

PROJECT	2016 VALIDATION SCORE	2017 VALIDATION SCORE
Provider Data Management	70/76 = 92% High Confidence	73/88= 83% Confidence

All three projects had a justified rationale using the analysis of data. Research questions were stated clearly. The interventions were applicable to the project goals. The Provider Data Management PIP rates were near goal (0%) for three of the four measures. The Well Care Program and Breast Cancer Screening PIPs also noted increases in rates, although the results were not legible on several pages of the documentation for both of the PIPS. Documentation is to be revised to make certain the reader can clearly view all images and information presented. The following table lists the specific errors by project along with recommendations.

TABLE 7: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Well Care Program	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented on pages 21-23. The benchmark is listed as baseline rate. This should not be the case. The benchmark is the industry measure of best performance and is typically based on published data.	Revise the results table to reflect a benchmark goal for each measure considered the best performance for Molina, not the baseline measurement rate.
	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis for CY 2015 measures was not provided. The information on pages 25 and 26 of documentation displays information about incentives, but does not offer a description of the analysis of the data.	At the end of the results Table, provide an interpretation of the rate change from year to year in Section III.A.

Project	Section	Reasoning	Recommendation
Provider Data Management	Did the study use objective, clearly defined, measurable indicators?	Quantifiable Measures are defined on pages three and four. The numerator and denominator are defined. The baseline goal and benchmark goal are not clearly presented. The baseline goal is a goal above the known current rate. The benchmark is the industry measure of best performance and is typically based on published data. In this case, the benchmark is the lowest rate for each measure, as lower is better.	Adjust the table on pages three and four so the benchmark goal is reflective of the measure of best performance considered by Molina. The baseline goal is higher than the benchmark goal, as lower is better.
	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented on page eight. The time period measurements are varied and are listed as one day (1/2/2016 and 1/2/2017) which is misleading. Denominators and benchmark goals are not included in the results table documentation.	Include the start date and end date for Re-measurements three and four in the time periods in Table on page 8. Include denominator and benchmark goal in the results table for each measure so rates can be validated.

Details of the validation of the performance measures and Performance Improvement Projects are found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 5, Quality Improvement Findings, indicate that 87% of the standards received a "Met" score.

Figure 5: Quality Improvement Findings

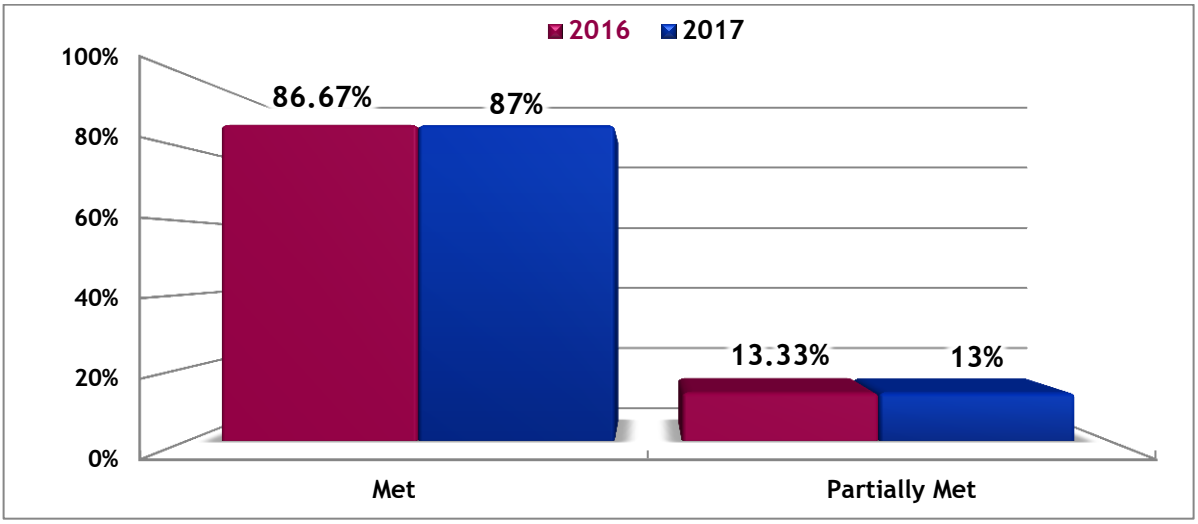


TABLE 8: Quality Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Quality Improvement Program	The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	Met	Partially Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Performance Improvement Projects employ sound methodology with rates improving.
- HEDIS rates are improving for most measures, with substantial improvement in the WCC and CDC measures.

Weaknesses

- The *QI Program Description* incorrectly implies Molina is measuring provider compliance with each of the clinical and preventative practice guideline.
- The committee minutes reviewed demonstrated the Quality Improvement Committee met regularly. However, meeting frequency was not included in the committee charter.

- The HEDIS measure 30-day Follow Up after Hospitalization for Mental Illness decreased 14% from 66% last year to 52% this year. It is recommended this measure be evaluated closely, with action plans to increase that rate generated and implemented.
- The performance improvement project documentation did not include a clear presentation of the results and findings or an analysis of the rates year to year for each measure.

Quality Improvement Plan

- Update the *QI Program Description* to clearly reflect the monitoring conducted to assess provider compliance with the clinical and preventive practice guidelines. If the health plan has chosen specific guidelines to measure, the program description should indicate that.
- Correct the errors identified in the performance improvement project documentation.

Recommendation

- Update the Quality Improvement Committee charter to include meeting frequency.

E. Utilization Management

Molina's Healthcare Services (HCS) Program is comprised of Care Access and Monitoring (CAM) (formerly known as Utilization Management), the Transitions Program, and the Case Management Program. The *Healthcare Services Program Description*, along with established policies and procedures, defines utilization management (UM) and case management (CM) requirements and processes, and guides staff in the performance of CAM and CM functions. The HCS Program is reviewed, evaluated, and updated annually under the direction of the Health Care Services Committee (HCSC) and Quality Improvement Committee (QIC).

HCS activities are coordinated and conducted under the direction of the Chief Medical Officer (CMO), Dr. Cheryl Schafer, and the Vice President of Healthcare Services, Debra Enigl. Associate Medical Directors include Delores Baker, MD, Robert Shrouds, MD, and Nikitas Thomarios, D.O. The behavioral health (BH) Associate Medical Director, Dr. Thomarios, serves as the designated behavioral health care practitioner with involvement in the implementation of the behavioral health care aspects of the CAM Program. Pharmacy services are coordinated and conducted under the direction of the CMO and the Director of Pharmacy Services, Adrienne Matthews, PharmD.

As required by the *SCDHHS Contract, Section 8.4.2.7*, Molina has developed a Preferred Provider Program which, based on performance, offers increased member assignment and a reduction or simplification of prior authorization requirements. Providers who achieve

the Preferred Provider designation are subject to continued monitoring of quality and UM performance metrics at defined intervals to continue participation in the program. Onsite discussion revealed there are currently no providers who have received this designation.

A few issues were noted in documentation of utilization management and appeal processes and requirements in policies, the *Member Handbook*, the *Provider Manual*, etc. Despite these documentation issues, review of approval, denial, and appeal files reflected staff handle authorization and appeals functions appropriately. However, initial denial notice of action letters occasionally contained acronyms and/or abbreviations members may not understand. Of note, Molina implemented a process to review and edit appeal resolution letters for appropriate language prior to mailing to providers and members. CCME encouraged Molina to adopt a similar process for initial notice of action letters to enhance member understanding of letter content. Case management processes are thoroughly and appropriately documented. Review of case management files confirmed staff follows appropriate processes.

As indicated in *Figure 6: Utilization Management Findings*, 87% of the standards in the UM section were scored as "Met." Scores of "Partially Met" are related to documentation of requirements and/or processes for sterilization, post-stabilization services, and appeals. *Table 9: Utilization Management Comparative Data* highlights standards showing a change in score from 2016 to 2017.

Figure 6: Utilization Management Findings

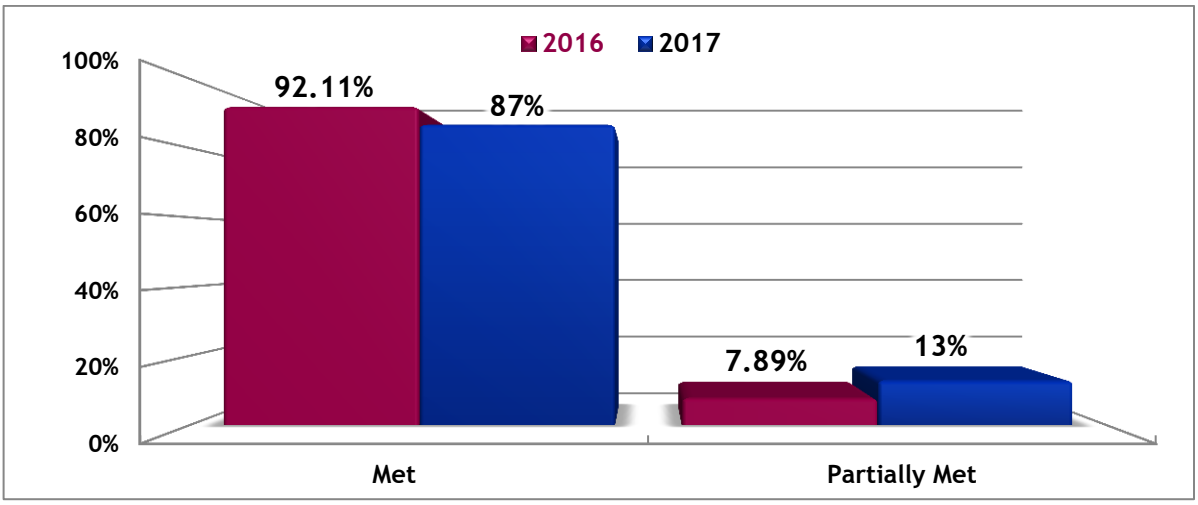


TABLE 9: Utilization Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to the mechanism to provide for a preferred provider program	Partially Met	Met
Medical Necessity Determinations	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Partially Met
	Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Partially Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including the definitions of an action and an appeal and who may file an appeal	Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Approval files reflect when pediatric criteria are not available, staff review adult criteria and include those findings when referring the review to a medical director for determination.
- Processes have been implemented to review and edit appeal resolution letters for appropriate language prior to mailing to providers and members.

Weaknesses

- Policy MHSC HCS-CAM-325, Authorization Process, Section K (1) states, "MHSC will provide notice of the review decision as expeditiously as the member's health condition requires, but no later than the specified timeframes in Table 2." However, there is no Table 2 within the policy.
- Policy MHSC HCS-CAM-365, Clinical Criteria for Utilization Management Decision Making, Section B (page 2), lists the approved resources for clinical criteria in order of hierarchy. Several items in this list do not definitively state the criteria used and could result in staff confusion:
  - McKesson InterQual Criteria or comparable clinical decision support criteria selected for use by Molina Healthcare, Inc.
  - Hayes Technology Assessments or comparable evidence based review products selected for use by Molina Healthcare, Inc.
- The Provider Manual, page 18, states, "Signature of consent on the sterilization consent form must not be more than 180 days old at the time of the procedure." It does not indicate the signature cannot be less than 30 days old except in case of emergency abdominal surgery or premature delivery.
- Policy MHSC HCS-CAM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff, does not include follow-up activities for scores below the established IRR benchmark and does not state to which committees IRR results are reported.
- Policy MHSC HCS-384, Post Service Review – Emergent Care Visits, does not address all requirements for coverage of post-stabilization services.
- The Provider Manual does not address requirements for coverage of post-stabilization services.
- Discrepancies in who may issue a denial determination were noted as follows:
  - Procedure MHSC PHARM-02, Pharmacy Prior Authorization Requests, item B (7), states denials may be issued by a clinical pharmacist, pharmacy director, medical director, or chief medical officer.
  - Procedure MHSC PHARM-02, Pharmacy Prior Authorization Requests, item D (2) (a), states denials may be issued by a clinical pharmacist, medical director, or chief medical officer.
  - Policy MHSC HCS-CAM-325, Authorization Process, Table 1, states denials may be issued by an MD, DO, or PharmD.
- Notice of action letters (initial denials) sometimes contain acronyms and/or abbreviations members may not understand.

- The documentation below contains an incomplete definition of an action. All are missing that an action includes the failure to provide services in a timely manner and the failure of the MCO to act within timeliness guidelines in the disposition of grievances and appeals.
  - The Member Handbook, page 40
  - The Molina website
- The *Member Handbook* contains appropriate information regarding who may file an appeal, but does not indicate providers and others must have consent to file an appeal on the member's behalf.
- The *Member Handbook* does not indicate the member can request to examine the appeal file and other documents related to the appeal.
- The following documents define the timeframe for appeal resolution but fail to indicate the notice of the resolution must be sent within the same timeframe:
  - Policy MHSC-MIRR-02, Standard Appeal Process
  - Policy MHSC-MIRR-03, Expedited Appeal Process
- The *Member Handbook* includes appropriate information regarding continuation of benefits, but because of its placement in the Expedited Appeals section, page 42, the information appears to apply only to expedited appeals.

Quality Improvement Plan

- Revise the *Provider Manual*, page 18, to indicate the signature of consent on the sterilization consent form must be at least 30 days old at the time of the procedure. Refer to the *SCDHHS Policy & Procedure Guide, Section 4.2.28*.
- Update Policy MHSC HCS-384, Post Service Review – Emergent Care Visits, to include all requirements for coverage of post-stabilization services as defined in *Federal Regulation § 422.113 (c)* and the *SCDHHS Contract, Sections 4.6.10* through *4.6.12*.
- Update the *Provider Manual* to include coverage requirements for post-stabilization services. Refer to *Federal Regulation § 422.113 (c)* and the *SCDHHS Contract, Sections 4.6.10* through *4.6.12*.
- Revise the *Member Handbook* and website to contain the complete definition of an action. Refer to the *SCDHHS Contract, Amendment Two, Section 9.1* and *Federal Regulation § 438.400 (b)*.
- Revise the *Member Handbook* to include persons filing an appeal on a member's behalf must have written consent. Refer to the *SCDHHS Contract, Amendment Two, Section 9.1.1*.

- Revise the *Member Handbook* to include members can request to examine the appeal file and other documents related to the appeal. Refer to the *SCDHHS Contract, Amendment Two, Section 9.1.4.4.3*.
- Revise Policies MHSC-MIRR-02 and MHSC-MIRR-03 to indicate the notice of appeal resolution must be sent no later than 30 days from receipt for standard appeals or 72 hours from receipt for expedited appeals. Refer to the *SCDHHS Contract, Amendment Two, Sections 9.1.6.1.2* and *9.1.6.1.3*.

Recommendations

- Revise Policy MHSC HCS-CAM-325 to add the referenced Table 2 or to remove the reference to the table.
- Revise Policy MHSC HCS-CAM-365, Clinical Criteria for Utilization Management Decision Making, page two, to remove the ambiguity from items three and four in the list of approved clinical review criteria.
- Revise Policy MHSC HCS-CAM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff, to include follow-up activities for scores below the benchmark and to define the committees to which IRR results are reported.
- Revise Procedure MHSC PHARM-02, Pharmacy Prior Authorization Requests (items B (7) and D (2) (a)) and Policy MHSC HCS-CAM-325, Authorization Process, to contain consistent information on who may issue denial determinations. Clarify these policies and procedures to indicate pharmacy directors and PharmD staff may issue denials only if they are licensed pharmacists.
- Ensure notice of action letters are written in language members will understand. Avoid the use of acronyms and/or abbreviations.
- Update the *Member Handbook* to clarify information regarding continuation of benefits applies to both standard and expedited appeals.

F. Delegation

Molina's process includes contracting with each delegated entity for the specific processes that are delegated. A sample credentialing delegation addendum was received in the desk materials. *Table 10, Delegated Entities and Services*, shows Molina's delegated entities and services.

Table 10: Delegated Entities and Services

Delegated Entities	Delegated Services
Bon Secours St. Francis (BSSF), Managed Health Resources (MHR), Augusta University (AU), Greenville Hospital System (GHS), Medical	Credentialing/Recredentialing

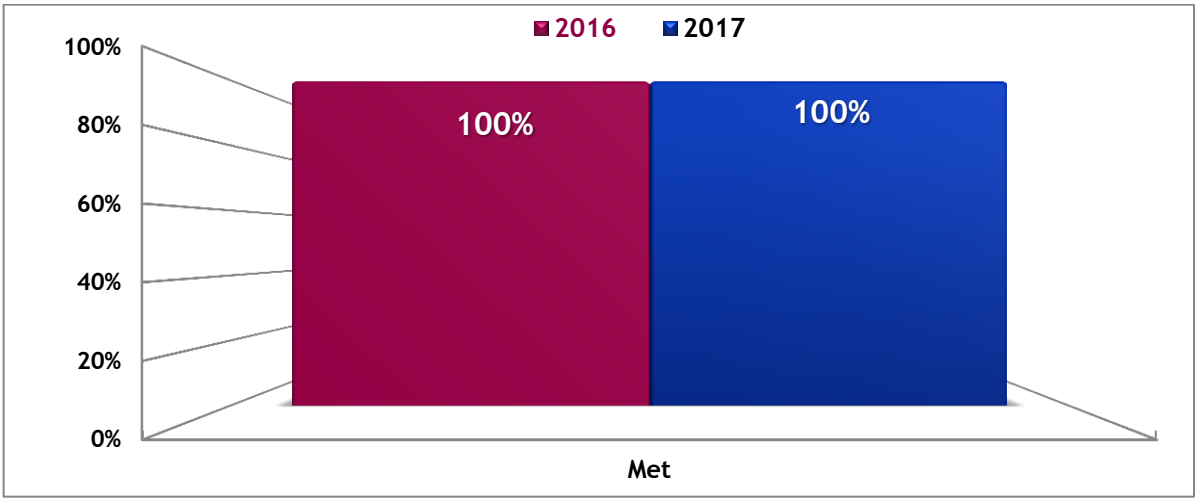
Delegated Entities	Delegated Services
University of South Carolina (MUSC), Preferred Care IPA (PCI),Regional Health Plus (RHP), March Vision Care	
Aperture	Primary Source Verification for Credentialing & Recredentialing

Several policies address delegation which includes pre-assessment audits for entities being considered for delegation and performance monitoring of delegated entities on an annual basis. In addition, delegates report quarterly on the delegated activities. All delegation oversight is monitored and approved by the SC Delegation Oversight Committee. When deficiencies are identified, corrective action plans are implemented with follow-up audits, as appropriate.

Policy MHSC DR-01, Credentialing Program Policy, states the following requirement for delegation, "Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass MHSC's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and SCDHHS regulations and requirements for the Medicaid and Medicare programs, with a score of at least 90%." However, onsite discussion revealed a pre-delegation assessment is conducted for all new delegates. If the entity is NCQA accredited, then the pre-assessment is focused on state requirements. CCME suggested the language be adjusted to reflect a pre-delegation assessment is conducted even if the entity is NCQA accredited.

Evidence of pre-delegation assessment for RHP and annual audits for the remaining delegated entities was received, with corrective action oversight, as appropriate. As indicated in *Figure 7, Delegation Findings*, all the standards in the Delegation section were scored as "Met".

Figure 7: Delegation Findings



Weaknesses

- Policy MHSC DR-01, Credentialing Program Policy, does not reflect that a pre-delegation assessment is conducted even if the delegated entity is NCQA accredited.

Recommendations

- Ensure the language related to delegated credentialing in Policy MHSC DR-01, Credentialing Program Policy, reflects that a pre-delegation assessment is being conducted even if the entity is NCQA accredited.

G. State Mandated Services

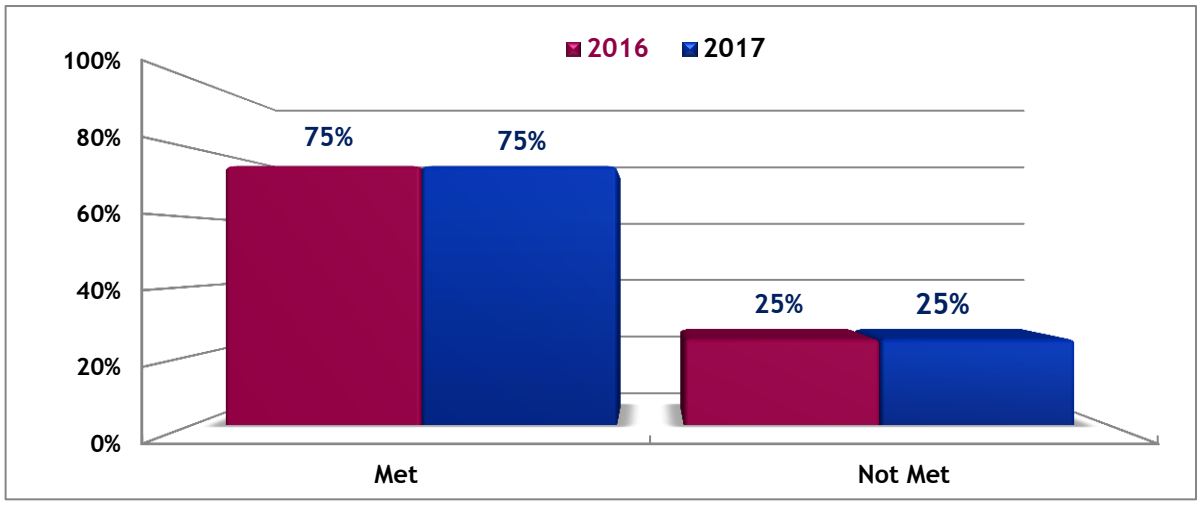
Molina provides members with all core benefits required by the *SCDHHS Contract*.

Providers are informed of the expectation that preventive health guidelines (PHGs) will be followed and EPSDT services will be provided to Molina membership. The guidelines are disseminated to providers via direct mail, newsletters, provider relations representatives, and the Molina website. Molina assesses provider compliance with delivery of EPSDT and preventive health services, annually, through the medical record review process.

The 2017 External Quality Review revealed Molina has not adequately addressed a deficiency noted in the previous EQR regarding supplying evidence of the required biennial security audit, its reports, and corresponding corrective action plan. Also, no evidence is given for the required security audit prior to June 30, 2016.

Molina received a score of "Met" for 75 % of the standards in the State-Mandated Services, as illustrated in *Figure 8, State Mandated Services*.

Figure 8: State Mandated Services



Weaknesses

- The following issue was noted on the previous EQR and has not been corrected:
  - Molina has not supplied evidence of the required biennial security audit, its reports, and corresponding corrective action plan. Also no evidence is given for the required security audit prior to June 30, 2016.

Quality Improvement Plan

- Ensure all deficiencies identified in the external quality review are addressed.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

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

The Carolinas Center *for* Medical Excellence
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

January 9, 2017

Mr. Tom Lindquist
Molina Healthcare of South Carolina
4105 Faber Place Drive, Suite 120
Charleston, SC 29405

Dear Mr. Lindquist:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2017 External Quality Review (EQR) of Molina Healthcare of SC 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 Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **March 2nd and 3rd.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **January 23, 2017.**

Submission of all the desk materials will be different than in the past. This year we have a new secure file transfer website for uploading desk materials electronically to CCME. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance. I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support.

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 2017

MATERIALS REQUESTED FOR DESK REVIEW

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

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

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

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

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization. Please note this information will be used to conduct our telephone access study.

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.

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

10. The Quality Improvement work plans for 2016 and 2017.

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

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

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

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

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

18. A complete list of all members enrolled in the case management program from July 2016 through December 2016. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

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

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

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings.

23. A copy of the Grievance, Complaint and Appeal logs for the months of February 2016 through December 2016.

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

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

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

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development,

when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

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

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

33. Sample contract used for delegated entities. 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. 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;
    b. reporting frequency and format;

c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);
d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
e. 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;
f. 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;
g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files made in the months of February 2016 through December 2016. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.
    d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of February 2016 through December 2016, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2017

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copy of a policy addressing requirements for coverage of post-stabilization services.

3. The following credentialing files were missing information or need explanation:
   a. Steven Bull, MD PCP: Proof of search for the SSDMF; proof of malpractice insurance active at the time of credentialing
   b. Lisa Bozik, MD IM PCP: Proof of search for the SSDMF
   c. Thomas Key, OBGYN Specialist: Proof of search for the NPPES (NPI)
   d. Sukirti Bista, Pediatrics PCP: Proof of search for the SSDMF

4. The following recredentialing files were missing information or need explanation:
   a. Please provide explanation of how provider performance is taken in to account at recredentialing.
   b. Bonnie Crickman, MD PCP: Proof of queries for SAM, SC Excluded Provider List, SSDMF, NPPES (NPI), and Medicare Opt Out
   c. Olajide Balogun, MD Pediatrics PCP: Proof of queries for the SSDMF, NPPES
   d. Patricia Barrineau, NP PCP: : Proof of queries for the SSDMF, NPPES
   e. Fam Nabmil, MD Surgeon: Proof of queries for SAM, SC Excluded Provider List, SSDMF, NPPES (NPI), and Medicare Opt Out
   f. Kerry Sims, MD OB/GYN: Proof of queries for SAM, SC Excluded Provider List, SSDMF, NPPES (NPI), and Medicare Opt Out

5. Copy of the provider Office Site Review Tool mentioned in Policy MHSC CR-04.

6. The following appeals files were missing information and/or need explanation:
   a. Appeal file # 2 — need copies of the consent for provider to appeal on member's behalf, the MD appeal review, and the appeal resolution letter.
   b. Appeal file # 4 — need explanation for the date on the acknowledgement letter. The file indicates the appeal was received on 3/2/16; however, the acknowledgement letter was dated 2/15/16.
   c. Appeal file # 7 — need a copy of the consent for provider to appeal on member's behalf. Also need an explanation of the delay in sending the acknowledgement letter—the appeal was received on 3/24/16, but the acknowledgement letter was dated 4/13/16.
   d. Appeal file # 9 — need a copy of the consent for provider to appeal on member's behalf. Also, need explanation of who issued the determination to process this expedited appeal request as a standard appeal.
   e. Appeal file # 12 — need a copy of the consent for provider to appeal on member's behalf.
   f. Appeal file # 15 – need a copy of the consent for provider to appeal on member's behalf.
   g. Appeal file # 19 – need a copy of the consent for provider to appeal on member's behalf.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
  - BREAST CANCER SCREENING
  - PROVIDER DATA MANAGEMENT
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM Validation Worksheet

Plan Name:	**Molina**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2015-2016**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NCQA Volume 2: HEDIS® Technical Specifications for 2016

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**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

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**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
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**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

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**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

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**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Documentation/tools were adequate for medical record abstraction.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
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**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

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
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

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	80
Measure Weight Score	80
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 PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**BREAST CANCER SCREENING PROGRAM (FORMERLY MOBILE MAMMOGRAPHY PROGRAM)**
Reporting Year:	2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY 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**	Information was given that shows the need for better screening procedures and offering more access to care for members on page 2.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated on page 2.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is clearly defined on page 9.
3.2 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 were related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not done for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or*	**NA**	Sampling was not done for this study.

Component / Standard (Total Points)	Score	Comments
census used:		
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not done for this study.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented on page 11.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted on page 11.
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**	Method of collecting data is documented on page 11.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection will occur once per month.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis will be conducted once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed on page 11.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions for members and department are documented beginning on page 36.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	On page 13, rates for baseline, CY 2015, and CY 2016 as of 12/1/2016 were reported as in progress.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	BCS HEDIS measure results are displayed in the table on page 13. Mobile mammogram screening results are shown on page 39 for the last three calendar years.
8.3 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**	Comparisons for initial and repeat measurements were offered.
8.4 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**	Program recommendations were documented, but not legible beginning on page 33.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The screening percentage increased from 1.08% in CY 2014 to 3.63% in CY 2015 to 4.37% in CY 2016

Component / Standard (Total Points)	Score	Comments
		(preliminary).
9.3 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**	Based on the bar charts provided, the improvement is partially attributed to the improved access to care for members.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	The HEDIS BCS measure increased significantly, p=.017, as documented on page 13.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement has been demonstrated, according to preliminary results, from CY 2015 to CY 2016 as shown on page 13 for HEDIS rate and on page 39 for Mobile Mammography Event results.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	5
Verify	NA	NA

Project Score	96
Project Possible Score	96
Validation Findings	100%

AUDIT DESIGNATION
High Confidence in Reported Results

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**PROVIDER DATA MANAGEMENT**
Reporting Year:	2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY 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**	QNXT system revealed issues with provider specialty discrepancies.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in Section A, page 2.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Quantifiable Measures are defined on pages 3 and 4. The numerator and denominator are defined. The baseline goal and benchmark goal are not clearly presented. The baseline goal should be a goal that is above the known current rate. The benchmark is the industry measure of best performance and is typically based on published data. In this case, the benchmark should be the lowest rate for each measure, as lower is better. Recommendation: Adjust the table on pages 3 and 4 so the benchmark goal is reflective of the measure of best performance considered by Molina. The baseline goal should be higher than the benchmark goal in this case, as lower is better.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong	**Met**	Measures are related to process of care.

Component / Standard (Total Points)	Score	Comments
associations with improved outcomes? **(1)**		
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**NA**	No enrollees are part of this PIP.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**NA**	No enrollees are part of this PIP.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not done for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not done for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not done for this study.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	The data are described in SCDHHS Provider File and QNXT Provider Data (shown in Section C.1).
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Programmed pull documented in Section C.2.
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**	Programmed pull documented in Section C.2.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Using continuous data collection cycle as shown in Section C.4.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis indicated as continuous in Section C.4.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of staff are listed on page 7.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions to address barriers are documented on page 9.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data analysis was continuous, with full analyses each year.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	Results are presented on page 8. The time period measurements are varied, and are listed as one day (1/2/2016 and 1/2/2017) which is misleading. Denominators are not included in documentation.

Component / Standard (Total Points)	Score	Comments
		Recommendation: Include the start date and end date for re-measurements 3 and 4 the time periods in Table on page 8. Include denominator and benchmark goal in the results table for each measure so rates can be validated.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Comparisons for statistical significance are not utilized due to non-sampling.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis is included on page 9.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology was used at baseline and remeasurement for all measures.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates are improving (lower is better).
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not required due to non-sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Rates have remained very low (which is the goal) for measures 1, 2, and 3. Rate decreased from baseline to remeasurement 1 for measure 4.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	5
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	0
8.3	NA	NA
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	NA	NA
Step 10		
10.1	5	5
Verify	NA	NA

Project Score	73
Project Possible Score	88
Validation Findings	83%

AUDIT DESIGNATION
Confidence in Reported Results

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**WELL-CARE PROGRAM**
Reporting Year:	2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY 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**	HEDIS measure evaluation revealed an opportunity for improvement.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in Section A on page 2.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Quantifiable Measures are defined on pages 8-14.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to health status and processes of care with strong associations with improved outcomes.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 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)**	**Met**	Sampling technique considered CI and margin of error.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	HEDIS specifications for sampling were followed.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained a sufficient number of enrollees.

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 are specified in Section C.1 and C.2.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources are specified in Section C.1.
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**	Programmed pull documented in Section C.2.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Using continuous data collection cycle as shown in Section C.4.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis conducted once per year in Section C.4.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are documented on page 18, Section C.2
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Member, Provider, and Department interventions have been undertaken.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are performed yearly as indicated in the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	Results are presented on pages 21-23. The benchmark is listed as baseline rate, and this should not be the case. The benchmark is the industry measure of best performance and is typically based on published data. Recommendation: Revise the results table to reflect a benchmark goal for each measure considered the best performance for Molina, not the baseline measurement rate.
8.3 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**	Initial and repeat measurements were shown, with the exception of the W15 measure which had only baseline data.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Not Met**	Analysis for CY 2015 measures was not provided. The information on pages 25 and 26 of documentation displays information about incentives, but does not offer a description of the analysis of the data. Recommendation: At the end of the results table,

Component / Standard (Total Points)	Score	Comments
		provide an interpretation of the rate change from year to year in Section III.A.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates improved for all but two measures, AAP and CAP.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement in performance appears to be results of interventions that have been implemented.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	There were significant increases for AWC and all three WCC measures. There were non-significant increases for W34 and AAP measures. The W15 and CAP measures do not have complete information to run statistical analyses.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	HEDIS values are verified with Inovalon software rates.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	0
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	20	20

Project Score	125
Project Possible Score	131
Validation Findings	95%

AUDIT DESIGNATION
High Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
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 Survey Validation Worksheet

Plan Name	**MOLINA**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2016
Review Performed	2017

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

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**	Definition of the study population was clearly defined. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 1,823. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 28.9% (n=497 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although the response rate was below the NCQA target rate. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and auditable approach to the implementation and analysis of the surveys. SPH Analytics as a vendor provides a full report of the process and results meeting the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 28.9%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Regarding composite scores: • Getting Needed Care: Below 25th percentile • Getting Care Quickly: 56th percentile • How Well Doctors Communicate: 32nd percentile • Customer Service <10th percentile • Shared Decision Making: 71st percentile Customer Service received the lowest score and Shared Decision Making received the highest scores. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	CAHPS Results from the previous year were distributed to providers in the Fall newsletter. Documentation: *Fall 2016 Provider Newsletter*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

CCME EQR Survey Validation Worksheet

Plan Name	**Molina**
Survey Validated	**CAHPS CHILD (AND CHILD CCC) 5.0H**
Validation Period	2016
Review Performed	2017

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

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**	Definition of the study population was clearly defined. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 3,490 according to NCQA. Molina had a sample size of 4,297 (2,310 general population and 1,987 supplemental sample). Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

Survey Element		Element Met / Not Met	Comments And Documentation
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 25.8% (n=571 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although, the response rate was below the NCQA target rate. Per the report on pages 2-3, it cannot be determined which respondents out of the total sample qualify as having a chronic condition. Given that a denominator for this equation cannot be determined, there is no response rate provided for the CCC Population. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions	
7.1	Identify the technical strengths of the survey and its documentation.	The use of a CAHPS certified vendor allows for a standardized and auditable approach to the implementation and analysis of the surveys. SPH Analytics as a vendor provides a full report of process and results meeting the necessary requirements and expectations of a survey report.	
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.	
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 25.8%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.	
7.4	What conclusions are drawn from the survey data?	*General Population (using Quality Compass)* • Getting Needed Care: 53rd percentile • Getting Care Quickly: 49th percentile • How Well Doctors Communicate: 66th percentile • Customer Service: 69th percentile • Shared Decision Making: 82nd percentile • Health Promotion and Education: 37th percentile • Ease of Filling out Forms: 23rd percentile Ease of Filling Out Forms is the area with the highest need for improvement, followed by Health Promotion and Education.	*CCC Population (using Quality Compass)* • Getting Needed Care: 88th percentile • Getting Care Quickly: 77th percentile • How Well Doctors Communicate: 93rd percentile • Customer Service: 99th percentile • Shared Decision Making: 64th percentile • Health Promotion and Education: 40th percentile • Ease of Filling out Forms: 56th percentile Health Promotion and Education is the area with the highest need for improvement, followed by Ease of Filling Out forms.

Results Elements		Validation Comments And Conclusions
		Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness of care is part of the CAHPS 5.0 survey. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	**Molina Healthcare of SC**
Collection Date:	2017

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 Healthcare of South Carolina (Molina) has a comprehensive set of policies and procedures organized in a consistent manner. Policy MHSC-AD-02, Annual Policy Review, states Molina reviews policies on an annual basis and updates, as necessary. This policy was updated January 27, 2017 and now states the presence of at least 51% of voting members constitute a quorum, and approval by at least 3/5 voting members present is required to pass a motion. All policies indicate the line of business they apply to. Molina has achieved Commendable NCQA Accreditation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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:						Molina's organizational chart demonstrates ample executive leadership and overall staffing locally within South Carolina. Molina is supported by Molina Healthcare, Inc., the parent company located in Long Beach, California.
1.1 *Administrator (CEO, COO, Executive Director);	X					The Plan President for Molina Healthcare of South Carolina is Tom Lindquist. He is responsible for the day-to-day business activities and reports to the local Board of Directors. The Chief Operations Officer (COO) is Dora Wilson.
1.2 Chief Financial Officer;	X					The Vice President of Finance and Analytics is Thomas (Clark) Phillip. Post-payment review staff includes 2 qualified individuals who are able to conduct unannounced, onsite provider reviews.
1.3 * Contract Account Manager;	X					Nicole Melton-Mitchell is Associate Vice President of Government Contracts and is the contract manager.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/Administrator,	X					Claims are processed by the corporation in Long Beach, California. Dora Wilson, COO does plan oversight of claims and staff is available to assist providers with claims issues. Molina processes 90% of claims electronically.
1.4.2 Network Management Claims/Encounter Processing Staff,	X					Diana Michalic oversees plan encounter functions under the directions of Thomas (Clark) Phillip.
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Vice President of Healthcare Services is Debra Enigl. She is supported by 4 directors working in Care Access and Monitoring, Case Management, Healthcare Services Operations, and Behavioral Health.
1.5.1 Pharmacy Director,	X					Adrienne Matthews is the Pharmacy Director, is a Pharm D, and registered pharmacist in South Carolina. Per onsite discussion, an offer has been extended to fill an open position for an additional pharmacist.
1.5.2 Behavioral Health Coordinator,	X					The position for Behavioral Health Director is vacant at this time. It was vacant at the time of last year's review, filled, and then vacated in November 2016. Molina is actively recruiting for this position. Molina has an integrated system for review and case management of both medical and behavioral health service requests. *Recommendation: Fill the position for the Behavioral Health Director as soon as possible.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.3 Utilization Review Staff,	X					Molina works in partnership with members and practitioners to promote a seamless delivery of health care services and to coordinate medical and behavioral health services.
1.5.4 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Associate Vice President of Quality is Patricia Zigon. Suzzanne Murray serves as Quality Director.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Director of Provider Network Operations is Kimberly-Coad-Ascue. Jennifer Marze is the Director of Provider Services also overseeing Member Engagement, Community Engagement, and Community Materials.
1.7.1 *Provider Services Staff,	X					Provider services staff consists of provider contracts, credentialing, provider representatives, and provider inquiry, research, and resolution staff.
1.8 *Member Services Manager;	X					Michael Musto is the Customer Service Manager.
1.8.1 Member Services Staff,	X					Member Services staff consists of senior and associate member services representatives. Training is conducted to inform member representatives of any new or changed services provided to members.
1.9 *Medical Director;	X					Dr. Cheryl Shafer (Internal Medicine) is the Chief Medical Officer and Vice President of Medical Affairs. Other Medical Directors include: •Dr. Delores Baker, Ob-Gyn

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Dr. Richard Shrouds, Pediatrician •Dr. Nickitas Thomarios, Psychiatrist Dr. Thomarios is in the process of obtaining his South Carolina license. Physician specialists and local Behavioral Health consultants are available as consultants to the medical directors at Molina. *SCDHHS Contract Section 2.2, Exhibit 1*, states "the Contractor shall have a board certified psychiatrist in the State of South Carolina who has at least 3 years combined experience in mental health and substance abuse services." *Recommendation: Make certain Dr. Thomarios obtains his SC licensure.*
1.10 *Compliance Officer;	X					Jamilah Deans Muhammad is the Director of Compliance.
1.11 * Interagency Liaison;	X					Beverly Hamilton serves as Director of Government Contracts/Interagency Liaison. LaDawn Simmons is the Senior Specialist Government contracts.
1.12 Legal Staff.	X					Molina has legal counsel available locally from external sources and support from Molina Healthcare's corporate legal staff.
2. Operational relationships of MCO staff are clearly delineated.	X					Operational relationships are clearly depicted on the organization chart submitted in the desk materials.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					Per onsite discussion, all minimum educational and licensure requirements are found in the job descriptions. The Healthcare Services Program Description includes the licensure requirements for UM functions and Medical Directors.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Based on documents provided, 91% of claims are processed within 30 days and 99.46% of claims processed within 90 days. The MCO has systems in place to process claims. The information provided describes how those systems are updated as needed. The internal benchmark information provided by the MCO states "Comparisons are also sometimes made to internal benchmarks and NCQA's accreditation benchmarks. Enrollment (and member months) is compared to the plan's internally generated enrollment and membership statistics."
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Molina's Claims/Encounters Inbound/Outbound processes implement HIPAA 5010 requirements, including the contracted EFT requirements. Additionally, Molina recently upgraded its QNXT Payment system to the latest version.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Molina's process documentation shows it is capable of meeting the requirements of updating the eligibility/enrollment databases and handling 834 transactions. The material provided also shows Molina meets the formats and methods specified by HIPAA and SCDHHS. Finally, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						MCO's documentation demonstrates its ability to uniquely identify a distinct Medicaid member across its platforms and identify and correctly process any potential duplicate records.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Molina's ISCA documentation demonstrates the ability to provide the required reports and meet contractual obligations. Documentation included report examples, employee training data, quality control measures, data flow diagrams, infrastructure details, and performance data indicating claims can be processed.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.			X			Molina has not supplied evidence of the required biennial audit, its reports, and corresponding corrective action plan. Also no evidence was given of the required security audit prior to June 30, 2016. *Quality Improvement Plan: A security audit needs to be performed by an independent third party as required. The resulting audit report and corrective action plan is to be submitted. Schedule biennial security audits going forward.*
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Policies and procedures exist to sufficiently verify system and information security and access management.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.		X				Molina provided documentation of a detailed disaster/business continuity plan in place stating, "Molina performs disaster recovery (DR) testing at least once each year to ensure the current DR process is up to date and is working as expected. Any anomalies are remediated and retested if appropriate to ensure success."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, no documentation was presented describing a testing of the plan, the results of the testing, and any revisions made to the plan based on testing. *Quality Improvement Plan: Testing and resulting documentation of the Disaster Recovery plan needs to be provided.*
I D. Compliance/Program Integrity						
1. The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					Molina has a South Carolina Compliance Plan, compliance director, a Fraud, Waste and Abuse Plan, and several policies and procedures defining how Molina confirms compliance to federal and state requirements for program integrity. Plans were updated in January 2016. The Compliance Plan indicates the plan is reviewed periodically. However, Policy MHSC COM - 09 Review of Compliance Program, states the plan is reviewed annually. The Molina Hotline for reporting fraud, waste, and abuse is found on the Molina website, in the *Member Handbook*, and the *Provider Manual*. How to report suspicion of non-compliance, fraud, waste, or abuse is posted in Molina's office space. In addition to reporting quarterly to the Board of Directors, the compliance officer may report compliance issues to the Plan President or the Corporate Compliance Department, as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Per onsite discussion, Molina is expanding the desk audit process to include desks located in satellite offices. The goal remains 100% compliance to HIPAA guidelines. Employees receive HIPAA training and sign confidentiality agreements upon hire and, annually, thereafter. *Recommendation: Confirm the timeframe for regular review of the Compliance Plan is consistent in the Program Description and Policy COM - 09, Review of Compliance Program.*
2. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				The Compliance Plan includes the responsibilities of the Compliance Committee membership. Policy MHSC COM 05, Compliance Committee Charter, and committee minutes define a quorum as a simple majority (51%). All vote outcomes is determined by a majority of those present. Meeting minutes indicate meetings are well-attended and a quorum was met for all meetings. It is noted the membership listings and numbers of members on the Compliance Committee was inconsistent in following documents: •2016 Medicaid QI Program Description, Appendix B •The Compliance Plan, page 10 states members shall not exceed 7 •The Compliance Committee Membership Matrix Please note 2 policies are numbered MHSC COM-05, the Compliance Charter, and a communications policy titled Marketing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Materials. *Quality Improvement Plan: Update the documents listed with consistent information on committee membership and the number of members on the committee.*
I E. Confidentiality						
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					Molina has multiple policies and procedures explaining the requirements for release of Protected Health Information (PHI). Employees receive training on Molina's Code of Conduct on first day of orientation. Members receive Notice of Privacy Practices in the *Member Handbook*.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The credentialing and recredentialing program is defined in Policy MHSC CR-01, Credentialing Program Policy. The credentialing program was developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The credentialing program is reviewed annually and updated, as needed. Page 28 of Policy MHSC CR-01 does not contain the updated information regarding Ownership/ Controlling Interest Disclosure that was added to the table on page 20. *Recommendation: Ensure Policy MHSC CR-01 contains consistent information on pages 20 and 28 regarding disclosure of ownership.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Peer Review & Credentialing Committee (PRC) is the oversight committee for the provider credentialing program and also provides peer review for certain quality of care concerns. The PRC is chaired by Medical Director, Dr. Delores Baker. Chief Medical Officer, Cheryl Shafer, serves as back-up committee chair. Additional voting members include Medical Director, Dr. Nickitas

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Thomarios, and four network providers. Specialties represented on the committee include OB/GYN, internal medicine, pediatrics, cardiology, and psychiatry. Additional non-voting employees of Molina attend the meetings as well. The *PRC Charter* states a quorum is met with the presence of three network physician members and a review of committee minutes showed that a quorum was met at all the meetings reviewed.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The credentialing file review showed the files were organized and contained appropriate documentation.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.11 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
3.1.12 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.13 Ownership Disclosure form.	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					Molina conducts provider office site visits in accordance with Policy MHSC CR-04, Office Site & Medical Record Keeping Practices. The policy states that Molina assesses quality, safety and accessibility of office sites where care is delivered through its process of standards for Office Site and Medical Record Keeping Practices. At the time of initial credentialing, a site review is conducted at each location in which a PCP or OB/GYN acting as a PCP sees Molina's members. If a practitioner moves an office location or adds a location, a new site review is conducted within 45 days of receiving the notification. Practitioner office sites must demonstrate at least 90% compliance and if a deficiency is noted during the review, a follow up review is conducted to ensure correction of the deficiency. Evidence of provider office site reviews was received in the credentialing files.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The recredentialing file review showed files were organized and contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of Service System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.10 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.12 Ownership Disclosure form.	X					
4.3 Site reassessment if the provider location has changed since the previous credentialing activity.	X					Provider office site visits will be conducted within 45 days of receipt of a grievance regarding the quality, safety, and accessibility of all provider office sites as defined in Policies MHSC CR-04, Office Site & Medical Record Keeping Practices, and MHSC CR_01, Credentialing Program.
4.4 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy MHSC QI 500.000, Potential Quality of Care, Critical Incidents, Adverse Events and Never Events, states Molina monitors, manages, and improves the quality of clinical care and services received by its members, providers, and staff by investigating all potential quality of care, critical incidents, adverse events, and never events occurring in all settings of care. The policy defines the procedures for identification, documentation, review, and resolution of potential quality of care issues including Serious Reportable Adverse Events (SRAE) and critical incidents identified by members, internal sources, or external sources. The Credentialing Program defines the process of ongoing monitoring which includes investigating practitioner-specific grievances and monitoring

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						practitioner adverse events. A range of actions is defined, including notification to authorities and practitioner appeal rights.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					The credentialing and recredentialing process for organizational providers is defined in Policy CR-02, Assessment of Organizational Providers. The policy is comprehensive and a review of organizational provider files showed appropriate documentation.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Ongoing monitoring of sanctions is addressed in the Policy CR_01 Credentialing Program. The policy states Molina monitors practitioner sanctions between re-credentialing cycles for all practitioner types and takes appropriate action against practitioners when occurrences of poor quality is identified.
II B. Adequacy of the Provider Network						
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy MHSC-PC-011, Availability of Health Care, establishes standards for primary care geographic distribution in compliance with contract guidelines. Evidence of GEO access reports were received in the desk materials.
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-		X				Access standards for specialty care and behavioral health practitioners are defined in Policy MHSC-PC-011, Availability of Health Care. In addition, the policy states Molina also determines the top five specialties based on the number of visits for the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
network specialist with no benefit penalty.						time period which includes extracted claims data, including all visits. Evidence of GEO access reports were received in the desk materials. The *Practitioner Availability and Network Adequacy Analysis* (report date 10/6/16) shows established member-to-provider ratios for behavioral health providers, but the information is not listed in Policy MHSC-PC-011. Policy MHSC-PC-003, Out of Network Coverage, outlines the process to ensure that members receive adequate and timely services when contracted specialty care physicians and other types of healthcare provider may not be available within the Molina network. The enrollee will incur no additional expenses beyond what the enrollee would have to pay for services by a contracted provider. *Quality Improvement Plan: Update Policy MHSC-PC-011, Availability of Health Care, to include the member-to-provider ratios for behavioral health providers addressed in the Practitioner Availability and Network Adequacy Analysis (report date 10/6/16).*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy MHSC-PC-011, Availability of Health Care, states the Provider Contracting Department develops a written availability evaluation and plan, annually, outlining Molina's strategy for maintaining an adequate network of practitioners. The evaluation reviews network availability against

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						established standards and assessment of the cultural, racial, and linguistic needs of Molina members. On a quarterly basis, Molina assesses against established standards to measure practitioner availability and, when deficiencies are identified, will implement efforts for corrective action. This is accomplished through Geo Access reporting.
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				Molina assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of its practitioners, as needed, through analyzing member and demographic data, assessing the provider network and ensuring race/ethnicity and language information is appropriately assigned, educating providers on interpreter services, among other initiatives. Members can obtain customer service assistance in their native language. Molina employs a multi-lingual staff and offers a telephonic interpretation service to provide additional support. The *Provider Manual*, page 41, mentions the *Cultural Competency Plan* and states providers may use links on the Molina website to obtain the full *Cultural Competency Plan*. However, the information could not be found. *Quality Improvement Plan: Ensure the full Cultural Competency Plan is listed on the website as stated in the Provider Manual.*

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 outlined in the contract.	X					Molina *Provider Directories* are available on the internet website, in paper copy, and by calling the Member Services Department via telephone. The paper directory is broken in to five regions addressing all counties served. The paper directory and web-based directory contain appropriate information for members.
3. Practitioner Accessibility						
3.1 The MCO formulates and insures 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, states Molina annually performs provider availability and after hour's surveys of its contracted providers. The survey evaluates primary care, specialty care, and behavioral healthcare appointment availability for routine care visits, urgent care visits, and consultation. The survey also evaluates the average wait time in the practitioner's office. The results of the survey are evaluated and action plans are developed for provider education. Policy MHSC-PS-005 has the following issues: •It does not address the availability standards for behavioral health or for specialists. •It does not explain the process for how Molina assesses provider availability and after hour's standards (i.e. phone calls, paper survey, etc.).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						In addition, the following issues were identified between documents: •The *Medicaid Provider Orientation* does not mention standards for specialists; and lists the office wait time as "not to exceed 30 minutes" when Policy MHSC-PS-005 and the *Provider Manual* state the wait time as "not to exceed 45 minutes". •The *Provider Manual* does not mention the HEDIS measure for behavioral health, "Follow up of an acute BH hospitalization with a BH provider who can prescribe medications within 7 days post discharge" as listed on slide 31 of the *Medicaid Provider Orientation*. •For appointments, the *Provider Manual*, page 28, shows the routine specialty care standard as "within 12 weeks." However, the *Practitioner Availability and Network Adequacy Analysis* (report date 10/6/16), page 4, shows the specialty care standard as being measured "within 4 weeks". *Quality Improvement Plan: Address the issues found in Policy MHSC-PS-005, Provider Availability Standards; the Medicaid Provider Orientation; and Provider Manual relating to provider availability.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			In reference to the results of the *Telephonic Provider Access Study* conducted by CCME, calls were successfully answered 44% of the time (135 out of the 305 providers), which estimates to between 39% and 49% for the entire population. When compared to last year's results of 48%, this year's study proportion decreased from the previous measure, but was, statistically,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						unchanged. *Quality Improvement Plan: Regarding members' access to their providers, look for barriers in the update process so having up-to-date provider contact information for members is not an issue.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy MHSC-PS-009, Provider Orientation, states all newly contracted providers will receive timely training and materials designed to educate the providers. Training is administered by a provider services representative and training is scheduled each month for all providers that were added to the network from the previous month. Training topics include Molina's operations and website, the provider welcome packet, PCP responsibilities, the *Provider Manual* (including benefits, claims, authorizations, referral processes), claims filing processes, reimbursement rates, enrollee eligibility, fraud and abuse prevention, cultural competence, and HIPAA requirements.
2. Initial provider education includes:						
2.1 MCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				The Winter 2016 Provider Update effective 3/1/16 says zero copays for home health, durable medical equipment (DME) and ambulatory surgical; however the *Provider Manual* has the following issues:, •Page 16 shows $3.40 copay ambulatory surgical center •Page 17 shows $3.40 copay for durable medical equipment •Page 17 shows $3.30 copay for home health services •Page 19 for prescription drugs/pharmacy states, "Special Note- no copay for children under age 18 and pregnant women". However, it should state "age 19" instead of "age 18" because the coverage applies to age 18 and under. •Page 19 does not show any coverage information for podiatry services. •Page 20 does not show specific coverage information for vision services/optometrists. The website states age 21+ glasses every two years; age 20 and under glasses every year if needed. *Quality Improvement Plan: Correct the member benefit information in the Provider Manual for home health, DME, ambulatory surgical, and prescription drugs/pharmacy. Add additional information to podiatry and vision services/optometrists.*
2.4 Procedure for referral to a specialist;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 training is provided via face-to-face visits from Provider Services Representatives, faxes, e-communication, newsletter mailings, webinars, and the Molina website.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy MHSC QI 900.000, Preventive Health Guidelines, establishes a procedure by which Preventive Health Guidelines for the prevention and early detection of illnesses and disease are reviewed, adopted, and updated. The Clinical Quality Improvement Management Committee (CQIC), including practitioners, is responsible for the review, updating, and adoption of Preventive

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Health Guidelines at least every two years for use by practitioners, network providers, and members. The guidelines are age-specific recommendations that are relevant to the enrolled membership.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive health guidelines are disseminated by direct mail to affected physicians (PCPs and OB/GYNs), physician newsletters, Provider Relations Representative site visits, and are placed on the Molina website. The practice guidelines are also mentioned in the *Provider Manual*.
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					
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					Molina measures performance of preventive care annually using the results of HEDIS® indicator data collection as defined in Policy MHSC QI 900.000, Preventive Health Guidelines. The medical record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review process is used to measure individual practitioner delivery of preventive care and services along with other relevant performance goals.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy MHSC QI 900.100, Clinical Practice Guidelines, defines the process of review and adoption of clinical practice guidelines to provide up-to-date treatment and diagnostic information to providers, to reduce inter-provider variation, and improve overall health care quality. Adopted clinical guidelines address asthma, chronic obstructive pulmonary disease, diabetes, heart failure, high blood pressure, obesity, attention-deficit/hyperactivity disorder in children and adolescents, and depression disorder.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					Molina reviews and revises guidelines at least every two years and more frequently as clinical evidence is updated. Once the guidelines have been reviewed and modified by a dedicated quality improvement committee, Molina providers will be notified of any changes and updates by fax, mail, provider newsletters, and the website. The clinical practice guidelines are also mentioned in the *Provider Manual*. Printed copies of all guidelines are available upon request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					Molina ensures practitioner compliance by adopting guidelines for at least two medical conditions and at least two behavioral conditions as defined in Policy MHSC QI 900.100, Clinical Practice Guidelines. Medical record audits are utilized for monitoring adherence to the guidelines as defined in Policy MHSC QI 120.000, Standards of Medical Record Documentation.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy MHSC-HCS-CM-081, Continuity of Care and Coordination, states Molina staff ensures appropriate provider access and a smooth transition for each member utilizing coordination of care for all medical, ancillary, behavioral health, and LTSS benefits. The policy defines the process for monitoring and facilitating continuity and coordination of care between PCPs and other entities.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy MHSC QI 120.000, Standards of Medical Record Documentation, states Molina maintains standards for the organization and documentation of medical records and assesses practitioners against these standards. The policy defines the minimum standards for medical record documentation and information is also listed in the *Provider Manual*.
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					Molina conducted a medical record review audit in 2016 with a sample size of 145 medical records consisting of 29 unique in-network providers throughout the state of South Carolina. Out of 145 medical records requested, Molina received and audited 140 records. Results showed 25 provider groups passed (89.29% of 28 groups audited) with a score of 90% and above. Three provider groups failed (10.71%) with a score of 89% and below One provider group was not scored due to not receiving records within the audit time frame.
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				Policy MHSC QI 120.000, Standards of Medical Record Documentation, states, "The Provider is responsible to retain their records for at least ten (10) years for adult patients and at least thirteen (13) years for minors." However, medical record retention requirements are not addressed in the *Provider Manual*. *Quality Improvement Plan: Update the Provider Manual to address the medical record retention requirements defined in Policy MHSC QI 120.000, Standards of Medical Record Documentation.*

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MHSC ME 04, Member Bill of Rights, includes member rights and responsibilities and the following locations inform members about their rights and responsibilities: •The Member Handbook •The Molina website The *Provider Manual* informs providers on member rights and responsibilities. The provider contracts state the MCO encourages providers to openly communicate with members regarding their health and well-being.
2. Member rights include, but are not limited to, the right:	X					All rights as defined below are detailed in Policy MHSC ME 04, Member Bill of Rights and the Member Handbook.
2.1 To be treated with respect and dignity;						
2.2 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 they be amended or corrected as specified in Federal regulation;						
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 it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:		X				Procedure MHSC-ME-01, New Member Outreach, states new members will receive the welcome packet within 14 calendar days from the date their eligibility file is received. The member ID Card will be mailed separate from the Welcome Packet within 2 weeks. The Molina ID Card includes all required information. Onsite discussion confirmed Molina tracks returned mail and has a return rate of 3.5%. The score of "Partially Met" was due to elements missing in the subsequent standards.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The *Member Handbook* includes a grid of covered services and more detail is provided in the narrative sections. Onsite discussion confirmed Molina does cover up to 8 chiropractor visits as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						stated. This is an added value because the SCDHHS Physicians *Provider Manual* states the core benefit is limited to 6 visits per year.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						The *Provider Manual*, *Member Handbook*, and Policy MHSC-PS-006, Family Planning Services states all female members can self-refer to participating or non-participating providers for family planning services.
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The *Member Handbook* provides complete information on how to obtain urgent, emergent, and after-hours care.
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						Policy MHSC HCS-CM-081, states Care Coordinators provide service authorizations, referrals,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						coordination, and/or provide assistance in scheduling medically necessary services. Healthcare Services staff coordinate the following: •Facilitating care between PCP's and specialists as appropriate •Facilitate communication with providers and members •Assistance with scheduling, as necessary •Assist with out-of-network services including specialty care services •Services the member may receive from other health care providers •Assistance with determining the need for services outside core benefits and referrals to appropriate service providers •Coordinate the delivery of core benefits with services that are reimbursed fee for service by SCDHHS •Share information with other health care bodies to prevent duplication of services
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						Multiple policies and procedures and the *Member Handbook* detail how members access pharmacy services. Policy MHSC PHARM 02, Procedure for Prior Authorization, includes an emergency 5 day supply and continuation of benefits when a member changes health plans. Members are informed in the *Member Handbook* that co-pays for prescription drugs applies to members age 19 or and older who are not pregnant.
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Selecting and changing a PCP is well documented in the *Member Handbook*. Members can request a change by calling Member Services or going to the Molina website. A new ID card will be mailed to the member.
1.12 Procedures for disenrolling from the MCO;						Policy/Procedure MHSC-ME-05, Medicaid Member Disenrollment, defines Molina's process for disenrollment within 90 days of enrollment, for cause, and reasons Molina may disenroll a member. The member is informed about disenrollment rights in the *Member Handbook*. The list of Rights and Responsibilities states members receive a description of disenrollment rights at least annually. Molina confirmed this occurs in the Spring and Fall member newsletters and is also posted to the Molina website.
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The *Member Handbook* informs members how to access the provider directory on the website or request information by phone. According to onsite discussion, the provider directory is a regional directory and members can request a printed copy. Frequent updates are performed. The search feature on Molina's website includes the required information.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						The Molina *Member Handbook* includes a multi-lingual, non-discrimination notification and sufficient information on translation and interpretation services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Services department is described throughout the *Member Handbook* and includes the toll-free number to reach them. The fax number and mailing address are found on the grievance form and on the Molina website. Molina expressed concern over providing an e-mail address to members to prevent PHI exposure on an unsecured network.
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Molina website includes detailed information on well-checkup schedules and what is included. Minimal information on well-child visits and EPSDT services is provided in the *Member Handbook*. The *Member Handbook* does not inform parents about some of the components of a well-child exam including Psychosocial and Behavioral Assessments, Nutritional Assessment, Growth and development (weight, height, BMI, blood pressure), or oral health. Finally, it does not stress the importance of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						these visits or define any incentives provided for completion of these visits. See the *SCDHHS Contract, Section 3.14.1.11.* *Quality Improvement Plan: Provide additional information about the components of well-child/EPSDT visits. Include any encouragement and incentives Molina offers for the completion of well-child visits.*
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can received assistance with executing an advance directive;						
1.22 The SCDHHS fraud hotline and fraud email address and toll-free line;						The *Member Handbook* and the *Provider Manual* include: •The toll-free SCDHHS Fraud Hotline and email address. •The toll-free Molina hotline for reporting compliance issues or fraud, waste, and abuse The Molina website includes thorough information regarding fraud, waste, and abuse and provides examples for members.
1.23 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Policy MHSC-ME-07, Changes in Benefits, includes notification of change in benefits 30 days prior to the effective date of the change. The same policy states Molina will make a good faith effort to give notification by mail to members within 15 days after receipt of a provider termination notice. This applies to providers from whom members received

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						his or her primary care from, or was seen on a regular basis.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy COM-01, Communications Policy and Procedure, details the process for measuring reading comprehension level and approval by DHHS of all member education materials prior to use. Members are informed how to obtain materials translated into their preferred language.
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					The Member Services call center meets or surpasses SCDHHS requirements for speed of answer < 30 seconds, no more than 1 percent of calls receive a busy signal, and abandonment rate of < 5% as defined the *SCDHHS Contract* and Molina Policy MHSC-MS-01, Contact Center Performance. The Member Services department is available from 8 am until 6 pm Monday through Friday. Translation services are available for doctor visits and 24 hours a day by phone. The Nurse Advice Line is open 24 hours a day, 7 days a week via a different toll-free number from the call-center. Onsite discussion revealed if a member calls the Member Services department after-hours or on weekends, they are instructed to call a different number to reach the Nurse Advice Line or they can leave a message. The automated prompts do not include an option to talk directly to a nurse or clinician. See *SCDHHS Contract, Section 3.19.11.* *Recommendation: Consider including the capability for calls received in the call-center after-hours or*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						on weekends to provide direct access to Nurse-Advice line or licensed clinician without having to dial a second number.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					Members receive guidance about the difference between a grievance and an appeal from member services call center staff as noted in grievance files. Members identified as inappropriately using the emergency room or other services are referred for case management and re-education.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHSC-ME-05, Procedure for Medicaid Disenrollment, defines Molina's process for disenrollment and is consistent with contract requirements found in the *SCDHHS Contract, Section 3.13.*
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Members are informed in the *Member Handbook* how they choose or change their PCP. Policy MHSC MS-43, PCP Reassignment and Grievance Tracking, details the process used for auto-assignment and changing a PCP upon request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Policy MHSC QI 900.000, Preventive Health Guidelines, states PHGs are reviewed and updated every 2 years by the CQIC which includes practitioners, network providers, and members. The Molina website includes child preventive health schedules and guidance for adult screenings. The *Member Handbook* informs members about disease management for asthma, behavioral health, COPD, CAD, diabetes, and others. Recommended screenings for adults are included in the *Member Handbook* and the call center has built-in alerts for members needing specific screenings.
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					Molina uses various resources to identify pregnant members including the Notice Of Pregnancy forms, claims data, eligibility data, and pharmacy data. The *Member Handbook* includes information on Molina's Motherhood Matters Pregnancy Program. The WIC program is described and includes contact information for members to apply for these services.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					Per the *Medicaid QI Program Description*, to meet the EPSDT guidelines, Molina uses preventive health guidelines based on U.S. Preventive Services Task Force Recommendations. Per Policy QI 900.000, Preventive Health Guidelines, Molina measures population based performance of preventive care annually using the results of HEDIS indicator data collection. The medical record review process is used to measure individual practitioner delivery of preventive care and services, and other relevant performance goals.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						HEDIS performance results are reported annually to the CQIC, Quality Improvement Committee, Molina Board of Directors, and to practitioners and provider groups. Molina does encourage participation through direct mailings, phone calls, reminders, and through provider gaps in care reports. Providers are encouraged to contact members about compliance. Onsite discussion revealed Molina offers to assist providers in making phone contact to members.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Molina conducts member and community outreach and community health education programs throughout the state for members and the general public. Events are held at local churches, community centers, or public facilities. Attendance at these events is tracked.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					Both the child and adult CAHPS was performed by SPH Analytics, an NCQA certified vendor.
1.1 Statistically sound methodology, including probability sampling to insure that 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Results were analyzed by vendor and summarized by Molina.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					Molina has a policy and procedure in place to review the results of the survey, identify and prioritize the issues, and respond to the issues to improve member satisfaction. The results were also discussed during committee meetings.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Member satisfactions results were reported to Providers in the *Fall 2016 Provider Newsletter*, although the specific population is not identified in the report.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were shared with the QIC as reflected in the committee minutes dated September 27, 2016.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MHSC-MIRR-001, Grievance Disposition Process, defines the process for handling grievances received verbally or in writing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					The following documents define a grievance as "an expression of dissatisfaction about any matter other than an action" and include who may file a grievance: •The *Member Handbook* •The *Provider Manual* •The Molina website •Policy MHSC-MIRR-001, Grievance Disposition Process.
1.2 The procedure for filing and handling a grievance;	X					The following documents include the correct information on the timeframe to file a grievance, how to file a grievance, that Molina will provide assistance to file, and a toll-free number with TTY capability: •The Member Handbook; •The Provider Manual; •The Molina website; and •Policy MHSC-MIRR-001, Grievance Disposition Process. These documents, with the exception of the *Member Handbook* include written grievances will be acknowledged in writing within 5 business days. The *Member Handbook* does not include this in the body of the handbook. However, it is located on the blank grievance form provided in the *Member Handbook*.
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Timeliness guidelines used for grievance resolution are defined across all documentation. Molina resolves grievances within 90 calendar days of receipt.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;		X				Policy MHSC-MIRR-001 Grievance Disposition Process, states grievances related to clinical quality of care are forwarded to the Quality Improvement Department for investigation and resolution. This policy states on page 3 that for grievances related to the denial for an expedited resolution of an appeal are forwarded to Member Inquiry and Research (MIRR) department. The department gathers additional information and forwards the request to a health care professional with appropriate clinical expertise in treating the member's condition or disease for resolution. Onsite discussion with Dr. Shafer indicated health care professionals could be someone other than the medical director, such as social workers, nurses, physical therapists, etc. *SCDHHS Contract Section 9.1.4.3* states the individuals who make decisions on Grievances and Appeals are individuals: *9.1.4.3.1.* "Who were not involved in any previous level of review or decision making." *9.1.4.3.2.* "Who, if deciding: (1) an Appeal of a denial based on lack of Medical Necessity; (2) a Grievance regarding denial of expedited resolution of an Appeal; or (3) a Grievance or Appeal that involves clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the Medicaid Managed Care Member's condition or disease."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						One quality of care concern regarding inappropriate behavior by a provider was not sent to the Medical Director for review. It is also a concern that the grievance was resolved in 87 days, within timeliness standards. However, in this case, if the inappropriate behavior had been substantiated, there is the possibility this behavior would have continued for nearly 3 months before being addressed. Policy MHSC-MIRR-001, Grievance Disposition Process, does not define when a medical director is consulted as part of grievance resolution. Grievances about clinical quality of care or service, grievances regarding the denial of an expedited appeal, or all grievances related to the delivery of medical care did not include when a medical director was consulted as part of the resolution. Policy QI 122.000 was labeled as Potential Quality of Care Issues; however, when opened it was actually titled Provider Communication Regarding the Quality Improvement Program. No other policy was found addressing quality of care issues. *Quality Improvement Plan: Update Policy MHSC-MIRR-001, Grievance Disposition Process, or develop a new policy addressing grievances to include when a medical director is consulted as part of the resolution. Develop a process to train staff handling grievances to identify grievances requiring special handling by a medical director or*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						require attention sooner than contract requirements to guarantee member safety.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Molina maintains a log for grievances, including grievances resolved on the initial phone call and all other grievances. Policy MHSC-MIRR-001, Grievance Disposition Process, states grievance documentation is maintained for a period of 10 years.
2. The MCO applies the grievance policy and procedure 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. Of the grievance files reviewed, documentation was found lacking in 2 files. Grievance acknowledgement and resolution letters meet contract requirements for content. Molina conducts training with call center staff to make certain grievances are appropriately identified and categorized.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					An analysis of grievances is conducted quarterly and the analysis is presented to the QIC to help identify potential issues and quality improvement opportunities. The minutes for the QIC meetings include reporting and discussion of grievance concerns. Molina's analysis indicates the majority of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievances are related to the category Access and Availability. Molina stated due to the Provider Directory improvements in process, members may have had difficulty locating providers. Molina is analyzing specific access and availability components to help identify specific provider type's members are having difficulty accessing. This remains an ongoing issue. Provider types include Ob-Gyn, Orthopedics, Dermatologists, vision providers, and pain management. *Recommendation: Continue to drill into grievance data to identify areas needing improvement. Develop strategies to address these issues.*
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					Policy MHSC-HP-16, Confidential Information, defines the standards established for confidentiality of information concerning members, employees, and others. At the time of initial employment, each new member of Molina Healthcare's workforce must sign the *Workforce Confidential Information Agreement*.
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Policy MHSC-MS-43, PCP Reassignment and Grievance Tracking, states requests for PCP change, if due to quality of care, is documented as a grievance and forwarded to the Appeals and Grievances team. The call center will assist the member in finding a new PCP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHSC-MIRR-001 Grievance Disposition Process, states grievances related to clinical quality of care are forwarded to the Quality Improvement Department for investigation and resolution.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					Onsite discussion confirmed grievances related to a member's request to change PCPs due to dissatisfaction are reviewed and tracked as grievances.
3. The timeliness guideline for completing a member's request to change their PCP is consistent with contract requirements.	X					A member request to change PCPs is handled at the time of the request.

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						
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's *2016 Medicaid Quality Improvement (QI) Program Description* outlines the processes in-place for measuring and improving the care and services received by its members and their providers. The *2017 Program Description* is expected to be completed by the end of March.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.		X				Molina monitors provider performance of select clinical practice guidelines and preventive health guidelines quarterly. *QI Program Description*, page 38, includes the list of adopted clinical practice guidelines. It states "To evaluate the effectiveness, Molina measures performance against important aspects of each clinical practice and preventative guidelines." The program description implies Molina is measuring each guideline. During onsite discussion, Molina's staff indicated the health plan had chosen specific guidelines to measure. *Quality Improvement Plan: Update the QI Program Description to clearly reflect the monitoring conducted to assess provider compliance with the clinical and preventive practice guidelines. If the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						health plan has chosen specific guidelines to measure, the program description must indicate that.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Molina has developed a *QM Work Plan*, which includes objectives, goals, action plan for each objective, responsible party, and timeline. This work plan is reviewed and updated quarterly.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee provides oversight for the overall quality and performance of Molina.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership for this committee includes the Chief Medical Officer, who chairs the committee, members from various departments across the organization, and provider representatives. A quorum of 60% of the members with no less than three provider representatives is necessary to enact or implement decisions.
3. The QI Committee meets at regular quarterly intervals.	X					The committee minutes reviewed demonstrated the Quality Improvement Committee met regularly. However, meeting frequency was not included in the committee charter. *Recommendation: Update the Quality Improvement Committee charter to include meeting frequency.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					Quality Improvement Committee membership information received with the desk materials lists 22 voting members. However, the committee minutes are inconsistent regarding who is considered a voting member and who are non-voting members. Minutes for February and June 2016 did not include all voting members. The minutes for September and December included all voting members. This was discussed and Molina explained there was a recent change and the minutes now reflect all of the voting members of the committee.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Molina uses Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements. The 2016 HEDIS performance measure rates were compared to the 2015 HEDIS rates. One rate had a noticeable decline in score (more than a 10% decrease), which was 30-day Follow Up after Hospitalization for mental Illness. This rate decreased 14% from 66% to 52%. The WCC and CDC measures increased substantially. The complete validation results are found in *Attachment 3, EQR Validation Worksheet*.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Three projects were validated using *the CMS Protocol for Validation of Performance Improvement Projects*. They included Breast Cancer Screening, Well Care Program, and Provider Data Management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				All three projects had a justified rationale for using the analysis of data. Research questions were stated clearly. The interventions were applicable to the project goals. The Provider Data Management PIP rates were near goal (0%) for three of the four measures. The Well Care Program and Breast Cancer Screening PIPs also noted increases in rates, although the results were not legible on several pages of the documentation. It is recommended the documentation be revised to make certain the reader can clearly view all images and information presented. The complete validation results are found in *Attachment 3, EQR Validation Worksheet*. *Quality Improvement Plan: Correct the errors identified in the performance improvement projects.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					*Policy MHSC-QI-302.000, Quality Measurement*, describes the process and criteria used to report and monitor physician level performance. Individual practitioner reports are reviewed by the Medical Director and sent to the practitioners for review and follow-up.
IV F. Annual Evaluation of the Quality Improvement Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					At least annually, the Quality Department is responsible for formally evaluating the effectiveness of the QI program. The program evaluation for 2016 was not received. According to the health plan, the evaluation will be submitted to the QI Committee during first quarter 2017.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *Healthcare Services (HCS) Program Description* describes the components of Molina's Health Care Services Program, comprised of Care Access and Monitoring, the Transitions Program, and the Case Management Program. The program description defines the goals and objectives, functions, accountability, organizational structure, and staffing model for the HCS Program. Major goals and initiatives for 2016 are defined. Specific UM processes are defined in various Care Access and Monitoring (CAM) and Case Management (CM) policies.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					Policy MHSC HCS-CAM-325, Authorization Process, defines procedures, personnel, and standards for decision-making and notification to members and providers when evaluating authorization requests.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					Guidelines/standards used for determining medical necessity are defined in the *HCS Program Description* and Policy MHSC HCS-CAM-365, Clinical Criteria for Utilization Management Decision Making.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for determination timeliness are consistently and correctly documented in various program descriptions, policies, the *Member Handbook*, and the *Provider Manual*. Policy MHSC HCS-CAM-325, Authorization Process, Section K (1) states, "MHSC will provide notice of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review decision as expeditiously as the member's health condition requires, but no later than the specified timeframes in Table 2." However, there is no Table 2 within the policy. *Recommendation: Revise Policy MHSC HCS-CAM-325 to add the referenced table or remove the reference.*
1.5 consideration of new technology;	X					Policy MHSC HCS-CAM-323, Authorization of New Medical Technologies (Experimental and Investigational Services), appropriately defines review processes for requests for which no pre-established criteria or guidelines exist.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Molina has developed a Preferred Provider Program allowing providers to be eligible for increased member assignment and reduced or simplified prior authorization requirements based on analysis of practitioner performance. This designation is based on meeting specific QI and UM performance measures, such as HEDIS metrics, medical record documentation, low incidence of UM medical necessity denial decisions, and emergency department utilization. Providers approved for the Preferred Provider Program are subject to bi-annual analysis of quality and UM performance metrics to establish continued eligibility and participation in the program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion confirmed there are currently no providers who have received this designation. This is partially due to the high number of procedures performed in PCP offices, requiring no prior authorization.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Cheryl Schafer is the chief medical officer (CMO). Associate Medical Directors include Delores Baker, MD; Robert Shrouds, MD, and Nikitas Thomarios, D.O. The CMO's responsibilities include, but are not limited to, implementation, evaluation, and outcomes of the HCS Program, participation in various committees, evaluation of new technology, clinical reviews for denial determinations, and evaluation of inter-rater reliability of physician reviewers. Medical directors/associate medical directors report to the CMO. Their responsibilities include, but are not limited to, implementation of the HCS Program, participation in various committees, conducting reviews and clinical discussions with physicians, issuing medical necessity determinations, consulting with HCS personnel, staff development, and peer reviews with practitioners to discuss potential denials. The behavioral health (BH) associate medical director serves as the designated behavioral health care practitioner with involvement in the implementation of the behavioral health care aspects of the UM program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The HCS Program is reviewed, evaluated, and updated annually under the direction of the Health Care Services Committee (HCSC) and Quality Improvement Committee (QIC). A quantitative and qualitative analysis is completed to identify barriers and assess whether annual goals were met. Corrective action plans are developed for goals that are not met. The HCS work plan and 2015 evaluation are combined into one document. The evaluation was approved by the HCS Committee Chairperson, Chief Medical Officer, and Plan President on 3/9/16. The evaluation includes Care Access and Monitoring activities, goals, methods of evaluation, results, barriers, and future plans. Review of the *HCS Program Description* confirms major goals and initiatives are included.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy MHSC HCS-CAM-365, Clinical Criteria for Utilization Management Decision Making, Section B, page 2, lists the approved resources for clinical criteria in order of hierarchy. Items three and four in this list do not definitively state the criteria allowed and could result in confusion for staff: •McKesson InterQual Criteria or comparable clinical decision support criteria selected for use by Molina Healthcare, Inc. •Hayes Technology Assessments or comparable evidence based review products selected for use by Molina Healthcare, Inc. Onsite discussion confirmed the phrase “or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						comparable evidence based review products selected for use by Molina Healthcare, Inc." will be removed from these items. *Recommendation: Revise Policy MHSC HCS-CAM-365, Clinical Criteria for Utilization Management Decision Making, page 2, to remove the ambiguity from items three and four in the list of approved clinical review criteria.*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Approval files reflect appropriate criteria are reviewed for each request. Additional information is requested when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.		X				Policy MHSC HCS-CAM-358, Abortions, Hysterectomies, and Sterilizations, defines coverage and authorization requirements for these procedures and is compliant with the requirements found in the *SCDHHS Contract* as well as the *SCDHHS Policy & Procedure Guide*. The *Member Handbook* provides appropriate information on requirements for coverage of abortions, hysterectomies, and sterilizations. The *Provider Manual*, page 18, states, "Signature of consent on the sterilization consent form must not be more than 180 days old at the time of the procedure". This is incomplete information. It does not include the signature cannot be less than 30 days old except in case of emergency abdominal surgery or premature delivery. Refer to *the SCDHHS Policy & Procedure Guide, Section 4.2.28*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Revise the Provider Manual, page 18, to include the signature of consent on the sterilization consent form must be at least 30 days old at the time of the procedure.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					The *HCS Program Description* and Policy MHSC HCS-CAM-325, Authorization Process, confirm medical directors or their delegates may modify or waive specific review criteria, if necessary, to accommodate an individual member need or special variations in the capabilities of the local delivery system.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy MHSC HCS-CAM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff, defines the process used to monitor the consistency in application of review criteria. Inter-rater reliability (IRR) audits are performed at least annually or more frequently if opportunities for improvement are identified. The department goal for IRR audit outcomes is at least 90%. The policy does not provide details on follow-up activities for scores below the benchmark. It states action plans are developed, as needed. However, the *2016 Inter-Rater Reliability Analysis* reported to the HCSC on 6/22/16 states, "If a staff member scores below 90% there is a documented action plan based on results." Onsite discussion confirmed that for scores below the benchmark, remedial training is provided to the individual or team. Retesting is then conducted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The policy also does not state to which committees IRR results are reported. Onsite discussion revealed results are reported to the HCSC and QIC. Other methods to verify consistency in application of medical necessity criteria include: •Staff orientation and training programs •Regular and ad hoc staff meetings to update staff on new programs, policies, and review criteria •Periodic staff audits •Review of documentation and determination content and quality in UM files *Recommendation: Revise Policy MHSC HCS-CAM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff, to include follow-up activities for scores below the benchmark and to define the committees to which IRR results are reported.*
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Pharmacy formulary restrictions include age limits, prior authorization requirements, quantity limits, and step therapy requirements. Over-the-counter medications are covered with a valid prescription. Drugs included Molina's Preferred Drug List (PDL) are reviewed and approved by the Pharmacy and Therapeutics (P&T) Committee. The P&T Committee membership includes practicing pharmacists, physicians, and nurses representing plan leadership in the provider network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Procedure MHSC-PHARM-02, Pharmacy Prior Authorization Requests, defines processes for review of medication authorization requests. Members are entitled to a provision of no less than a 5-day emergency supply of all prescription drugs when a prior authorization request is required and/or pending. Provision of up to a 30-day supply of medication is granted if there is a delay in issuing a coverage determination for a medication authorization request.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.		X				*Federal Regulation § 422.113 (c)* and the *SCDHHS Contract, Sections 4.6.10* through *4.6.12* define requirements for coverage of post-stabilization services. Policy MHSC HCS-384, Post Service Review – Emergent Care Visits, appropriately defines an emergency medical condition and addresses use of an out-of-network provider for emergency care until the patient is medically stable for transfer. However, it does not address other requirements for coverage of post-stabilization services as defined in *Federal Regulation* or the *SCDHHS Contract*. Also, the *Provider Manual* does not address requirements for coverage of post-stabilization services. *Quality Improvement Plan: Update Policy MHSC HCS-384, Post Service Review - Emergent Care Visits, to include all requirements for coverage of post-stabilization services as defined in Federal Regulation § 422.113 (c) and the SCDHHS Contract,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Sections 4.6.10 through 4.6.12. Update the Provider Manual to include coverage requirements for post-stabilization services.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Policy MHSC HCS-CAM-364, Appropriate Professionals Making UM Decisions, states appropriately licensed clinical staff members review requests requiring assessment of clinical information and/or application of medical necessity criteria. When HCS staff cannot approve a request, medical directors are responsible for reviewing for medical necessity. Discrepancies in who may issue a denial determination were noted as follows: •Procedure MHSC PHARM-02, Pharmacy Prior Authorization Requests, item B (7), states denials may be issued by a clinical pharmacist, pharmacy director, medical director, or chief medical officer. •Procedure MHSC PHARM-02, Pharmacy Prior Authorization Requests, item D (2) (a), states denials may be issued by a clinical pharmacist, medical director, or chief medical officer. •Policy MHSC HCS-CAM-325, Authorization Process, Table 1, states denials may be issued by an MD, DO, or PharmD. Pharmacy directors and PharmD staff may issue denials only if they are licensed pharmacists. *Recommendation: Revise Procedure MHSC PHARM-02,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Pharmacy Prior Authorization Requests (items B (7) and D (2) (a)) and policy MHSC HCS-CAM-325, Authorization Process, to contain consistent information on who may issue denial determinations. Clarify these policies and procedures to indicate pharmacy directors and PharmD staff may issue denials only if they are licensed pharmacists.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Denial files reflect appropriate requests for additional information, as needed, to render a determination.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files reflect appropriate reviewers issue denial determinations.
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					Denial files reflect timely decisions and notification of the determinations. Notice of action letters contain the rationale for the determination along with a reference to the criteria or benefit provision used to render the determination. However, the letters sometimes contain acronyms and/or abbreviations members may not understand. *Recommendation: Ensure notice of action letters are written in language members can easily understand. Avoid the use of acronyms and/or abbreviations.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					Policies MHSC-MIRR-002, Standard Appeal Process, and MHSC-MIRR-003, Expedited Appeal Process, define processes for receiving, processing, resolving, and responding to appeals.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				The following contain an incomplete definition of an action. All are missing that an action includes the failure to provide services in a timely manner and the failure of the MCO to act within timeliness guidelines in the disposition of grievances and appeals. •The *Member Handbook*, page 40 •The Molina website (http://www.molinahealthcare.com/members/sc/En-US/mem/medicaid/overvw/quality/Pages/appeals.aspx) The *Member Handbook* contains appropriate information regarding who may file an appeal, but does not include providers and others must have consent to file an appeal on the member's behalf. *Quality Improvement Plan: Revise the Member Handbook and website to contain the complete definition of an action. Refer to the SCDHHS Contract, Amendment Two, Section 9.1* and *Federal Regulation § 438.400 (b). Revise the Member Handbook to include persons filing an appeal on a member's behalf must have written consent. Refer to the SCDHHS Contract, Amendment Two, Section 1.1.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing an appeal;		X				The *Member Handbook* states members may provide additional information to support an appeal, but does not indicate the member can request to examine the appeal file and other documents related to the appeal. This information is included in the Notice of Action letter. *Quality Improvement Plan: Revise the Member Handbook to include members can request to examine the appeal file and other documents related to the appeal. Refer to the SCDHHS Contract, Amendment Two, Section 9.1.4.4.3.*
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					Policies MHSC-MIRR-02, Standard Appeal Process, and MHSC-MIRR-03, Expedited Appeal Process, appropriately define who may review and make determinations on appeals. Policies HCS-CAM-303, Inpatient Admission Review, and MHSC-HCS-CAM-371, Practitioner Access to Plan Physician Reviewer, address peer-to-peer requirements appropriately.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				The following documents appropriately define the timeframe for appeal resolution, but fail to include that notice of the resolution must be sent within the same timeframe: •Policy MHSC-MIRR-02, Standard Appeal Process •Policy MHSC-MIRR-03, Expedited Appeal Process

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Refer to the *SCDHHS Contract, Amendment Two, Sections 9.1.6.1.2 and 9.1.6.1.3.* *Quality Improvement Plan: Revise Policies MHSC-MIRR-02 and MHSC-MIRR-03 to indicate the notice of appeal resolution must be sent no later than 30 days from receipt for standard appeals or 72 hours from receipt for expedited appeals.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					The *Member Handbook* includes appropriate information regarding continuation of benefits, but because of its placement, in the Expedited Appeals section on page 42, the information appears to apply only to expedited appeals. *Recommendation: Update the Member Handbook to clarify information regarding continuation of benefits applies to both standard and expedited appeals.*
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal files reflect appropriate reviewers, timely determinations, and appropriate information in the notice of determination letters. Of note, appeal files contained evidence of letters being reviewed and edited for appropriate language prior to mailing to providers and members, as well as the use of an appeals checklist providing a snapshot of each appeal from receipt through resolution.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement	X					Policies MHSC-MIRR-02, Standard Appeal Process, and MHSC-MIRR-03, Expedited Appeal Process, indicate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
opportunities, and reported to the Quality Improvement Committee.						appeals information is maintained on a monthly basis and reported quarterly to SCDHHS. A quarterly appeals analysis is reported to the QIC. Review of committee minutes confirms reporting and discussion of appeals data at appropriate intervals.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management						
1. The MCO utilizes case management techniques to insure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					Molina's Case Management Program provides full integration of physical health, behavioral health and support, and social support services to eliminate fragmentation of care and to provide a single, individualized plan of care for members. Molina's Case Management Program was adapted from the corporate Integrated Care Management and Complex Case Management program and modified to meet state regulatory and contractual agreements. Multiple methods are used to identify members as potential candidates for case management, and after initial screening and assessment, members are stratified into four levels of acuity and case management involvement: •Level 1 health management for low-risk members •Level 2 case management for medium-risk members •Level 3 complex case management for high-risk members •Level 4 complex case management for imminent-risk members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Per the *HCS Program Description*, Molina's CM program staff work to coordinate health care services provided and/or arranged by the state, such as Targeted Case Management (TCM), to assist members in gaining access to needed medical, educational, social, and other services. This avoids service duplication and ensures members' needs are met. TCM services are available to a variety of eligible members including, but not limited to, alcohol and substance abuse disorders, children in foster care, the chronically mentally ill, emotionally disturbed children, children in the juvenile justice system, those with mental retardation and related disabilities, head and spinal cord injuries or related disabilities, sickle cell disease, and adults needing protective services. CM files reflect appropriate CM functions are performed with CM involvement in assisting members to obtain needed services, referrals, community resources, etc.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Policy MHSC HCS-CAM-362, Monitoring to Ensure Appropriate of Utilization, describes processes Molina uses to detect and correct potential under- and over-utilization of medical and behavioral health care services and resources.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Molina monitors and analyzes data on the following topics in regards to utilization: •Medical/Surgical Admits per 1000 •Behavioral Health Admits per 1000 •ER Visits per 1000 •Readmission percentage

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Molina's delegation process includes contracting with each delegated entity for the specific processes that are delegated. A sample credentialing delegation addendum was received in the desk materials. Molina delegates credentialing and recredentialing to the follow entities: Bon Secours St. Francis (BSSF), Managed Health Resources (MHR), Augusta University (AU), Greenville Hospital System (GHS), Medical University of South Carolina (MUSC), Preferred Care IPA (PCI), Regional Health Plus (RHP), and March Vision Care. Molina delegates primary source verification for credentialing and recredentialing to Aperture.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Several policies address delegation which includes pre-assessment audits for entities being considered for delegation and performance monitoring of delegated entities on an annual basis. In addition, delegates report quarterly on the delegated activities. All delegation oversight is monitored and approved by the SC Delegation Oversight Committee. When deficiencies are identified, corrective action plans are implemented with follow-up audits, as appropriate. Policy MHSC DR-01, Credentialing Program Policy, states the following requirement for delegation, "Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass MHSC's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and SCDHHS regulations and requirements for the Medicaid and Medicare programs, with a score of at least 90%." However, onsite discussion revealed a pre-delegation assessment is conducted for all new delegates. If the entity is NCQA accredited, then the pre-assessment is focused on state requirements. CCME suggested the language be adjusted to reflect a pre-delegation assessment is conducted even if the entity is NCQA accredited. Evidence of pre-delegation assessment for RHP along with annual audits for the remaining delegated entities was received with corrective action oversight, as appropriate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the language related to delegated credentialing in Policy MHSC DR-01, Credentialing Program Policy, reflects that a pre-delegation assessment is conducted even if the entity is NCQA accredited.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Policy MHSC QI 900.000, Preventive Health Guidelines, states adopted Preventive Health Guidelines are distributed via direct mail to affected physicians, physician newsletters, provider relations representative site visits, and the Molina website. Providers are informed in the *Provider Manual* of the expectation that preventive health guidelines will be followed and provider compliance will be assessed. Providers' compliance with delivery of preventive care and services and other relevant performance goals is measured, annually, by the medical record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review process.
1.2 performing EPSDTs/Well Care.	X					A detailed description of EPSDT services and requirements for delivery of those services is included in the *Provider Manual*. Providers are informed via the *Provider Manual* of the expectation that EPSDT services will be rendered and documented, as required, with provider compliance assessment. Providers' compliance with delivery of EPSDT services is measured, annually, by the medical record review process.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Molina has not supplied evidence of the required biennial security audit, its reports, and corresponding corrective action plan. Also no evidence is given for the required security audit prior to June 30, 2016. This issue was noted on the previous EQR and has not been corrected. *Quality Improvement Plan: Ensure all deficiencies identified in the external quality review are addressed.*