2020 External Quality Review

MOLINA HEALTHCARE OF SOUTH CAROLINA

Submitted: May 21, 2020

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2020 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Molina Healthcare of South Carolina (Molina) since the 2019 Annual Review.

The goals of the review are to:

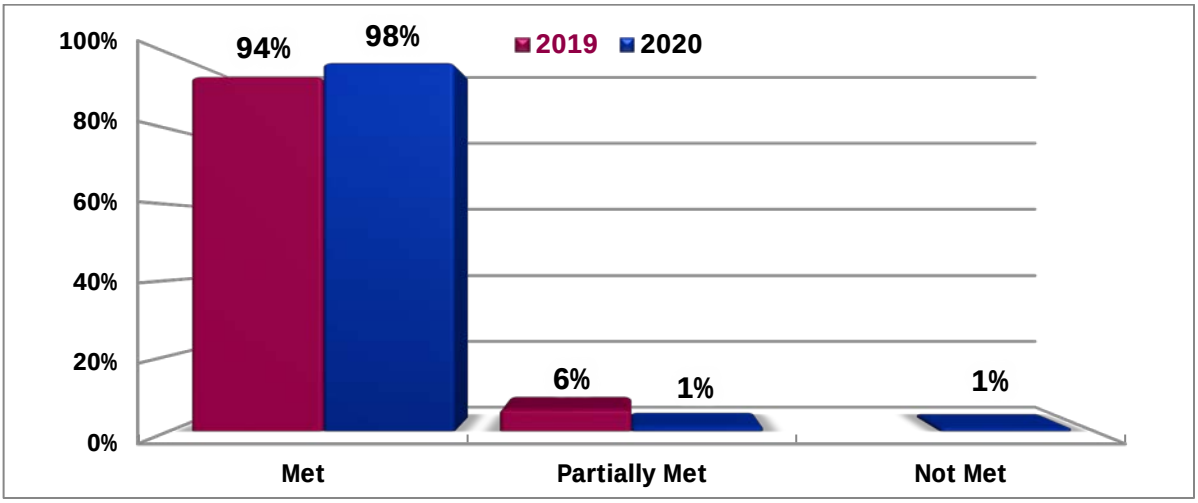
- Determine if Molina is following service delivery as mandated in the MCO contract with SCDHHS.
- Evaluate the status of deficiencies identified during the 2019 Annual Review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

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

Overall Findings

The 2020 annual EQR shows that Molina achieved a "Met" score for 98% of the standards reviewed. As the following chart indicates, 1% 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 2019 review results.

Figure 1: Annual EQR Comparative Results



Administration:

Molina has established processes for reviewing and revising policies and procedures on an annual basis. The Administrative and Policy Committee reviews and approves all policy and procedure revisions and staff are informed of updates by department leadership through email, staff meetings, etc.

All key positions are filled, and adequate staffing is in place to ensure Molina can provide required health care products and services to its membership.

Molina's claims payment averages to date for 2020 are 95.9% of claims paid within 30 days and 100% paid within 90 days. For 2019, claims payment rates were 96% (30 days) and 99.99% (90 days). Although security and resilience are often forgotten as organizations diversify IT resources, Molina has resisted this tendency and focused on security and recovery capabilities as systems are maintained and updated. Molina tests and audits its systems to ensure its efforts are implemented correctly and functioning as expected. The most recent audit and test results indicate that Molina is adhering to sound practices to ensure the integrity of its IT resources.

The Molina Healthcare of South Carolina Compliance Plan and Molina Healthcare of South Carolina, Inc. SFY 2019 - 2020 Fraud, Waste, and Abuse Plan, along with related policies and procedures, thoroughly document processes to ensure compliance with applicable laws and to detect, prevent, investigate, and report potential health care fraud, waste, and abuse (FWA). The Compliance Plan includes the organization's Code of Business Conduct and Ethics to guide staff in proper and ethical business conduct. Staff are advised they may contact a supervisor, the Compliance Department, or the General Counsel for questions about compliance and FWA issues. Staff are informed of their

responsibility to report violations of law or policy. Compliance and FWA training are provided to new employees at the time of hire and annual training is mandatory for all employees. Auditing and monitoring activities are conducted to identify compliance deficiencies, respond to reports of suspected non-compliance, and to assess the effectiveness of corrective measures implemented to address previously identified deficiencies. Reports generated from auditing, monitoring, and investigation activities are maintained by the Compliance Officer and shared with the Board of Directors and affected management, as appropriate.

Provider Services:

Processes for credentialing and recredentialing providers are documented in a policy; however, CCME noted the policy does not specify Molina's timeframe for processing a credentialing application. The Credentialing Program Policy requires that applications must be completed in their entirety and indicates incomplete applications result in discontinuing the processing of the application and an administrative denial or administrative termination from the network. However, file review confirmed Molina processed several incomplete applications as if they were complete.

The Professional Review Committee (PRC) is chaired by a Molina Medical Director and makes recommendations regarding credentialing decisions using a peer review process. CCME noted the committee's membership includes an appropriate array of external providers of various specialties. The Professional Review and Credentialing Committee Charter does not clearly define the quorum for the committee. One PRC meeting did not have the presence of a quorum. Onsite discussion revealed the meeting was halted and all votes were taken by email after the date of the meeting, but this was not reflected in the meeting minutes.

Molina defines standards for provider access and availability and runs Geo Access reports to assess availability. The plan demonstrated efforts to address a corrective action plan for neurology and urology specialists in Beaufort, Georgetown, and Hampton counties and discussed the recruitment process used in attempts to cure the deficiency.

CCME conducted a Telephonic Provider Access Study that focused on primary care providers. The 74% answer rate reflects an increase in successful calls that is statistically significant (p=<.001) when compared to results of 57% in 2019.

Member Services:

Molina has policies and procedures that define and describe member rights and responsibilities, as well as methods of notifying members of their rights and responsibilities. New members receive a Welcome Packet with instructions for contacting Member Services, selecting a primary care provider (PCP), and initiating services.

However, there is no documentation in Policy and Procedure, MHSC-ME-01, New Medicaid Member Outreach and Education or the Welcome Packet that new members are notified of their enrollee rights. The plan provides a list of preventive health guidelines and encourages members to obtain recommended preventive services. The annual member newsletter, "A Guide to Accessing Quality Health Care," is posted to the member website and each member household receives a mailed postcard informing them the newsletter is available for viewing.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continues to be conducted annually via a third-party vendor. The 2019 survey response rates continue to be below the National Committee for Quality Assurance target response rate of 40%. CCME provided recommendations to address identified issues.

Processes and requirements for handling member grievances are thoroughly and correctly documented in all information sources reviewed. Molina tracks, trends, and analyzes grievance data quarterly and annually. Results are reported to the Quality Improvement Committee (QIC) to help identify potential issues and quality improvement opportunities.

CCME's review of grievance files confirmed the process documented in Procedure MHSC-MRT-001, Grievance Disposition Process, Section B (5), is not being followed for grievances related to network providers that do not involve potential quality of care issues. These grievances are closed at the time of the referral to the Provider Services Department with no documentation of investigation or resolution and with a generic resolution provided to the member. This is a repeat finding from the previous EQR.

Quality Improvement:

Molina's 2019 Medicaid Quality Improvement (QI) Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually. Molina's Board has delegated the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC provides oversight and direction in assessing the appropriateness of care and service delivery.

Annually, Molina develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2019 and 2020 QI Work Plans. The 2020 Work Plan was marked as a draft. There were several errors identified in the 2020 Work Plan regarding the benchmark and goals listed for the provider access, availability of the contact center, and medical record monitoring.

According to Molina's 2019 QI Program Description, Molina conducts a formal evaluation of the QI program annually. The evaluation includes all quality activities with a description of limitations, barriers to improvements, recommendations, and the overall

effectiveness of the program. Molina provided the 2018 Molina of South Carolina QI Program Evaluation/Executive Summary. This summary did not include all quality improvement activities. Practitioner availability and accessibility of services, patient safety initiatives, medical record review activities, delegation monitoring, and performance improvement project results were not included.

Molina uses Inovalon, a certified software organization, for calculation of HEDIS rates. CCME found the measures met all requirements. The comparison from the previous to the current year revealed a substantial improvement (>10%) in several rates including Medication Management for People with Asthma, 51-65 Years of age, 50% Compliance, Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Follow-up Care for Children Prescribed ADHD Medication, and Initial Phase and Continuation and Maintenance Phase. The only measure with a substantial decrease was Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) 6-11 years. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	MEASURE YEAR 2017	MEASURE YEAR 2018	CHANGE FROM 2017 TO 2018
Substantial Increase in Rate (>10% improvement)			
Medication Management for People With Asthma (mma)			
51-64 Years: Medication Compliance 50%	58.54%	72.22%	13.68%
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	60.16%	71.19%	11.03%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	45.68%	60.05%	14.37%
Continuation and Maintenance (C&M) Phase	57.09%	76.74%	19.65%
Substantial Decrease in Rate (>10% decrease)			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)- 6-11 years	64.00%	52.63%	-11.37%

Quality Withhold Measures

There are 12 quality clinical withhold measures reported for MY2018 (RY 2019). As per the Medicaid Playbook and Policy and Procedure Guide for Managed Care Organizations, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points

attained for each measure are multiplied by the individual measure's weight and then summed to obtain the quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Diabetes measure rates generated the highest index score, followed by Women's Health, and then Pediatric Preventive Care.

Table 2: Quality Withhold Measures

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.77%	90	6	5.05
HbA1c Control (< =9)	47.49%	25	3	
Eye Exam (Retinal) Performed	61.87%	90	6	
Medical Attention for Nephropathy	93.41%	75	5	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	86.37%	75	5	4.05
Breast Cancer Screen	58.83%	50	4	
Cervical Cancer Screen	58.15%	25	3	
Chlamydia Screen in Women (Total)	60.04%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	69.1%	50	4	2.85
Well Child Visits in 3rd, 4th, 5th & 6th Years of Life	60.83%	10	2	
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	73.24%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication - Initiation	60.05%	90	6	3.25
Antidepressant Medication Management Effective Continuation Phase Treatment	25.16	<10	1	
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total	58.4	25	3	

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	25.42	25	3	
Follow Up After Hospitalization for mental Illness - 7 Day Follow Up Total	33.45	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	39.74	25	3	

Molina submitted three projects for validation. They included Improving Claims Accuracy and Provider Satisfaction, Well Care Visits, and Breast Cancer Screening. All PIPs received a score within the "High Confidence Range." *Table 3: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 3: Performance Improvement Project Validation Scores

PROJECT	2019 VALIDATION SCORE	2020 VALIDATION SCORE
Breast Cancer Screening (Clinical)	84/85=99% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Well Care Visits (Clinical)	104/105=99% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Improving Claims Accuracy and Provider Satisfaction (Non-clinical)	79/90=88% Confidence in Reported Results	90/90=100% High Confidence in Reported Results

Utilization Management:

CCME's assessment of utilization management (UM) includes reviews of program descriptions, program evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. Policies and procedures define how UM, medical necessity determinations, appeals, and CM services are operationalized and provided to members. The UM Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health.

Service authorization requests are conducted by appropriate reviewers utilizing InterQual Criteria or other established criteria.

Overall, review of UM approval and denial files provided evidence that appropriate processes are followed. Issues were identified with providing appeals instructions to members related to members having access to their appeals file prior to the resolution and providing consistent addresses for submitting written appeals.

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

Delegation:

Molina enters into written agreements with all entities performing delegated functions. Written agreements with the delegation entities include the specific activities to be delegated and information about pre-delegation assessment, annual oversight, and ongoing monitoring of delegated activities, requirements for and restrictions on sub-delegation, reporting and submission requirements, actions taken for non-performance or substandard performance, and sanction monitoring and reporting requirements.

Policies and procedures address delegation requirements and processes, including pre-delegation assessment, annual assessment, ongoing monitoring, reporting and submission requirements, and action taken in response to substandard performance.

Review of delegation oversight documentation confirmed Molina conducts appropriate oversight of delegated entities.

State Mandated Services:

Provider compliance with providing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through member medical record documentation reviews and HEDIS reports of well-child visits. Molina provides all core benefits specified by the *SCDHHS Contract*. A Quality Improvement Plan item from the 2019 EQR relating to member grievances was not addressed.

Table 4: Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2019 review.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2019	39	1	0	0	0	40
2020	40	0	0	0	0	40
Provider Services						
2019	73	5	0	0	0	78
2020	79	0	0	0	0	79
Member Services						
2019	32	1	0	0	0	33
2020	32	0	1	0	0	33
Quality Improvement						
2019	13	2	0	0	0	15
2020	12	2	0	0	0	14
Utilization						
2019	43	2	0	0	0	45
2020	44	1	0	0	0	45
Delegation						
2019	1	1	0	0	0	2
2020	2	0	0	0	0	2
State Mandated Services						
2019	4	0	0	0	0	4
2020	3	0	1	0	0	4

METHODOLOGY

The process CCME used for the EQR activities was based on protocols developed by 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 February 3, 2020, CCME sent notification to Molina that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Molina to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on February 17, 2020 and reviewed in CCME's offices (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on April 22nd and 23rd. Because of issues with Covid 19, the onsite was conducted via WebEx. The onsite teleconference focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite . Onsite activities included an entrance conference, interviews with Molina's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *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 on the tabular spreadsheet (Attachment 4).

A. Administration

The review for the Administration section included policy and procedure management, organizational chart and staffing, information systems, compliance, program integrity, and confidentiality.

Molina ensures policies and procedures are reviewed at least annually. Policy review and revision is conducted by individual departments to make sure they address current requirements and practices. Once reviewed by the department, the Administrative and Policy (A&P) Committee is responsible for reviewing and approving any updates. Additional governing committees also review and approve policy revisions as needed. Staff are informed of policy and procedure updates by their department's leadership through email, staff meetings, etc. Although Molina does not currently use a policy management software platform, this is being considered for the future.

CCME's review of staffing and the Organizational Chart confirms contractually required key positions are filled and adequate staffing is in place to ensure Molina can provide all required health care products and services to its membership.

The information systems review, along with onsite discussion, revealed the claims payment averages for 2020 are 95.9% of claims paid within 30 days and 100% paid within 90 days. For 2019, claims payment rates were 96% at 30 days and 99.99% at 90 days. The information systems review also confirmed that, although security and resilience are often forgotten as organizations diversify IT resources, Molina has resisted this tendency and focused on security and recovery capabilities as systems are maintained and updated. To ensure its efforts are implemented correctly and functioning as expected, Molina tests and audits its systems. The most recent audit and test results indicate that Molina is adhering to sound practices to ensure the integrity of its IT resources.

The Molina Healthcare of South Carolina Compliance Plan (Compliance Plan) and Molina Healthcare of South Carolina, Inc. SFY 2019 - 2020 Fraud, Waste, and Abuse Plan (FWA Plan), along with related policies and procedures, thoroughly document processes to ensure compliance with all applicable laws and policies that govern Molina's activities and to detect, prevent, investigate, and report potential health care fraud, waste, and abuse (FWA). The "Code of Business Conduct and Ethics" section of the Compliance Plan provides guidance about proper and ethical business conduct applicable to all employees, officers, and directors. Staff are encouraged to contact an immediate supervisor, the Compliance Department, or the Company's General Counsel for questions about compliance and FWA issues. Staff are informed of their responsibility to report violations of law or policy.

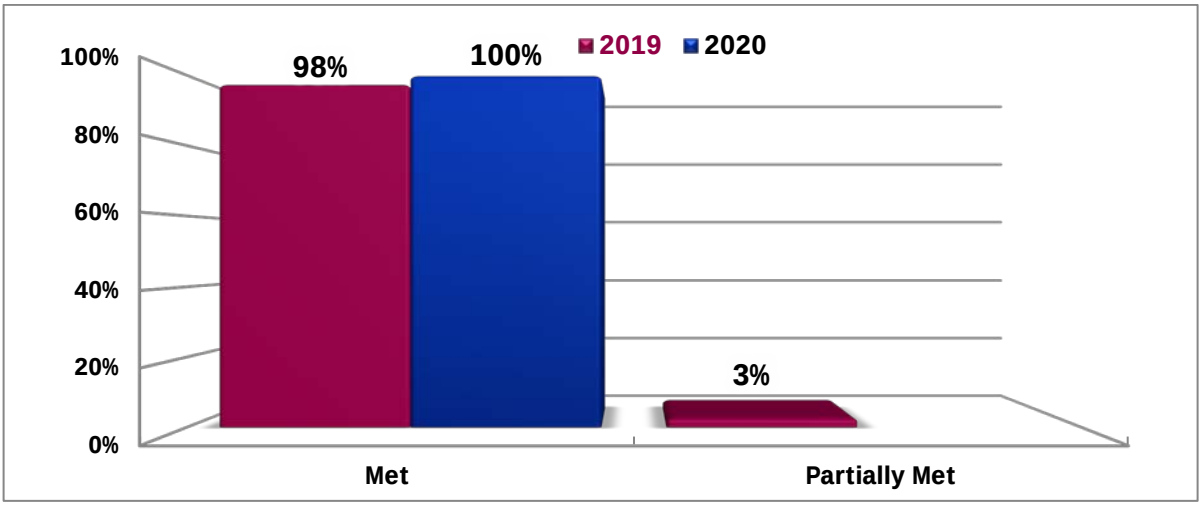
Compliance and FWA training are provided to new employees at the time of hire and annual training is mandatory for all employees. Compliance training includes the Code of Business Conduct and Ethics, the Compliance Plan, legal requirements affecting employee groups, reporting responsibilities, consequences of non-compliance, and the necessity of adhering to corrective action plans. FWA training includes recognition, detection, prevention, and reporting of suspected FWA activities, the impact of FWA on healthcare,

definitions of terminology, the Deficit Reduction Act and False Claims Act, the "Whistleblower Provision," and the non-retaliation policy.

Auditing and monitoring activities are conducted to identify compliance deficiencies, respond to reports of suspected non-compliance, and to assess the effectiveness of corrective measures implemented to address previously identified deficiencies. These activities include but are not limited to desk audits, surveys, interviews, document audits, and phantom member/provider claims or inquiries. Reports generated from auditing, monitoring, and investigation activities are maintained by the Compliance Officer and shared with the Board of Directors and affected management, as appropriate.

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

Figure 2: Administration Findings



Percent may not total 100% due to rounding

Table 5: Administration Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Compliance/ Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including exclusion status monitoring	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Molina focuses on system recoverability and validation of recovery capabilities by performing regular recovery exercises.
- Molina uses security best practices and is developing an organizational roadmap for upcoming security enhancements.

Weaknesses

- Onsite discussion confirmed the quorum for the Compliance Committee is 50% of the voting members plus one. However, Policy MHSC COM 05, Compliance Committee Charter, states, "A simple majority constitutes a quorum for the purposes of conducting committee business."

Recommendations

- Clarify the quorum for the Compliance Committee in Policy MHSC COM 05 to indicate it is a simple majority of voting members of the committee.

B. Provider Services

Processes for credentialing and recredentialing providers for participation in Molina's network are documented in policy. However, CCME noted the policy does not specify Molina's timeframe for processing a credentialing application.

The Professional Review Committee (PRC) makes recommendations regarding credentialing decisions using a peer review process. A Molina Medical Director provides oversight of the Credentialing Program, chairs the PRC, and appoints all committee members. The committee's membership includes an appropriate array of external providers, with specialties including pediatrics, internal medicine/cardiology, OB/GYN, and a physician assistant. The Professional Review and Credentialing Committee Charter definition of the quorum for the committee is unclear. One PRC meeting did not have the presence of a quorum. Onsite discussion revealed the meeting was halted and all votes were taken by email after the date of the meeting, but this information was not reflected in the meeting minutes.

The Credentialing Program Policy requires that applications must be completed in their entirety and that incomplete applications result in Molina discontinuing the processing of the application and an administrative denial or administrative termination from the network. However, two initial credentialing files did not have complete information regarding hospital admitting privileges and one initial credentialing application and one recredentialing application did not have a response to a question asking if laboratory services are provided at a practice location. Molina processed these applications as if they were complete.

Policies define availability and accessibility standards that comply with contract guidelines. Providers are informed of accessibility standards in the Provider Manual. CCME noted minor issues where standards were omitted from policies and the Provider Manual.

Molina contracts with Quest Diagnostics to conduct quarterly Geo Access reports to assess network availability. During the onsite teleconference, Molina discussed the efforts made towards addressing the Provider Network corrective action plan (CAP) in 2019 and explained that the urology deficiency was successfully cured and discussions with providers were in process to cure the neurology deficiency. Staff also reported that a barrier to recruiting providers into Molina's network is that the providers in those deficient counties have excessive member panels and are reluctant to take on new patients.

Molina annually performs provider appointment and after-hours telephonic surveys for primary care providers, specialists, and behavioral health practitioners. Results of the appointment accessibility audit conducted in 2019 showed improvement from the prior year.

Policy MHSC QI 011, Practitioner Network Cultural Responsiveness gives an overview of Molina's activities to ensure services and materials are provided in a culturally-competent manner to members, including those with limited English proficiency. Molina maintains culturally and linguistically appropriate resources and training modules on the provider website and informs providers of their availability.

Molina's National Quality Improvement Committee (NQIC) selects, reviews, and approves preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) based on scientific evidence and recommendations made by national clinically-based organizations. The selected PHGs and CPGs are relevant to the health plan's population. Once approved by the NQIC, the PHGs and CPGs are reviewed by the local health plan's QIC for initial approval and adoption and at least every 2 years thereafter. Appropriate practitioners are included in the review and adoption of PHGs and CPGs.

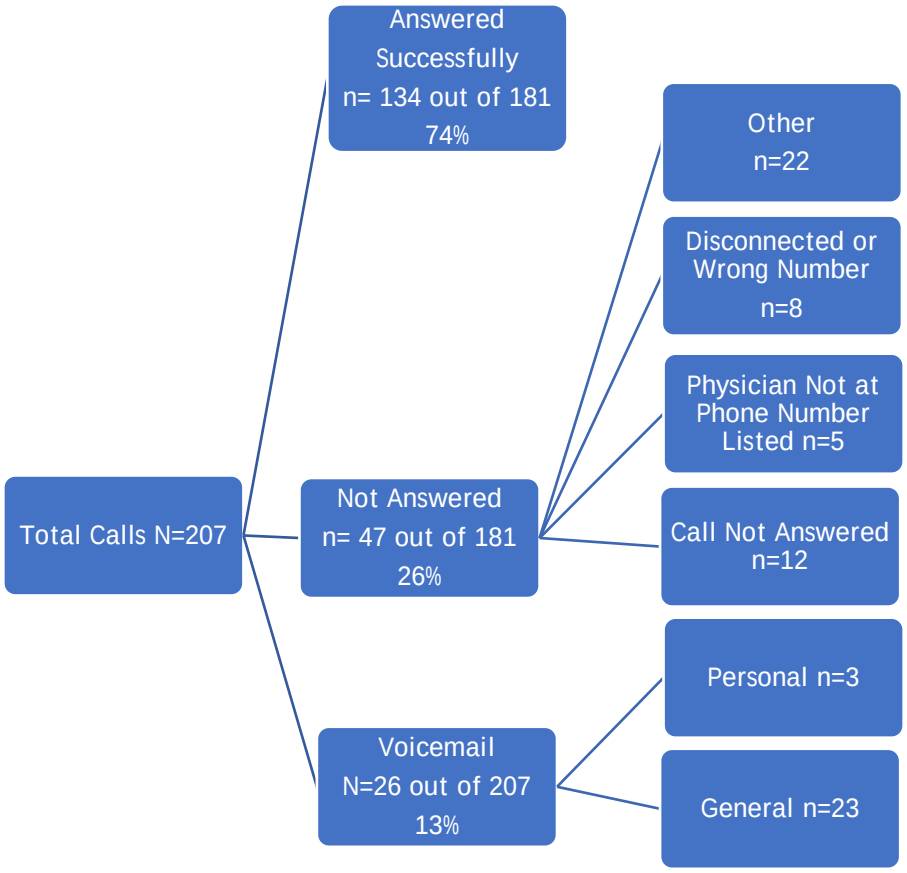
The Quality Improvement Department is responsible for distributing new, updated, and revised PHGs and CPGs to providers via orientation materials, Provider Manuals, newsletters, special mailings, and fax blasts. The PHGs and links to the CPGs are included on Molina's website. Provider Service representatives orient new providers to all guidelines via the Provider Manual and/or distribute them during the provider orientation visit. Paper copies are available upon request.

Provider compliance with medical record documentation standards is monitored through the annual medical record audit. Any deficiencies are addressed with providers. The 2019 medical record review consisted of 150 member records and included 30 providers who scored 90% or higher.

Provider Access and Availability Study

As part of the annual EQR process for Molina, CCME conducted a Telephonic Provider Access Study focused on primary care providers (PCPs). The Molina Provider File contained a population of 2,812 PCPs. From that, a random sample of 207 PCPs was selected for the provider access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. Calls were successfully answered 74% of the time (134 of 181) when omitting 26 calls answered by personal or general voicemail messaging services. *Figure 3: Telephonic Provider Access Study Results* provides an overview of the successfully and unsuccessful answered calls.

Figure 3: Telephonic Provider Access Study Results



Per *Table 6: Telephonic Access Study Answer Rate Comparison*, when compared to last year's results of 57%, this year has an increase in successful calls that is statistically significant (p=<.001).

Table 6: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2019 Review	272	57%	<.001
2020 Review	207	74%	

For calls not answered successfully (n=47 calls), 12 (26%) were unsuccessful because the phone was not answered or went to a busy signal. Of the 103 who answered the questions regarding accepting Molina, 99 (96%) of the providers indicated they accept Molina, and two (2%) indicated that they accept Molina under certain conditions.

Sixty-one (61) providers of 95 (64%) responded that they are accepting new Medicaid patients. The 61 providers that responded to the item indicated an application or prescreen was necessary. Of the 45 that answered the question, 18 (40%) indicated that there were no prescreen requirements and the remaining 27 (60%) indicated that an application or prescreen was necessary. Of those 27, eight (30%) indicated that an application must be filled out; one (3%) require a review of medical record; and 16 (59%) required both an application and a medical record review. Two of the 27 (7%) had a prescreen requirement of meeting with a coordinator.

Figure 4: Provider Services Findings shows that 100% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings

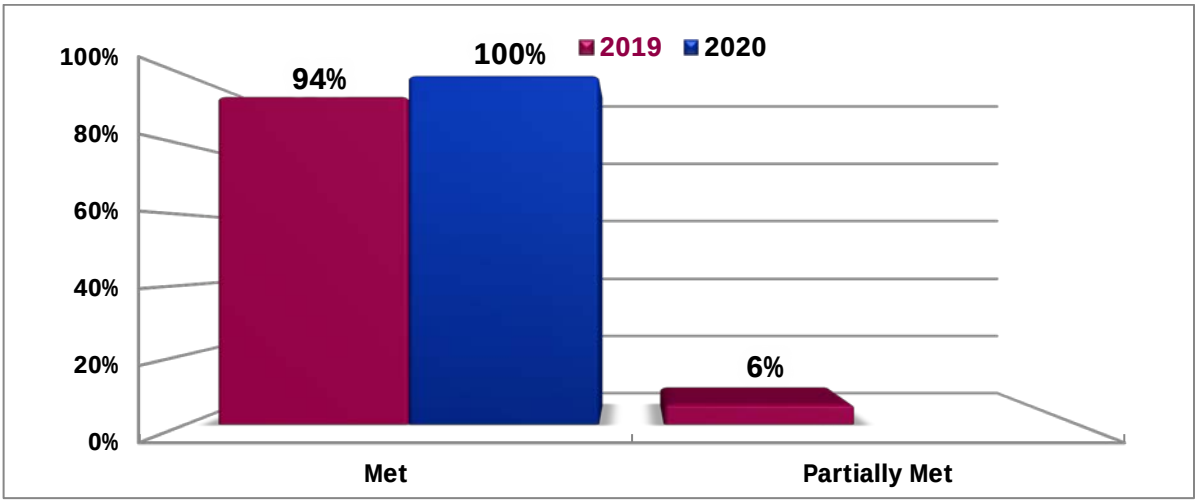


Table 7: Provider Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- The Provider Access Study successful call rate increased compared to last year.
- Molina maintains a wealth of information for providers on its website, including resources for culturally and linguistically appropriate services, training modules, Preventive Health and Clinical Practice Guidelines, etc.

Weaknesses

- Policy MHSC CR-01, Credentialing Program Policy does not specify Molina's timeframe for processing a credentialing application.
- CCME's review of Professional Review and Credentialing Committee minutes revealed the 12/19/19 meeting did not have the presence of a quorum. Onsite discussion confirmed the meeting was halted and all votes were taken by email after the date of the meeting. This information was not reflected in the meeting minutes.
- Policy MHSC-CR 01, Credentialing Program Policy requires credentialing and recredentialing applications to be complete in their entirety. The policy indicates incomplete applications result in Molina discontinuing processing of the application and an administrative denial or administrative termination from the network. File review revealed that Molina did not follow its policy and processed several incomplete applications (hospital admitting privileges and laboratory services) as complete.
- Two initial credentialing files and one recredentialing application did not contain evidence of a Clinical Laboratory Improvement Amendment (CLIA) Certificate for practice locations indicating laboratory services are provided. Molina staff indicated the locations mentioned above were not included in contracting for the providers; however, there was nothing in the credentialing or recredentialing files to specify the locations for which the providers were being contracted.
- Policy MHSC-PC-011, Availability of Health Care does not specify the standard for the percentage of members to have access to a hospital.
- Issues for specialty referral standards were identified in the Provider Manual included:

- Appointment times in the table on page 56, indicate routine Specialist Care appointment are within 12 weeks; however, per *SCDHHS Contract, Section 6.2.3.1.5.3*, routine care should be provided with four weeks and a maximum of 12 weeks for unique specialists.
- The requirements for emergent visits immediately upon referral and for urgent medical condition care appointments within forty-eight (48) hours of referral or notification of the Primary Care Physician are omitted.

- Policy MHSC-PS-005, Provider Availability Standards, omitted the following requirements for specialty referrals:
  - Emergent visits immediately upon referral.
  - Urgent medical condition care appointments within 48 hours of referral or notification of the PCP.
  - Routine care appointments within four weeks and a maximum of twelve (12) weeks for unique specialists.

Recommendations

- Revise Policy MHSC CR-01 to include the timeframe for processing a credentialing application. Refer to the *SCDHHS Contract, Section 2.8.2.4.2*.
- Ensure committee minutes reflect the actions taken in response to the absence of a quorum.
- Ensure all provider applications are complete, as required by Policy MHSC-CR 01. If an application does not include a response for provider admitting privileges or the response is that privileges are pending, Molina must verify the provider's current status or admitting plan. Providers who do not manage care in an inpatient setting should supply the name of a practitioner or hospital to whom patients will be referred for admission or provide a detailed plan if they do not have an arrangement in place.
- Include information in credentialing and recredentialing files indicating which of the provider's practice locations are included in contracting.
- Edit Policy MHSC-PC-011, Availability of Health Care to include the standard that 90% of eligible members will have access to a hospital in the required time and distance standards, as specified in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.1*.
- Ensure all appointment standards for specialty referrals are correctly documented in the Provider Manual and in Policy MHSC-PS-005, Provider Availability Standards, as required in the *SCDHHS Contract, Section, 6.2.3.1.5*.

C. Member Services

The review of Member Services included policies and procedures, member rights, member informational materials, grievances, and the Member Satisfaction Survey. Molina's Member Handbook is thorough, easily understood, and meets the sixth-grade reading comprehension level as required by SCDHHS.

Molina's website has quick links and resources for members to access information such as the Member Handbook, Provider Directory, and newsletters. Members receive a Welcome Packet with instructions for accessing the Member Handbook, Provider Directory, Notice of Privacy Practice, and member education information. However, the Welcome Packet and Policy and Procedure, MHSC-ME-01, New Medicaid Member Outreach and Education does not include information on enrollee rights.

The Member Handbook informs members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions on how to access benefits. Additionally, the Member Handbook provides information on obtaining Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The handbook is available in Spanish and alternate formats including large font, audio, and Braille.

Member Services staff are located in Mississippi and Florida and are available per contract requirements via a toll-free number. The toll-free Member Services telephone number routes calls to Interactive Voice Response (IVR) menus that allow callers to reach appropriate staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday. The toll-free number and mailing address are in the Member Handbook and on the website; however, the fax number and email address are not found in the Member Handbook or on the website.

Molina contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, to conduct both the Child and Adult surveys. The response rates were below the NCQA target of 40%. The Adult survey had more than the required sample size of at least 411 (n=481), and the response rate of 29% is higher than the 2019 rate (26.8%). For Child Surveys, the required sample of 411 was not met (n=391), and response rates increased slightly from 23.4% in 2018 to 23.9% in 2019. The minimum required sample of 411 was met (n=817) with a response rate of 19.6% in 2019 for the Children with Chronic Conditions (CCC) survey. Results of the CAHPS survey are distributed to providers and presented to the Quality Improvement Committee (QIC).

Processes and requirements for handling member grievances are thoroughly documented in policy, the Member Handbook, Provider Manual, and on Molina's website. Grievance data is tracked, trended, and an analysis of grievances is conducted quarterly, with the

results reported to the QIC to help identify potential issues and quality improvement opportunities. In addition to the quarterly analysis, a yearly analysis of the previous year is conducted. A review of Molina's QIC minutes confirms an update of grievance data and activity is presented during each meeting. As contractually required, Molina maintains a grievance log and retains all grievance documentation and related correspondence for at least 10 years.

Procedure MHSC-MRT-001, Grievance Disposition Process, Section B (5), states that for grievances related to network providers and not involving potential quality of care issues, resolution will be sent from Provider Services back to the MRT Specialist to complete the grievance process "and notify the member of the grievance resolution." CCME's review of grievance files revealed that this procedure is not being followed. Grievances referred to the Provider Services Department are closed with no documentation of investigation or resolution of the member's grievance, and a generic resolution is provided to the member. This is a repeat finding from the previous EQR.

Figure 5: Member Services Findings shows that 97% of the standards in Member Services received a "Met" score.

Figure 5: Member Services Findings

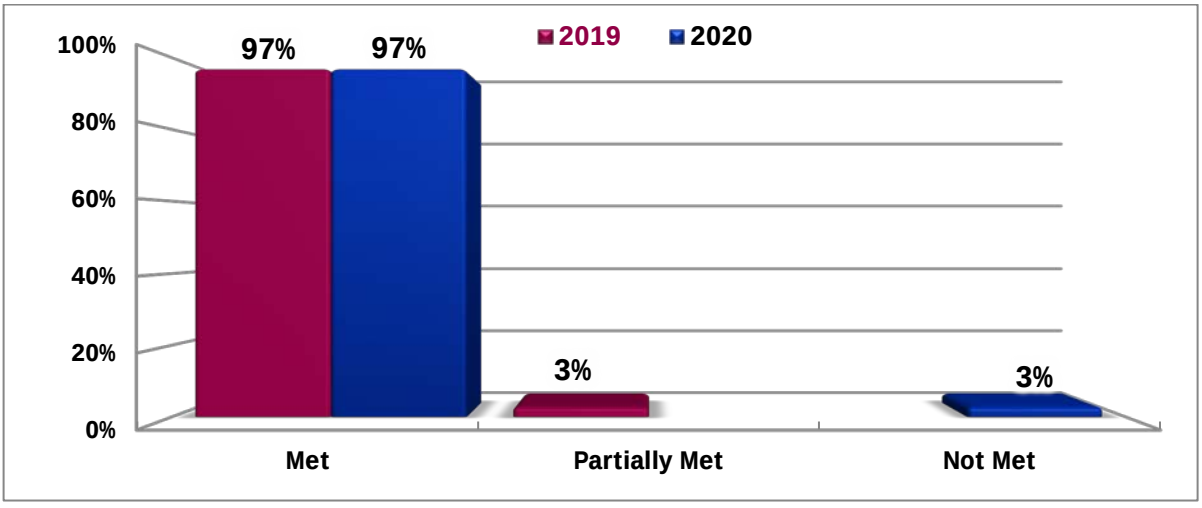


Table 8: Member Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Grievances	The MCO applies grievance policies and procedures as formulated	Partially Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- The website has a dedicated tab of "Annual Reminders" that covers some of the required member communication.
- Member Services staff monitor select website traffic to member and provider services and resources.

Weaknesses

- The Member Handbook and website do not include the fax number and email address for Member Services.
- Policy and Procedure, MHSC-ME-01, New Medicaid Member Outreach and Education on enrollee rights and the Welcome Packet does not include information on enrollee rights.
- Response rates for the Child and Adult CAHPS surveys were below the NCQA target of 40%.
- CCME's review of grievance files revealed that grievances referred to Provider Services were closed with no documentation of investigation or resolution of the issues included in the grievance. The member was provided a generic resolution that did not specifically address the member's grievance. This is a repeat finding from the previous EQR.

Quality Improvement Plans

- Revise grievance processes to ensure grievance files include documentation of the investigation of all issues raised by the member, findings of the investigation, and any actions taken to address the specific issues about which the member filed the grievance. Ensure resolution information provided to the member specifically addresses all issues raised in the member's grievance and the actual resolution of those issues.

Recommendations

- Include the Member Services fax number and email address in the Member Handbook as required in the *SCDHHS Contract, Section 3.13.2.,9* and consider adding it to the member website to be consistent.

- Edit Policy or Procedure, MHSC-ME-01, New Medicaid Member Outreach and Education to include new members are provided information on enrollee rights. Ensure Molina provide information on enrollee rights to new members.

- Because low CAHPS survey response rates affect generalizability of results, continue working with SPH Analytics to increase response rates for Adult and Child surveys.

D. Quality Improvement

The 2019 Medicaid Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.

Molina's Board of Directors has the ultimate authority and accountability for oversight of the Quality Improvement (QI) Program. The Board has delegated the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC provides oversight and direction in assessing the appropriateness of care and service delivery. The QIC receives reports from QI subcommittees, advises, and directs the subcommittees. Molina's Chief Medical Officer and Quality Lead co-chair the QIC. Members includes senior management and internal department staff and network practitioners specializing in pediatrics, OB/GYN, family medicine, and cardiology.

Annually, Molina develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2019 and 2020 QI Work Plans. The 2020 work plan was marked as a draft. There were several errors identified in the 2020 work plan regarding the benchmark and goals listed for provider access, availability, the contact center, and medical record monitoring. Specifics are noted in the weaknesses section.

According to Molina's 2019 QI Program Description, Molina conducts a formal evaluation of the QI program annually. The evaluation includes all quality activities with a description of limitations, barriers to improvements, recommendations, and the overall effectiveness of the program. Molina provided the 2018 Molina of South Carolina QI Program Evaluation/Executive Summary. This summary did not include all quality improvement activities. Practitioner Availability and Accessibility of Services, patient safety initiatives, medical record review activities, delegation monitoring, and performance improvement project results were not included.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

Molina uses Inovalon, a certified software organization, for calculation of HEDIS rates. CCME found the measures met all requirements. The HEDIS 2018 rate, the HEDIS 2019 rate, and the change in rates are presented in *Table 9: HEDIS Performance Measure Data*. The rates shown in green indicate a substantial (>10%) improvement and the rates shown in red indicate a substantial (>10%) decline.

Table 9: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	82.53%	90.27%	7.74%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	65.45%	73.24%	7.79%
Counseling for Nutrition	58.39%	62.04%	3.65%
Counseling for Physical Activity	51.09%	56.20%	5.11%
Childhood Immunization Status (cis)			
DTaP	73.48%	74.94%	1.46%
IPV	86.86%	84.18%	-2.68%
MMR	88.32%	88.08%	-0.24%
HiB	82.24%	83.70%	1.46%
Hepatitis B	84.67%	84.91%	0.24%
VZV	89.05%	87.59%	-1.46%
Pneumococcal Conjugate	73.72%	77.13%	3.41%
Hepatitis A	85.40%	82.97%	-2.43%
Rotavirus	70.56%	70.07%	-0.49%
Influenza	38.69%	37.96%	-0.73%
Combination #2	68.86%	70.32%	1.46%
Combination #3	65.45%	68.86%	3.41%
Combination #4	64.23%	66.67%	2.44%
Combination #5	55.96%	58.64%	2.68%
Combination #6	31.87%	32.60%	0.73%

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Combination #7	54.99%	57.18%	2.19%
Combination #8	31.63%	32.60%	0.97%
Combination #9	27.49%	28.71%	1.22%
Combination #10	27.25%	28.71%	1.46%
Immunizations for Adolescents (ima)			
Meningococcal	67.64%	77.13%	9.49%
Tdap	85.64%	87.10%	1.46%
HPV	27.49%	32.12%	4.63%
Combination #1	66.91%	76.40%	9.49%
Combination #2	26.28%	31.87%	5.59%
Lead Screening in Children (lsc)	69.59%	69.34%	-0.25%
Breast Cancer Screening (bcs)	58.13%	58.83%	0.70%
Cervical Cancer Screening (ccs)	56.05%	58.15%	2.10%
Chlamydia Screening in Women (chl)			
16-20 Years	53.81%	57.16%	3.35%
21-24 Years	62.63%	68.35%	5.72%
Total	56.04%	60.04%	4.00%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	78.09%	81.59%	3.50%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.89%	26.46%	-0.43%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	65.17%	68.76%	3.59%
Bronchodilator	76.30%	78.10%	1.80%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	55.59%	57.39%	1.80%
5-11 Years: Medication Compliance 75%	26.76%	28.35%	1.59%
12-18 Years: Medication Compliance 50%	48.10%	56.25%	8.15%
12-18 Years: Medication Compliance 75%	23.65%	27.29%	3.64%
19-50 Years: Medication Compliance 50%	55.22%	57.53%	2.31%
19-50 Years: Medication Compliance 75%	31.34%	31.51%	0.17%
51-64 Years: Medication Compliance 50%	58.54%	72.22%	13.68%
51-64 Years: Medication Compliance 75%	39.02%	42.59%	3.57%
Total: Medication Compliance 50%	52.88%	57.61%	4.73%

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Total: Medication Compliance 75%	26.44%	28.92%	2.48%
Asthma Medication Ratio (amr)			
5-11 Years	80.39%	79.71%	-0.68%
12-18 Years	70.43%	72.03%	1.60%
19-50 Years	55.81%	54.37%	-1.44%
51-64 Years	55.74%	48.78%	-6.96%
Total	72.91%	71.49%	-1.42%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	45.26%	50.12%	4.86%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	77.78%	76.92%	-0.86%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy: 21-75 Years (Male)	71.72%	79.08%	7.36%
Statin Adherence 80%: 21-75 Years (Male)	50.00%	52.26%	2.26%
Received Statin Therapy: 40-75 Years (Female)	73.83%	71.43%	-2.40%
Statin Adherence 80%: 40-75 Years (Female)	46.36%	53.08%	6.72%
Received Statin Therapy: Total	72.62%	75.40%	2.78%
Statin Adherence 80%: Total	48.41%	52.63%	4.22%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	91.48%	89.77%	-1.71%
HbA1c Poor Control (>9.0%)	54.50%	47.49%	-7.01%
HbA1c Control (<8.0%)	40.88%	44.19%	3.31%
Eye Exam (Retinal) Performed	65.21%	61.87%	-3.34%
Medical Attention for Nephropathy	92.94%	93.41%	0.47%
Blood Pressure Control (<140/90 mm Hg)	53.04%	55.46%	2.42%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	60.79%	62.22%	1.43%
Statin Adherence 80%	44.99%	45.24%	0.25%
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	60.16%	71.19%	11.03%
Effectiveness of Care: Behavioral Health			

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	41.10%	39.50%	-1.60%
Effective Continuation Phase Treatment	27.69%	25.16%	-2.53%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	45.68%	60.05%	14.37%
Continuation and Maintenance (C&M) Phase	57.09%	76.74%	19.65%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	72.15%	NA
6-17 years - 7-Day Follow-Up	NR	50.00%	NA
18-64 years - 30-Day Follow-Up	NR	54.46%	NA
18-64 years - 7-Day Follow-Up	NR	26.98%	NA
65+ years - 30-Day Follow-Up	NR	NA*	NA
65+ years - 7-Day Follow-Up	NR	NA*	NA
Total - 30-Day Follow-Up	64.53%	59.43%	-5.10%
Total - 7-Day Follow-Up	40.31%	33.45%	-6.86%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	66.56%	NA
6-17 years - 7-Day Follow-Up	NR	43.65%	NA
18-64 years - 30-Day Follow-Up	NR	51.25%	NA
18-64 years - 7-Day Follow-Up	NR	36.88%	NA
65+ years - 30-Day Follow-Up	NR	NA*	NA
65+ years - 7-Day Follow-Up	NR	NA*	NA
Total - 30-Day Follow-Up	58.93%	57.41%	-1.52%
Total - 7-Day Follow-Up	42.37%	39.60%	-2.77%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: 13-17 Years	8.33%	NA	NA
7-Day Follow-Up: 13-17 Years	5.56%	NA	NA
30-Day Follow-Up: 18+ Years	14.14%	17.77%	3.63%
7-Day Follow-Up: 18+ Years	9.09%	12.18%	3.09%
30-Day Follow-Up: Total	13.66%	18.33%	4.67%
7-Day Follow-Up: Total	8.80%	12.38%	3.58%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	76.87%	79.82%	2.95%

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	74.34%	74.21%	-0.13%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	82.35%	NA	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	68.38%	72.34%	3.96%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	0.00%	NA	NA
6-11 Years	18.58%	20.00%	1.42%
12-17 Years	22.43%	27.67%	5.24%
Total	21.22%	25.42%	4.20%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	91.03%	91.62%	0.59%
Diuretics	90.27%	91.83%	1.56%
Total	90.69%	91.72%	1.03%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.26%	0.92%	-0.34%
Appropriate Treatment for Children With URI (uri)	82.87%	87.58%	4.71%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	26.49%	26.68%	0.19%
Use of Imaging Studies for Low Back Pain (lbp)	66.48%	63.34%	-3.14%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	NA	NA
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	0.50%	0.00%	-0.50%
Total	0.34%	0.00%	-0.34%
Use of Opioids at High Dosage (uod)	31.59	2.44%	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	273.63	25.40%	NA
Multiple Pharmacies	79.41	9.35%	NA
Multiple Prescribers and Multiple Pharmacies	46.08	4.46%	NA

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	5.51%	NA
18-64 years - >=31 Days covered	NR	2.60%	NA
65+ years - >=15 Days covered	NR	NA	NA
65+ years - >=31 Days covered	NR	NA	NA
Total - >=15 Days covered	NR	5.51%	NA
Total - >=31 Days covered	NR	2.60%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	78.08%	79.69%	1.61%
45-64 Years	88.52%	89.17%	0.65%
65+ Years	NA	NA	NA
Total	81.57%	82.97%	1.40%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	95.25%	96.73%	1.48%
25 Months - 6 Years	85.37%	86.11%	0.74%
7-11 Years	90.05%	89.88%	-0.17%
12-19 Years	88.97%	89.48%	0.51%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	18.18%	NA	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	4.55%	NA	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	0.00%	NA	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	0.00%	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	32.26%	40.54%	8.28%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	20.00%	25.23%	5.23%
Initiation of AOD Treatment: 13-17 Years	30.77%	39.67%	8.90%
Engagement of AOD Treatment: 13-17 Years	18.34%	23.97%	5.63%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	37.85%	40.92%	3.07%

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.15%	7.38%	-0.77%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	45.11%	50.59%	5.48%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	19.87%	22.78%	2.91%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	38.35%	37.96%	-0.39%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	10.42%	9.41%	-1.01%
Initiation of AOD Treatment: 18+ Years	38.13%	39.74%	1.61%
Engagement of AOD Treatment: 18+ Years	10.37%	10.70%	0.33%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	37.24%	40.96%	3.72%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	8.04%	7.77%	-0.27%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	44.55%	50.29%	5.74%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	19.63%	22.65%	3.02%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	37.48%	38.22%	0.74%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	11.79%	11.01%	-0.78%
Initiation of AOD Treatment: Total	37.45%	39.74%	2.29%
Engagement of AOD Treatment: Total	11.11%	11.57%	0.46%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	87.36%	86.37%	-0.99%
Postpartum Care	64.66%	69.83%	5.17%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	0.00%	NA	NA
6-11 Years	64.00%	52.63%	-11.37%
12-17 Years	64.13%	61.63%	-2.50%

MEASURE/DATA ELEMENT	MY 2017 (HEDIS 2018)	MY 2018 (HEDIS 2019)	PERCENTAGE POINT DIFFERENCE
Total	63.64%	58.40%	-5.24%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.77%	0.73%	-1.04%
1 Visit	2.03%	0.49%	-1.54%
2 Visits	3.29%	2.19%	-1.10%
3 Visits	7.09%	4.14%	-2.95%
4 Visits	8.35%	8.52%	0.17%
5 Visits	12.66%	14.84%	2.18%
6+ Visits	64.81%	69.10%	4.29%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	63.52%	60.83%	-2.69%
Adolescent Well-Care Visits (awc)	50.36%	51.58%	1.22%

*Note: * indicates small denominator; NR= not reported; NA= not applicable due to missing data or small denominator*

The comparison from the previous to the current year revealed a substantial improvement (>10%) in several rates including Medication Management for People with Asthma, 51-65 Years of Age, 50% Compliance, Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Follow-up Care for Children Prescribed ADHD Medication, Initial Phase and Continuation, and Maintenance Phase. The only measure with a substantial decrease was Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) 6-11 years. Molina mentioned that this rate differential might be due to a coding/documentation issue. The low rate for use of opioids at a high dosage was discussed during the onsite, and Molina shared information on the pharmacy lock-in program that prevents members from obtaining opioids from multiple pharmacies and/or multiple prescribers. *Table 10: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 10: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	MEASURE YEAR 2017	MEASURE YEAR 2018	CHANGE FROM 2017 TO 2018
Substantial Increase in Rate (>10% improvement)			
Medication Management for People With Asthma (mma)			
51-64 Years: Medication Compliance 50%	58.54%	72.22%	13.68%
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	60.16%	71.19%	11.03%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	45.68%	60.05%	14.37%
Continuation and Maintenance (C&M) Phase	57.09%	76.74%	19.65%
Substantial Decrease in Rate (>10% decrease)			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)- 6-11 years	64.00%	52.63%	-11.37%

Quality Withhold Measures

There are 12 quality clinical withhold measures reported for MY2018 (RY 2019). As per the Medicaid Playbook and Policy and Procedure Guide for Managed Care Organizations, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by the individual measure's weight then summed to obtain the quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 11: Quality Withhold Measures*. The Diabetes measure rates generated the highest index score, followed by Women's Health, and then Pediatric Preventive Care.

Table 11: Quality Withhold Measures

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.77%	90	6	5.05
HbA1c Control (< =9)	47.49%	25	3	
Eye Exam (Retinal) Performed	61.87%	90	6	

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
Medical Attention for Nephropathy	93.41%	75	5	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	86.37%	75	5	4.05
Breast Cancer Screen	58.83%	50	4	
Cervical Cancer Screen	58.15%	25	3	
Chlamydia Screen in Women (Total)	60.04%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	69.1%	50	4	2.85
Well Child Visits in 3rd,4th,5th&6th Years of Life	60.83%	10	2	
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	73.24%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	60.05%	90	6	3.25
Antidepressant Medication Management Effective Continuation Phase Treatment	25.16	<10	1	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	58.4	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	25.42	25	3	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	33.45	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	39.74	25	3	

Performance Improvement Project Validation

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

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

Molina submitted three projects for validation. They included Improving Claims Accuracy and Provider Satisfaction, Well Care Visits, and Breast Cancer Screening. All PIPs received a score within the High Confidence Range. *Table 12: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 12: Performance Improvement Project Validation Scores

PROJECT	2019 VALIDATION SCORE	2020 VALIDATION SCORE
Breast Cancer Screening (Clinical)	84/85=99% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Well Care Visits (Clinical)	104/105=99% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Improving Claims Accuracy and Provider Satisfaction (Non-Clinical)	79/90=88% Confidence in Reported Results	90/90=100% High Confidence in Reported Results

Last year, the recommendations were to include interventions in the document for the Provider Satisfaction PIP. The PIP did include barriers and interventions, and claims-related rates have improved to exceed goal rates (decreased). The Improving Claims Accuracy and Provider Satisfaction rate improved since the last remeasurement but is not at goal rate. Regarding Well-Care Visits, the results showed that the rates did increase once hybrid rates were calculated for the calendar year 2018 data, except for W34. There are many barriers and interventions involved due to the large number of outcomes being measured. Interventions for members and providers should be continued and revised according to data analyses to increase well-care visit rates.

For the Breast Cancer Screening PIP, the rate improved when using the latest available finalized data, which is calendar year 2018. The calendar year 2019 data will be finalized in mid-2020. The interventions seem to be more focused on member outreach and incentives according to the report. Once the final rates are available, the interventions should continue to be adjusted, as needed, to increase the screening rate.

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

Molina achieved "Met" scores for 86% of the standards in the QI section. *Figure 6: Quality Improvement Findings* provides an overview of the scores in 2018 compared to the current review scores.

Figure 6: Quality Improvement Findings

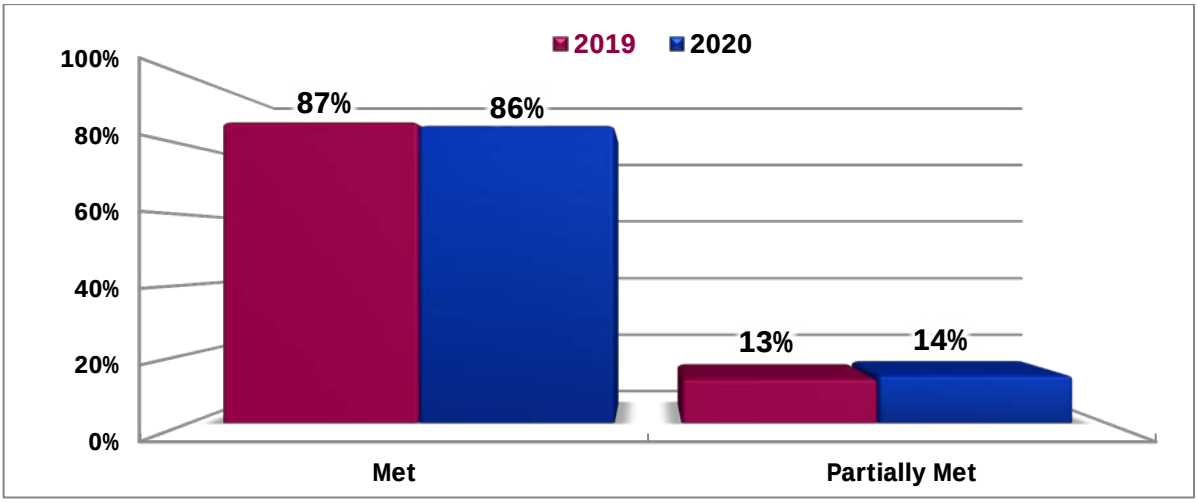


Table 13: Quality Improvement Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
The Quality Improvement (QI) Program	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Partially Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- The performance improvement projects received a validation score in the "High Confidence" Range.

Weaknesses

- Policy and Procedure PC-011, Provider Contracting lists the standards for PCP to member ratios and the distance and time access requirements. The following goals were incorrect in the 2020 Work Plan:
  - The ratio of PCPs to members being measured does not include FQHCs and RHCs (page 13).
  - The ratio of OB/GYNs is incorrectly listed as 1:5,000 members (page 14).
  - The goal listed for high impact specialists to member is 90% instead of the ratio of specialists to members (page 14).
  - For PCPs, only distance is measured. The access standard for time is not measured (page 16).
  - For high impact, high volume specialists, the distance goal (30 miles) is incorrect and time is not included. Also, OB/GYNs are not included in the measurement (page 17).
  - The distance goal (30 miles) is incorrect for behavioral health providers and time is not included (page 18).
- Policy MHSC-PS-005, Provider Availability Standards, and the Provider Manual include the appointment standards. The following issues were noted in the 2020 QI Work Plan related to appointment access:
  - Routine appointments are listed as within 4 weeks in the policy and in the Provider Manual. The Work Plan lists the goal as within 6 weeks (page 20).
  - Follow-up routine appointment for behavioral health providers is listed as "X" in the Work Plan (page 23).
  - Routine appointment for specialty providers is listed as 30 calendar days in the 2020 Work Plan (page 26) and the policy lists this standard as within 12 weeks.
- Policy MHSC-MS-01, Contact Center Performance, lists the performance standards for the contact center. The following were issues identified in the 2020 QI Work Plan.
  - The service level goal is listed as 85% within 30 seconds and the average speed to answer (ASA) goal is listed as 30 seconds in the Work Plan. The policy does not mention service level and lists the ASA goal as 80% (pages 20 and 52).

  - The ASA goal is listed as 95% within 30 seconds on page 23 of the Work Plan. The policy lists the goal as 80%.
- The 2018 Molina of South Carolina QI Program Evaluation/Executive Summary did not include all quality improvement activities. Practitioner Availability and Accessibility of Services, patient safety initiatives, medical record review activities, delegation monitoring, and performance improvement project results were not included.

Quality Improvement Plans

- Correct the errors identified in the 2020 QI Work Plan.
- A complete evaluation of the QI Program should be conducted annually to include all QI activity results, barriers encountered, and recommendations for improvements.

E. Utilization Management

CCME's assessment of utilization management (UM) includes reviews of program descriptions and evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. The Health Care Services (HCS) Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina.

Service authorization requests are conducted by appropriate reviewers using InterQual Criteria and other established criteria and meet timeframe requirements. During the onsite teleconference, CCME requested clarification of pharmacy authorization timeframes. Molina pharmacy staff confirmed that pharmacy authorizations are acknowledge via an automatic fax within 24 hours, standard determinations are made within 14 days, and this process has been approved by SCDHHS.

Molina assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing of both physician and non-physician reviewers and pharmacy staff. Reports indicate that five of 11 clinical review nurses scored below the 90% benchmark and received remediation.

Review of UM approval and denial files revealed staff consistently follow established processes and requirements for processing authorization requests. Appropriate peer reviewers issue determinations for those requests that cannot be approved on initial review by UM staff. Appeal files reflect appropriate processes are followed throughout the appeal review; however, CCME could not determine how members are informed they can have access to their appeal case file and other documents related to the appeal prior to the resolution timeframe. Additionally, inconsistent addresses for submitting written appeals were noted.

The Care Management Program Description outlines the framework for the program's goals, scope, and lines of responsibility. Molina uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels; however, there was no documentation that standards from the Case Management Society of America (CMSA) are followed. CM files indicate care management activities are conducted as required and Care Managers follow policies to conduct the appropriate level of care coordination.

Molina monitors and analyzes relevant data of potential or actual inappropriate under- or over-utilization which may impact health care services, coordination of care, and appropriate use of services and resources.

Overall, minor documentation issues were identified across several documents in various areas and CCME offered recommendations to address them.

As illustrated in *Figure 7: Utilization Management Findings*, 98% of the standards in the UM section are "Met." Standards scored as "Partially Met" are discussed in detail in the Weaknesses section of this report.

Figure 7: Utilization Management Findings

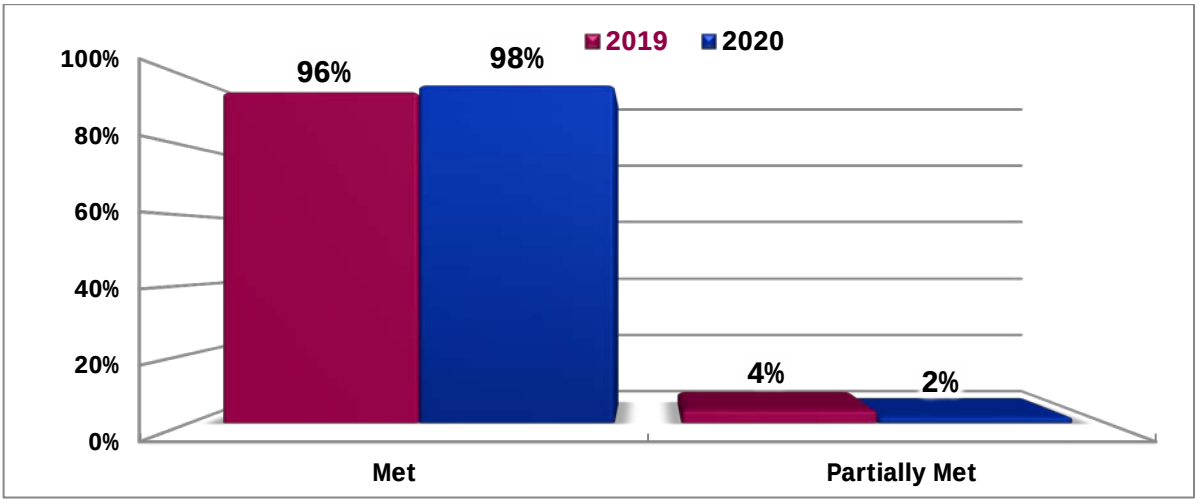


TABLE 14: Utilization Management Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 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
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including the procedure for filing an appeal	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Appeal resolution letters are written in language that is easily understood.
- Case Managers consistently conduct pre-call reviews and assess for gaps in care.

Weaknesses

- Instructions and a link to access the Consent for Sterilization Form from SCDHHS are found on page 110 of the Provider Manual and on page three of Procedure MHSC HCS-UM-358; however, these instructions are not posted on the provider website.
- The Consent for Sterilization Form is referenced as SCDHHS 1723 instead of DHHS-687 in Procedure MHSC HCS-UM-358.
- The redlined version of the 2020 Pharmacy Program Description has references of a "5-day" emergency supply marked for deletion without replacing it with a different time frame.
- In addition to describing the process for authorized representatives to file appeals, Policy MHSC-MRT-002, Standard Appeal Process, further includes the statement, "a member's consent for treatment serves as consent for the provider to appeal on the member's behalf. Molina considers medical records and/or a provider's history of paid claims for services rendered to the member as evidence that a member has signed a consent for treatment." This consideration is not communicated in the Provider Manual or Member Handbook.

- Members are not informed they have access to their appeal case file and other documents related to the appeal prior to the resolution timeframe.
- The Member Handbook and Policy and Procedure MHSC-MRT-002, Standard Appeal Process does not include an address to which written appeals can be submitted.
- Addresses provided for members and providers to submit written appeals are slightly different in the Provider Manual, Adverse Benefit Determination letter template, and the member website.
- No documentation was identified that the Care Management Program and Care Coordination activities comply with Case Management Society of America (CMSA) standards.

Quality Improvement Plans

- Ensure that members are informed they have access to their appeal case file and documents related to the appeal in advance of the resolution timeframe, as required by the *SCDHHS Contract, Section 9.1.4.4.*3 and stated in Policy MHSC-MRT-002, Standard Appeal Process. Include this requirement in documents such as the Member Handbook, appeal acknowledgement letters, and/or Adverse Benefit Determination notices.
- In the Member Handbook and Policy or Procedure MHSC-MRT-002, Standard Appeal Process, include the address to which written appeals can be submitted.
- Provide consistent addresses for members and providers to submit written appeals in the Provider Manual, Adverse Benefit Determination letter template, and the member website.

Recommendations

- Provide instructions and a link for providers to access the Consent for Sterilization Form on the provider website under "Frequently Used Forms."
- In Procedure MHSC HCS-UM-358, Abortions, Hysterectomies, and Sterilizations, correct the reference number in the Consent for Sterilization Form from "SCDHHS 1723" to "DHHS-687."
- Ensure the final 2020 Pharmacy Program Description indicates members are allowed a 72-hour emergency supply of prescription drugs when a prior authorization request is required.
- In the Provider Manual and Member Handbook, include the statement, "a member's consent for treatment serves as consent for the provider to appeal on the member's behalf. Molina considers medical records and/or a provider's history of paid claims for

services rendered to the member as evidence that a member has signed a consent for treatment."

- Document that Molina follows the standards of practice set forth by the CMSA as required in *SCDHHS Contract, Section 5.2*.

F. Delegation

Molina enters into written agreements with all entities performing delegated functions. The delegated services are defined in *Table 15: Delegated Entities and Services*.

Table 15: Delegated Entities and Services

Delegated Entities	Delegated Services
Credentialing	Aperture; March Vision; MedXM; AnMed; Augusta University Medical Center; Bon Secours St. Frances; Greenville Hospital Systems; Managed Health Resources; Medical University of South Carolina; Palmetto Health-USC Medical Group; Regional Health Plus; United Physicians
Call Center	March Vision
Claims	March Vision

Written agreements with the delegation entities include the specific activities to be delegated and information about:

- Pre-delegation assessment
- Annual oversight and ongoing monitoring of delegated activities
- Requirements for and restrictions on sub-delegation
- Reporting and submission requirements
- Actions taken for non-performance or substandard performance
- Sanction monitoring and reporting requirements

Policies and procedures address delegation requirements and processes, including pre-delegation assessment, annual assessment, ongoing monitoring, reporting and submission requirements, and action taken in response to substandard performance.

Review of delegation oversight documentation confirmed Molina conducts appropriate oversight of delegated entities.

As noted in *Figure 8: Delegation Findings*, all standards in the Delegation section of the review were scored as "Met" for the 2020 EQR.

Figure 8: Delegation Findings

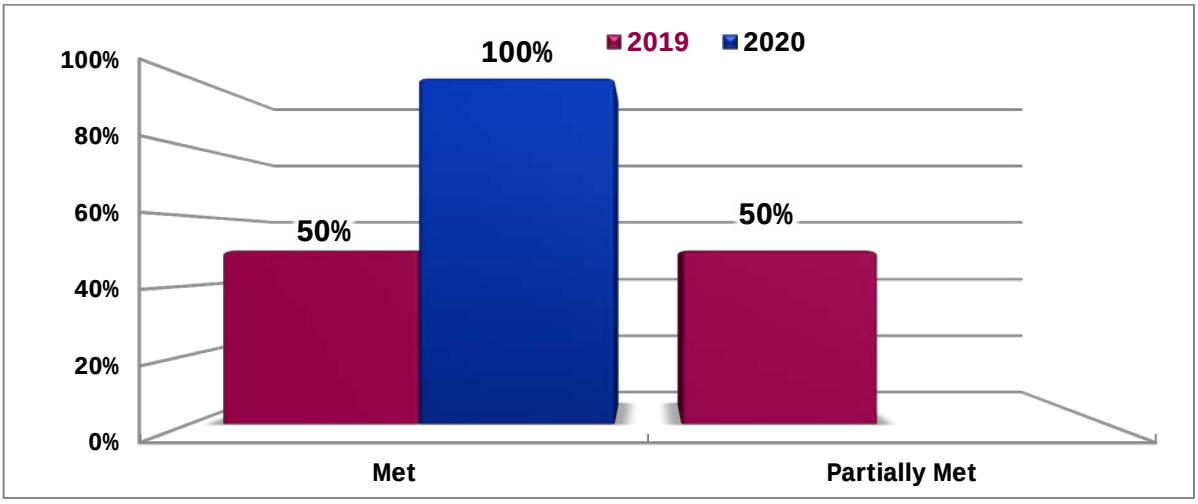


Table 16: Delegation Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

G. State Mandated Services

Molina's EPSDT Program follows the American Academy of Pediatrics periodicity schedule for required screenings and health treatments. The plan monitors compliance with immunization and EPSDT requirements by, but not limited to, reviewing PCP rates for immunization and well-child visits and through random medical record reviews conducted by the Quality Improvement Department. Additionally, Molina provides all core benefits specified by the *SCDHHS Contract*.

A Quality Improvement Plan from the 2019 EQR relating to closing member grievances prior to investigation and providing inadequate information in the member's notification of grievance resolution was not addressed.

As indicated in *Figure 9: State Mandated Services*, standards in the State Mandated Services section are scored as 75% "Met."

Figure 9: State Mandated Services

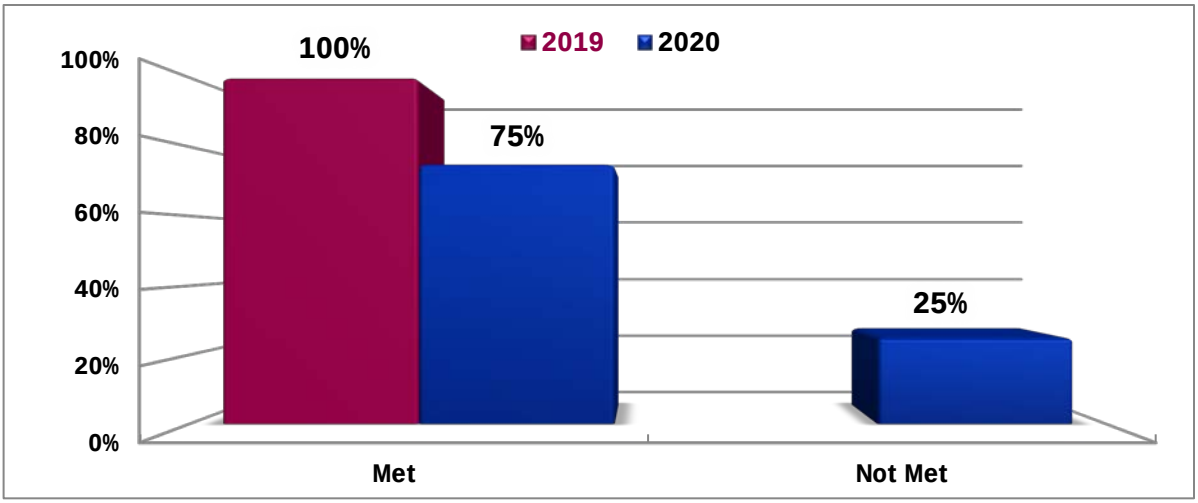


TABLE 17: State Mandated Services Comparative Data

SECTION	STANDARD	2019 REVIEW	2020 REVIEW
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews.	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Weaknesses

- A deficiency from the previous EQR related to closing member grievances prior to investigation and providing inadequate information in the member's notification of grievance resolution was found to be uncorrected.

Quality Improvement Plans

- Ensure all deficiencies identified in the EQR 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

February 3, 2020

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

Dear Ms. Wilson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2020 External Quality Review (EQR) of Molina Healthcare of South Carolina is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **April 22nd and 23rd.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **February 17, 2020.**

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

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

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

Excel Spreadsheet Format

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

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

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

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

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

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

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

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

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

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

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

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

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

18. A complete list of all members enrolled in the case management program from February 2019 through January 2020. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

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

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

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

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

23. A copy of the Grievance, Complaint and Appeal logs for the months of February 2019 through January 2020.

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

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

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

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

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.
    j. A copy of the claims processing monitoring reports covering the period of February 2019 through January 2020.

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

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

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

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    c. reporting frequency and format;
    d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    f. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    g. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    h. calculated and reported rates. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files (<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 behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of February 2019 through January 2020. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of February 2019 through January 2020, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Additional information for the credentialing and recredentialing files on the attached list.

3. Additional information for grievance files on the attached list.

4. The 2020 QI Program Description.

5. Copies of QIC minutes reflected the most recent review and approval of the following Clinical Practice Guidelines:
    a. Management of PTSD and Acute Stress Disorder
    b. Treatment of Patients with Bipolar Disorder
    c. Treatment of Patients with Panic Disorder

6. Molina Copy of Provider Newsletter with 2019 CAHPS Member Satisfaction Survey Results.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PM Validation Worksheet

Plan Name:	**Molina**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**2019 (MY2018)**
Review Performed:	**2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019 Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation was appropriate.

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**	Data sources for denominator were complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of denominator was accurate.

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**	Data sources for numerator were complete and accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of numerator was accurate.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Abstraction methods was accurate.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Hybrid methods was accurate.
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**	Numerator for rates is accurate.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Sample was unbiased.
S2. Sampling	Sample treated all measures independently.	**MET**	Sampling was appropriate.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sample methods met specifications.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately. All audit standards were met.
R2. Reporting	Was the measure reported according to specifications?	**MET**	Measures were reported according to specifications (HEDIS) as per audit report by Attest Health Care Advisors.

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	5	MET	5

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	**85**
Measure Weight Score	**85**
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:	**IMPROVING CLAIMS ACCURACY AND PROVIDER SATISFACTION**
Reporting Year:	2019
Review Performed:	2020

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**	Evaluation of provider satisfaction 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 addressed a broad spectrum of 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 were defined.
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 were related to processes of care.
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)**	**NA**	Sampling was not used.
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 used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified in Section C.1 and C.2.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources were 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**	Survey, claims, complaints data 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 continuous in Section C.4.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel were documented.
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 were reported on page 11.
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 were performed on continuous basis.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented clearly.
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**	Baseline, remeasurement 1, and remeasurement 2 were displayed.
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 for each measure was provided in the report.
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**	Methodology was reported.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rate increased for satisfaction; rates improved for claims outcomes (decreased).
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 all three measures were a result of provider and claims system interventions. Claims measures both exceeded the goal rate (claim disputes rate is below 1,7% and claims adjustments rate is below 5%).
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical calculations not necessary for non-sampling.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Cannot judge yet. Two of three measures have met or exceeded target, but multiple remeasurements after meeting target rate have not yet occurred.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

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	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**90**
Project Possible Score	**90**
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:	**WELL-CARE PROGRAM**
Reporting Year:	2019
Review Performed:	2020

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 addressed 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 8-15.
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 were 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 as 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 were 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 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 in 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 and appear to be impacting rates positively, based on HEDIS 2017 and HEDIS 2018 rates. Rates for HEDIS 2019 will be available in July 2019.
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 data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented clearly.
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 in the report.
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 for each measure at each measurement period was provided in the report.
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**	Latest available rates were assessed and showed that AWC rate decreased; W34 rate decreased; W15 rate decreased; AAP decreased; CAP decreased; WCC- BMI decreased; WCC- Nutrition Counseling decreased; WCC- Counseling Activity decreased;

Component / Standard (Total Points)	Score	Comments
		The final HEDIS rates will be available mid-year, so calendar year 2019 analysis will be completed August 2020. Using finalized data for calendar year 2018, all measures improved except W34. AAP, and CAP. WCC-BMI had statistically significant improvement.
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 was related to intensive intervention efforts.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Where applicable, statistical significance was noted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not applicable until goal rates are met for outcomes.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

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	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	NA	NA
Verify	NA	NA

Project Score	111
Project Possible Score	111
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:	**BREAST CANCER SCREENING PROGRAM**
Reporting Year:	2019
Review Performed:	2020

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 given demonstrates 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 3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure was clearly defined.
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 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**	The relevant population was 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 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.

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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources were noted.
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 was documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection occurs 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 were listed.
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 were documented.
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 19, rates for each year were reported.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	BCS HEDIS measure results were displayed in the table on page 19.
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 baseline and repeat measurements were documented.
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 and results from incentive, mailings, and other interventions are reported.
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 with final rates available showed an increase from calendar year 2017 to calendar year 2018. The results for calendar year 2019 will be available in mid-2020.
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 was related to member incentives and education/contact/outreach.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical significance was tested. Rate and rate improved but not significantly at the .05 level.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge until benchmark rate has been met for at least three consecutive measurement periods.

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	NA	NA
Verify	NA	NA

Project Score	91
Project Possible Score	91
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 Survey Validation Worksheet

Plan Name	**Molina**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2019
Review Performed	2020

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 was documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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 was documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
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 were documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
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**	Sample size requirement was met. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
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: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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 were clear and appropriate. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
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.	**MET**	Response rate was evaluated, and implications of response rate were noted. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report* *QIC Minutes Dec 2019*

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: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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 allowed for a standardized and auditable approach to the implementation and analysis of the surveys. SPH Analytics provided a full report of processes, including 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 29% (n=481 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, but the NCQA target response rate was not.
7.4	What conclusions are drawn from the survey data?	The top three measures were rating of personal doctor, getting care quickly and rating of health care. The lowest three measures were rating of specialist, health promotion and education, and shared decision making. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
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 is encompassed in the results of CAHPS survey. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

CCME EQR Survey Validation Worksheet

Plan Name	**Molina**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2019
Review Performed	2020

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 was documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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 was documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
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: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
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 sample size is adequate. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
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: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
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.	**MET**	Response rate was evaluated, and implications of response rate are noted. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report* *QIC Dec 2019*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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 audited approach to the implementation and analysis of the surveys. •SPH Analytics as a vendor provides a full report of process and results that meets 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 23.9% (n=391 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was not met, nor was the NCQA target response rate.
7.4	What conclusions are drawn from the survey data?	Top three measures were coordination of care, rating of specialist, and getting care quickly. The lowest three measures were rating of health care, rating of health plan, and rating of personal doctor. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
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 is encompassed in the results of CAHPS survey. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

CCME EQR Survey Validation Worksheet

Plan Name	**Molina**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2019
Review Performed	2020

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 was documented. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

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 was documented. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
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 were documented. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
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 was utilized. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
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: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
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.	**MET**	Response rate was evaluated, and implications of response rate were noted. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

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: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

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 audited approach to the implementation and analysis of the surveys. •SPH Analytics as a vendor provides a full report of process and results that meets 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 19.6% (n=817 valid surveys) for the general and supplemental samples. The response rate for the general population was 18% with n=425 valid surveys. The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, but the NCQA target response rate was not.
7.4	What conclusions are drawn from the survey data?	Top three measures were rating of personal doctor, rating of health care, and getting care quickly. The lowest three measures were rating of health plan, health promotion and education, and coordination of care. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report* *QIC Minutes Dec 2019*
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 is encompassed in the results of CAHPS survey. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2019 CAHPS® Child w/ CCC Medicaid Survey Summary Report*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Molina Healthcare of SC**
Collection Date:	2020

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					As documented in Policy MHSC-AD-02, Annual Policy Review and its corresponding procedure, all policies and procedures are reviewed at least annually by their individual departments to ensure current requirements and practices are documented. The Administrative and Policy (A&P) Committee reviews and approves updates to policies and procedures. Additional governing committees also review and approve policy revisions as needed. Changes to policies and procedures are communicated to department

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						management and disseminated to staff in various forums, such as email, staff meetings, etc. Molina does not currently use a policy management software platform but is considering this for the future. A policy review schedule and spreadsheet are maintained on a shared drive, and staff access policies and procedures via a shared drive.
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:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Dora Wilson is the Plan President.
1.2 Chief Financial Officer (CFO);	X					Edward Mohr is Chief Financial Officer for the SC plan.
1.3 *Contract Account Manager;	X					Beverly Hamilton is the Associate Vice President, Government Contracts and serves as the Contract Account Manager.
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					John Segars, AVP of Health Plan Operations, provides oversight of claims functions, and Diana Michalic, Manager of Business Analytics /

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Encounters, oversees encounter functions.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Debra Enigl, RN is Vice President, Healthcare Services. Missy Lewis, RN, serves as the Director, Healthcare Services for Utilization Management and Tammy Webb, Ph.D, MSN serves as the Director, Health Care Services for Case Management.
1.5.1 Pharmacy Director,	X					Jacqueline Jacobi is Director of Pharmacy Services.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Patricia Zigon is the Associate Vice President, Quality Management. Wilson Huang is Manager, Quality.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					The Organizational Chart reflects adequate staffing for Quality Assessment and Performance Improvement functions. The Organizational Chart reflects a vacancy for an Analyst HEDIS/Quality Interventions. Discussion with health plan staff revealed this position is on hold and has not been filled.
1.7 *Provider Services Manager;	X					Heather Eddins is Manager, Provider Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7.1 *Provider Services Staff,	X					The Organizational Chart reflects adequate staffing for Provider Services functions. Vacancies were noted for Director, Provider Contracts, and a Credentialing Coordinator. Discussion with health plan staff revealed these positions are on hold and will not be filled at this time.
1.8 *Member Services Manager;	X					
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Richard Shrouds, MD is the Interim Chief Medical Officer. Delores Baker, MD is Medical Director and Nikitas Thomarios, DO is the Behavioral Health Medical Director. Onsite discussion confirmed Molina will be adding two part-time Medical Directors soon.
1.10 *Compliance Officer;	X					Molina's Compliance Officer is Niurka Adorno, Director, Compliance.
1.10.1 Program Integrity Coordinator;	X					Emily Strickland is the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 *Interagency Liaison;	X					Brandon Hulko, Director of Government Contracts, is the Interagency Liaison.
1.12 Legal Staff;	X					Liz Stone is Assistant General Counsel. Molina has legal counsel through an administrative services agreement with its parent company, Molina Healthcare, Inc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 Board Certified Psychiatrist or Psychologist;	X					
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Onsite discussion confirmed for 2019, the 30-day claims payment rate was 96% and the 90-day rate was 99.99%. Year-to-date rates for 2020 are 95.9% of claims paid within 30 days and 100% paid within 90 days.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Molina's documentation states its systems are capable of handling electronic transactions in a variety of electronic formats.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Molina's systems update enrollment information daily. Claims processing systems rely on algorithms and claim data to identify potential duplicates. If duplicates are identified, the records are merged to consolidate the duplicates into one record.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Molina's systems run NCQA-Certified software systems to generate reports and calculate HEDIS data.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Molina's documentation states the organization is focusing on consistency and application of security capabilities across the organization. The organization is implementing proactive and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						automated security solutions to monitor data security and compliance.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Documentation states Molina practices the principal of least privilege and implements that principal by using roles to avoid accidental account misconfigurations. Additionally, Molina requires system access privileges to have documentation of approval and audit trails.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Molina's Business Continuity Process documentation includes step by step recovery tasks and processes, and addresses recovery resources, team member requirements, schedules of recovery activity, details of failover and failback operations, and system validation processes. Molina's recovery capabilities were most recently tested April 20, 2019. The reported results indicate the recovery efforts were successful and were completed ahead of schedule.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Compliance Plan documents processes to ensure compliance with all applicable laws and policies that govern Molina's activities. The FWA Plan documents processes to detect, prevent, investigate, and report potential health care fraud, waste, and abuse (FWA). A host of related policies and procedures provide greater detail on these processes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Compliance Plan includes a section titled, "Code of Business Conduct and Ethics" which is applicable to all employees, officers, and directors. All employees receive a copy of the Compliance Plan and it is available to staff on a SharePoint site. New employees sign the Code of Business Conduct and Ethics. Staff are encouraged to contact his or her immediate supervisor, the Compliance Department, or the General Counsel for questions about the standards of business ethics, and are informed they must report violations of law and/or policies, including FWA, to the Compliance Department, by phone or online, or to the General Counsel.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						Roles and responsibilities of the Compliance Officer, who is responsible for implementing the Compliance functions and activities, are discussed in the Compliance Plan. The Compliance Officer reports to the Board of Directors and to the Plan President. Functions of the Program Integrity Coordinator are addressed in the FWA Plan.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						Annual Compliance and FWA training are mandatory for all employees. Compliance training includes the Code of Business Conduct and Ethics, the Compliance Plan, major legal requirements affecting employee groups, reporting responsibilities, consequences of non-compliance, and the necessity of adhering to corrective action plans. FWA training includes recognition, detection, prevention, and reporting of suspected FWA activities, the impact of FWA on healthcare, definitions of terminology, the Deficit Reduction Act and False Claims Act, the "Whistleblower Provision," and the non-retaliation policy. The Medicaid Provider Orientation dated January 2020 includes sections on HIPAA, FWA, and the Deficit Reduction Act. Imbedded links allow users to go directly to related information on Molina's website, and provides a number for reporting suspicions of FWA is included.
2.6 Lines of communication;						Employees are provided with information about their responsibility to report suspected compliance issues, available reporting methods,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and that confidential reporting is available. In addition, reporting options are found on Molina's Compliance SharePoint site. Employees are advised they may report issues in person or by phone to the Compliance Officer or by using a third-party compliance reporting system, AlertLine, which allows anonymous reporting. The FWA Plan states "posters displaying the Compliance Hotline number are placed in conspicuous areas in Molina's offices, instructing staff to report not only compliance, but fraud related issues as well."
2.7 Enforcement and accessibility;						The Compliance Officer, along with the Compliance Committee, develops policy for degrees of disciplinary action that may be imposed for instances of non-compliance or government sanction, such as debarment or exclusion. Disciplinary actions are reviewed by Human Resources for appropriateness and documented in the employee's personnel file. Policy MHSC COM 16, Disciplinary and Corrective Action Process – Employees conveys Molina's expectation that employees comply with applicable state and federal laws and regulations, CMS policy guidance, and Molina policies and procedures, and conduct themselves according to the Code of Business Conduct and Ethics. The policy states disciplinary actions

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resulting from failure to comply with any of these include, but are not limited to, verbal or written counseling, training, written warning, corrective action plan, suspension, and termination. Based on the situational severity, Molina may skip one or more of these actions. In addition, certain violations will result in reporting to regulatory agencies, civil penalties, or criminal prosecution. Employees are informed of potential disciplinary actions through initial and ongoing Compliance training. The disciplinary/corrective action process is also available to staff on a SharePoint site.
2.8 Internal monitoring and auditing;						Molina conducts auditing and monitoring activities to identify compliance deficiencies, respond to reports of suspected non-compliance, and to assess the effectiveness of corrective measures implemented to address previously identified deficiencies. These auditing and monitoring activities include, but are not limited to, desk audits, surveys, interviews, document audits, and phantom member/provider claims or inquiries. Reports generated from auditing, monitoring, and investigation activities are maintained by the Compliance Officer and shared with the Board of Directors and affected management, as appropriate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Response to offenses and corrective action;						The Compliance Officer is responsible for investigating suspected or alleged compliance issues. The Special Investigation Unit (SIU) conducts investigations related to FWA, primarily those involving allegations against providers or members. Individuals with specific investigative expertise in the management of fraud investigations may be used to investigate instances of suspected healthcare fraud. The FWA Plan details activities involved in investigations of providers and members. Policy P-MHI-SIU-102, Opening and Conducting Investigations provides additional detailed information about conducting FWA investigations.
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						The FWA Plan, page 8, states, "Molina checks employees against exclusion lists prior to hire and monthly thereafter." Page 15 and 16 provide additional information, including that Molina must also ensure it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals from the provision of items and services that are Molina's contractual obligation. Molina's failure to adhere to these provisions may result in liquidated damages and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sanctions, up to and including, the termination of this contract. Molina will not knowingly have a relationship with individuals who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Affiliated individuals are defined as a director, officer, or partner of Molina, a person with a beneficial ownership of five person or more in Molina, a person with an employment, consulting, or other arrangement with Molina for the provision of items and services significant and material to Molina's obligations under its contract with SCDHHS. Molina performs the same screening of employees and administrative contractors as required by the contract. All employees are checked against the federal LEIE as part of the hiring process. In addition, a vendor conducts a monthly review of the LEIE to identify employees whose status may have changed. Employees are also checked against the South Carolina List of Excluded Individuals as part of the hiring process. The results of all these reviews are reported to Molina monthly, and appropriate action is taken.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional detail about exclusion status monitoring is found in Policy MHSC-HR-1.1, OIG/GSA Exclusion List Reporting.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Committee Membership Matrix indicates the committee meets quarterly and is chaired by the Plan Compliance Officer. Voting members include Plan President; Chief Medical Officer; VP/Director, Finance; VP/Director, Healthcare Services/UM; AVP/Director, Network Management/Provider Services; AVP/Director, Government Contracts; and AVP/Director, Quality Improvement. Onsite discussion confirmed the quorum for the Compliance Committee is 50% of the voting members plus one. However, Policy MHSC COM 05, Compliance Committee Charter, states, "A simple majority constitutes a quorum for the purposes of conducting committee business." CCME's review of Compliance Committee meeting minutes confirmed the presence of a quorum at each meeting. *Recommendation: Clarify the quorum for the Compliance Committee in Policy MHSC COM 05 to indicate it is a simple majority of voting members of the committee.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Compliance Officer's responsibilities include investigating instances of suspected non-compliance. The SIU conducts investigations related to health care FWA. Policy P-MHI-SIU-102, Opening and Conducting Investigations includes instructions for consistency when opening SIU complaints and investigations, explains steps required for handling complaints alleging fraud, waste, and abuse, and describes considerations for conducting preliminary and full investigations, as well as the inputs, outputs, and possible resolutions.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes for provider payment suspensions and recoupments of overpayments are addressed in the FWA Plan and ISCA documentation.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy MHSC-PHARM-03, Pharmacy Lock-In Program and its associated procedure provide details on the implementation, maintenance, and management of the Statewide Pharmacy Lock-in Program (SPLIP).
I E. Confidentiality						

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

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 a manner consistent with contractual requirements.	X					Policy MHSC CR-01, Credentialing Program Policy defines Molina's process for credentialing and recredentialing providers for participation in its network. CCME's review of the policy revealed the policy does not specify Molina's timeframe for processing a credentialing application. The *SCDHHS Contract, Section 2.8.2.4.2* requires completion within 60 calendar days of receipt of a completed credentialing application and a signed provider agreement. Onsite discussion confirmed the internal goal is 20 days from receipt of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						application to a determination. *Recommendation: Revise Policy MHSC CR-01 to include the timeframe for processing a credentialing application.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Professional Review Committee (PRC) makes recommendations regarding credentialing decisions using a peer review process. Policy CR-01, Credentialing Program Policy indicates a Molina Medical Director provides oversight of the Credentialing Program, chairs the PRC, and appoints all committee members. Review of committee minutes confirms an appropriate array of external providers (with specialties including pediatrics, internal medicine/cardiology, and OB/GYN, along with a physician assistant) are included in the committee's membership. The Professional Review and Credentialing Committee Charter defines the structure, duties, responsibilities, and meeting frequency of the PRC. The document also specifies "The presence of four (4) voting providers at any regular or special meeting shall constitute a quorum for the purpose of conducting business." CCME's review of committee minutes revealed the 12/19/19 meeting did not have the presence of a quorum. Onsite discussion confirmed the meeting was halted and all votes were taken by email after the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						date of the meeting. This information was not reflected in the meeting minutes, however. *Recommendation: Ensure committee minutes reflect the actions taken in response to the absence of a quorum.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					CCME noted most credentialing files contained a copy of the malpractice insurance certificate, but four files did not. Onsite teleconference discussion revealed that Molina accepts current application attestation of valid malpractice insurance in lieu

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of receiving a certificate. This complies with requirements specified in Policy MHSC-CR 01, Credentialing Program Policy.
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					Policy MHSC-CR 01 Credentialing Program Policy states, "The application must be completed in its entirety" and "Practitioners must list all current hospital privileges on their credentialing application." The policy also states, "If the practitioner does not provide the information necessary to complete the application process in the time requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina network." The following issues related to hospital admitting privileges were identified in initial credentialing files: •In one initial credentialing application, the fields for hospital admitting privileges were incomplete. •In one initial credentialing application, the provider indicated hospital admitting privileges

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						were "pending" and patients would be referred to the Emergency Room for the hospitalist to admit. *Recommendation: Ensure all provider applications are complete, as required by Policy MHSC-CR 01. If an application does not include a response for provider admitting privileges or the response is that privileges are pending, Molina must verify the provider's current status or admitting plan. Providers who do not manage care in an inpatient setting should supply the name of a practitioner or hospital to whom patients will be referred for admission or provide a detailed plan if they do not have an arrangement in place.*
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					The following issues related to laboratory services and CLIA Certificates were identified in initial credentialing and recredentialing files: •One initial credentialing did not have a response to a question asking if laboratory services are provided at a practice location. •Two initial credentialing files did not contain evidence of a CLIA Certificate for practice locations indicating laboratory services are provided. Onsite teleconference discussion revealed Molina only verifies the CLIA Certificate for locations for which the provider is being contracted, and that the locations mentioned above were not included

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						in contracting for the providers. However, there was nothing in the credentialing or recredentialing files to specify the locations for which the providers were being contracted. *Recommendation: Include information in credentialing and recredentialing files indicating which of the provider's practice locations are include in contracting.*
3.1.16 Ownership Disclosure form.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					One recredentialing application did not have a response to a question asking if laboratory services are provided at a practice location. Onsite discussion revealed Molina only verifies the CLIA Certificate for locations for which the provider is being contracted and that the location referenced above was not included in contracting. However, there was nothing in the recredentialing file to specify the location for which the provider was being contracted. *Recommendation: Include information in recredentialing files indicating which of the provider's practice locations are included in contracting.*
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					Molina monitors providers for member complaints/grievances, failure to comply with the quality assurance program, adverse events, patterns of substandard care, incidents of gross or flagrant substandard care, inappropriate referral patterns, site review standards, medical record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation and record-keeping standards, etc. This information is considered during the recredentialing process.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy CR-01, Credentialing Program Policy addresses indications for which a provider must be reviewed by the PRC. For practitioners who fail to meet performance expectations pertaining to quality of patient care, the PRC may place the provider on a watch status, require formal corrective action, or deny or revoke network participation. If the Medical Director determines there is an immediate risk to patients, a practitioner may be suspended from the network without prior notice, pending review and investigation of information relevant to the case.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					Policy MHSC CR-02, Assessment of Organizational Providers describes credentialing and recredentialing processes for organizational providers.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					
II B. Adequacy of the Provider Network						
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.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy and Procedure MHSC-PC-011, Availability of Health Care defines the mechanism used to monitor network adequacy for the type, number, and geographic distribution of primary care providers, specialists, and behavioral health practitioners. Results of Geo Access time and distance reports indicate Molina meets the geographic standards for PCPs for 90% of the eligible population as required by SCDHHS Policy and Procedure guidelines.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MHSC-PC-011, Availability of Health Care correctly defines access standards for specialty care providers, behavioral health providers, and hospitals. However, the policy did not specify that the standard for hospitals is 90% of the Managed Care Eligible population in the county must have access, as required by and *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.1.* During the onsite, Molina confirmed the goal is for 90% of eligible members to access a hospital in the required time and distance. Geo Access time and distance reports reflect provider availability standards measurement for specialists per county. However, in October 2019 Molina was notified of time and distance deficiencies in the provider network. *Recommendation: Edit Policy MHSC-PC-011,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Availability of Health Care to include that 90% of eligible members will have access to a hospital in the required time and distance parameters, as specified in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.1.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy and Procedure MHSC-PC-011, Availability of Health Care states network access and availability reports are generated quarterly and data is reported to and monitored by the Quality Improvement Committee (QIC).
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					Policy MHSC QI 011, Practitioner Network Cultural Responsiveness describes how Molina collects information about practitioner race/ethnicity and language and publishes it in the Provider Directories. Additionally, during initial orientation, providers receive "Training on disability awareness and sensitivity, and cultural and linguistic competency", as stated in Procedure MHSC-PS-010, Provider and Practitioner Education. Culturally and linguistically appropriate resources and training modules such as "A Physician's Practical Guide to Culturally Competent Care" are available on the provider website.

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					The Provider Network CAP December 2019 report describes how Molina demonstrated efforts to increase urology providers in Beaufort County and neurology providers in Georgetown and Hampton counties, after notification from SCDHHS. The urology deficiency was successfully cured and encouraging discussions with providers were in process to cure the neurology deficiency. During the onsite teleconference, Molina explained the recruitment processes used to maintain, expand, or correct deficiencies in the provider network, and confirmed that the procedures are not documented.
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					Molina's online searchable Provider Directory is updated daily, and members can request a paper copy by contacting Member Services. Members can search for several provider types including PCPs, specialists, pharmacies, hospitals, nurse midwives, behavioral health providers, LTSS providers, and ancillary providers. Procedure MHSC-PNA-01, Provider Directory Validation, describes the process for updating the provider directory, which consists of various outreach campaigns used to verify and update provider information.
3.Practitioner Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy and Procedure MHSC-PS-005, Provider Availability Standards defines the procedure for annually monitoring member access to primary care services, behavioral health services, high-volume/high-impact specialists, and emergency care. Providers are informed of the appointment availability standards in the Provider Manual, on the website, and in newsletters. Molina conducted a provider appointment accessibility audit in 2019. The Accessibility of Services Analysis report indicates performance results for urgent care, routine care (symptomatic and asymptomatic), and after-hours access exceeds the 80% compliance goal in each category. The total score was 99%, noting one general practice/nurse practitioner who completed the survey did not provide adequate after-hours access. Standards for medical and behavioral health appointment types are correctly documented in the Accessibility of Services Analysis report; however, documentation issues for specialty referrals standards were identified in the Provider Manual and Policy MHSC-PS-005, Provider Availability Standards. Issues in the Provider Manual are:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Appointment times in the table on page 56 indicate routine specialist care appointments are within 12 weeks; however, per SCDHHS Contract, Section 6.2.3.1.5.3, routine care should be provided within four weeks and a maximum of 12 weeks for unique specialists. •The requirements for emergent visits immediately upon referral and for urgent medical condition care appointments within 48 hours of referral or notification of the Primary Care Physician are omitted. Policy MHSC-PS-005,Provider Availability Standards, omitted the following three requirements for specialty referrals: •Emergent visits immediately upon referral •Urgent medical condition care appointments within 48 hours of referral or notification of the Primary Care Physician •Routine care appointments within four weeks and a maximum of twelve (12) weeks for unique specialists. *Recommendation: Ensure all appointment standards for specialty referrals are correctly documented in the Provider Manual and Policy MHSC-PS-005, Provider Availability Standards, as required in the SCDHHS Contract, Section 6.2.3.1.5.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					The results of the Telephonic Provider Access Study conducted by CCME reflect calls were answered successfully 74% of the time (134 of 181) when omitting 26 calls answered by personal or general voicemail messaging services. When compared to last year's results of 57%, this year has an increase in successful calls that is statistically significant (p=<.001). For those not answered successfully (n=47 calls), 12 (26%) were unsuccessful because the phone was never answered or went to a busy signal. Of the 103 who answered the question regarding accepting Molina, 99 (96%) of the providers indicated they accept Molina, and two (2%) indicated that they accept Molina under certain conditions. Sixty-one providers out of 95 (64%) responded that they are accepting new Medicaid patients. 45 (74%) of the 61 providers that responded to the item indicated an application or prescreen was necessary. Of the 45 that answered the question, 18 (40%) indicated that there were no prescreen requirements and the remaining 27 (60%) indicated that an application or prescreen was necessary. Of those 27, 8 (30%) indicated that an application must be filled out; 1 (3%) require a review of medical records; and 16 (59%) required both an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						application and a medical record review. Two of the 27 (7%) had a prescreen requirement of meeting with a coordinator.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy MHSC-PS-010, Provider and Practitioner Education indicates providers receive training information at the initiation of their contract, during monthly/quarterly provider site visits, as needed, and/or upon request.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines						
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-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, along with its associated procedure, documents Molina's processes for selecting, adopting, and implementing preventive health guidelines (PHGs).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina's National Quality Improvement Committee (NQIC) selects, reviews, and approves PHGs based on scientific evidence and recommendations made by national clinically-based organizations. The selected PHGs are relevant to the health plans' population. Once approved by the NQIC, the PHGs are reviewed by the local health plan's QIC for approval and adoption. PHGs are reviewed and updated at least every 2 years.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					The Quality Improvement (QI) Department is responsible for distributing new, updated, and revised PHGs to providers via orientation materials, Provider Manuals, newsletters, special mailings, and fax blasts. The guidelines are included on Molina's website. Provider Service representatives orient new providers to the PHGs in the Provider Manual and/or distribute them during the provider orientation visit. Paper copies are available upon request.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					The process for adoption and ongoing review of clinical practice guidelines (CPGs) is documented in Policy MHSC QI-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, and in its associated procedure. CPGs are adopted for conditions and ages that are relevant to the plan's member population. All CPGs are reviewed, using appropriate practitioner input, at least every 2 years and when new scientific evidence is released, or new national guidelines are published.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					The QI Department is responsible for distributing new, updated, and revised CPGs to providers via orientation materials, Provider Manuals, newsletters, special mailings, and fax blasts. Links to the CPGs are available on Molina's website. Provider Service representatives orient new providers to the CPGs in the Provider Manual and/or distribute them during the orientation visit.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Procedure MHSC-HCS-CM-081 PROC, Continuity of Care and Coordination discusses Molina's process for verifying all members receive continuity of care for medical, behavioral, and pharmacy benefits with their existing services per federal or state guidelines.
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					Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation describes how Molina monitors and evaluates PCP compliance with documentation standards in member medical records. The 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					The Standard Medical Record Review Analysis for Calendar Year 2019 describes the methodology, results, and analysis of medical record documentation standards. The 2019 annual medical record review consisted of 150 member records and included 30 providers who scored 90% or higher.
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					Accessibility to member medical records by Molina is documented on page 55 in the Provider Manual and in the provider's Ancillary Services Agreement.

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 guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Molina guarantees member rights and responsibilities as outlined in Policy MHSC-ME-04, Member Bill of Rights and Responsibilities. Members are informed of their rights in the Spring 2019 Guide to Accessing Quality Health Care, on the website, and in the Member Handbook. Additionally, members can obtain information from Member Services and providers are notified of member rights and responsibilities in the Provider Manual.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in the Member Handbook, Provider Manual, and on the website.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy and Procedure MHSC-ME-01, New Medicaid Member Outreach and Education state members are provided a Welcome Packet within 14days of Molina receiving the member's enrollment data from SCDHHS. It includes their ID card along with directions to access or request a Member Handbook and a Provider Directory from the website, and the Notice of Privacy Practice.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						A table listing copayments and limits of coverage are in the Member Handbook, Provider Manual, and on the website. Copayments do not apply to children younger than 19 years old, pregnant women, or institutionalized individuals. Services not covered are clearly listed in the Member Handbook, as well as on page 19 in the Provider Manual.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The process and requirements for prior approval on medical, behavioral health (BH), and pharmaceutical services are described in the Member Handbook. Services that require prior approval are indicated in the table of covered services. Prior approval is not required for family planning services, emergency visits, or BH. Additionally, services that require prior authorization are clearly listed throughout the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook includes information about obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and to find participating pharmacies or to contact Member Services to obtain this information.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						The list of member rights in the Member Handbook includes the right to be notified of any significant changes to the benefits package at least 30 days before the intended effective date of the change. Changes to the Preferred Drug List are accessible on the website indicating the specific drug change and the effective date. Procedure MHSC-ME-07, Changes in Benefits says Molina will send written notice within at least 15 days of becoming aware of the PCP's termination from the network.
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Page 13 in the Member Handbook provides instructions for members to change their PCP. Additionally, members can manage PCP selections by creating an account on the My Molina Portal or calling Member Services for assistance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The Member Handbook informs members to use the online Provider Directory or call Member Services to obtain information on, but not limited to, the PCP's gender, hospital affiliation, language spoken, and address.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						*SCDHHS Contract, Section 3.13*. requires the health plan to provide information on enrollee rights to new members. Policy and Procedure, MHSC-ME-01, New Medicaid Member Outreach and Education does not mention that enrollee rights are provided in the Welcome Packet. During the onsite teleconference, Molina reported the Welcome Packet has instructions to access member rights on the website and provided a copy for review. However, upon review CCME did not identify information for enrollee rights in the Welcome Packet. *Recommendation: Edit Policy, MHSC-ME-01, New Medicaid Member Outreach and Education to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include new members are provided information on enrollee rights. Ensure Molina provide information on enrollee rights to new members.
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						Members receive an ID Card in the mail with the Welcome Packet and have the ability to view it after downloading the Molina Mobile App. The Member Handbook provides necessary information on how to use the ID Card to obtain services, as well as how not to use the ID Card to avoid fraud and abuse.
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	X					A description of Member Services, the toll-free number, and the mailing address are in the Member Handbook and on the website. However, the fax number and email address are not found in the Member Handbook or on the website. *Recommendation: Include the Member Services fax number and email address in the Member Handbook as required in SCDHHS Contract, Section 3.13.2.9 and consider adding it to the member website to be consistent.*
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook, Provider Manual, and website correctly provide information about EPSDT services and lists a schedule of recommended services from birth through 21 years of age.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Molina notifies members of their right to request a copy of the Provider Directory and Member Handbook annually as noted in Procedure MHSC-COMM-03, Member Collateral Materials, and on the member website under the "Annual Notice" tab.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Procedure MHSC-ME-07, Changes in Benefits describes Molina notifies members in writing within 15 days after a receipt of a provider's termination from the network and at least 30 days before the effective date of a change in benefits.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Procedure MHSC-COMM-03, Member Collateral Materials defines requirements for member program materials and states member materials are written no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. 12-point font is used for regular print member materials and large-print materials are printed no smaller than 18-point font.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					Molina has several policies and procedures describing the requirements for Member Service operations such as MHSC-MS-22, Member Service Toll-Free Phone Number, MHSC-MS-11, Member & Provider Contact Center Staffing Levels, and MHSC MS-12, Quality. The Member Services Call Center is staffed Monday through Friday from 8 a.m. to 6 p.m. Discussions during the onsite teleconference revealed call center staff are located in Mississippi and Florida. Outside of the normal business hours, the Interactive Voice Response (IVR) system instructs to call 911 or go to the nearest Emergency Room (ER) for life-threatening emergencies. Callers are given the option to leave a message to which a response is provided within one business day. The TTY number for the Member Services Call Center and the 24-hour Behavioral Crisis Hotline are published in the Member Handbook are made available for members. The Nurse Advice Line is available to provide medical advice 24 hours a day via a toll-free telephone number.
III C. Member Enrollment and Disenrollment						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Page 11 in the Member Handbook describes the process for members to choose a PCP. Members can select one PCP for all members of the family or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						choose different PCPs as appropriate for their needs. Molina will assign a PCP if the member has not selected one within the required timeframe.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Procedure MHSC-ME-05, Medicaid Member Disenrollment defines the process for Molina initiated disenrollment. Molina must request member disenrollment in writing to SCDHHS who is responsible for disenrollment actions to remove a member from the Plan. Requests for member disenrollment cannot be for adverse change in health status, utilization of medical services, diminished mental capacity, or disruptive behavior related to the member's special needs.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members are informed of scheduled preventive health services, available case management programs, and how to obtain educational support for medical, behavioral health, and pharmaceutical services on the website, Member Handbook, and via member newsletters. Health information is available for all members in various age groups and incentives are offered for members to participate in the recommended services through the My Health Pays™ Rewards Program. During the onsite teleconference, Molina explained the annual member newsletter, "A Guide to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Accessing Quality Health Care" is posted to the member website by the corporate department and each member household receives a mailed postcard informing them newsletter is available for viewing. Molina also discussed website traffic is monitored to evaluate how members are visiting required pages and will discuss results internally among plan leadership.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					Policy and Procedure MHSC-AD-03, EPSDT Notification, Tracking and Follow-up describes how Molina monitors members for EPSDT services. Information about the EPSDT/Well-Child program is communicated in the Member Handbook, Provider Manual, and the website. Molina sends letters and postcards to remind members about immunizations and screenings that are due and offers assistance in scheduling appointments and transportation for these services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					Policy & Procedure MHSC-HCS-CM-002, High Risk Pregnancy–Screening and Triage to Disease Management/Case Management describe how the corporate office identifies pregnant members to provide educational materials regarding their

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pregnancy, postpartum care, and newborn care, and offers an incentive to complete a required number of prenatal and postnatal visits. Additionally, timeliness of prenatal care is tracked with HEDIS monitoring of pregnant members.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Molina contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct the adult and child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					The sample size for the Adult survey was adequate and exceeded the minimum sample size of 411 (n=481), but the response of 29% is below the NCQA target of 40%. The Child survey did not meet the required NCQA sample of 411 (n=391) and response rates slightly increased, from 23.4% in 2018 to 23.9% in 2019. For the Child CCC survey, the minimum required sample of 411 was met from general and supplemental samples (n=817) with a response rate of 19.6%, which is lower than the 2018 rate of 24.8%. For the general population, the minimum required sample size was met (n=425) with a response rate of 18%, also lower than the 2018 rate of 23.9%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Discussions during the onsite teleconference revealed Molina uses various regulatory compliance methods, such as face-to-face encouragement to complete the survey and reminding members of the survey during calls. Molina commented that it is difficult to initiate new methods to improve response rate due to regulations. *Recommendation: Continue working with SPH Analytics to increase response rates for Adult and Child surveys.*
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					SPH Analytics summarizes and details all results from the adult and child surveys. The QI Evaluation an analysis of data and action steps to achieve higher scores for member satisfaction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The results were presented to the Quality Improvement Committee and action plans were initiated to address problematic measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					CAHPS Outcome report was presented to the QIC Committee as reflected in QIC Meeting Minutes from December 5, 2019.
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-MRT-001, Grievance Disposition Process and its associated procedure define requirements and Molina's processes for handling member grievances.
1.1 The definition of a grievance and who may file a grievance;	X					
1.2 Procedures for filing and handling a grievance;	X					Procedures for filing and handling grievances are found in Policy MHSC-MRT-001 and its associated procedure. The Member Handbook, Provider Manual, and Molina's website include requirements for filing grievances, timeframes for resolution, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;	X					
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Molina maintains a log of grievances meeting contractual requirements. Procedure MHSC-MRT-001, Grievance Disposition Process states Molina provides a quarterly report of grievances to SCDHHS. The procedure also confirms "Grievance documentation, along with relevant correspondence, will be maintained for a period of ten (10) years, or in compliance with policy MHSC-AD-01 Record Retention." CCME confirmed Policy MHSC-AD-01, Record Retention requires retention of all non-permanent documents and records for 10 years (or 5 years from the expiration date of any service contract or amendment with SCDHHS), whichever is later.
2. The MCO applies grievance policies and procedures as formulated.			X			During the previous EQR, CCME noted that grievances referred to the Provider Services department were closed and members were provided resolution prior to receiving resolution from the referred department. For the current EQR, CCME noted this issue

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						continues. CCME's review of grievance files revealed that for grievances referred to Provider Services, there is no documentation of investigation or resolution of the issues about which the member voiced dissatisfaction. The Member Resolution Team informs the member that the Provider Services Department will review their concerns, that corrective action and education will be done if needed, and this will be monitored closely. The resolution provided to the member does not specifically address the member's grievance. Of note, Procedure MHSC-MRT-001, Grievance Disposition Process, Section B (5), states that for grievances related to network providers and not involving potential quality of care issues, resolution will be sent from Provider Services back to the MRT Specialist to complete the grievance process "and notify the member of the grievance resolution." As noted above, this is an uncorrected deficiency from the previous EQR. *Quality Improvement Plan: Revise grievance processes to ensure grievance files include documentation of the investigation of all issues raised by the member, findings of the investigation, and any actions taken to address the specific issues about which the member filed the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievance. Ensure resolution information provided to the member specifically addresses all issues raised in the member's grievance and the actual resolution of those issues.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Molina tracks, trends, and analyses grievances and reports the analysis to the QIC, regulatory agencies, and to SCDHHS. Molina reviews and monitors call tracking logs to ensure appropriate handling and coding of member calls. Education and coaching will occur as needed. An analysis of grievances is conducted quarterly and presented to the QIC to help identify potential issues and quality improvement opportunities. A yearly analysis of the previous year is conducted as required by NCQA. CCME's review of QIC minutes confirms an update of grievance data and activity is presented during each meeting.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The 2019 Medicaid Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The QI Program Description outlines the scope of the QI program that includes over and underutilization data collection and analysis.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				Annually, Molina develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2019 and 2020 QI Work Plans. The 2020 Work Plan was marked as a draft. There were several issues identified in the 2020 work plan regarding the benchmark and goals listed. Those included: • Policy and Procedure PC-011, Provider Contracting, lists the standards for PCP to member ratios and the distance and time access requirements. The following goals were incorrect in the work plan: o The ratio of PCPs to members being measured does not include FQHCs and RHCs (page 13). o The ratio of OB/GYNs is incorrectly listed as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						1:5,000 members (page 14). o The goal listed for high impact specialists to member is 90% instead of the ratio of specialist to member (page 14). o For PCPs, only distance is measured; the access standard for time is not measured (page 16). o For high impact, high volume specialists, the distance goal (30 miles) is incorrect and time is not included. Also, OB/GYNs are not included in the measurement (page 17). o The distance goal (30 miles) is incorrect for behavioral health providers and time is not included (page 18). • In Policy MHSC-PS-005, Provider Availability Standards, and the Provider Manual, the following issues were noted in the QI Work Plan related to appointment access: o Routine appointments are listed as within 4 weeks in the policy and in the Provider Manual. The QI Work Plan lists the goal as within 6 weeks (page 20). o Follow-up routine appointment for behavioral health providers is listed as "X" in the QI Work Plan (page 23). o Routine appointment for specialty providers is listed as 30 calendar days in the QI Work Plan (page 26). The policy lists this standard as within 12 weeks. • Policy MHSC-MS-01, Contact Center Performance, lists the performance standards for the contact center. o Service level goal is listed as 85% within 30 seconds and the average speed to answer (ASA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						goal is listed as 30 seconds. The policy does not mention service level and lists the ASA goal as 80%. (page 20 and 52). o The ASA goal is listed as 95% within 30 seconds on page 23. The policy lists the goal as 80%. • The medical record monitoring discussed on page 35 and 39 of the QI Work Plan lists the goal as 80%. The medical record monitoring tool and procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, lists this goal as 90%. *Quality Improvement Plan: Correct the errors identified in the 2020 QI Work Plan.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Molina's Board of Directors has the ultimate authority and accountability for the oversight of the QI Program. The Board has delegated the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC provides oversight and direction in assessing the appropriateness of care and service delivery. The QIC receives reports from, advises, and directs the subcommittees.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Molina's Chief Medical Officer and Quality Lead co-chair the QIC. Members includes senior management and internal department staff and network practitioners specializing in pediatrics, OB/GYN, family medicine, and cardiology.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The QI Committee meets at regular quarterly intervals.	X					The QIC meets no less than quarterly and a quorum is defined as 51% of the committee members with no less than half of the network providers. A review of the minutes shows the QIC met at regular intervals. The required quorums were met for each meeting.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions.
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 for calculation of HEDIS rates. CCME found the measures met all requirements. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.*
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					Molina submitted three projects for validation. They included Improving Claims Accuracy and Provider Satisfaction, Well Care Visits, and Breast Cancer Screening.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Last year, the recommendations were to include interventions in the document for the Provider Satisfaction PIP. The PIP did include barriers and interventions, and claims-related rates have improved to exceed goal rates (decreased). The Improving Claims Accuracy and Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Satisfaction rate improved since the last remeasurement but is not at goal rate. Regarding Well-Care Visits, the results showed that the rates did increase once hybrid rates were calculated for the calendar year 2018 data, except for W34. There are many barriers and interventions involved due to the large number of outcomes being measured. Interventions for members and providers should be continued and revised according to data analyses to increase well-care visit rates. For the Breast Cancer Screening PIP, the rate improved when using the latest available finalized data, which is calendar year 2018. The calendar year 2019 data will be finalized in mid-2020. The interventions seem to be more focused on member outreach and incentives according to the report. Once the final rates are available, the interventions should continue to be adjusted, as needed, to increase the screening rate. All PIPs received a score within the "High Confidence" Range. Details of the validation of the PIPs are found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Feedback is provided via newsletters, provider relations representatives, the Provider Manual, as well as other sources.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.		X				According to Molina's 2019 QI Program Description, Molina conducts a formal evaluation of the QI program annually. The evaluation includes all quality activities with a description of limitations, barriers to improvements, recommendations, and the overall effectiveness of the program. Molina provided the 2018 Molina of South Carolina QI Program Evaluation/Executive Summary. This summary did not include all quality improvement activities. Practitioner Availability and Accessibility of Services, patient safety initiatives, medical record review activities, delegation monitoring, and performance improvement project results were not included. *Quality Improvement Plan: A complete evaluation of the QI Program should be conducted annually to include all QI activity results, barriers encountered, and recommendations for improvements.*
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Healthcare Services (HCS) Program Description outlines the goals, scope, and staff roles for physical, behavioral health (BH), and pharmaceutical services for members in South Carolina. Several policies, such as MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, and MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff, provide guidance on utilization management (UM) processes and requirements. The program description was last reviewed and approved by the Health Care Services Committee (HCSC) on November 25, 2019.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for Service Authorization time frames are correctly described in Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, the UM Program Description, Member Handbook, and Provider Manual.
1.5 consideration of new technology;	X					Consideration of new technology or new uses of existing technologies is addressed in Policy and Procedure MHSC-HCS-UM-323, Authorization of New Medical Technologies, and in the HCS Program Description.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Molina has a Provider Profiling Program as described on page 72 of the HCS Program Description and on page 67 of the Provider Manual. During the onsite teleconference, discussions confirmed Molina is addressing issues identified in the 2019 QIP. Staff reported eligibility criteria for the preferred provider program have been updated, provider groups have accepted invitations to participate, and other ongoing efforts are being considered.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The roles of the Chief Medical Officer and the Medical Directors for physical and behavioral health services are described in the HCS Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting UM reviews, and participation on plan committees. Dr. Richard D. Shrouds is currently the Chief Medical Director and Dr. Nickitas Thomarios is the BH Medical Director. Additionally, Julie Hernandez, PharmD, the Clinical Pharmacist, works in collaboration with the HCS Department and oversees the Pharmacy Program.
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 Description and HCS Annual Evaluation are reviewed and approved by the HCS Committee and Quality Improvement Committee annually. The HCS Program Evaluation includes analysis of utilization management, care management, disease management, and pharmacy resources, metrics, and key performances indicators. The HCS Program Description also outlines the structure and processes of the Medical Management Department. Procedure MHSC-HCS-UM-363, Continuity of Use of Clinical Utilization Criteria by Molina Health Plans, explains clinical criteria are reviewed annually with participation of physician members of the HCS Committee, and updated as needed. HCS Committee minutes reflect the 2018 HCS Program Evaluation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and 2019 HCS Program Description were presented and approved on November 25, 2019.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Molina uses several review criteria, such as, but not limited to, InterQual Criteria™, Medicaid Coverage Guidelines, and internal clinical policies. Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making and the HCS Program Description list nationally recognized clinical support tools and evidence-based criteria used for determining medical necessity. Individual circumstances and the local delivery system are considered when determining medical appropriateness.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM approval files reflect Care Review Clinicians and physician reviewers use approved criteria and relevant medical information to determine medical necessity.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Procedure MHSC HCS-UM-358, Abortions, Hysterectomies, and Sterilizations, the Provider Manual, and on Molina's website. Additionally, the criteria for utilization are communicated in the Member Handbook. The Abortion Statement and Surgical Justification Review for Hysterectomy forms are found on the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider website under "Frequently Used Forms" and in the appendix of the Provider Manual. Instructions and a link for accessing the Consent for Sterilization Form from SCDHHS are found in the Provider Manual and in Procedure MHSC HCS-UM-358; however, these instructions are not posted on the provider website. CCME noted page 2 of Procedure MHSC HCS-UM-358 references the Consent for Sterilization Form as SCDHHS 1723 instead of DHHS-687. *Recommendation: Provide instructions and a link for providers to access the Consent for Sterilization Form on the provider website under "Frequently Used Forms." In Procedure MHSC HCS-UM-358, Abortions, Hysterectomies, and Sterilizations, correct the reference number for the Consent for Sterilization Form from "SCDHHS 1723" to "DHHS-687."*
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy and Procedure MHSC-HCS-UM-363, Continuity of Use of Clinical Utilization Criteria by Molina Health Plans describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy and Procedure MHSC-HCS-UM-366, Consistency in Application of Medical Necessity Criteria for Healthcare Services Staff and the HCS Program Description describe how Molina assess consistency

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						in applying clinical criteria. Molina conducts monthly quality audits and annual inter-rater reliability testing (IRR) for clinical staff reviewers, physicians, non-physicians, and BH clinicians. Action plans for reviewers scoring below the benchmark of 90% will be established. Procedure MSC PHARM-09_IRR, Consistency in Application of Medical Necessity Criteria for Pharmacy Services Staff describes how the Pharmacy Services Department conducts annual IRR audits and monthly staff audits. The Q2 2019 MHSC HCSC Committee minutes and the 2019 QIC Meeting Packet reflect IRR scores above the benchmark for medical directors and pharmacy. However, remedial training was provided to 5 out of 11 clinical review nurses who scored below 90%, as reported in the 2018 Molina Healthcare of South Carolina Inter-Rater Reliability Analysis and the 2018 HCS Program Evaluation.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the Preferred Drug List (PDL), which identifies over-the-counter (OTC) medications that are covered. Negative PDL changes are posted on the website. The National P&T Committee Formulary Updates Summary confirms Molina publishes negative PDL changes to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the website at least 30 days prior to the effective date. The National Pharmacy and Therapeutics (P&T) Committee includes physicians and pharmacists who are not Molina employees but participate in making decisions regarding PDL management activities. Pharmacy documents, such as the Pharmacy Program Description and Procedure MHSC- PHARM-02, Pharmacy Prior Authorization Requests, states that a prior authorization response is given within 24 hours of request and determination within 14 days of requests for standard requests and expedited within 72 hours. During the onsite teleconference, Molina pharmacy staff confirmed that an automatic fax acknowledgement is sent to the provider in 24 hours, a standard determination is made within 14 days, and this process has been approved by SCDHHS.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Procedure MHSC-PHARM-02, Pharmacy Prior Authorization Requests and Procedure MHSC-PHARM-03, Pharmacy Lock-in Program indicate a 72-hour supply of medication will be approved while a prior authorization request is pending. CCME discussed that the redlined 2020 Pharmacy Program Description submitted for review contains references to a 5-day emergency supply that are marked for deletion without replacing them with a

STANDARD	SCORE					COMMENTS
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						different timeframe. Molina staff confirmed the time frame should be a 3-day emergency supply of prescription drugs when a prior authorization is pending. *Recommendation: Ensure the final 2020 Pharmacy Program Description indicates members are allowed a 72-hour emergency supply of prescription drugs when a prior authorization request is required and/or pending, as required by the SCDHHS Contract, Section 11.10.3.5.*
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists as outlined in Procedure MHSC-HCS-UM-364, Appropriate Professionals Making UM Decisions. Physician specialties include internal medicine, family practice, and behavioral health. The list of UM Physician reviewers shows a diversity of clinical specialties.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification, the UM Program Description, and *SCDHHS Contract* requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files reflect review by a medical director when UM Clinical Staff can not approve requests that do not meet medical appropriateness criteria.
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					
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 adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Molina has several policies and accompanying procedures that outline appeals processes, such as Policy MHSC-MRT-002, Standard Appeal Process, Policy MHSC-MRT-003, Expedited Appeal Process, and Policy MHSC MS-20, Member Appeals. Additionally, instructions are provided in the Provider Manual, Member Handbook, and the member tab of the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definitions of an adverse benefit determination and an appeal and who may file an appeal are included in Policy MHSC-MRT-002, Standard Appeal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Process, Policy MHSC MS-20, Member Appeals, the Provider Manual, the Member Handbook, and the website. These documents appropriately indicate that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf. However, Policy MHSC-MRT-002, Standard Appeal Process further includes the statement that "a member's consent for treatment serves as consent for the provider to appeal on the member's behalf. Molina considers medical records and/or a provider's history of paid claims for services rendered to the member as evidence that a member has signed a consent for treatment." This consideration is not communicated in the Provider Manual or Member Handbook. *Recommendation: In the Provider Manual and Member Handbook, include the statement "a member's consent for treatment serves as consent for the provider to appeal on the member's behalf. Molina considers medical records and/or a provider's history of paid claims for services rendered to the member as evidence that a member has signed a consent for treatment."*
1.2 The procedure for filing an appeal;		X				The procedure for filing an appeal is documented in Policy MHSC-MRT-002, Standard Appeal Process, the Provider Manual, Member Handbook, and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member website. Page 3 of Policy MHSC-MRT-002, Standard Appeal Process states, "MHSC provides the member and his or her representative, as well as regulatory or oversight agencies, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by MHSC in connection with the appeal of the adverse benefit determination. MHSC provides this information free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c)." The Member Handbook, appeal acknowledgement letters, and the Adverse Benefit Determination notice do not include information that members have access to the case file and other documents related to the appeal prior to the resolution timeframe, and CCME could not identify how Molina meets the requirement. During the onsite teleconference, Molina staff explained the member is informed of this requirement in the appeal resolution letter. The following issues are noted with addresses provided for members and providers to submit written appeals: •Neither the Member Handbook nor Policy or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Procedure MHSC-MRT-002, Standard Appeal Process, includes an address where written appeals can be submitted. •The addresses to submit written appeals are slightly different in the Provider Manual, Adverse Benefit Determination letter template, and the member website. The website has a physical street address and the other documents have a P.O. Box. •The Provider Manual and website state, "Molina Healthcare of South Carolina Attn: MIRR Dept." and the denial letter states, "Molina Healthcare Appeals dept." *Quality Improvement Plan: Ensure that members are informed they have access to their appeal case file and documents related to the appeal in advance of the resolution timeframe, as required by the SCDHHS Contract, Section 9.1.4.4.3, and stated in Policy MHSC-MRT-002, Standard Appeal Process. Include this requirement in documents such as the Member Handbook, appeal acknowledgement letters, and Adverse Benefit Determination notices. In the Member Handbook and Policy or Procedure MHSC-MRT-002, Standard Appeal Process, include an address where written appeals can be submitted. Ensure the address to submit written appeals is consistently documented in the Provider Manual, Adverse Benefit Determination letter template. and the member website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy and Procedure MHSC-MRT-002, Standard Appeal Process, Policy and Procedure MHSC-MRT-003, Expedited Appeal Process, the Member Handbook, and the Provider Manual indicate standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt, and meet all timeframe requirements for resolution and notification.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal files reflected timely acknowledgment and resolution, and determinations were made by appropriate reviewers.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement	X					Policy MHSC-MRT-002, Standard Appeal Process states all appeals are tracked and trended for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
opportunities, and reported to the Quality Improvement Committee.						analysis. The analysis is reported to the QIC as evidenced in QIC meeting meetings. Medical, BH, and pharmaceutical appeals are separately tracked, categorized, and analyzed for trends and potential improvement opportunities as identified in the 2018 MHSC Program Evaluation. Categories for medical necessity appeals include pharmacy, outpatient, inpatient, and durable medical equipment.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The 2018 HCS Program Description and Policy and Procedure MHSC-HCS-CM-044, Case Management Clinical Guideline and Tools, outline the framework for case management/care coordination program goals, objectives, lines of responsibility, and operations for physical and behavioral health services. Additionally, the Provider Manual and Member Handbook provide descriptions of the CM program.
2. The MCO has processes to identify members who may benefit from case management.	X					The HCS Program Description, Policy SC.CM.02, Care Coordination/Care Management Services, and other policies describe methods for identifying and referring eligible members into case management, such as review of clinical claims, health risk assessment results, medical records, and utilization management data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					Molina's approach to care management processes is outlined in Procedure MHSC-HCS-CM-047, Integrated Care Management Program and Complex Case Management. It describes in detail the CM services provided to members in each stratification level: •Level 1 (Health Promotion and Disease Management) •Level 2 (Case Management) •Level 3 (Complex Case Management) •Level 4 (Hospice/Palliative Care)
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Molina has processes to refer members, such as those with alcohol and substance abuse and children in foster care, for Targeted Case Management services provided by SCDHHS. Care Managers utilize the Clinical Care Advanced web-based health management documentation system to assess, coordinate, and manage care for members. This system has evidence-based and clinical decision-making tools that are consistent with NCQA and Utilization Review Accreditation Commission (URAC) Standards. CCME could not identify if the CM program follows CM standards of practice from the Case Management Society of America (CMSA). Onsite discussions confirmed that the Care Management Program and Care Coordination activities comply with CMSA standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Document in a Program Description or policy that Molina follows the standards of practice set forth by the CMSA as required by the SCDHHS Contract, Section 5.2.
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					The Transition Coordinator is Kathy Carpineto, RN, Manager Care Management Transition of Care.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					Policy and Procedure MHSC-HCS-CM-361, CM Audit Review defines the process used to review and analyze HCS staff performance on a monthly basis. The HCS Program Description describe the purpose and process used to measure member satisfaction, indicates all aspects of the program are measured and analyzed annually, and the information obtained is used to assess strengths and weaknesses. Evaluation results and future plans are reflected in the 2018 HCS Program Evaluation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate CM activities are conducted as required and Care Managers follow policies to conduct the appropriate level of case management. Pre-call interview processes are consistently conducted and HIPAA verification and identified care-gaps are consistently addressed.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					Molina monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization which may impact health care services, coordination of care, and appropriate use of services and resources as described in Policy MHSC-HCS-UM-362, Monitoring to Ensure Appropriate Utilization.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Health Care Services Committee meeting minutes indicate Molina analyzed and monitored data, and offered recommendations based on findings for several services regarding utilization. During the onsite teleconference, Molina shared challenges in hiring staff for Transition of Care program; however, they are in the process of recruiting for one position to continue reducing readmission rates.

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 enters into written agreements with all entities performing delegated functions. Credentialing and recredentialing activities are delegated to the following entities: •Bon Secours St. Francis (BSSF) •Managed Health Resources (MHR) •Augusta University Medical Center (AU) •Greenville Hospital Systems (GHS) •Medical University of South Carolina (MUSC) •Regional Health Plus (RHP) •March Vision, •United Physicians •MedXM •PHUSC Medical Group Additional delegated activities include primary source verification for credentialing and recredentialing (Aperture) and call center and claims functions (March Vision).
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would	X					Policies and procedures address delegation requirements and processes, including pre-delegation assessment, annual assessment, ongoing monitoring,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
apply to the MCO if the MCO were directly performing the delegated functions.						reporting and submission requirements, and action taken in response to substandard performance. Review of delegation oversight documentation confirmed Molina conducts appropriate oversight of delegated entities.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Molina ensures pediatric and adolescent immunization requirements are monitored as described in Procedure MHSC-AD-03, EPSDT Notification, Tracking and Follow-up Procedure, and Policy and Procedure MHSC-QI-120, Standards of Medical Record Documentation. Additionally, the 2018 QI Program Evaluation reflects child and adolescent immunizations are evaluated for improvement opportunities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 performing EPSDTs/Well Care.	X					Molina follows the EPSDT periodicity schedule according to the American Academy of Pediatrics (AAP). Methods such as annual medical record reviews are used to ensure EPSDT requirements are tracked and providers are informed of impending or missed EPSDT services by receiving a member non-compliant list.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			A deficiency from the previous EQR related to closing member grievances prior to investigation and providing inadequate information in the member's notification of grievance resolution was found to be uncorrected. *Quality Improvement Plan: Ensure all deficiencies identified in the EQR are addressed.*