Constellation Quality Health

South Carolina External Quality Review

Comprehensive Technical Report for Contract Year ' 24 – 25

Submitted: April 11, 2025

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*. To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) contracted with Constellation Quality Health (Constellation), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all managed care organizations (MCOs) participating in the Healthy Connections Choices and/or Healthy Connections Prime Programs. The MCOs, also referred to as health plans, for the Healthy Connections Choices Programs include:

- Absolute Total Care (ATC)
- Healthy Blue
- Humana Healthy Horizons (Humana)
- Molina Healthcare of South Carolina (Molina)
- Select Health of South Carolina (Select Health)

For the Healthy Connections Prime Programs, the Coordinated and Integrated Care Organizations (CICOs) include:

- First Choice VIP Care Plus by Select Health of South Carolina (Select Health)
- Molina Healthcare of South Carolina (Molina)
- Wellcare Prime by Absolute Total Care (Wellcare)

Constellation is also required to conduct EQR for SC Solutions, a primary care case management program providing care coordination for the Medically Complex Children's Waiver program.

The purpose of EQRs is to ensure that Medicaid enrollees receive quality health care through a system that promotes quality, timeliness, accessibility, and coordination of all services. This report is a compilation of the findings of the annual reviews completed during the 2024-2025 EQR contract year. As directed by SCDHHS, the review of Healthy Blue originally scheduled to commence on January 6, 2025, was not conducted. Constellation did conduct the Mental Health Parity assessment for Healthy Blue in December 2024. Therefore, this report only contains the Mental Health Parity assessment for Healthy Blue.

The process Constellation used for the EQRs is based on the Centers for Medicare & Medicaid Services (CMS) EQR Protocols, February 2023, developed for the review of Medicaid MCOs. The reviews for the Healthy Connections Choices MCOs included a desk review of documents; a virtual onsite visit; a Telephonic Provider Access Study; compliance review; mental health parity assessment; and validation of performance improvement projects (PIPs), performance measures (PMs), network adequacy, and satisfaction surveys.

The reviews for the Healthy Connections Prime CICOs included a desk review of documents; a virtual onsite visit; compliance review that focused on network adequacy for home and community-based services and behavioral health providers, over- and underutilization, and care transitions. SCDHHS did not require the CICOs to conduct performance improvement projects or collect performance measures during this reporting period. However, the CICOs were required to report specific CMS core measures. As requested by SCDHHS, the results of the CICOs performance data currently available are included as an attachment to this report. This data shows the CICOs performance on quality measures during 2022 and the results of surveys of Medicare / Medicaid Plan (MMP) enrollees conducted in 2022 or 2023. These measures were not validated by Constellation and only included as information.

Summary and Overall Findings

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

- Disenrollment Requirements and Limitations *(§ 438.56)*
- Enrollee Rights Requirements *(§ 438.100)*
- Emergency and Post-Stabilization Services *(§ 438.114)*
- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality *(§ 438.224)*
- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess the MCO's compliance with the 14 Subpart D and QAPI standards as related to quality, timeliness, and access to care, Constellation's review was divided into seven areas:

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation
- Mental Health Parity

The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

Administration

Appropriate processes are followed for new policy development and ongoing review. However, ATC's processes were incompletely documented, and Humana's policy contained inconsistent information about policy review and approval and included inappropriate information about another state's processes.

The MCOs' Organizational Charts display reporting and operational relationships of staff and indicate key positions, temporary/contingent personnel, shared services staff, etc. Most vacant positions have been filled or offers are pending. Overall staffing is sufficient to ensure the health plans can conduct the required activities and provide the required services.

Compliance Plans and Fraud, Waste, and Abuse/Program Integrity Plans describe processes to ensure compliance with laws, regulations, and contractual requirements and to prevent, detect, and respond to fraud, waste, and abuse. Codes of Conduct define expectations for appropriate business practices. Related policies and procedures provide detailed information about these topics. Issues were identified related to incomplete documentation about the Program Integrity Coordinator, incorrect contact information for State agencies, and a reference to another state's requirements for an Audit Work Plan. Compliance Committees routinely meet to assist in monitoring and oversight of the Compliance Programs. Humana launched a local (plan-level) Compliance Committee in March 2024.

Pharmacy Lock-In Programs are in place to manage members who use services at a frequency or amount that is not medically necessary and to ensure appropriate utilization of prescription medications. Issues with documentation of these programs were related to a discrepancy in documentation of the emergency supply of medication for members in the program and lack of documentation of timeframes applicable to the program. Humana reported they are implementing a process to identify additional members who may benefit from the program.

Processes for ensuring the confidentiality of protected information are addressed in policies, the Codes of Conduct, compliance training content, etc., and employees are educated about confidentiality and appropriate use of member information.

The health plans meet or exceed the contractually required claims processing timeliness requirements and can securely accept and generate HIPAA-compliant transactions. Health plan information management systems support the required reporting to the State. Documented mechanisms are in place to ensure the security of all data, and each health plan has a documented and regularly tested disaster recovery plan.

Provider Services

The health plans document credentialing and recredentialing processes and requirements in policies; however, multiple issues were identified with the documentation. Constellation reviewed a sample of initial credentialing and recredentialing files for practitioners and organizational providers. Deficiencies were found in the files for two of the four health plans. The health plans' Credentialing Committees use a peer-review process to make credentialing and recredentialing determinations. Committee membership includes network practitioners with an array of specialties. For one health plan, a deficiency was identified related to the quorum requirement for the Credentialing Committee.

Each of the MCOs has appropriate processes for conducting initial provider orientation and ongoing education. In addition, provider updates are disseminated through various print communications and the MCOs' websites. Provider Manuals are comprehensive resources for providers, although issues with Provider Manual documentation were noted for two health plans. The MCOs educate providers about medical record documentation standards and evaluate provider compliance with the standards. They also educate providers about adopted clinical practice and preventive health guidelines and the importance of following the guidelines for patient care. For one health plan, the review revealed a discrepancy in the frequency of guideline review by the MCO. Each of the health plans ensure their network providers monitor continuity and coordination of care, but one health plan did not document related processes in a policy.

Network Adequacy Validation: Constellation conducted a validation review of the MCOs' provider networks following the CMS protocol titled, *EQR Protocol 4: Validation of Network Adequacy*. The MCOs' provider networks were found to be adequate and consistent with the requirements of the CMS protocol. Review of Provider Network File Questionnaires revealed the MCOs have appropriate processes for classifying, storing, and updating provider enrollment data. The health plans have established geographic access standards for their provider networks and monitor the compliance with those standards. The MCOs address identified network gaps to ensure members can receive needed care. All the MCOs monitor primary care provider (PCP) panel status, and three of the four monitor the panel status of specialists. The MCOs follow the contractually required appointment access standards with the exception of one plan (related to specialty emergent visits). The MCOs evaluate provider

compliance with the appointment access standards and address identified performance issues.

The MCOs maintain Provider Directories that are available in print versions and on the health plans' websites. Each health plan also maintains an online tool to search for providers. Issues were identified with the Provider Directories for three of the four MCOs. The MCOs validate information in their Provider Directories through routine call studies, provider outreach campaigns, review of information obtained through credentialing processes, etc.

As a part of the annual review process for all plans, Constellation conducted a Telephonic Provider Access Study focusing on PCPs. Results revealed consistent declines in successful contact rates and provider confirmation of plan participation across all plans. Availability of providers accepting new Medicaid patients also declined across all MCOs. Appointment availability showed mixed results. Due to the lack of improvement in successful contact rates, all four plans received a "Not Met" score regarding the standard: "Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results."

The health plans employ a variety of processes to ensure their provider networks can serve members with diverse cultural and linguistic needs and physical limitations. The MCOs include cultural competency resources for providers on their websites.

Member Services

Each MCO provides information about member rights and responsibilities through various materials such as Member Handbooks, Provider Manuals, welcome kits, newsletters, and websites. New member materials are provided within 14 days of enrollment. These materials are available in formats that consider special needs, disabilities, and limited English proficiency. Member Handbooks include instructions for obtaining a copy annually and details about benefits, services, fees, and authorization requirements.

Member Services Call Centers are available via a toll-free telephone number, toll-free fax, and TTY from 8:00 a.m. to 6:00 p.m., Monday through Friday for each health plan. Information is available to members about access to the Nurse Advise Line and other emergency resources. Performance standards for speed of answer, average hold time, and the disconnect rate for incoming calls are reviewed for compliance. Members are informed of the steps for automatic PCP assignment upon enrollment and process for disenrollment when requested.

Health plans conducted Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for adults, children, and children with chronic conditions as required. Constellation validated these surveys using CMS Protocol 6 to ensure reliability and validity. All

health plans met validation criteria, but survey response rates were significantly below the National Committee for Quality Assurance (NCQA) target, ranging from 6.2% to 15.2%. Most response rates declined compared to the previous year, indicating ongoing challenges in member engagement.

Processes for filing and handling grievances are detailed in various member materials and on health plan websites. Timelines for acknowledgment, resolution, and extensions are clearly outlined. Grievances are logged and categorized, and trends are reported quarterly. Constellation reviewed grievance files and found all were resolved on time and reviewed by qualified personnel. Recommendations were discussed onsite for one MCO, and letters included required elements and next steps for members.

Quality Improvement

Health plans are contractually required to establish and implement a comprehensive quality assessment and performance improvement program. The SCDHHS Contract requires the health plans to have a written description of the Quality Improvement (QI) Program, which should focus on health outcomes and include detailed objectives, program structure, accountabilities, details of the scope for the QI program, and an annual evaluation. To demonstrate compliance with this requirement, each health plan submitted their QI Program Descriptions outlining how they integrate quality assurance, management, and improvement into daily operations, with defined performance metrics and accountability.

Members and providers are informed of the QI Program in the Member Handbook. the Provider Manual, and on the health plan websites. However, the information shared on Select Health's website was outdated. Humana's website stated "We want you to feel confident that you made the right choice in your plan. View the HEDIS State of Health Care Quality Report." A link was provided for the HEDIS® State of Health Care Quality Report on the NCQA website, which was a summary report of performance measure results for commercial, Medicare and Medicaid health plans, but not specific to Humana's plan.

The Quality Work Plan is a key component of the health plans' continuous quality improvement cycle. The Quality Work Plan is developed annually and reflects the ongoing progress of quality activities and includes recommendations for improvement based on the annual Program Evaluation. ATC and Select Health provided the 2023 and 2024 QI work plans, detailing planned activities, objectives, timeframes, responsible parties, and updates. Humana's 2024 work plan included activities for continuity and coordination between medical and behavioral health providers with an annual report to be generated and presented to the Quality Assurance Committee at the August 2024 meeting. However, the meeting minutes did not include this report. During the onsite, Constellation requested a copy of this report, and a copy

of the committee meeting minutes demonstrating this activity was discussed. These documents were not received.

Responsibility for the QI Programs is overseen by a committee appointed by the health plans Board of Directors. The quality committees are composed of senior staff and participating network providers. The committees meet quarterly, with additional meetings scheduled as needed. Minutes for each meeting are recorded and presented at the next meeting for review and approval. Humana's Quality Assurance Committee charter states, "voting members are expected to attend each meeting; in their absence, a proxy representation is requested." The meeting minutes reviewed did not identify the proxy representative when a voting member was absent.

Annually, the health plans evaluate the effectiveness of the QI Programs. Each health plan provided copies of their annual evaluations. The evaluations outlined accomplishments, analyzed data and outcomes compared to goals, included limitations or barriers to meeting objectives, and stated conclusions and recommendations for the upcoming year.

Performance Measure Validation: Constellation conducted a validation review of the HEDIS measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. For the validation process, Constellation applies the three activities for each MCO to support the auditing process per *42 CFR § 438.330 (c)* and *§ 457.1240 (b)*. The Performance Measure (PM) Validation found that all of the health plans were fully compliant with all HEDIS measures and met the requirements. *Table 1: HEDIS Measures with Substantial Increases or Decreases* highlights the HEDIS measures with substantial increases or decreases. Rates shaded in green indicate a substantial improvement (>10%), and rates shaded in red indicate a substantial decline (>10%). All rates reported by the MCOs and the statewide averages are included in the Quality Improvement section of this report.

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)
Substantial Increase in Rate (>10% improvement)				
Childhood Immunization Status (CIS)				
DTaP	66.91%	50.61%	64.23%	75.91%
IPV	82.73%	62.77%	83.45%	88.56%
MMR	84.43%	70.32%	83.21%	89.78%
HiB	78.83%	59.85%	78.10%	85.16%
Hepatitis B	84.91%	62.77%	79.32%	86.13%
VZV	83.94%	70.32%	82.48%	88.81%

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)
Pneumococcal Conjugate	70.32%	49.39%	68.61%	78.35%
Hepatitis A	83.70%	71.53%	81.02%	87.59%
Rotavirus	68.86%	44.77%	65.69%	72.75%
Influenza	23.84%	22.87%	28.47%	29.93%
Combination #3	62.29%	41.85%	58.15%	69.59%
Immunizations for Adolescents (IMA)				
Meningococcal	76.89%	46.58%	68.37%	74.32%
Tdap/Td	86.37%	61.64%	84.18%	86.54%
Cervical Cancer Screening (CCS)	57.47%	44.28%	56.20%	61.86%
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Poor Control (>9.0%) ** *	30.41%	34.55%	43.07%	40.39%
HbA1c Control (<8.0%)	61.07%	56.69%	47.93%	50.12%
Eye Exam (Retinal) Performed (EED) +	44.77%	49.39%	53.28%	50.12%
Blood Pressure Control for Patients With Diabetes (BPD)	69.34%	65.69%	63.02%	61.56%
Kidney Health Evaluation for Patients With Diabetes (KED)	36.04%	28.24%	28.31%	31.60%
Follow-Up Care for Children Prescribed ADHD Medication (ADD) +				
Initiation Phase	47.36%	41.54	52.89%	44.55%
Continuation and Maintenance (C&M) Phase	61.26%	38.10%	62.65%	53.46%
Follow-Up After Hospitalization for Mental Illness (FUH)				
Total - 30-Day Follow-Up	59.34%	55.35%	55.59%	64.72%
Follow-Up After Emergency Department Visit for Substance Abuse (FUA) +				
30-Day Follow-Up: Total	24.01%	34.72%	28.63%	24.83%
7-Day Follow-Up: Total	15.97%	20.83%	19.75%	16.44%
Use of Opioids From Multiple Providers (UOP) **				
*Multiple Prescribers ** *	18.90%	20.99%	21.27%	22.80%
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 30 Months of Life (First 15 Months)	55.21%	36.59%	58.43%	57.86%
Substantial Decrease in Rate (>10% decrease)				
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	72.08%	59.09%	72.78%	68.61%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	47.22%	50.00%	71.43%	55.88%
Pharmacotherapy for Opioid Use Disorder (POD)	32.64%	36.23%	33.78%	33.99%
Use of Imaging Studies for Low Back Pain (IBP)	67.40%	59.89%	66.87%	68.60%

**A lower rate for this measure indicates improvement.
+Measure had revisions for HEDIS MY 2023 that may affect trending according to NCQA Memo

Performance Improvement Project Validation: The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by

CMS titled, *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. Each health plan is required to submit PIPs to Constellation for review annually. Ten projects were validated for the health plans. Results of the validation and project status for each project are displayed in *Table 2: Results of the Validation of PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

Table 2: PIP Validation Results

Project	Validation Score	Status
ATC		
Hospital Readmissions	80/80=100% High Confidence in Reported Results	The Hospital Readmissions PIP aims to reduce the annual rate of readmissions within 30 days for 18- to 64-year-old patients. The readmissions PIP has three measurement periods. The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge declined from 15.5% in 2022 to 15.3% in 2023. The benchmark is set at 15%. This PIP is retiring.
Timeliness of Prenatal Care	93/93=100% High Confidence in Reported Results	The Timeliness of Prenatal Care clinical PIP was initiated in 2023 using a baseline rate from the measure year 2022 HEDIS rate. As of this review, only the baseline rate was available. The hybrid rate was 84.43% with a benchmark of 88.32%.
Adult Access to Preventive Health Care	74/75=99% High Confidence in Reported Results	The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The PIP showed a decline in the annual rate from 2021 (78.18%) to 2022 (72.46%). The 2023 measure year rate in the quarterly quality assessment document showed a rate of 76.73%.
Humana		
Human Papillomavirus Vaccine (HPV)	80/80=100% High Confidence in Reported Results	The HPV Vaccine PIP is aimed at increasing HPV vaccines among 9–13-year-olds. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the human papillomavirus vaccines. HPV vaccine rates improved from 11.54% in MY2022 to 16.44% in MY2023.
Prenatal and Postpartum (PPC)	100/100=100% High Confidence in Reported Results	The aim for the Prenatal and Postpartum PIP is to increase the rate of eligible women receiving timely prenatal and postpartum care. The purpose of this project is to align with state efforts of increasing postpartum compliance in SC by 15% by 2026. This PIP has two indicators: timeliness of prenatal care and postpartum care. The timeliness indicator decreased by 6.8% from MY2022 (92.7%) to MY2023 (85.9%); and the PPC rate improved 7.02% from 72.06% in MY2022 to 79.08% in MY2023.
Molina		
Improving Encounters Acceptance Rates	79/79=100% High Confidence in Reported Results	The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from 97.30% in 2022 to 98.69% in 2023. The goal is 100%. The 837P rejection rate declined from 2.70% to 1.31%. The goal for this measure is 2% and thus, the most recent rate has exceeded the goal. For 2024, Molina will participate in the SCDHHS

Project	Validation Score	Status
		workgroup, as they transition their current encounter system to avoid unintended issues.
Child and Adolescent Well-Care Visits	80/80=100% High Confidence in Reported Results	The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed improvement in the Child and Adolescent Well-Care Visits (Total) rate from 44.40% to 49.32%.
Immunizations for Adolescents	73/74=99% High Confidence in Reported Results	The Immunizations for Adolescents PIP examines adolescents, 13 years of age, with one dose of meningococcal vaccine, one tetanus, Tdap, and HPV by their 13th birthday. The hybrid and administrative rates were reported and showed a decline from 2022 at 32.36% to 28.12% for 2023. Additional locations with incentives for members may help improve the rate, as well as the initiation of additional interventions reflected in the PIP report.
Select Health		
Diabetes Outcomes Measures	100/100=100% High Confidence in Reported Results	The aim for the Diabetes Outcomes Measures PIP is to lower HbA1c levels by providing additional education and outreach, specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and whose HbA1c levels are not <8%). The diabetes outcomes rate measures for the year 2024 were not in the report, but a quarterly report as of April 2024 was submitted. The HEDIS audit reports showed improvement for HbA1c Control (<8%) from 42.09% in MY2022 to 50.12% in MY2023. Controlling High Blood Pressure at <140/90 mm/hg improved from 61.31% in MY2022 to 61.56% in MY2023.
Well Care Visits for the Foster Care Population	74/75 = 99% High Confidence in Reported Results	The aim for the Well Care Visits for Children and Adolescents in Foster Care PIP is to increase compliance with well-care visits for children and adolescents in foster care. For this PIP, there are several rates monitored. Several of these rates have been retired, thus the plan is tracking the current HEDIS measures only, including the Well-Child Visits in the First 30 Months of Life (W30) and the Child and Adolescent Well Care Visits (WCV). The W30 for the first 15 months showed a 2023 rate of 53.96%, a slight decline from 54.93% in 2022. The W30 for 15–30 months showed 84.0%, a decline from the 2022 rate of 87.01%. The WCV rate for 3–11-year-olds was 76.82%, which is a slight improvement over the 2022 rate of 76.30%. For 12–17-year-olds, the WCV rate was 71.61%, a decline from the 2022 rate of 72.22%. For 18–21-year-olds, the WCV rate was 43.25%, a slight decline from the 2022 rate of 43.54%. The total WCV rate was 71.31%, down from 71.47% in 2022.

Utilization Management

Constellation conducted a comprehensive evaluation of each health plan's Utilization Management (UM) program, reviewing key documents such as the UM Program Description, Provider Manual, Member Handbook, and a sample of approval, denial, appeal, and case management files. The program's purpose, scope, and goals are clearly outlined in the UM Program Description and are evaluated annually.

Each plan is overseen by a Chief Medical Officer (CMO) who provides clinical supervision of the UM Program. In addition, Behavioral Health Medical Directors, Pharmacy Directors, and other licensed clinicians support the UM Managers, ensuring the program operates effectively on a day-to-day basis. These leaders are responsible for staff supervision, training, consistent application of UM criteria, and maintaining adequate documentation.

Initial review determinations are made by licensed clinical staff, utilizing approved clinical criteria. The UM Program Descriptions and associated policies include guidelines addressing UM determination timeliness requirements. Each health plan has policies to guide UM decisions, including clinical criteria, timeliness, and communication standards, all of which are overseen by licensed health professionals. To ensure consistency and quality, annual reliability reviews are conducted to assess the performance of reviewers, with corrective actions or additional training provided to those whose performance falls below a 90% consistency benchmark.

Standard authorizations are processed within 14 calendar days, while urgent requests are processed within three days. Two levels of medical necessity reviews are in place: Level I reviews do not result in denials or reductions, while Level II reviews may lead to adverse determinations, which are made by the Medical Director or an appointed designee. A review of the approval and denial files across the health plans confirms that the files were processed in accordance with the respective policies and contractual requirements. Members are notified of denial decisions and are informed of their right to appeal or request a State Fair Hearing. Peer-to-peer reviews are available upon request.

While most health plans offer a Preferred Provider Program, ATC was unable to provide detailed information regarding the structure of their program, how providers are informed about it, or how preferred provider status is identified and tracked within the plan.

Processes for handling member appeals are described in policies, Member Handbooks, Provider Manuals, UM Program Descriptions, and are found on the health plan websites. Appeal terminology is defined, along with steps for filing an appeal. Timeframes associated with appeal acknowledgement, resolution and extension were clearly documented. Appeals are logged, categorized, and analyzed for trends and quality improvement opportunities. Constellation found the following issues with the appeal process.

- Humana's appeal policy does not indicate that members may file a grievance when they disagree with a 14-day extension request. This was an issue identified in the previous (2024) EQR and not corrected.

- Molina's policy/procedure and appeal request form incorrectly stated a verbal appeal must be followed by a written request. This was identified during the 2023 EQR and was not corrected.
- Select Health was not sending the appeal resolution notification by certified mail with return receipt requested as required by the *SCDHHS Contract, Section 9.1.6.3.1.1.*

The health plans offer Care Management, Disease Management, and Population Health Management programs that are outlined in various program descriptions and policies. Various resources are utilized to identify potential candidates for care management services. Once a member is referred, health plans deliver care management services tailored to the member's assessed needs and risk level. Specialized services are also offered to address the unique health needs of members and to promote their active engagement in their care. The sample care management files reviewed during the EQR demonstrated that care management activities are conducted as required. However, several of ATC's care management files did not follow the unable to contact guidelines as outlined in their policy and program description.

Delegation

The delegation review includes the health plans policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. Constellation requested a list of delegated entities, the services delegated, and a copy of the oversight monitoring.

The health plans conduct a pre-delegation review prior to the activation of a delegation agreement. This review includes an evaluation of the entity's program, associated policies and procedures, staffing capabilities, and performance record to ensure compliance with all requirements. Performance is monitored through routine reporting, oversight meetings, and annual evaluations to ensure continued compliance with standards. Corrective Action Plans are required for any deficiencies identified. Severe or unresolved deficiencies may lead to the revocation of the delegation agreement. Copies of the pre-delegation audits, routine reporting and annual monitoring were provided for all health plans.

Mental Health Parity Assessment

Constellation was required to conduct a Mental Health Parity assessment to determine if the MCOs met the Mental Health Parity requirements outlined in the *Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008*. This assessment was conducted as a two-step process. Step one involves assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs), such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limitations on the scope or duration of benefits. The

Mental Health Parity assessment was conducted for ATC, Healthy Blue, Molina, Select Health, and Humana. Healthy Blue is in the first year of operation and does not yet have a full data set for reporting purposes.

The MCOs provided various documents to demonstrate compliance with the Federal Parity Act, including program descriptions, utilization and network access reports, handbooks, benefit maps, and assessment tools. All plans include behavioral health licensed clinicians and used evidence based, industry standard assessment tools for mental health/substance use disorder (MH/SUD). Molina also reported using internal criteria for some services and was cautioned against this.

The MCOs included MH/SUD focused questions on the interrater Reliability (IRR) assessment. Three plans demonstrated equivalent scores, while two required additional training and retesting for MH/SUD clinicians. Two of the plans reported minimal to no quality-of-care issues in MH/SUD and two plans were not able to provide data differentiating between behavioral and medical based reports.

In terms of Utilization Management, Humana completes first level reviews and has delegated their mental health adverse determinations and appeals for MH/SUD to an external contractor. None of the remaining plans report any potential parity differences in their UM processes.

Out-of-network requests and geographic access to providers were assessed for comparability of provider networks. ATC and Select Health report higher numbers of out-of-network requests for MH/SUD and it was recommended that SUD requests be separated from MH to help further identify possible causation. Plans generally were able to demonstrate parity for non-prescriber geographic access. Disparity in geographic access occurred with psychiatric inpatient providers in a few areas for Humana and Healthy Blue.

Stringency was evaluated by examining denial and appeal rates. Healthy Blue reported higher denials for inpatient services but not outpatient, with no overturned appeals. Higher overturned appeal rates were noted for Select Health and ATC, although for ATC this was based on a small number of denials and does not represent a parity issue.

Constellation compared pharmacy denials and appeals when the information was available. Due to the nature of this data, plans are not always able to differentiate between MH/SUD and medical/surgical (MS) pharmacy authorizations. Humana reported slightly higher MH/SUD pharmacy denials with no overturned appeals, while the remaining plans either reported lower rates or were not able to supply the necessary data.

Two templates were provided to each health plan to complete the mental health parity assessment. The templates allow the plan to enter information based on copay, session limits,

day limits, etc. for medical/surgical and mental health benefits. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. For all health plans, there were no financial requirements for mental health benefits that exceeded the financial requirement predominant value for medical/surgical benefits, thus, parity was met.

Overall, the assessment found that mental health services are aligned with the medical/surgical financial and treatment limitations and all health plans met the requirements for Mental Health Parity.

SC Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. Constellation's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs.

Administration

Solutions has established processes for policy development, management, and ongoing review. These processes include annual policy review with revision as needed. Policies are accessible by staff, and leaders oversee policy implementation.

The Chief Medical Officer/Executive Director oversees day-to-day operations and is responsible for clinical decision-making, supported by a Medical Advisor. Staffing levels were appropriate, and vacant positions were filled. Processes are followed to ensure clinical staff have valid and active professional credentials. Review of a sample of employee files found that the required checks and validations were conducted.

The Compliance Program includes employee education, reporting mechanisms, internal inquiries and corrective action when indicated, as addressed in the 2024 Compliance Program Description. The Compliance Officer develops, implements, and monitors the Compliance Program. Comprehensive compliance training is provided to employees at employment and annually. Solutions enforces a non-retaliation policy for those reporting compliance issues.

Information Systems Capabilities Assessment (ISCA) documentation confirms Solutions has security and privacy administrative policies in place to ensure data and information are protected. These policies are regularly reviewed and updated. A business continuity plan is in place to provide guidance for maintaining and restoring operations if a disruptive incident

occurs. Solutions performed a successful tabletop Disaster Recovery exercise in October 2023.

Provider Services

Solutions addresses provider orientation and ongoing education processes for all network providers, as well as disseminating provider updates as needed, in policy. However, the policy did not provide detailed information about these processes. Additionally, the review found that Solutions was not in compliance with policy requirements for providing formal training to all providers and for disseminating at least annual provider updates.

The 2024 Enhanced Provider Network Orientation document and the 2024 MCCW Provider Manual were comprehensive and provided information about topics providers need in order to function effectively within Solutions' network. Both documents were available on Solutions' website. Additionally, the "Providers" page on Solutions' website gave information about the MCCW, use of the Medicaid guidelines and the SCDHHS Preferred Drug List, information about reporting Fraud, Waste, and Abuse, the Notice of Non-discrimination, contact information for free language services, and links to the credentialing application, the SCDHHS website, and the list of SCDHHS Provider Manuals.

Quality Improvement

Solutions' Quality Improvement (QI) Program is described in the 2024 Strategic Quality Plan (SQP), which includes goals, objectives, and structure. The QI Program follows a systematic process for quality management, including planning, standards development, identifying improvement opportunities, use of performance measures, clinical care standards, data collection, monitoring, analysis, performance improvement, follow-up, and reporting.

Solutions has two ongoing performance improvement projects:

1. Annual Visit and Initial Monthly Summary Reports and the Enhanced Provider Network: Aims to enhance PCP involvement in the care process, with most of the goals met or exceeded.
2. Enhanced Provider Network: Lacked a clear aim, background, baseline data, measures, goals, and a data collection plan.

The Compliance & Quality Management Committee (CQMC) develops and implements the QI Program, ensuring it aligns with the organization's strategic goals. Solutions conducts an annual formal program evaluation. The Quality and Performance Improvement Annual Report for Calendar Year 2023 lacked clarity and did not mention monthly monitoring of excluded providers, results for Emergency/Disaster Preparedness activity and the case audits conducted.

Care Coordination/Case Management

Solutions provides coordinated care for participants, led by the Chief Medical Officer/Executive Director. Care coordination is provided by Registered Nurses (RNs) and in May 2024, Licensed Practical Nurses (LPNs) with similar experience were implemented to provide care coordination. Care Coordinators act as liaisons between families, medical providers, and community services, ensuring seamless transitions across healthcare settings. Care Advocates provide support with administrative tasks, while the Durable Medical Equipment (DME) Team handles equipment needs. Parent Advocates assist families with additional guidance.

The team develops a treatment plan with the family and the treatment plans are tailored to the participant's needs and goals, with input from all parties involved. Materials are available in English and Spanish, and Solutions works with SCDHHS to ensure accessibility. Contact numbers for complaints are included, and Solutions is working to update them. Constellation's review confirmed proper assessments, follow-ups, and visits were conducted.

Coordinated and Integrated Care Organizations Annual Review

Constellation conducted an EQR of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those plans include ATC, Molina, and Select Health. This review focused on network adequacy for home and community-based services (HCBS) and behavioral health providers, over- and underutilization, and care transitions.

Provider Network Adequacy

The CICOs are required by contract to maintain a network of HCBS providers that is sufficient to provide all enrollees with access to a full range of covered services in each geographic area. The CICOs are also required to have a network of Behavioral Health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard. Wellcare only had one county that did not meet the requirements for Adult Day Health Services. Select Health and Molina's HCBS provider network met the minimum requirements. All of the CICOs maintained a sufficient network of behavioral health providers to provide all enrollees with access to covered services.

Evaluation of Over and Under-Utilization

The CICOs are required to monitor and analyze utilization data to look for trends or issues that may provide opportunities for quality improvement. The over- and under-Utilization monitoring focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing

homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services. The CICOs provided their over- and under-utilization monitoring results. The documentation demonstrated that the monitoring and analysis of trended data is conducted as required.

Care Transitions

Constellation reviewed each CICO's Program Descriptions and policies related to care transitions. The CICOs were also required to submit a file of enrollees hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. The CICOs were directed to only include those enrollees readmitted with a diagnosis that met the definition of a potentially avoidable hospitalization, which were defined by SCDHHS as Bacterial Pneumonia, Urinary Tract Infection, Congestive Heart Failure (CHF), Dehydration, COPD/Asthma, and Skin Ulcers. Based on the file received from each CICO, a random sample of files was requested for review. The review found that Molina and Select Health are not conducting the appropriate care transitions functions as required by the contract. Files lacked documentation of collaboration with the facility Case Management or Discharger Planning staff, notification and participation of the enrollee's PCP, and medication monitoring. In addition, the files reflected untimely attempts to contact the member or caregiver to conduct the 72-hour follow-up.

Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. Technical assistance is provided to each health plan until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which each health plan implemented the actions to address deficiencies identified during the previous EQR. Findings of the EQRs confirmed ATC, Humana, Molina, Select Health, and the CICOs, Molina and First Choice VIP Care Plus, were found to have uncorrected deficiencies as noted in *Table 3: Uncorrected Deficiencies from Previous EQR*. The complete QIP report for each health plan is included as an attachment to this report.

Table 3: Uncorrected Deficiencies from Previous EQR

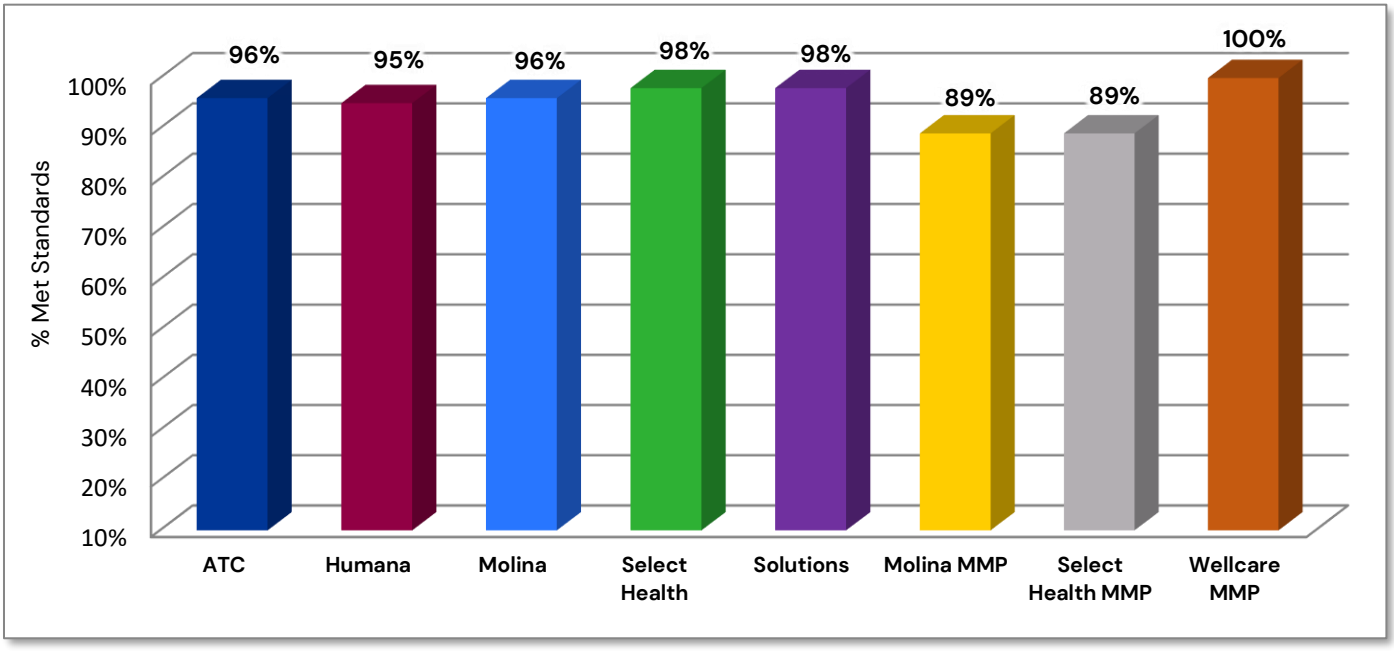
Health Plan	Uncorrected Deficiencies
ATC	ATC failed to implement the changes needed for their Preferred Provider Program.
Humana	The grievance acknowledgement timeframe was not corrected in Policy SC.MCC.005, Member Grievances and Appeals.

Health Plan	Uncorrected Deficiencies
	The QI work plan was not updated timely and did not note when the timeframe for completing and reporting a QI activity was not met.
	The Quality Assurance Committee meeting minutes did not include information about when a proxy representative is used for any absent voting members.
	Policy SC.MCC.005, Member Grievances and Appeals, was not updated to include information regarding the member's right to file a grievance if they disagree with an extension request.
Molina	The deficiency related to appeals was not corrected. The appeal process requires a member who files an appeal verbally to follow up with a written appeal request.
Select Health	There was no improvement in the percentage of successfully answered calls for the provider access call study conducted by Constellation.
Molina MMP	The transition of care (TOC) file review contained the following issues: • Files lack documentation of collaboration with the facility Case Management or Discharge Planning staff to ensure a safe transition. Most of the documentation was the communication to the facility regarding the approval of the admission. • Documentation of any needed clinical and non-clinical supports, transition/aftercare appointments, and any barriers for after-care was lacking in two files. • Three files lacked documentation of outreach to members to conduct the 72-hour follow-up post discharge. For one of the three files, the attempt to reach the member was documented, however this attempt was outside of the 72-hour window. • Medication monitoring adherence after the initial 72-hour follow-up was not evident in four files. • Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done.
First Choice VIP Care Plus	Constellation reviewed a sample of 30-day readmission files submitted by Select Health and found issues related to the lack of attempts to contact the facility's Case Management/Discharge Planning staff and lack of documentation of the medication monitoring performed after the 72-hour follow-up.

Conclusions

Overall, the health plans met most of the standards reviewed during the 2024 – 2025 EQRs. The following figure illustrates the percentage of "Met" standards achieved by each health plan. Also, *Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of the health plans' compliance scores specific to each of the *Subpart D* and QAPI standards where applicable. Areas noted as needing improvements included network adequacy, coordination and continuity of care, credentialing, grievances, appeals, practice guidelines, and quality.

Figure 1: Health Plans Overall Percentage of Met Standards



Scores were rounded to the nearest whole number

Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Federal Standards	ATC	Humana	Molina	Select Health	SC Solutions
Disenrollment Requirements and Limitations *(§ 438.56)*	100%	100%	100%	100%	N/A
Enrollee Rights Requirements *(§ 438.100)*	100%	100%	100%	100%	N/A
Emergency and Post-Stabilization Services *(§ 438.114)*	100%	100%	100%	100%	N/A
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	75%	75%	83%	83%	N/A
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	89%	100%	100%	100%	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	100%	100%	100%	100%	N/A

Federal Standards	ATC	Humana	Molina	Select Health	SC Solutions
Provider Selection *(§ 438.214, § 457.1233)*	97%	97%	97%	97%	N/A
Confidentiality *(§ 438.224)*	100%	100%	100%	100%	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	100%	90%	95%	95%	N/A
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	100%	100%	100%	100%	N/A
Practice Guidelines *(§ 438.236, § 457.1233)*	100%	100%	89%	100%	N/A
Health Information Systems *(§ 438.242, § 457.1233)*	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	100%	88%	100%	100%	100%

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

Recommendations and Opportunities for Improvements

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

Table 5: Strengths Related to Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Health plan staffing is sufficient to conduct all required activities and to provide the required services. All required key positions are filled.	✓		
Timeliness of claims payment meets or exceeds contractual requirements for all MCOs.	✓	✓	
The MCOs have disaster recovery plans that are routinely tested.	✓		
Each health plan has written Compliance Plans, FWA Plans or Program Integrity Plans, and policies that detail processes for ensuring compliance with laws, regulations, and contractual requirements, and to prevent, detect, and respond to actual or alleged FWA.	✓		
The MCOs' Compliance Committees meet routinely to assist in the monitoring and oversight of MCO Compliance Program. The committees are chaired by the Compliance Officers, with ATC's committee co-chaired by the Plan President.	✓		
The health plans require initial and annual compliance training for all employees, subcontractors, the Board of Directors, etc.	✓		

Strengths	Quality	Timeliness	Access to Care
Employees are educated about confidentiality requirements and the appropriate use of protected member information.	✓		
Provider Services			
Credentialing Committees meet routinely and use a peer-review process to make credentialing decisions.	✓		✓
No major issues were identified in the credentialing and recredentialing files for practitioners.	✓		✓
The MCOs monitor providers for quality of care and/or service issues and take action to address any identified issues.	✓		✓
Each of the MCOs monitors providers for sanctions and exclusions to ensure providers are not prohibited from receiving Federal funds.	✓		✓
Appropriate processes are in place for initial provider orientation and ongoing provider education. Updates are also provided through mailings, faxes, newsletters, etc.	✓		
The MCOs adopt, educate providers about, and assess provider compliance with clinical practice and preventive health guidelines.	✓		
Each of the health plans monitors continuity and coordination of care between PCPs and other providers using a variety of data sources.	✓		✓
The health plans educate providers about medical record documentation standards and assess provider compliance through routine medical record audits. Action is taken to address identified issues.	✓		
Policies clearly state the geographic access standards for PCPs and specialists.			✓
The MCOs contract with all required Status 1 and Status 2 provider types.	✓		✓
The health plans regularly assess their provider networks and implement interventions to address any identified network gaps.	✓		✓
Programs are in place to ensure MCO networks can meet the cultural, diversity, language, and other special needs of members.	✓		✓
All four health plans were validated as meeting CMS and state-defined network adequacy standards, confirming that they maintain sufficient numbers and geographic distribution of providers to support member access to care.	✓		✓
Each plan demonstrated well-developed systems for maintaining provider enrollment data, with layered verification processes that include credentialing, taxonomy validation, and regular updates to provider directories. These systems help ensure network information is as accurate and current as possible.	✓	✓	✓
All MCOs utilize Quest Analytics or equivalent enterprise tools to regularly monitor provider-to-member geographic access, demonstrating an ongoing commitment to ensuring members can reasonably reach in-network care.	✓		✓
Member Services			
Each MCO's Member Handbook is a comprehensive resource for members to understand their benefits and health plan services and processes.	✓		✓
Member materials are made available in alternate formats as needed to meet member needs by each health plan.			✓
The member satisfaction survey had a well-documented purpose, clear study objectives, and a defined audience, ensuring alignment with its intended goals and stakeholders. This clarity helps maintain focus and enhances the credibility of the findings.	✓		
The survey instrument was rigorously tested for both validity and reliability, confirming that it accurately measures what it intends to and produces consistent results over time.	✓		

Strengths	Quality	Timeliness	Access to Care
The study population and sampling frame were clearly defined, with appropriate methods used to minimize bias and ensure representativeness. The sampling process adhered to CAHPS survey guidelines, ensuring a sufficient sample size for meaningful analysis.	✓		
The survey followed a structured analysis plan using appropriate statistical methods, and all conclusions were supported by the data. The final report provided a thorough overview of the survey's purpose, implementation, and key findings, enhancing transparency and usability for decision-making.	✓		
The review of a sample of grievance files for each MCO found all were resolved within the appropriate timeframe and reviewed by appropriately credentialed reviewers.		✓	
Quality Improvement			
The QI Programs addressed a wide range of areas including clinical care, preventive health, emergency care, chronic care, behavioral health, customer service, network operations, and social determinants of health. It integrates quality improvement activities across all departments and care settings, ensuring a holistic approach to member health and service quality.	✓		
Health plans submitted detailed QI Program Descriptions that integrate quality assurance, management, and improvement into daily operations with defined performance metrics and accountability.	✓		
Providers receive information about their performance through various methods, including population health management reporting, comparative data reports, provider newsletters, and direct feedback via provider report cards.	✓		
Health plans evaluate the effectiveness of the QI Programs annually, outlining accomplishments, analyzing data and outcomes compared to goals, and providing conclusions and recommendations for the upcoming year.	✓		
Most plans, particularly ATC and Select Health, demonstrated strong or improved rates across multiple immunization series (DTaP, MMR, VZV, Hepatitis A, etc.). Humana and Molina also reported gains in select components.	✓		
Breast, cervical, and colorectal cancer screening rates increased for multiple plans, particularly ATC and Select Health.	✓		
Most plans showed positive performance in prescribing statins for diabetes and cardiovascular disease populations, with some improvement in adherence levels.	✓		
ATC, Select Health, and Humana performed well in adult access measures and well-child visit rates, with a generally positive trend in utilization of primary care.	✓		
All health plans consistently emphasize member outreach and education. Strategies include reminder systems, targeted outreach calls and texts, educational newsletters, and member incentives. These efforts are designed to increase preventive service utilization and encourage timely health care visits across various populations.	✓		
Provider engagement and education is a shared priority across all plans. Health plans support providers through newsletters, training sessions, provider town halls, and tip sheets. These resources help align provider practices with quality standards and improve compliance with key performance metrics.	✓		
Each plan demonstrates a commitment to data-driven performance monitoring. This includes the use of internal dashboards, HEDIS alert systems, gap analysis reports, and performance tracking tools. These systems enable real-time identification of care gaps and allow for targeted intervention strategies.	✓		
A multidisciplinary, team-based approach is used by all plans to improve care coordination. Care Management, Utilization Management, Quality Improvement, Pharmacy, and Medical Affairs staff are involved in collaborative efforts to enhance patient outcomes and streamline service delivery.	✓		

Strengths	Quality	Timeliness	Access to Care
Utilization Management			
The UM Program Descriptions are comprehensive and appropriately describe the goals, scope, and structure of each UM Program.	✓		✓
The sample approval and denial files indicated reviews were completed in a timely manner according to contractual standards for all health plans. Criteria and procedures for the evaluation of medical necessity of services for members were applied consistently.	✓		✓
Of the random appeal files reviewed for each EQR, all were addressed timely and were reviewed by appropriately credentialed staff.		✓	✓
Appeal acknowledgement and resolution letters for each MCO were clear with appropriate information needed specific to determination or next steps as applicable.	✓		✓
Some of the health plans offer specialized programs such as Sickle Cell and Adult and Preventative Rehabilitative Services for Primary Care Enhancement to aid in addressing specialized needs for members.	✓	✓	✓
All MCOs have formal policies and structured processes in place to detect and monitor over- and under-utilization.	✓		
Quarterly reporting mechanisms include data analysis, threshold monitoring, and clearly documented action plans.	✓		
Oversight and accountability are evident through regular committee reviews, integrated departmental collaboration, and use of Key Performance Indicators (KPIs) to guide interventions.	✓		
Delegation			
The Delegation Oversight Program for each MCO includes pre-delegation assessments, ongoing monitoring, and comprehensive annual audits.	✓		
The MCOs require all third-party entities to enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights.	✓		
Policies and procedures have been developed to guide the delegation of health plan activities to external entities.	✓		
Clear thresholds have been set and corrective action plans implemented as needed to ensure delegates meet the MCOs' standards and regulatory requirements.	✓		
Delegates are required to undergo ongoing monitoring and periodic reporting to help maintain continuous compliance and performance standards.	✓		
Mental Health Parity			
All plans use industry standard criteria for determination of MH/SUD approvals and denials.	✓		✓
MH/SUD specific questions are used for interrater reliability testing of utilization management staff.	✓		
Policies and standards are generally equivalent among each plan	✓		
Behavioral Health licensed staff are represented in positions of leadership within the corporate structure of each plan.	✓		
Four of the five plans have comparable denial rates between MH/SUD and medical/surgical (MS) authorization requests.			✓
The MH/SUD Provider Networks meet geo access standards with a few exceptions.			✓
All health plans demonstrated compliance with mental health parity requirements, ensuring that financial requirements and treatment limitations for mental health and substance use disorder benefits are no more restrictive than those for medical/surgical benefits.	✓		✓

Table 6: Weaknesses and Recommendations Related to Quality, Timeliness, and Access to Care

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Administration				
ATC and Humana policies do not fully address the process for policy approval.	*Ensure complete information about the policy approval process is included in appliable policy management policies, procedures, etc.*	✓		
The documentation of the Pharmacy Lock-in Program lacked information about the emergency supply of medication (Molina) and the timeframes for finalizing a member's restriction to one pharmacy and notifying members of their removal from the program (Select Health).	*Ensure documentation of Pharmacy Lock-in Program is complete and addresses all requirements.*	✓		✓
Provider Services				
One MCO incorrectly documented the quorum requirement on the Credentialing Committee meeting minutes template. This MCO held one Credentialing Committee meeting and made decisions without the presence of a quorum.	*Ensure the Credentialing Committee quorum requirement is correctly documented and that a quorum is present for all meetings in which decisions are made.*	✓		
One MCO does not clearly document primary source verification requirements for organizational provider credentialing and recredentialing in policy. The file review for the MCO revealed inconsistences in the process followed for verifying organizational provider information.	*Ensure policies clearly define the acceptable sources and processes for verifying organizational provider credentialing and recredentialing information, and that the documented processes are followed.*	✓		
Additional issues identified in the health plans' policies include: • Two of the four MCOs did not address all provider rights related to credentialing and recredentialing in policy. • One health plan inconsistently documented the frequency of reviewing clinical practice and preventive health guidelines in policy. • One health plan did not document its processes for monitoring continuity and coordination of care between PCPs and other providers.	*Ensure policies completely and correctly document processes, requirements, and activities.*	✓		✓
Issues were identified in two MCOs' Provider Manuals, including:	*Ensure Provider Manuals include complete and correct documentation of member benefits, the process for self-referral to services, appointment access timeframes, etc.*	✓		✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
• Incomplete and/or inconsistent documentation of member benefits. • Incorrect documentation of the requirements for self-referral to behavioral health services. • Incorrect appointment scheduling timeframe for specialty emergency visits.				
Issues were identified in the MCOs' Provider Directories, including: • Failure to include practice names/group affiliations and age groups. • Failure to include contractually required language regarding PCP selection by members of a family. • Failure to include all required provider types.	*Ensure Provider Directories meet all contractual requirements and include all required information.*	✓		✓
One health plan does not monitor specialists' panel status, as contractually required.	*All MCOs should monitor specialists' panel status to ensure members have appropriate access to these providers.*	✓		✓
Decreased successful contact rates were noted across all plans for the secret shopper calls, indicating limited member access.	*Strengthen provider directory validation and provider outreach protocols to improve contact accuracy.*	✓	✓	✓
Inconsistencies were noted in provider confirmation of plan participation during secret shopper calls.	*Conduct regular audits and reconciliation between directory listings and actual contracting status.*	✓		✓
During secret shopper calls, a declining number of providers indicated they are accepting new Medicaid patients.	*Enhance provider engagement strategies and incentives to increase participation in Medicaid and improve new patient access.*	✓	✓	✓
Member Services				
Humana does not have a current policy that addressed member responsibilities as noted in the *SCDHHS Contract, Section 3.16*.	*Member responsibilities should be included in the policy.*	✓		
Discrepancies were noted in Humana's policy regarding the timeframe for acknowledging a grievance.	*Ensure the timeframe for acknowledging a grievance is consistent in all documents.*		✓	
Quality Management				
Humana's QI work plan was not updated timely and did not note when the timeframe for completing and reporting the continuity and coordination of care activity was not met. This was an issue identified during the 2024 EQR and not corrected.	*Develop a process to ensure the QI work plan is updated timely. Include the party responsible for making the change(s).*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Humana's Quality Assurance Committee meeting minutes did not include information about when a proxy representative is used for absent voting members. This was an issue identified during the 2024 EQR and not corrected.	*Update the Quality Assurance Committee meeting minutes template to ensure a proxy representative and the voting member the proxy represents is clearly noted in the meeting minutes.*	✓		
Follow-up rates after hospitalization or ED visits for mental illness or substance use disorder remain low or declined across several plans.	*Strengthen care coordination and case management processes at discharge; consider incentives for follow-up visits within 7 and 30 days.*	✓		
Although the initiation of AOD treatment rates showed some gains, engagement remains low across all plans, especially for Molina and ATC.	*Expand access to behavioral health integration in primary care; pilot peer support models and contingency management programs.*	✓		
Most of the health plans showed increases or stagnant rates in opioid-related overuse and inappropriate antibiotic prescribing, especially Humana.	*Implement clinical decision support tools and provider education programs focused on guideline-concordant prescribing and diagnostics.*	✓		
Inconsistent performance improvement over time in key measures such as adolescent well-care visits, postpartum care, and diabetes management. Some plans show early gains that later decline or plateaued.	*Strengthen sustainability strategies through continuous quality improvement cycles, enhance performance accountability structures, and integrate follow-up audits to maintain gains.*	✓		
Lower-than-target rates in adolescent immunizations (HPV, Tdap, Meningococcal) persist across multiple plans, despite outreach efforts and incentives.	*Enhance adolescent engagement strategies by incorporating school-based health programs, mobile immunization units, and provider-level incentives specifically tied to adolescent vaccination completion.*	✓		✓
Limited documentation of measurable equity-focused interventions beyond basic disparity analysis, particularly in rural or underserved populations.	*Expand health equity initiatives with specific, measurable interventions—such as community partnerships, targeted social determinant support services, and equity dashboards to monitor disparities more effectively.*	✓		✓
Utilization Management				
ATC was unable to provide details regarding the structure of their Preferred Provider Program, how providers are informed about it, or how preferred provider status is identified and tracked within the plan. This issue was identified during the previous EQR for ATC and was not corrected.	*Develop and implement a Preferred Provider Program in accordance with SCDHHS Contract, Section 8.5.2.8 and include the specifics for the program in respective policies.*	✓		
Humana's appeal policy does not indicate that members may file a grievance when they disagree with a 14-day extension request. This was an	*Update policies to indicate that a grievance can be filed if the filer disagrees with a request for an extension.*		✓	✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
issue identified in the previous (2024) EQR and not corrected.				
Molina's policy/procedure and appeal request form incorrectly stated a verbal appeal must be followed by a written request. This was identified during the 2023 EQR and was not corrected.	*Update all documents related to the process for filing an appeal and remove the requirement that a standard request for an appeal received verbally must be followed by a written request.*			✓
SCDHHS Contract, Section 9.1.6.3.1.1 requires the appeal resolution notification be sent to the member via certified mail with return receipt requested. Select Health revised and removed this requirement in the appeal policy. The sample appeal files reviewed did not include evidence that the notices had been sent to the member via certified mail.	*Revise the process for sending the appeal resolution notifications to the member via certified mail with return receipt requested as required by the SCDHHS Contract, Section 9.1.6.3.1.1 9. Comply with contractual requirements to ensure appeal resolution notices are sent via certified mail.*	✓		✓
ATC's case management files demonstrated staff were not following ATC's policy when a case manager was unable to reach a member.	*Reeducate staff on the unable to reach process and ensure adherence to the established policy standards.*	✓		✓
Mental Health Parity Assessment				
For ATC, a higher rate of out-of-network authorization requests for MH/SUD services was noted compared to medical/surgical services.	*Separate data for MH from SUD to help determine root cause.*			✓
For ATC, a lower level of satisfaction with getting routine and urgent care MH/SUD appointments was noted than the level of satisfaction for medical/surgical routine and urgent care appointments.	*Separating MH and SUD data could help pinpoint specifically which subset of this population is having the issue of accessing care.*			✓
Healthy Blue administers a CAHPS survey annually, but no corresponding survey for MH members.	*Conduct a survey of member satisfaction with mental health services (i.e., ECHO).*	✓		✓
For Healthy Blue, there was no appeals data present for denials, which are a significantly higher proportion of service requests than for medical/surgical requests.	*Continue to track MH and SUD separately in order to pinpoint opportunities more readily. Ensure any inquiries about clinical denials made to member services that are resolved on the call (if any) are categorized appropriately.*	✓		✓
There is limited geographic access to inpatient psychiatric care in three counties for Humana.	*Review system to ensure configuration does not deny out of network services for inpatient psychiatric care in counties where access is limited.*			✓
For Humana, provider availability for MH/SUD services is lower than for medical/surgical primary care and specialty services.	*Continued monitoring of ECHO scores and out-of-network utilization to identify network opportunities.*			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina uses internally developed criteria. This poses a risk to parity, both in comparability and stringency.	*Continue to ensure there is parity in internally developed utilization management criteria.*			✓
For Select Health, out-of-network requests for MH/SUD services are more than triple those for medical/surgical services.	*Continue network expansion to all available providers until improved provider to member ratio and provider accessibility scores in deficit areas*			✓
Select Health's appeal overturn rates were higher for MH/SUD than medical/surgical services.	*Separate MH from SUD to help identify root cause.*			✓

Assessment and Recommendation for SCDHHS' Quality Strategy

The 2024-2025 EQR assessment results highlight health plan strengths, weaknesses, and recommendations, demonstrating the effectiveness of SCDHHS' strategy in ensuring plan compliance, enhancing quality of care, and aligning healthcare goals with priority initiatives. The Quality Strategy establishes clear goals and standards that align with CMS priority areas, serving as a framework for system-wide improvements. Based on these objectives, Constellation has developed targeted recommendations to support MCOs in fulfilling the Quality Strategy's goals. These recommendations are detailed in *Table 7: SCDHHS Quality Initiatives*.

Table 7: SCDHHS Quality Initiatives

SCDHHS Quality Goal	Recommendation
Quality Goal 1: Assure the quality and appropriateness of care delivered to members enrolled in managed care	• Expand care coordination and multidisciplinary case management, particularly post-discharge, to reduce readmissions. • Enhance provider training and use of performance dashboards and tip sheets to reinforce evidence-based practices. • Integrate standing orders, EMR alerts, and care gap reports to support timely delivery of preventive and chronic care services.
Quality Goal 2: Assure Medicaid members have access to care and a quality experience of care	• Strengthen member engagement through continued use of multi-modal CAHPS survey outreach strategies (e.g., mail, text, phone). • Improve appointment availability and timeliness by increasing telehealth access, expanding provider networks, and incentivizing acceptance of new patients. • Implement real-time member support tools (e.g., automated appointment scheduling reminders, transportation coordination, and after-hours support lines).
Quality Goal 3: Assure MCO contract compliance	• Maintain regular audit cycles and data validation processes to ensure compliance with HEDIS and encounter data requirements.

SCDHHS Quality Goal	Recommendation
	• Monitor network adequacy through real-time directory updates and geo-access reports. • Conduct quarterly compliance reviews to verify MCO adherence to reporting protocols and contract provisions.
Quality Goal 4: Manage continuous performance improvement.	• Require sustained use of quality improvement cycles and remeasurement periods in all PIPs. • Promote rigorous PIP methodology validation using CMS protocols to ensure reliable results.
Quality Goal 5: Conduct targeted population quality activities.	• Strengthen equity-focused initiatives through disparity dashboards, targeted outreach in rural and underserved communities, and social determinants of health interventions. • Launch targeted adolescent outreach programs to address gaps in immunizations and well-care visits. • Develop specialized care management approaches for high-risk populations (e.g., foster care, behavioral health, chronic conditions).

Note. Recommendations are based on SCDHHS Quality Strategy Draft May 2022

The external quality review underscored the importance of structured, data-driven approaches to quality improvement, contract compliance, and population health management, each of which is directly reflected in the corresponding recommendations. For example, the emphasis on strengthening care coordination, provider engagement, and performance tracking supports Quality Goals 1 and 4 by promoting the delivery of high-quality, appropriate care and driving sustained performance improvement. Similarly, the recommendations related to survey outreach, appointment availability, and provider access reflect the documented challenges in member experience and access, as outlined in the CAHPS survey analysis and telephonic provider access study, aligning well with Quality Goal 2.

In addition, the recommendations aimed at reinforcing compliance mechanisms and auditing processes directly address Quality Goal 3 by ensuring MCOs maintain adherence to regulatory requirements, HEDIS specifications, and encounter data validation. The strategies proposed under Quality Goal 5 further support the state's emphasis on targeted quality activities, particularly those addressing disparities in immunization rates, adolescent care, and chronic disease outcomes. Altogether, the recommendations offer actionable next steps that are consistent with the observations, validations, and improvement opportunities resulting from the external review, in efforts to position SCDHHS for continued advancement in quality, access, and equity.

BACKGROUND

As detailed in the Executive Summary, Constellation, as the EQRO, conducts an EQR of each MCO participating in the Medicaid Managed Care Program on behalf of SCDHHS. Federal regulations require that EQRs include four mandatory activities: validation of PIPs, validation of PMs, network adequacy validation, and an evaluation of compliance with state and federal regulations for each health plan.

Federal regulations also allow states to require optional activities that include:

- Validating encounter data
- Administering or validating consumer and provider surveys
- Calculating additional PMs
- Conducting PIPs and quality of care studies

Constellation is required by contract to validate the MCO's consumer and provider surveys, conduct quality of care studies, and conduct readiness reviews.

After completing the review of the required and optional EQR activities, Constellation submits a detailed technical report to SCDHHS and the health plans. This report describes the data aggregation and analysis and the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths, weaknesses, recommendations for improvement, and the degree to which the plan addressed quality improvement recommendations made during the prior year's review.

Annually, Constellation prepares a comprehensive technical report for the State. This report is a compilation of the individual annual review findings. For 2024–2025, this report contains data for ATC, Healthy Blue (Mental Health Parity only), Humana, Molina, and Select Health, and includes EQR findings for the plans participating in the Healthy Connections Prime Program under review during this reporting period. Those included: Select Health, Molina, and Wellcare.

METHODOLOGY

The process Constellation used for the EQR activities was based on protocols CMS developed for the EQR of a Medicaid MCO and includes a desk review of documents submitted by each health plan and virtual onsite visits. After completing the annual review, Constellation submits a detailed technical report to SCDHHS and the health plans. For a health plan not meeting requirements, Constellation requires the plan to submit a quality improvement plan for each standard identified as not fully met. Technical assistance is provided to each health plan until

all deficiencies are corrected. A copy of the QIP reports is included as an attachment to this report. The following table displays the dates of the EQRs conducted for this contract period.

Table 8: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Report Submitted
ATC Wellcare MMP	10/7/24	12/11/24 – 12/12/24	1/9/25
Healthy Blue (Mental Health Parity)	10/22/24	11/15/2024	12/3/2024
Humana	11/18/24	1/15/25 – 1/16/25	2/13/25
Molina Molina MMP	5/6/24	6/20/24 – 6/21/24	7/19/24
Select Health Select Health MMP	7/8/24	8/21/24 – 8/22/24	9/19/24
Solutions	6/3/24	7/24/24	8/16/24

FINDINGS

The plans were evaluated using standards developed by Constellation and summarized in the tables for each of the sections that follow. Constellation scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an up arrow (↑) indicates the score for that standard improved from the previous review, and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows are unchanged from the previous review.

Managed Care Organizations

The following is a summary of the findings for ATC, Humana, Molina, Select Health, and the mental health parity assessment for Healthy Blue.

Administration

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

The review for the Administration section encompasses policy management, MCO staffing, information management systems, compliance, program integrity, and confidentiality.

Each health plan follows proper processes for developing, managing, and reviewing policies and procedures. They review and revise policies annually, educate staff about new and updated policies, and store policies in accessible locations for staff. For Molina, it was noted that some policies included references within the policy to state-specific addenda, while others did not include references to existing addenda. Issues with the health plans' policies regarding policy development and ongoing management were noted, including:

- ATC's Policy Management policy did not include information about committee involvement in the review and approval of quality and utilization management policies.
- Humana's Maintenance of Written Policies and Procedures policy contained inconsistencies regarding SCDHHS review and approval of policies and included inappropriate information about the Oklahoma Health Care Authority reviewing and approving policies and procedures and references to the Oklahoma market.

The MCOs' Organizational Charts display reporting and operational relationships of staff and indicate key positions, temporary/contingent personnel, shared services staff, etc. Review of the Organizational Charts and the related onsite discussion revealed most vacant positions have been filled and/or offers are pending. For remaining vacancies, recruitment efforts continue. ATC's Key Personnel list incorrectly indicated some case management staff were not in-state; however, through the Quality Improvement Plan process, it was determined that the original Key Personnel list incorrectly identified the number of case management staff for the SC Medicaid line of business, and that for SC Medicaid, all case managers are located in SC.

Each of the MCOs has a Compliance Plan and a Fraud, Waste, and Abuse (FWA) Plan or Program Integrity Plan which describe processes to ensure compliance with laws, regulations, and contractual requirements as well as processes for preventing, detecting, and responding to suspected or alleged FWA. The health plans also have established Codes of Conduct which define expectations for appropriate and ethical business practices and conduct. Detailed information about these topics is included in policies and procedures. Additional topics addressed in the documentation include information about the Compliance Committee, compliance training, communication, enforcement, investigations of identified issues, etc. Reviews of these documents revealed issues related to:

- Documentation of the roles/responsibilities of the Program Integrity Coordinator (Humana)
- Contact information for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance (Molina)
- A reference to another state's requirements for the Audit Work Plan (Molina)

Health plan Compliance Committees assist in the implementation, monitoring, and oversight of the MCOs' Compliance Programs. Each health plan's Compliance Committee meets at a

quarterly cadence. The committees for Humana, Molina, and Select Health are chaired by the Compliance Officer. ATC's committee is co-chaired by the Compliance Officer and the Plan President. Membership of the committees includes health plan leadership, Program Integrity/Special Investigations Unit staff, etc. Three of the four MCOs define the quorum requirement for the Compliance Committee; however, Humana reported that the South Carolina Medicaid Compliance Committee, which held its initial meeting in March 2024, has no decision-making role and therefore no quorum is required.

Pharmacy Lock-In Programs have been established by each MCO to manage members who have been identified as using services at a frequency or amount that is not medically necessary and to ensure appropriate utilization of prescription medications. No issues were noted with the Pharmacy Lock-in Programs for ATC and Humana. For Molina, a discrepancy in documentation of the emergency supply of medication that can be provided to members in the Pharmacy Lock-in Program was identified. For Select Health, the Beneficiary Lock-In Program policy lacked documentation of the timeframe for finalizing a member's restriction to one pharmacy and the timeframe for notifying members of their removal from the program. Of note, Humana reported they are finalizing a process for internal review to identify members, outside of those identified by SCDHHS, who may benefit from the Program and expects to implement this by the end of Q1 2025.

Processes for ensuring the confidentiality of protected information are addressed in policies, the Codes of Conduct, compliance training content, etc. Employees are notified and educated about the expectation that they protect member information and use the information only for appropriate purposes.

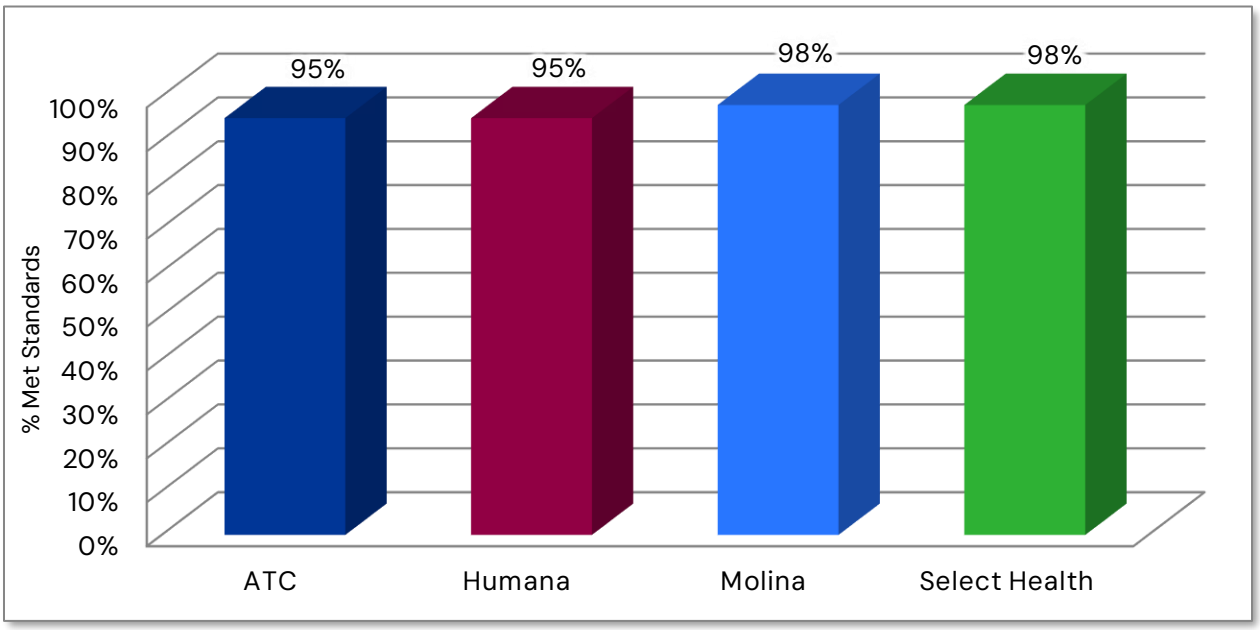
Information Management Systems Assessment

The health plans meet or exceed the contractually required claims processing timeliness requirements. The plans' documentation reflects they can accept and generate HIPAA-compliant transactions with mention of the use of secure Electronic Data Interchange systems. The health plans track member demographic and enrollment information and take action to resolve duplicate member records. The EQRs found that the plans' information management systems support the required reporting to the State, and mechanisms are in place to ensure the security of all data and are documented in policies and procedures. All the health plans have implemented disaster recovery plans which are regularly tested. In addition, Humana and Molina have established business continuity plans.

The reviews of the Administration section for each of the health plans confirmed that the MCOs appropriately addressed and implemented the Quality Improvement Plans to address all Administration deficiencies identified in the previous EQRs. Refer to *Attachment 1* for details of these deficiencies and the health plans' responses.

As noted in *Figure 2: Administration Findings*, the percentage of "Met" scores ranged from 95% to 98%.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, and recommendations for the Administration section of the review are included in the tables below.

Table 9: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Health plan staffing is sufficient to conduct all required activities and to provide the required services. All required key positions are filled.	✓		
Timeliness of claims payment meets or exceeds contractual requirements for all MCOs.	✓	✓	
The MCOs have disaster recovery plans that are routinely tested.	✓		
Each health plan has written Compliance Plans, FWA Plans or Program Integrity Plans, and policies that detail processes for ensuring compliance with laws, regulations, and contractual requirements, and to prevent, detect, and respond to actual or alleged FWA.	✓		
The MCOs' Compliance Committees meet routinely to assist in the monitoring and oversight of MCO Compliance Program. The committees are chaired by the Compliance Officers, with ATC's committee co-chaired by the Plan President.	✓		
The health plans require initial and annual compliance training for all employees, subcontractors, the Board of Directors, etc.	✓		

Strengths	Quality	Timeliness	Access to Care
Employees are educated about confidentiality requirements and the appropriate use of protected member information.	✓		

Table 10: Administration Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
ATC and Humana policies do not fully address the process for policy approval.	*Ensure complete information about the policy approval process is included in appliable policy management policies, procedures, etc.*	✓		
The documentation of the Pharmacy Lock-in Program lacked information about the emergency supply of medication (Molina) and the timeframes for finalizing a member's restriction to one pharmacy and notifying members of their removal from the program (Select Health).	*Ensure documentation of Pharmacy Lock-in Program is complete and addresses all requirements.*	✓		✓

Table 11: Administration Comparative Data

Standard	ATC	Humana	Molina	Select Health
General Approach to Policies and Procedures				
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Partially Met ↓	Partially Met ↓	Met	Met
Organizational Chart / Staffing				
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: *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED)	Met	Met	Met	Met
Chief Financial Officer (CFO)	Met	Met	Met	Met
*Contract Manager	Met	Met	Met	Met
Information Systems Personnel Claims and Encounter Manager/ Administrator	Met	Met	Met	Met
Network Management Claims and Encounter Processing Staff	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
Utilization Management (Coordinator, Manager, Director)	Met	Met	Met	Met
Pharmacy Director	Met	Met	Met	Met
Utilization Review Staff	Met	Met	Met	Met
*Case Management Staff	Partially Met ↓	Met	Met	Met
*Quality Improvement (Coordinator, Manager, Director)	Met	Met	Met	Met
Quality Assessment and Performance Improvement Staff	Met	Met	Met	Met
*Provider Services Manager	Met	Met	Met	Met
*Provider Services Staff	Met	Met	Met	Met
*Member Services Manager	Met	Met ↑	Met	Met
Member Services Staff	Met	Met	Met	Met
*Medical Director	Met	Met	Met	Met
*Compliance Officer	Met	Met	Met	Met
*Program Integrity Coordinator	Met	Met	Met	Met
Compliance/ Program Integrity Staff	Met	Met	Met	Met
*Program Integrity FWA Investigative/Review Staff	Met	Met	Met	Met
*Interagency Liaison	Met	Met	Met	Met
Legal Staff	Met	Met	Met	Met
*Behavioral Health Director	Met	Met	Met	Met
Operational relationships of MCO staff are clearly delineated	Met	Met	Met	Met
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*				
The MCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	Met	Met	Met
The MCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met
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	Met	Met	Met	Met
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	Met	Met	Met	Met
The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented	Met	Met	Met	Met
Compliance/Program Integrity				
The MCO has a Compliance Plan to guard against fraud and abuse	Met	Met	Met	Met
The Compliance Plan and/or policies and procedures address requirements, including: • Standards of conduct • Identification of the Compliance Officer and Program Integrity Coordinator • Inclusion of an organization chart identifying names and titles of all key staff • Information about the Compliance Committee • Compliance training and education • Lines of communication • Enforcement and accessibility • Internal monitoring and auditing • Response to offenses and corrective action • Data mining, analysis, and reporting • Exclusion status monitoring	Met ↑	Partially Met ↓	Met	Met
The MCO has an established committee responsible for oversight of the Compliance Program	Met	Met	Met	Met
The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met
The MCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met
The MCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met
The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Met	Met ↑	Partially Met ↓	Partially Met ↓
Confidentiality *42 CFR § 438.224*				
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met

Provider Services

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

The Provider Services section of the EQRs includes provider credentialing, network adequacy, initial and ongoing provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical record documentation.

Provider Credentialing and Selection

42 CFR § 438.214, 42 CFR § 457.1233(a)

Each of the MCOs has policies and procedures detailing credentialing and recredentialing processes and requirements. Issues were identified with documentation of organizational provider appeal rights for credentialing denials and other provider rights related to credentialing, the requirement for providers to be enrolled with SCDHHS as a SC Medicaid provider, the timeframe for notifying SCDHHS of a credentialing denial related to program integrity, and primary source verification requirements. Constellation reviewed a sample of initial credentialing and recredentialing files for practitioners and organizational providers. For the practitioner files, isolated instances of untimely verification of required elements at recredentialing were identified for ATC. For the organizational provider files, Humana's files reflected inconsistencies in the verification processes for required elements, and an isolated instance related to verification of the required CMS certification for one provider.

Credentialing Committees are in place to make credentialing and recredentialing determinations using a peer-review process. The Credentialing Committees are chaired by the health plans' Chief Medical Directors/Officers or Medical Directors and membership includes network practitioners with a variety of specialties. Each committee meets at a monthly cadence. ATC confirmed the quorum requirement for the Credentialing Committee is the presence of two thirds of the voting members; however, one meeting was held and decisions were made without the presence of the required quorum. No other issues were identified.

The health plans monitor providers for quality of care and service as well as provider sanctions and exclusions. Appropriate actions are taken when any issues are identified.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Each of the MCOs conducts provider orientation to give providers the information necessary to function effectively within the MCOs' networks. Orientation is conducted through various in-person and virtual forums within 30 days of a new provider entering the network. Ongoing provider education is conducted to ensure providers are updated about changes to services, benefits, processes, and requirements. Forums for ongoing education include face-to-face office/site visits, regional provider training sessions, webinars, and/or on-demand web trainings. In addition, provider updates are disseminated through various print communications, such as faxed information, newsletters, letters, electronic communications, and the MCOs' websites. The health plans' websites offer a variety of provider tools and information, and Provider Manuals are comprehensive resources for providers. Review of the Provider Manuals revealed issues related to documentation of member benefits (ATC, Molina) and procedures for referral to a specialist (Molina).

Medical record documentation standards are defined in policies and the health plans educate providers about the standards through provider orientation and ongoing education activities, Provider Manuals, health plan websites, etc. They assess providers' compliance with the standards through routine medical record audits and work with providers who do not meet the established scoring expectation to improve their performance.

The health plans also educate providers about the adopted clinical practice and preventive health guidelines that are specific to member demographics and health care and service needs. The adopted guidelines are evidence-based, sourced from nationally recognized entities, and regularly reviewed for updates; however, Molina's documentation reflected a discrepancy in the frequency of review. The health plans disseminate the guidelines to providers via health plan websites and in printed form upon request. Information about the guidelines is included in Provider Manuals, newsletters, faxes, mailings, etc.

ATC, Molina, and Select Health's policies adequately describe health plan processes for ensuring providers monitor continuity and coordination of care between PCPs and specialists, behavioral health providers, and other entities. Humana did not address these processes in a policy but reported that this monitoring is accomplished through HEDIS performance and medical record audit processes.

Network Adequacy Validation

42 CFR § 438.68 (a), 42 CFR § 438.14(b)(1) 42 CFR § 457.1218. 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Constellation conducted a validation review of the MCOs' provider networks following the CMS protocol titled, *EQR Protocol 4: Validation of Network Adequacy*. This protocol validates the health plans' provider networks to determine if *the* MCOs are meeting network standards defined by the State. To conduct this validation, Constellation requested and reviewed the following for each MCO:

- Member demographics, including total enrollment and distribution by age ranges, sex, and county of residence.
- Geographic access assessments, network development plans, enrollee demographic studies, population needs assessments, provider-to-enrollee ratios, in-network and out-of-network utilization data, and provider panel size limitations.
- A complete list of network providers.
- The total numbers of unique primary care and specialty providers in the network.
- A completed Provider Network File Questionnaire.
- Provider appointment standards and health plan policies.
- Provider Manual and Member Handbook.

- Sample of a provider contract.

Desk reviews of these documents were conducted to assess network adequacy. The MCOs' provider networks were found to be adequate and consistent with the requirements of the CMS protocol. The following is an overview of the results for each activity conducted to assess network adequacy.

Provider Network File Questionnaire

The purpose of the Provider Network File Questionnaire is to learn more about each MCO's methods for classifying, storing, and updating provider enrollment data. Constellation reviewed the information submitted by each health plan to determine if adequate procedures and processes are in place to maintain an accurate provider file directory. A summary of the findings is displayed in Table 12.

Table 12: Overview of Provider Network File Questionnaire Findings

Domain	ATC	Humana	Molina	Select Health
Data Management System	Portico is the Provider Management System; enrollment data stored in relational databases accessed via Portico.	Multi-system approach: APEX is the core business workflow system feeding CAS (claims), PIMS (directory), and OV (credentialing). MERLIN handles contract management.	QNXT is the core provider enrollment system; files are sent via iServe daily and updated manually in QNXT.	Facets is the provider enrollment software; LIFT database is being added to enhance provider-staff communications. Updates are made via provider rosters and change forms.
Data Verification	Verification occurs during roster validation; includes taxonomy updates (via NPPES), credentialing check, address standardization (Smarty Streets), phone/address updates, and status validation.	Verification via APEX business rules; includes credentialing (license, education, insurance), address formatting (USPS standards), and a new AI-driven vendor tool for routine verification.	Verification includes CAQH, NPI Junction File, Melissa Address Standardization, HiLabs, and Provider Change Form. Updates made as needed by Provider Configuration Management.	Verification by Provider Network Management and Operations teams, cross-checked via NPPES and SC Medicaid data; taxonomy, credentialing, and status updates validated with providers.
Updates to Provider Directories	Portico sends changes to the Find A Provider directory in real-time; updates processed FIFO and directory is updated daily.	Member-facing directory is generated from PIMS; online directory updated nightly, paper	Directory data is pulled quarterly from ePortal and routed through Communications and RRD for final review and	Provider directory is generated from Facets and sent daily to HealthSparq for updates daily.

Domain	ATC	Humana	Molina	Select Health
		directories monthly.	approval; file is updated monthly.	
Geographic Access Reporting	Quest Analytics is used; time and distance adequacy is reviewed and updated weekly (every Tuesday) for all provider types.	Quest Enterprise Solutions (cloud-based) is used; time/distance adequacy reviews conducted across provider types monthly.	Quest Enterprise Services software is used; time/distance adequacy reviews conducted quarterly across all provider types	Quest Analytics is used; time and distance adequacy reports are generated quarterly and additionally triggered when a provider group is terminated.

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

Geographic access standards for PCPs and specialists, as well as processes for monitoring the geographic adequacy of the provider networks, are appropriately documented in policy by all the MCOs. The health plans routinely assess the adequacy of their provider networks through analysis of geographic access mapping, network adequacy reports, member grievances related to practitioner access, member satisfaction survey results, etc. When geographic gaps are identified, the MCOs develop appropriate interventions to address the gap and ensure members can receive needed care. It was found that three of the MCOs (ATC, Molina, and Select Health) monitor both PCP and specialist panel status. Humana monitors PCP panel status but reported the health plan does not monitor the panel status for specialists, as contractually required.

Appointment access standards for PCPs and specialists are documented in policies, Provider Manuals, Member Handbooks, and/or on health plan websites. All were compliant with contractual requirements with the exception of ATC's documentation of the access standard for specialty emergent visits. The MCOs conduct call studies/surveys to evaluate provider compliance with the appointment access standards. Additionally, the health plans consider factors such as member satisfaction survey results as well as complaint, grievance, and appeal data. The health plans employ interventions, such as additional provider education and additional call studies, to address poor performance.

The MCOs maintain Provider Directories that are available in print versions and on the health plans' websites. Each health plan also maintains an online tool to search for providers. Issues identified with the Provider Directories include:

- ATC's 2024 Provider & Pharmacy Directory did not include practice names/group affiliations and age groups.
- Humana's and Molina's online provider search tools and the website pages on which they were located did not include the required statement that "an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs."
- Molina's PDF Provider Directory did not include dispensing pharmacies. Instead, it provided a hyperlink to search for pharmacy providers that required the user to create an account and sign in to access pharmacy information on an external website.
- Select Health's online and printed Provider Directories did not include dispensing pharmacies. A different area of the website included a hyperlink to a printable pharmacy network list, but the list was outdated and was a large Excel file saved as a PDF. This web page included a hyperlink to an external website that includes a searchable pharmacy directory; however, this was difficult to find because the Member Handbook directed the reader to a different location of the website to use this pharmacy search tool.

The MCOs validate information in their Provider Directories through routine call studies, provider outreach campaigns, review of information obtained through credentialing processes, etc.

The health plans ensure their provider networks can serve members with diverse cultural and linguistic needs and physical limitations. This is accomplished in a variety of ways, including collecting and evaluating member and provider demographic and language information, educating providers about cultural competency, providing cultural competency resources on MCO websites, analyzing grievances related to member cultural and linguistic needs, providing language services, and providing member materials in alternate formats and languages.

Provider Access and Availability Study

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

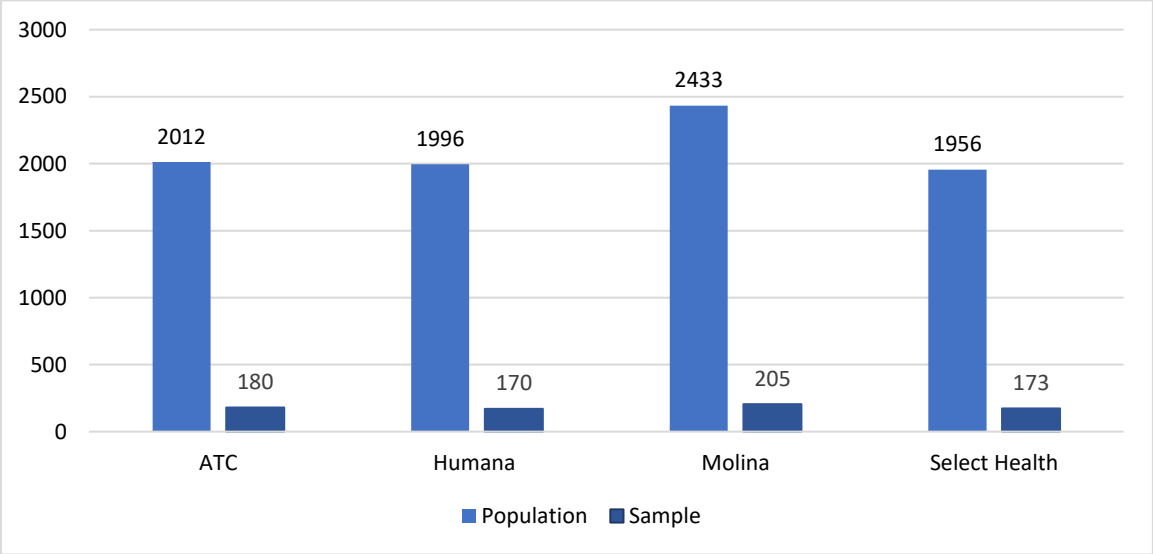
As a part of the annual review process for all plans, Constellation conducted a Telephonic Provider Access Study focusing on PCPs. For the study, Constellation requested and received a list of network providers and their contact information from each of the health plans. From each list, Constellation defined a population of PCPs and selected a statistically relevant sample for the study. Constellation attempted to contact these providers to ask a series of questions about the access plan members have to their PCPs.

The following charts summarize the Provider Access and Availability Study findings and compare the four plans surveyed as of this report.

Population and Sample Size

For the four MCOs reviewed, Constellation identified a total population of 8,397 PCPs. From each plan's population, Constellation randomly selected a total of 728 providers, as shown in *Figure 3: Population and Sample Sizes for Each Plan*.

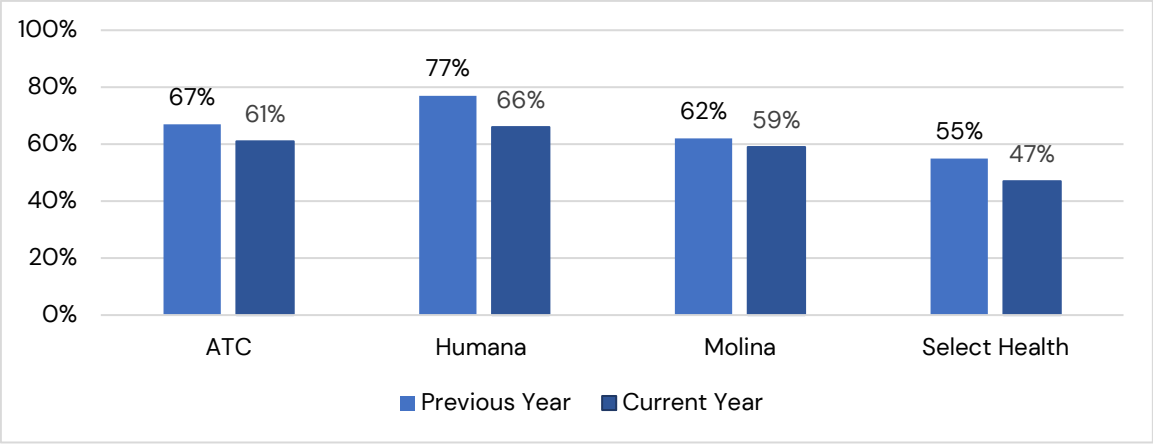
Figure 3: Population and Sample Sizes for Each Plan



Successfully Answered Calls

The successful contact rates for all four MCOs declined in the most recent secret shopper study compared to the previous year. ATC's contact rate dropped from 67% to 61%, while Humana saw a decrease from 77% to 66%. Molina experienced a decline from 62% to 59%, and Select Health fell from 55% to just 47%. These decreases suggest a consistent downward trend in successful contact performance across all plans, indicating potential areas for improvement in outreach effectiveness and provider accessibility.

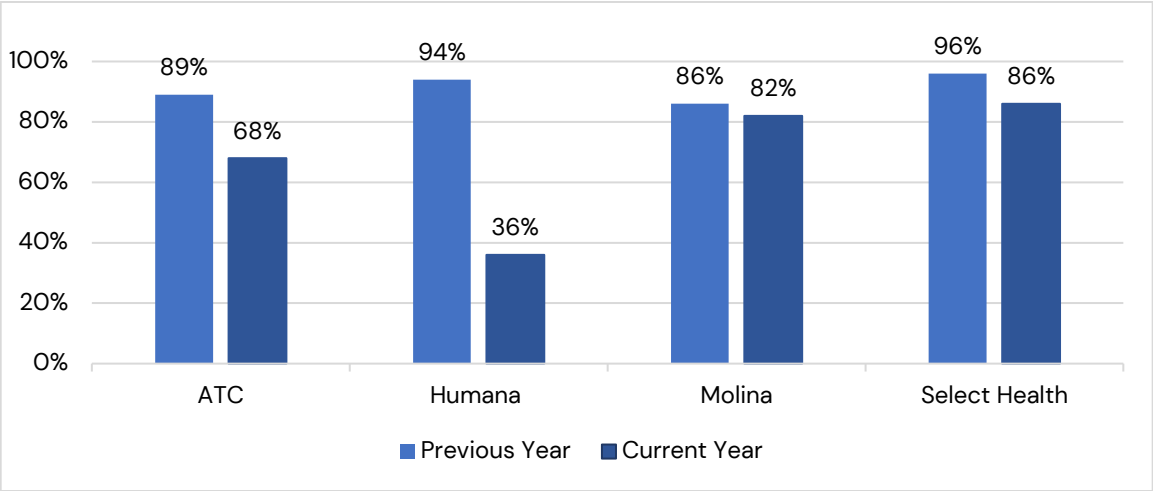
Figure 4: Percentage of Successfully Answered Calls



Currently Accepting the Plan

The secret shopper study also revealed a decline in the percentage of providers who confirmed they accept the health plan, with particularly sharp decreases for some plans. ATC dropped from 89% in the previous year to 68% in the current year, while Humana experienced a dramatic decrease from 94% to just 36%, representing the steepest decline among the plans. Molina saw a modest decrease from 86% to 82%, and Select Health, though also lower, remained relatively stable, decreasing from 96% to 86%. These results highlight variability in provider responses and suggest that provider directories and communications may not be consistently reliable across plans. See *Figure 5: Percentage of Providers Accepting the Plan*.

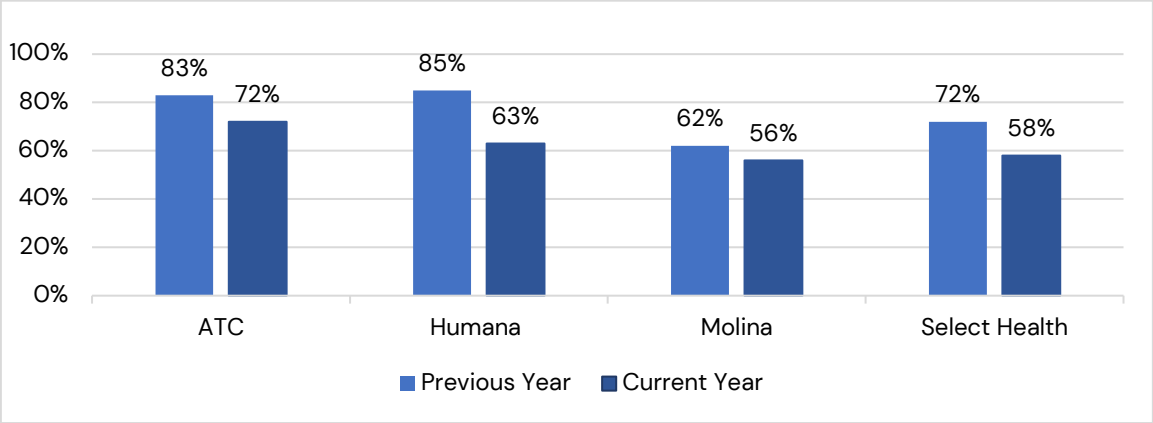
Figure 5: Percentage of Providers Accepting the Plan



Accepting New Medicaid Patients

Findings showed a downward trend in provider availability, specifically regarding whether providers were accepting new patients. All four health plans experienced declines compared to the previous year. ATC dropped from 83% to 72%, while Humana saw a more significant decrease from 85% to 63%. Molina's rate fell from 62% to 56%, and Select Health declined from 72% to 58%. These findings suggest a growing access barrier for new enrollees across all plans, indicating that even when providers are in network with a health plan, fewer are open to accepting new patients, potentially limiting timely access to care. See *Figure 6: Percentage of Providers Accepting Medicaid Patients*.

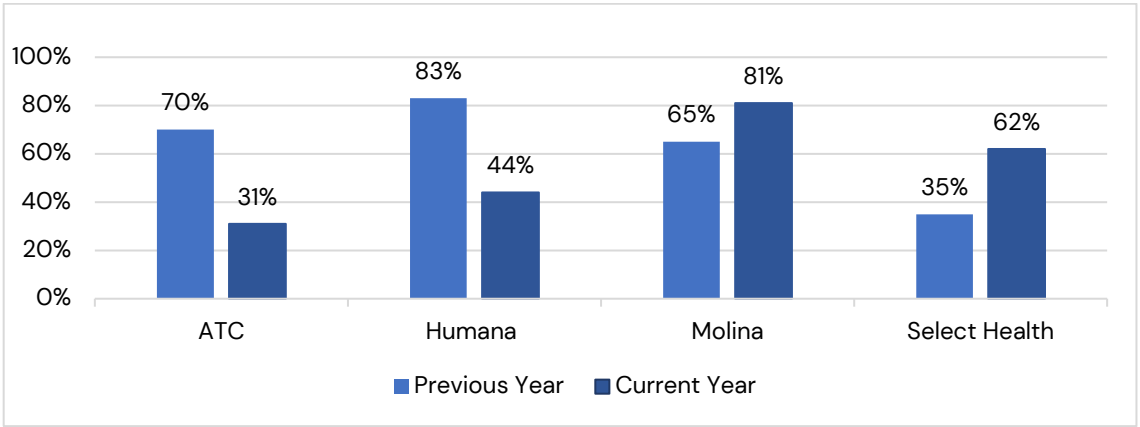
Figure 6: Percentage of Providers Accepting New Medicaid Patients



Appointment Availability

The secret shopper study revealed mixed results regarding appointment availability within contract timeliness requirements across the four health plans. ATC and Humana experienced significant declines, with ATC dropping from 70% to 31% and Humana from 83% to 44%, indicating a sharp reduction in timely access to care. In contrast, Molina showed a notable improvement, increasing from 65% to 81%, while Select Health also saw a substantial increase from 35% to 62%. These contrasting trends suggest that while some plans have made progress in improving timely appointment availability, others have seen concerning setbacks that may impact member access to prompt care. It is important to note, however, that several providers contacted during the study were unable to offer information on appointment availability due to the callers not having a member identification number. This limitation may affect the overall reliability of these findings and should be considered when interpreting the results. See *Figure 7: Providers with Appointment Availability within Contract Requirements*.

Figure 7: Providers with Appointment Availability within Contract Requirements

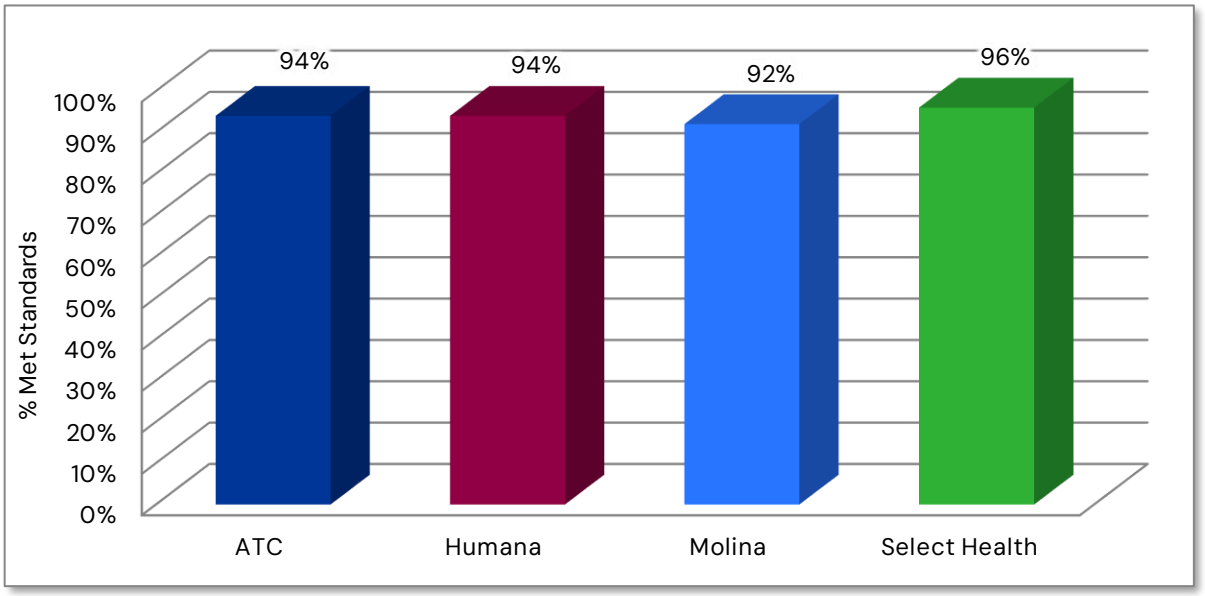


Summary of Study Findings

The secret shopper study reviewed a total sample of 728 providers across four MCOs, drawn from a population of 8,397 PCPs. Results revealed consistent declines in successful contact rates and provider confirmation of plan participation across all plans, with particularly steep drops observed for Humana. Availability of providers accepting new Medicaid patients also declined across all MCOs, suggesting increasing access challenges. Appointment availability showed mixed results, with improvements for Molina and Select Health, but sharp declines for ATC and Humana. Notably, several providers were unable to verify appointment information without a member ID number, which may limit the reliability of some findings. Due to the lack of improvement in successful contact rates, all four plans received a "Not Met' score regarding the standard, "Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results."

As noted in *Figure 8: Provider Services Findings*, the percentage of "Met" scores for the review of Provider Services ranged from 92% to 96%. It was found that ATC and Humana implemented the quality improvement plans from the previous EQRs to address all identified deficiencies.

Figure 8: Provider Services Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, and recommendations for the Provider Services section are found in Table 13 and Table 14.

Table 13: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Credentialing Committees meet routinely and use a peer-review process to make credentialing decisions.	✓		✓
No major issues were identified in the credentialing and recredentialing files for practitioners.	✓		✓
The MCOs monitor providers for quality of care and/or service issues and take action to address any identified issues.	✓		✓
Each of the MCOs monitor providers for sanctions and exclusions to ensure providers are not prohibited from receiving Federal funds.	✓		✓
Appropriate processes are in place for initial provider orientation and ongoing provider education. Updates are also provided through mailings, faxes, newsletters, etc.	✓		
The MCOs adopt, educate providers about, and assess provider compliance with clinical practice and preventive health guidelines.	✓		
Each of the health plans monitors continuity and coordination of care between PCPs and other providers using a variety of data sources.	✓		✓
The health plans educate providers about medical record documentation standards and assess provider compliance through routine medical record audits. Action is taken to address identified issues.	✓		
Policies clearly state the geographic access standards for PCPs and specialists.			✓
The MCOs contract with all required Status 1 and Status 2 provider types.	✓		✓
The health plans regularly assess their provider networks and implement interventions to address any identified network gaps.	✓		✓
Programs are in place to ensure MCO networks can meet the cultural, diversity, language, and other special needs of members.	✓		✓
All four health plans were validated as meeting CMS and state-defined network adequacy standards, confirming that they maintain sufficient numbers and geographic distribution of providers to support member access to care.	✓		✓
Each plan demonstrated well-developed systems for maintaining provider enrollment data, with layered verification processes that include credentialing, taxonomy validation, and regular updates to provider directories. These systems help ensure network information is as accurate and current as possible.	✓	✓	✓
All MCOs utilize Quest Analytics or equivalent enterprise tools to regularly monitor provider-to-member geographic access, demonstrating an ongoing commitment to ensuring members can reasonably reach in-network care.	✓		✓

Table 14: Provider Services Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
One MCO incorrectly documented the quorum requirement on the Credentialing Committee meeting minutes template. This MCO held one	*Ensure the Credentialing Committee quorum requirement is correctly documented and that a quorum is present for all meetings in which decisions are made.*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Credentialing Committee meeting and made decisions without the presence of a quorum.				
One MCO does not clearly document primary source verification requirements for organizational provider credentialing and recredentialing in policy. The file review for the MCO revealed inconsistences in the process followed for verifying organizational provider information.	*Ensure policies clearly define the acceptable sources and processes for verifying organizational provider credentialing and recredentialing information, and that the documented processes are followed.*	✓		
Additional issues identified in the health plans' policies include: • Two of the four MCOs did not address all provider rights related to credentialing and recredentialing in policy. • One health plan inconsistently documented the frequency of reviewing clinical practice and preventive health guidelines in policy. • One health plan did not document its processes for monitoring continuity and coordination of care between PCPs and other providers.	*Ensure policies completely and correctly document processes, requirements, and activities.*	✓		✓
Issues were identified in two MCOs' Provider Manuals, including: • Incomplete and/or inconsistent documentation of member benefits. • Incorrect documentation of the requirements for self-referral to behavioral health services. • Incorrect appointment scheduling timeframe for specialty emergency visits.	*Ensure Provider Manuals include complete and correct documentation of member benefits, the process for self-referral to services, appointment access timeframes, etc.*	✓		✓
Issues were identified in the MCOs' Provider Directories, including: • Failure to include practice names/group affiliations and age groups. • Failure to include contractually required language regarding PCP selection by members of a family. • Failure to include all required provider types.	*Ensure Provider Directories meet all contractual requirements and include all required information.*	✓		✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
One health plan does not monitor specialists' panel status, as contractually required.	*All MCOs should monitor specialists' panel status to ensure members have appropriate access to these providers.*	✓		✓
Decreased successful contact rates for the secret shopper calls were noted across all plans, indicating limited member access.	*Strengthen provider directory validation and provider outreach protocols to improve contact accuracy.*	✓	✓	✓
Inconsistencies were noted in provider confirmation of plan participation during secret shopper calls.	*Conduct regular audits and reconciliation between directory listings and actual contracting status.*	✓		✓
During secret shopper calls, a declining number of providers indicated they are accepting new Medicaid patients.	*Enhance provider engagement strategies and incentives to increase participation in Medicaid and improve new patient access.*	✓	✓	✓

Table 15: Provider Services Comparative Data

Standard	ATC	Humana	Molina	Select Health
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*				
The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met↑	Met	Partially Met ↓	Partially Met ↓
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Partially Met ↓	Met	Met	Met
The credentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met
Work history	Met	Met	Met	Met
Malpractice claims history	Met	Met	Met	Met
Formal application with attestation statement	Met	Met	Met	Met
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
Query of System for Award Management (SAM)	Met	Met	Met	Met
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met
Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Met	Met	Met
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met
Query of Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Met	Met	Met
Additional Requirements for Nurse Practitioners	Met	Met ↑	Met	Met
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met
Recredentialing conducted at least every 36 months	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met
Board certification if claimed by the applicant	Met	Met	Met	Met
Malpractice claims since the previous credentialing event	Met	Met	Met	Met
Practitioner attestation statement	Met	Met	Met	Met
Requery the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met
Requery of System for Award Management (SAM)	Met	Met	Met	Met
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met
Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Met	Met	Met
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met
Query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
In good standing at the hospitals designated by the provider as the primary admitting facility	Met	Met	Met	Met
Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Met	Met	Met
Additional Requirements for Nurse Practitioners	Met	Met	Met	Met
Review of practitioner profiling activities	Met	Met	Met	Met
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	Met	Met	Met	Met
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Partially Met ↓	Met	Met
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Met	Met	Met
Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*				
The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: Members have a primary care physician located within a 30-mile radius of their residence	Met↑	Met	Met	Met
Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met↑	Partially Met ↓	Met	Met↑
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Met	Met	Met	Met
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Met	Met
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met
The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy	Met	Met	Met	Met
Practitioner Accessibility The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met ↓	Met	Met ↑	Met↑
The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards	Met	Met	Met	Met
The MCO regularly maintains and makes available a Provider Directory that includes all required elements	Partially Met ↓	Partially Met	Partially Met ↓	Partially Met ↓

Standard	ATC	Humana	Molina	Select Health
The MCO conducts appropriate activities to validate Provider Directory information	Met	Met	Met	Met
The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results	Not Met ↓	Not Met ↓	Not Met ↓	Not Met
The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy"	Met	Met	Met	Met
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*				
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met
Initial provider education includes: MCO structure and health care programs	Met	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met	Met
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Partially Met ↓	Met	Partially Met ↓	Met
Procedure for referral to a specialist	Met	Met	Partially Met ↓	Met
Accessibility standards, including 24/7 access	Met	Met	Met	Met
Recommended standards of care	Met	Met	Met	Met
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met
Provider and member grievance and appeal procedures	Met	Met	Met	Met
Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met	Met	Met
Reassignment of a member to another PCP	Met	Met	Met	Met
Medical record documentation requirements	Met	Met	Met	Met
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	Met	Met	Met
Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*				
The MCO develops preventive health and clinical practice guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Partially Met ↓	Met
The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members	Met	Met	Met	Met
The guidelines include, at a minimum, the following if relevant to member demographics: Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
Recommended childhood immunizations	Met	Met	Met	Met
Pregnancy care	Met	Met	Met	Met
Adult screening recommendations at specified intervals	Met	Met	Met	Met
Elderly screening recommendations at specified intervals	Met	Met	Met	Met
Recommendations specific to member high-risk groups	Met	Met	Met	Met
Behavioral health services	Met	Met	Met	Met
Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*				
The MCO monitors continuity and coordination of care between PCPs and other providers	Met	Partially Met ↓	Met	Met
Practitioner Medical Records				
The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians	Met	Met	Met	Met
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Met	Met	Met
Medical Record Audit The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met
Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	Met	Met	Met

Member Services

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

Members are informed of their rights and responsibilities in Member Handbooks, Provider Manuals, welcome kits, member newsletters, and on health plan websites. Three of the four MCOs address both member rights and responsibilities in policies. However, Humana's policy only addressed member rights.

The Member Handbooks provide information regarding benefits and services, procedures for accessing elective, and urgent and emergency medical services. Information is also provided regarding selecting and changing a PCP and how to access the provider directory. Information about the services provided through Developmental Evaluation Centers was not found in the Member Handbook for two of the MCOs.

Member materials are provided at the appropriate reading level and in alternate languages and formats. Interpreter and translation services are available at no cost to members. The Member Handbook provides instructions for obtaining copies of the Member Handbook and other member materials in large print or in alternate languages if needed.

Member Services Call Centers are available via a toll-free telephone number, toll-free fax, and TTY from 8:00 a.m. to 6:00 p.m., Monday through Friday for each health plan. Information is available to members about access to the Nurse Advise Line and other emergency resources. Performance standards for speed of answer, average hold time, and the disconnect rate for incoming calls are reviewed for compliance. Members are informed of the steps for automatic PCP assignment upon enrollment and process for disenrollment when requested.

Member Satisfaction Survey

As contractually required, the health plans conducted the Adult, Child, and Children with Chronic Conditions versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. Using the protocol developed by CMS, *Protocol 6: Administration or Validation of Quality of Care Surveys*, Constellation validated the surveys to ensure that the results of the surveys were reliable and valid.

The results of the validations found all health plans met the overall validation criteria, demonstrating adherence to methodological standards and reliability in reporting. However, all plans reported survey response rates significantly below the NCQA target rate which may introduce bias into the generalizability of the findings. Response rates across plans were variable, ranging from 6.2% to 15.2%. While some improvements were noted, the majority of the response rates declined compared to the previous year, highlighting continued challenges in engaging members through CAHPS surveys. The validation findings are displayed in Table 16 below.

Table 16: Member Satisfaction Survey Validation Results

Section	CAHPS Survey Version	Reason	Recommendation
ATC			
Do the survey findings have any limitations or problems with generalization of the results?	5.1 H MY 2023 Adult	The response rate was 11.9%, an improvement over the previous response rate of 11.5%, but remains low and may introduce bias into the generalizability of the findings.	Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey.
	5.1 H MY 2023 Child	The response rate was 9.3%, a decline from the previous rate of 10.0% which may introduce bias into the generalizability of the findings.	
	5.1 H MY 2023 Child CCC	The response rate was 8.8%, a decline from the previous rate of 9.7% which	

Section	CAHPS Survey Version	Reason	Recommendation
		may introduce bias into the generalizability of the findings.	
Humana			
Do the survey findings have any limitations or problems with generalization of the results?	5.1 H MY 2023 Adult	The response rate for MY2023 was 10.7% which is a decline from last year's rate of 12.6% which may introduce bias into the generalizability of the findings.	Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey.
	5.1 H MY 2023 Child	The response rate for MY2023 was 6.9% which is a slight improvement over last year's rate of 6.8% but still may introduce bias into the generalizability of the findings.	
	5.1 H MY 2023 Child CCC	The response rate for MY2023 was 6.2%, which is a slight improvement over last year's rate of 6.0% but still may introduce bias into the generalizability of the findings.	
Molina			
Do the survey findings have any limitations or problems with generalization of the results?	5.1 H MY 2023 Adult	The response rate was 11.9%, which is a decline from the year's rate of 14.5% and may introduce bias into the generalizability of the findings.	Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey.
	5.1 H MY 2023 Child	The response rate was 10.5%, which is an improvement over last year's rate of 9.7%, but still may introduce bias into the generalizability of the findings.	
	5.1 H MY 2023 Child CCC	The response rate was 9.3%, which is a decline from last year's rate of 9.9%, and may introduce bias into the generalizability of the findings.	
Select Health			
Do the survey findings have any limitations or problems with generalization of the results?	5.1 H MY 2023 Adult	The response rate was 12.5% which is a decline from last year's rate and may introduce bias into the generalizability of the findings.	Continue efforts to increase survey participation by using multiple contact methods. Educate members and communicate the importance and impact of the survey.
	5.1 H MY 2023 Child	The response rate was 13.1%, which is a decline from last year's rate and may introduce bias into the generalizability of the findings.	
	5.1 H MY 2023 Child CCC	The response rate was 15.2%, which is a decline from last year's rate and may introduce bias into the generalizability of the findings.	

Grievances

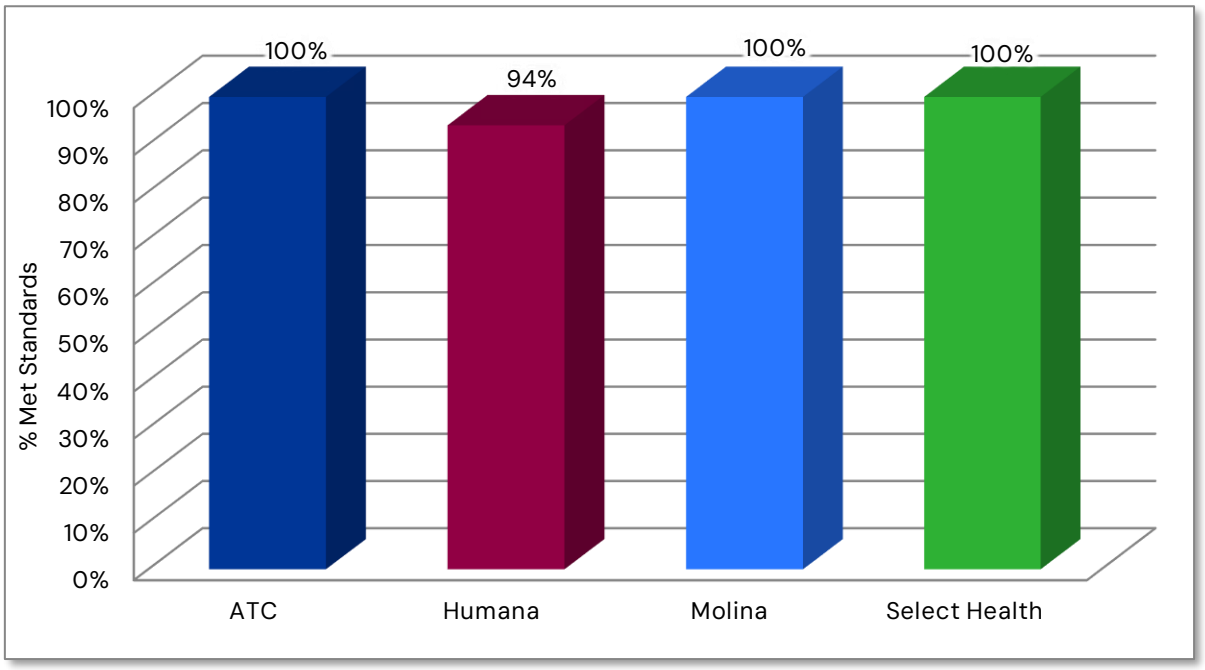
42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Processes for filing and handling grievances are provided in policies, Member Handbooks, Provider Manuals, member materials, and on each health plan's website. Timeframes for grievance acknowledgment, resolution, and extension, if needed, are described for three of the four MCO policies. However, Humana's grievance policy contained conflicting timeframes for grievance acknowledgement. This was a deficiency identified during the previous EQR and not corrected. Grievances are logged and categorized appropriately. Trends are reported quarterly as reflected in the minutes of internal quality committees.

Constellation reviewed a sample of grievance files for each MCO and found all were resolved within the appropriate timeframe and reviewed by appropriately credentialed reviewers. One grievance for ATC was not acknowledged in a timely manner and was closed with 67 days remaining due to missing information and inability to contact the member. During the onsite, it was recommended to review and revise processes and retrain staff to ensure consistent steps are taken for locating accurate contact information for members when additional information is needed to process a grievance.

Three MCOs, ATC, Molina and Select Health scored 100% and Humana scored 94% for the Member Services standards for the 2024 EQRs.

Figure 9: Member Services Findings



Scores were rounded to the nearest whole number.

Table 17: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Each MCO's Member Handbook is a comprehensive resource for members to understand their benefits and health plan services and processes.	✓		✓
Member materials are made available in alternate formats as needed to meet member needs by each health plan.			✓
The member satisfaction survey had a well-documented purpose, clear study objectives, and a defined audience, ensuring alignment with its intended goals and stakeholders. This clarity helps maintain focus and enhances the credibility of the findings.	✓		
The survey instrument was rigorously tested for both validity and reliability, confirming that it accurately measures what it intends to and produces consistent results over time.	✓		
The study population and sampling frame were clearly defined, with appropriate methods used to minimize bias and ensure representativeness. The sampling process. adhered to CAHPS survey guidelines, ensuring a sufficient sample size for meaningful analysis.	✓		
The survey followed a structured analysis plan using appropriate statistical methods, and all conclusions were supported by the data. The final report provided a thorough overview of the survey's purpose, implementation, and key findings, enhancing transparency and usability for decision-making.	✓		
The review of a sample of grievance files for each MCO found all were resolved within the appropriate timeframe and reviewed by appropriately credentialed reviewers.		✓	

Table 18: Member Services Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Humana did not have a current policy that addressed member responsibilities as noted in the *SCDHHS Contract, Section 3.16*.	*Member responsibilities should be included in a policy.*	✓		
Discrepancies were noted in Humana's policy regarding the timeframe for acknowledging a grievance.	*Ensure the timeframe for acknowledging a grievance is consistent in all documents.*		✓	

Table 19: Member Services Comparative Data

Standard	ATC	Humana	Molina	Select Health
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*				
The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities	Met	Partially Met ↓	Met	Met
Member rights include, but are not limited to, the right: • To be treated with respect and with due consideration for dignity and privacy • To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand • To participate in decision-making regarding their health care, including the right to refuse treatment • 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 • To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation • 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	Met ↑	Met	Met	Met
Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: • Benefits and services included and excluded in coverage • Direct access for female members to a women's health specialist in addition to a Primary Care Provider (PCP) • Access to second opinions at no cost, including use of an out-of-network provider if necessary • How members may obtain benefits, including family planning services from out-of-network providers • Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefit • Any requirements for prior approval of medical or behavioral health care and services • Procedures for and restrictions on obtaining out-of-network medical care • Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services • Policies and procedures for accessing specialty care • Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
• Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network • Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care • Procedures for disenrolling from the MCO • Procedures for filing grievances and appeals, including the right to request a State Fair Hearing • Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office • Instructions on how to request interpretation and translation services at no cost to the member • Member's rights, responsibilities, and protections • Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them • A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services • How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary • Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services • A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive • Information on how to report suspected fraud or abuse • Additional information as required by the contract and/or federal regulation				
Members are notified at least once per year of their right to request a Member Handbook or Provider Directory	Met	Met	Met	Met
Members are informed in writing of changes in benefits and changes to the provider network	Met	Met	Met	Met
Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met	Met	Met	Met
The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO	Met	Met	Met	Met
Member Enrollment and Disenrollment *42 CFR § 438.56*				
The MCO enables each member to choose a PCP upon enrollment and assists, if needed	Met	Met	Met	Met
MCO-initiated member disenrollment requests are compliant with contractual requirements	Met	Met	Met	Met
Preventive Health and Chronic Disease Management Education				

Standard	ATC	Humana	Molina	Select Health
The MCO informs members of available preventive health and disease management services and encourages members to utilize these services	Met	Met	Met	Met
The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits	Met	Met	Met	Met
The MCO provides education to members regarding health risk factors and wellness promotion	Met	Met	Met	Met
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care	Met	Met	Met	Met
Member Satisfaction Survey				
The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	Met	Met	Met	Met
Statistically sound methodology, including probability sampling to ensure it is representative of the total membership	Met	Met	Met	Met
The availability and accessibility of health care practitioners and services	Met	Met	Met	Met
The quality of health care received from MCO providers	Met	Met	Met	Met
The scope of benefits and services	Met	Met	Met	Met
Claim processing procedures	Met	Met	Met	Met
Adverse MCO claim decisions	Met	Met	Met	Met
The MCO analyzes data obtained from the member satisfaction survey to identify quality issues	Met	Met	Met	Met
The MCO implements significant measures to address quality issues identified through the member satisfaction survey	Met	Met	Met	Met
The MCO reports the results of the member satisfaction survey to providers	Met	Met	Met	Met
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	Met	Met	Met	Met
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*				
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:	Met	Met	Met	Met
The definition of a grievance and who may file a grievance	Met	Met ↑	Met	Met
Procedures for filing and handling a grievance	Met	Not Met ↓	Met	Met
Timeliness guidelines for resolution of a grievance	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee	Met	Met	Met	Met
Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Met	Met	Met	Met
The MCO applies grievance policies and procedures as formulated	Met	Met ↑	Met	Met
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met

Quality Improvement

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

Health plans are required by contract to establish and implement an ongoing comprehensive quality assessment and performance improvement program. The *SCDHHS Contract* requires the health plans to have a written description of the Quality Improvement (QI) Program, focusing on health outcomes and including detailed objectives, program structure, accountabilities, scope, and an annual program evaluation. To demonstrate compliance with this requirement, the health plans submitted their QI Program Descriptions, which describe how the health plans integrate quality assurance, management, and improvement into daily operations, with defined performance metrics and accountability. The QI Program descriptions detail the roles and responsibilities of various committees, departments, and key positions involved in overseeing quality improvement activities, monitoring performance, conducting audits, and ensuring compliance with standards.

Members and providers are informed of the QI Program in the Member Handbook, Provider Manual and on the health plan websites. However, Select Health's website information was outdated. The QI goals shared with providers were the 2023 program goals and the goals shared with members were the 2022 program goals. The QI section of Humana's website stated, "We want you to feel confident that you made the right choice in your plan. View the HEDIS State of Health Care Quality Report." A link was provided for the HEDIS® State of Health Care Quality Report on the NCQA website. However, this report was a summary report of performance measure results for commercial, Medicare, and Medicaid health plans and is not health plan specific. This issue was identified during the 2024 EQR and Constellation recommended that Humana update the website and include health plan specific HEDIS measure rates and CAHPS results. Constellation discussed this finding during the onsite.

Following that discussion, Humana added a link on the website that contained a summary of Humana's HEDIS and CHAPS results.

The Quality Work Plan is a key component of the health plans' continuous quality improvement cycle. The Quality Work Plan is developed annually and reflects the ongoing progress of quality activities and includes recommendations for improvements based on the annual Program Evaluation. ATC and Select Health provided the 2023 and 2024 QI work plans. These work plans included the yearly planned activities, objectives, timeframe for completion of each activity, responsible party, and updates.

Humana's 2024 and 2025 QI Work Plans specify activities planned or underway, assist in determining resources needed, and serve as a foundation for the tracking and reporting results. The 2024 work plan included two activities regarding the continuity and coordination between medical and behavioral health providers. According to the work plan, the annual report was to be generated and presented to the Quality Assurance Committee at the August 2024 meeting. For this activity Humana had set a goal of 50th percentile for the Diabetes Monitoring for People with Diabetes and Schizophrenia HEDIS measure and a medical record review to measure documentation of behavioral health providers' communications with PCPs. The Quality Assurance Committee meeting minutes for August 2024 did not include a report for this activity. During the onsite, Constellation requested a copy of this report, and a copy of the committee meeting minutes where this activity was discussed. A copy of a report titled Primary or Secondary Preventive Behavioral Healthcare Program Implementation was provided. This report did not address the Diabetes Monitoring for People with Diabetes and Schizophrenia or the medical record review. A copy of the 2024 QI work plan was also provided, and a note was added to the work plan that stated "Report with meeting minutes documenting activities #s 53 & 54 is no longer required due to health plan performance in BH measures being 2 star or higher. Can be removed from workplan (no longer NCQA requirement per accreditation team)." The work plan was not updated timely as this note was added after the onsite. Constellation also noted an issue with Humana's QI work plan during the 2024 EQR where the results or a report was not presented to the committee as noted in the work plan. Details regarding how Humana addressed this deficiency can be found in *Attachment 1: Assessment of Quality Improvement Plans from Previous EQR*.

Molina has developed a QI work plan that covers five years. This work plan serves as a roadmap for the implementation of quality improvement initiatives and helps ensure that activities are carried out in a timely and organized manner. The work plan received by Constellation contained several discrepancies regarding the results reported. For example, the activity for completing the QI Program Evaluation indicated the Goal was not met. However, on the Evaluation and Analysis page indicated the goal was met for this activity.

Responsibility for the QI Programs is overseen by a committee appointed by the health plans' Board of Directors. The quality committees are composed of senior staff and participating network providers. The committees meet quarterly, with additional meetings scheduled as needed. Minutes for each meeting are recorded and presented for review and approval at the next meeting. Humana's Quality Assurance Committee charter states, "voting members are expected to attend each meeting; in their absence, a proxy representation is requested." The meeting minutes reviewed did not identify the proxy representative when a voting member was absent. This was an issue identified during the 2024 EQR and not corrected.

Providers receive information about their performance through several methods. ATC offers population health management reporting designed to support providers in delivering timely, efficient, and evidence-based care. Humana provides practitioners with comparative data regarding quality through the Quality/Stars Report, the Medicaid PCP Quality Recognition Report, and the Gaps in Care Report. Molina shares quality improvement performance results with network providers in the provider newsletters, fax blasts; email, mail; and/or delivery to the practitioner's office. Select Health provides direct feedback to PCPs on their performance via a provider report card. The report card offers direct feedback on key quality measures compared to a peer group within the Select Health network.

Annually, the health plans evaluate the effectiveness of the QI Programs. Each health plan provided copies of their annual evaluations. The evaluations outline accomplishments as well as analyzed data and outcomes compared to goals, include limitations or barriers to meeting objectives, and state conclusions and recommendations for the upcoming year.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation conducted a validation review of the HEDIS measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. For the validation process, Constellation applies the three activities for each MCO to support the auditing process per *42 CFR § 438.330 (c)* and *§ 457.1240 (b)*. The following activities are conducted for Performance Measure Validation for the MCOs.

Performance Measure Validation Documentation Requested

Per the contract between the MCOs and SCDHHS, the MCOs were required to submit HEDIS data to NCQA. To ensure the HEDIS rates were accurate and reliable, SCDHHS required the MCO to undergo an NCQA HEDIS Compliance Audit. ATC, Humana, Molina, and Select Health contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Each MCO was required to submit the Completed NCQA Record of Administration, Data Management, and Processes (Roadmap) from the HEDIS Compliance Audit, associated

supplemental documentation, NCQA and Interactive Data Submission System (IDSS) files, the HEDIS Compliance Audit Final Audit Reports (FARs), and policies and procedures.

Performance Measure Validation Process

The following activities were conducted for the PM Validation for the MCOs.

Review of Data Management Processes to include:

- The health plan's measurement policies and procedures.
- The table and field definitions to ensure the correct data is being used to calculate the selected measures.
- The health plan's standard code mapping used in the calculation of the measures.
- A review of the health plan's policies and procedures for safeguarding confidential information.
- Compliance with HEDIS technical specifications for calculating and reporting PMs per certified auditor report.

Algorithmic compliance evaluation is completed:

- Complete source code and programming logic review that details the calculation of the numerator and denominator for the measure, including all intermediate data merges and data staging that are used to calculate the measure.
- Verification that all the correct clinical codes defined in the measure specification are used appropriately to calculate the measure.
- Verification that age groups and other measure stratification groups are correctly programmed as defined by the measure specification.

A scoring worksheet is used to evaluate and validate the HEDIS measures in accordance with the protocol developed by CMS titled, *EQR Protocol 2: Validation of Performance Measures*. This ensures that MCOs accurately calculate and report performance measures in alignment with standardized specifications outlined in the HEDIS Volume 2 Technical Specifications.

The validation process includes multiple components—General Measure Elements, Denominator and Numerator Elements, Sampling Methods, and Reporting Standards—using a structured set of audit elements. Each audit element is assigned a weighted point value based on its importance to overall data validity. Higher-weighted elements (e.g., data source accuracy, documentation, and programming adherence) are worth 10 points, while supporting or supplementary elements (e.g., sampling methodology or hybrid integration techniques) are assigned five points. Scoring is determined based on the following criteria:

Table 20: Audit Element Scoring

Audit Element Scoring	
MET (Fully Met)	Full point value awarded.
PARTIALLY MET	Partial credit awarded—5 points for 10-point elements and 3 points for 5-point elements.
NOT MET	Zero points awarded.

The overall validation score is calculated as a percentage, using the formula: (Total Points Earned ÷ Total Possible Points) × 100. This percentage score determines the Audit Designation. *Table 21* offers an overview of the audit categories and corresponding percentage ranges.

Table 21: Audit Designations based on Performance Measure Validation Results

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.

This scoring framework offers a consistent, transparent, and quantitative method for assessing the accuracy and reliability of reported HEDIS performance measures.

Performance Measure Validation Results

The Performance Measure (PM) Validation found that all the health plans were fully compliant with all HEDIS measures as shown in *Table 22: Performance Measure Validation Rating* and met the requirements per *42 CFR § 438.330 (c)* and *§ 457.1240 (b)*.

Table 22: Performance Measure Validation Rating

MCO	Performance Measure Validation Rating	EQRO Comments
ATC	Fully Compliant	Plan uses NCQA certified software. Attest Health Care Audit report noted compliance for HEDIS measures. HEDIS specifications were followed and found compliant.
Humana	Fully Compliant	HEDIS specifications were followed and found compliant. Plan uses NCQA certified software. Attest Health Care Audit report noted compliance for HEDIS measures.
Molina	Fully Compliant	HEDIS specifications were followed and found compliant. Plan uses NCQA certified software Cognizant for calculations. The audit report noted compliance with HEDIS measures.
Select Health	Fully Compliant	Plan uses NCQA certified software vendor, Inovalon. The audit report noted compliance with HEDIS measures. HEDIS specifications were followed and found compliant.

All relevant HEDIS PMs for the current measure year (MY 2022/2023), the previous measure year (MY2021/2022), and the change from the current to previous year are reported in *Table 23: HEDIS Performance Measure* Results. Rates shaded in green indicate a substantial improvement (>10%), and rates shaded in red indicate a substantial decline (>10%). The arrows indicate a change in the rate from the previous measure year. For example, an arrow pointing up (↑) indicates an improvement in the rate, a down arrow (↓) indicates the rate was lower than the previous measure year, and a bidirectional arrow (⇔) indicates no change in the rate from the previous year. Green arrows indicate improvement in performance, while red arrows indicate a decline. For measures where a lower rate is better, improvement is shown with a downward green arrow. Conversely, a red upward arrow reflects a worsening in measures where a lower rate is better (e.g., HbA1c Poor Control). Due to timing of the reviews, MY2022 data are presented for Molina and MY2023 data are presented for ATC, Humana, and Select Health.

Table 23: HEDIS Performance Measure Results

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)	Statewide Average
Effectiveness of Care: Prevention and Screening					

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)	Statewide Average
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile	76.89% ↑	76.40% ↑	70.07% ↓	74.19% ↑	74.39%
Counseling for Nutrition	65.94% ↑	65.69% ↑	58.15% ↓	60.30% ↑	62.52%
Counseling for Physical Activity	63.75% ↑	64.23% ↑	55.23% ↓	57.32% ↑	60.13%
Childhood Immunization Status (CIS)					
DTaP	66.91% ↑	50.61% ↑	64.23% ↓	75.91% ↑	64.42%
IPV	82.73% ↓	62.77% ↑	83.45% ↑	88.56% ↑	79.38%
MMR	84.43% ↑	70.32% ↑	83.21% ↑	89.78% ↑	81.94%
HiB	78.83% ↓	59.85% ↑	78.10% ↑	85.16% ↑	75.49%
Hepatitis B	84.91% ↑	62.77% ↑	79.32% ↓	86.13% ↓	78.28%
VZV	83.94% ↑	70.32% ↑	82.48% ↑	88.81% ↑	81.39%
Pneumococcal Conjugate	70.32% ↑	49.39% ↑	68.61% ↑	78.35% ↑	66.67%
Hepatitis A	83.70% ↑	71.53% ↑	81.02% ↑	87.59% ↑	80.96%
Rotavirus	68.86% ↓	44.77% ↑	65.69% ↓	72.75% ↑	63.02%
Influenza	23.84% ↓	22.87% ↑	28.47% ↓	29.93% ↓	26.28%
Combination #3	62.29% ↑	41.85% ↑	58.15% ↓	69.59% ↑	57.97%
Combination #7	55.47% ↑	34.06% ↑	51.34% ↓	59.37% ↑	50.06%
Combination #10	18.49% ↓	12.41% ↑	19.95% ↓	22.38% ↓	18.31%
Immunizations for Adolescents (IMA)					
Meningococcal	76.89% ↑	46.58% ↑	68.37% ↑	74.32% ↓	66.54%
Tdap/Td	86.37% ↑	61.64% ↑	84.18% ↑	86.54% ↓	79.68%
Combination #1	76.89% ↑	45.55% ↓	33.58% ↑	34.59% ↓	47.65%
Combination #2	29.93% ↑	16.10% ↑	68.13% ↑	73.99% ↓	47.04%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	30.66% ↑	16.44% ↑	32.36% ↑	33.78% ↓	28.31%
Lead Screening in Children (LSC)	63.48% ↑	55.72% ↑	58.42% ↓	67.55% ↑	61.29%
Breast Cancer Screening (BCS)	53.92% ↑	62.50%↑	52.60% ↑	56.81%↑	54.46%
Cervical Cancer Screening (CCS)	57.47% ↑	44.28% ↑	56.20% ↓	61.86% ↓	54.95%
Colorectal Cancer Screening (COL) +	41.02% ↑	21.65% ↑	39.63% N/A	43.60% ↑	36.48%
Chlamydia Screening in Women (CHL) +	61.48% ↑	56.80% ↓	58.78% ↑	60.05% ↓	59.28%
Effectiveness of Care: Respiratory Conditions					
Appropriate Testing for Children with Pharyngitis (CWP)	86.66% ↑	87.74% ↑	78.29% ↑	88.75% ↑	85.36%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	24.07% ↑	0.00* N/A	22.22% ↓	26.25% ↓	24.18%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	72.08% ↑	59.09% ↓	72.78% ↑	68.61% ↓	68.14%
Bronchodilator	79.51% ↓	78.79% ↑	79.25% ↑	85.81% ↑	80.84%

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)	Statewide Average
Asthma Medication Ratio (AMR)	59.33% ↓	50.00%* N/A	61.81% ↓	71.84% ↑	64.33%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	59.85% ↑	65.69% ↑	52.31% ↓	59.27% ↑	59.28%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	47.22% ↓	50.00%* ↑	71.43% ↑	55.88% ↓	58.18%
Statin Therapy for Patients With Cardiovascular Disease (SPC)					
Received Statin Therapy – Total	81.02% ↑	75.00%* ↓	82.32% ↑	81.96% ↑	81.77%
Statin Adherence 80% – Total	54.57% ↓	44.44%* ↑	56.26% ↑	65.36% ↑	58.73%
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation – Initiation (Total)	1.46% ↓	0.00%* ↔	3.65% ↑	3.45% ↑	2.85%
Cardiac Rehabilitation – Engagement1 (Total)	2.91% ↓	0.00%* ↔	5.11% ↓	3.45% ↓	3.82%
Cardiac Rehabilitation – Engagement2 (Total)	2.91% ↓	0.00%* ↔	1.46% ↓	3.45% ↓	2.61%
Cardiac Rehabilitation – Achievement (Total)	0.49% ↓	0.00%* ↔	0.00% ↓	1.48% ↓	.66%
Effectiveness of Care: Diabetes					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
*HbA1c Poor Control (>9.0%) ** *	30.41% ↓	34.55% ↓	43.07% ↓	40.39% ↓	37.11%
HbA1c Control (<8.0%)	61.07% ↑	56.69% ↑	47.93% ↑	50.12% ↑	53.95%
Eye Exam (Retinal) Performed (EED) +	44.77% ↑	49.39% ↑	53.28% ↑	50.12% ↑	49.39%
Blood Pressure Control for Patients With Diabetes (BPD)	69.34% ↑	65.69% ↑	63.02% N/A	61.56% ↑	64.90%
Kidney Health Evaluation for Patients With Diabetes (KED)	36.04% ↑	28.24% ↑	28.31% ↑	31.60% ↑	31.05%
Statin Therapy for Patients With Diabetes (SPD)					
Received Statin Therapy	65.64% ↑	50.00% N/A	63.53% ↓	60.12% ↓	59.82%
Statin Adherence 80%	51.23% ↓	47.62% N/A	50.40% ↑	59.40% ↑	52.16%
Effectiveness of Care: Behavioral Health					
Diagnosed Mental Health Disorders (DMHI) ++	25.10%	23.57%	25.96%	29.75%	26.14%
Antidepressant Medication Management (AMM) +					
Effective Acute Phase Treatment	45.36% ↑	58.74% ↓	46.66% ↓	52.23% ↑	50.75%
Effective Continuation Phase Treatment	28.41% ↓	39.16% ↑	28.32% ↓	34.49% ↑	32.60%
Follow-Up Care for Children Prescribed ADHD Medication (ADD) +					
Initiation Phase	47.36% ↑	41.54% ↓	52.89% ↑	44.55% ↑	48.27%
Continuation and Maintenance (C&M) Phase	61.26% ↑	38.10% * N/A	62.65% ↑	53.46% ↓	59.12%
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total – 30-Day Follow-Up	59.34% ↓	55.35% ↑	55.59% ↓	64.72% ↑	58.75%
Total – 7-Day Follow-Up	36.19% ↓	35.85% ↑	32.61% ↓	39.64% ↑	36.07%

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)	Statewide Average
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
Total - 30-Day Follow-Up	50.11% ↓	49.58% ↑	56.33% ↓	60.87% ↓	54.22%
Total - 7-Day Follow-Up	37.50% ↓	31.09% ↑	43.00% ↑	43.99% ↓	38.90%
Diagnosed Substance Use Disorders (DSU) ++					
Diagnosed Substance Use Disorders - Alcohol (Total) ++	1.70%	2.30%	1.66%	1.13%	1.70%
Diagnosed Substance Use Disorders - Opioid (Total) ++	1.56%	1.82%	1.78%	1.19%	1.56%
Diagnosed Substance Use Disorders - Other (Total) ++	2.89%	3.18%	2.96%	2.34%	2.89%
Diagnosed Substance Use Disorders - Any (Total) ++	4.95%	5.70%	5.05%	3.83%	4.95%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)					
Total - 30-Day Follow-Up	33.90% ↓	42.86%↑	43.84% ↑	36.84% ↑	39.36%
Total - 7-Day Follow-Up	19.18% ↓	32.14% ↑	29.35% ↑	22.65% ↑	25.83%
Follow-Up After Emergency Department Visit for Substance Abuse (FUA) +					
30-Day Follow-Up: Total	24.01% ↓	34.72% ↑	28.63% ↑	24.83% ↓	28.05%
7-Day Follow-Up: Total	15.97% ↓	20.83% ↑	19.75% ↑	16.44% ↓	18.25%
Pharmacotherapy for Opioid Use Disorder (POD)	32.64% ↓	36.23% ↓	33.78% ↓	33.99% ↑	34.16%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	78.50% ↑	81.29% ↑	80.72% ↑	79.09% ↑	79.90%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	70.71% ↑	81.82%*↑	66.67% ↓	75.10% ↓	70.83%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	85.19%*↑	100.00%* N/A	73.68%*↓	70.59%* ↑	NR
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	64.71% ↑	62.82% ↓	67.14% ↑	63.68% ↑	64.59%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood glucose testing - Total	57.22% ↑	57.89% ↑	50.96% ↓	55.73% ↓	54.64%
Cholesterol Testing - Total	38.65% ↑	34.21% ↑	30.05% ↑	35.22% ↓	34.64%
Blood glucose and Cholesterol Testing - Total	35.46% ↑	31.58% ↑	28.37% ↑	32.88% ↓	32.24%
Effectiveness of Care: Overuse/Appropriateness					
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) **	0.49% ↓	0.14%↑	0.45% ↓	0.52% ↑	0.40%
Appropriate Treatment for Children With URI (URI)					
Total	87.68% ↓	89.80% ↓	88.31% ↑	87.74% ↓	88.38%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)					
Total	52.82% ↓	63.91% ↑	59.03% ↑	52.63% ↓	57.10%
Use of Imaging Studies for Low Back Pain (IBP)	67.40% ↓	59.89% ↓	66.87% ↓	68.60% ↓	65.69%
Use of Opioids at High Dosage (HDO) **	3.83% ↑	1.85% ↑	1.16% ↑	2.55% ↓	2.35%
Use of Opioids From Multiple Providers (UOP) **					
Multiple Prescribers **	18.90%↑	20.99% ↓	21.27% ↓	22.80% ↑	20.99%

Measure/Data Element	ATC (MY 2023)	Humana (MY 2023)	Molina (MY 2022)	Select Health (MY 2023)	Statewide Average
Multiple Pharmacies **	2.60% ↑	3.70% ↑	1.31% ↓	3.69% ↑	2.83%
Multiple Prescribers and Multiple Pharmacies **	1.24% ↑	2.47% ↑	1.04% ↓	2.23% ↑	1.75%
Risk of Continued Opioid Use (COU)**					
Total – >=15 Days covered **	2.81% ↓	11.00% ↑	3.82% ↓	3.80% ↑	5.36%
Total – >=31 Days covered **	2.10% ↓	7.00% ↑	2.49% ↓	2.65% ↑	3.56%
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total	76.73% ↑	67.97% ↓	76.41% ↓	80.26% ↑	75.34%
Initiation and Engagement of AOD Dependence Treatment (IET) +					
Initiation of AOD Treatment: Total	42.54% ↑	49.67% ↑	42.06% ↑	39.33% ↑	43.40%
Engagement of AOD Treatment: Total	6.47% ↓	15.79% ↑	11.72% ↓	10.54% ↓	11.13%
Prenatal and Postpartum Care (PPC) +					
Timeliness of Prenatal Care	83.45% ↓	85.89% ↓	84.91% ↓	88.85% ↓	85.78%
Postpartum Care	76.40% ↑	79.08% ↑	77.86% ↑	79.34% ↑	78.17%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
Total	55.73% ↓	50.00%*↑	57.00% ↑	59.39% ↓	57.37%
Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)	55.21% ↑	36.59% ↑	58.43% ↑	57.86% ↑	52.02%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	69.11% ↑	46.93%↑	68.44% ↓	74.04% ↑	64.63%
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)	48.72% ↑	31.64% ↑	44.40% ↑	50.48% ↑	43.81%
Antibiotic Utilization for Respiratory Conditions (AXR) **					
*Antibiotic Utilization for Respiratory Conditions (Total)***	30.31% ↑	27.05%↑	23.16% N/A	31.19%↑	27.93%

Note:
*Unreliable rate due to a small denominator of less than 30 for plan and/or statewide average
**A lower rate for this measure indicates improvement.
+Measure had revisions for HEDIS MY 2023 that may affect trending according to NCQA Memo
++Neither a higher nor lower rate indicates better performance.
N/A = change in rate not able to be calculated as prior rate for health plan was not reported

ATC improved by 10 percentage points or more for the Blood Pressure Control for Patients With Diabetes (BPD), and the Kidney Health Evaluation for Patients With Diabetes (KED) rates. Rates fell by 10 percentage points or more for Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) rate.

Humana improved by 10 percentage points or more for the following MY 2023 HEDIS measures:

- Childhood Immunization Status (CIS), the indicators for DTaP, IPV, MMR, HiB, Hepatitis B, VZV, Pneumococcal Conjugate, Hepatitis A, Rotavirus, Influenza, and Combination #3.
- Immunizations for Adolescents (IMA), the indicators for Meningococcal and Tdap/Td indicators.
- Cervical Cancer Screening (CCS)
- Hemoglobin A1c Control for Patients with Diabetes (HBD), the HbA1c Poor Control and the HbA1c Control indicators.
- Eye Exam (Retinal) Performed (EED)
- Follow-Up After Hospitalization for Mental Illness (FUH), the Total – 30-Day Follow-up indicator.
- Follow-Up After Emergency Department Visit for Substance Abuse (FUA), the 30-Day Follow-Up: Total and the 7-Day Follow-Up: Total indicator.
- Use of Opioids from Multiple Providers (UOP), the Multiple Prescribers indicator.
- Well-Child Visits in the First 30 Months of Life (W30) *Life, the First 15 Months indicator*.

Rates fell by 10 percentage points or more for the Pharmacotherapy Management of COPD Exacerbation (PCE), the Systemic Corticosteroid indicator and the Use of Imaging Studies for Low Back Pain (IBP) rate.

Molina improved by 10 percentage points or more for the Follow-Up Care for Children Prescribed ADHD Medication (ADD), the Initiation Phase and the Continuation and Maintenance Phase indicators, and the Follow-Up After Emergency Department Visit for Substance Abuse (FUA), the 30-Day Follow-Up indicator. Rates fell by 10 percentage points or more for Pharmacotherapy for Opioid Use Disorder (POD).

Select Health improved by 10 percentage points or more for the Hemoglobin A1c Control for Patients with Diabetes (HBD), the HbA1c Poor Control indicator. Rates fell by 10 percentage points or more for Persistence of Beta-Blocker Treatment After a Heart Attack (PBH).

Performance Improvement Project Validation

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

Each MCO is required to submit to Constellation their performance improvement projects (PIPs) that have been conducted during the preceding 12 months for validation. For the 2024/2025 EQRs, the MCOs submitted the following PIPs:

Table 24: Performance Improvement Projects Submitted for Validation

MCO	Performance Improvement Project	Performance Improvement Project Aim
ATC	Hospital Readmissions	To reduce the annual rate of readmissions within 30 days for 18- to 64-year-old patients.
	Timeliness of Prenatal Care	Improve the percentage of women who delivered a live birth and had a prenatal visit in the first trimester.
	Adult Access to Preventive Health Care	Improve preventive care for adults 20 and older.
Humana	Human Papillomavirus Vaccine (HPV)	Increase HPV vaccines among 9–13-year-olds.
	Prenatal and Postpartum (PPC)	Increase the rate of eligible women receiving timely prenatal and postpartum care.
Molina	Improving Encounters Acceptance Rates	Improve the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims.
	Child and Adolescent Well-Care Visits	The aim for the Child and Adolescent Well-Care Visits PIP was to improve the rate of Well-Care Visits or a Comprehensive Well-Visit (for Ages 3 to 21).
	Immunizations for Adolescents	The Immunizations for Adolescents PIP examines adolescents, 13 years of age, with one dose of meningococcal vaccine, one tetanus, Tdap, and HPV by their 13th birthday.
Select Health	Diabetes Outcomes Measures	The aim for the diabetes PIP is to lower HbA1c levels for members who are in the poor control group (members whose lab results are available through data exchange and whose HbA1c levels are not <8%).
	Well Care Visits for the Foster Care Population	Increase compliance with well care visits for children and adolescents in foster care.

Technical Methods for Data Collection and Validation

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

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

Constellation validates and scores the submitted PIPs using the CMS-designed protocol to evaluate the validity and confidence in the results of each project using proprietary worksheets. These worksheets were developed based on the requirements included in Protocol 1, which

include the two activities displayed in *Table 25: Constellation's PIP Validation Activities per CMS Protocol*.

Table 25: Constellation's PIP Validation Activities per CMS Protocol

Step	Description	Step Questions
Activity One: Assess the PIP Methodology		
1	Review the Selected PIP Topic(s)	Are the selected PIP topic(s) appropriate?
2	Review the PIP Aim Statement	How appropriate and adequate is the aim statement?
3	Review the Identified PIP Population	Did the Plan clearly identify the population for the PIP in relation to the PIP aim statement?
4	Review Sampling Methods	Are the sampling methods appropriate and will they produce valid and reliable results?
5	Review the Selected PIP Variables and Performance Measures	Do the selected variables identify the Plan's performance on the PIP questions objectively and reliably and use clearly defined indicators of performance?
6	Review Data Collection Procedures	Are the procedures the Plan used to collect the data that inform the PIP measurement valid and reliable?
7	Review Data Analysis and Interpretation of PIP Results	Were appropriate techniques used, and were the analysis and interpretation of PIP results accurate?
8	Assess Improvement Strategies	Did the Plan apply appropriate interventions for achieving improvement?
9	Assess the Likelihood that Significant and Sustained Improvement Occurred	What is the likelihood that significant and sustained improvement occurred as a result of the PIP?
Activity Two: Perform Overall Validation and Reporting of PIP Results		
1	Perform Validation	Using the worksheet, score steps in Activity 1 to answer: Were the steps considered met, partially met, or not met? Which category does the overall PIP validation score fall into: High Confidence, Confidence, Low Confidence, or Not Credible?
2	Report Results	Are recommendations and/or corrective actions documented in the PIP validation worksheet and the CCO's annual report?

The PIP validation process follows a structured, nine-step methodology designed to ensure accuracy, reliability, and meaningful healthcare improvements. Each PIP is systematically reviewed to assess topic selection, aim statement clarity, population identification, sampling methods, PMs, data collection, analysis, intervention strategies, and sustainability of improvement. This comprehensive approach evaluates the methodological soundness of each

project, ensuring that findings are free from bias and capable of supporting data-driven decision-making.

A weighted scoring system is applied to each step, prioritizing critical areas that have the most significant impact on the validity of results. Higher weights are assigned to essential components, such as selecting appropriate PMs, using valid sampling techniques, and implementing meaningful improvement strategies. Other elements, including population documentation, data sources, and analysis procedures, are evaluated with proportionate weight to ensure a balanced and rigorous assessment. Each component is scored as "Met," "Not Met," or "Not Applicable" to provide a standardized and objective evaluation. Failure to meet key elements can significantly affect the overall credibility of the results.

The final validation score determines the level of confidence in the reported finding (see *Table 26*). Projects scoring 90 to 100% are classified as High Confidence, indicating strong methodological integrity with minimal documentation concerns. A Confidence rating between 70 and 89% suggests minor issues that introduce slight bias but do not compromise overall results. A Low Confidence rating between 60 to 69% signals major deviations from established methods that may impact data integrity, while projects scoring below 60% are deemed Not Credible, indicating significant flaws that prevent validation of the reported outcomes.

Table 26: Constellation's PIP Audit Designation Categories

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation 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.*

Overview of PIP Validation Results

A total of ten PIPs were submitted across the four MCOs, all of which were validated in the fully compliant range. These projects addressed a broad range of quality focus areas, including hospital readmissions, prenatal and postpartum care, child and adolescent well-care visits, adolescent immunizations, diabetes outcomes, and encounter data integrity. The PIPs were evaluated based on baseline performance, established goals, and up to three subsequent remeasurement periods. Each MCO implemented a variety of targeted interventions to

enhance care coordination, improve member engagement, and drive better health outcomes. The implemented PIP interventions highlight system-wide strengths in member outreach, provider collaboration, use of data analytics, and multidisciplinary care management. The variation in results also underscores opportunities for continued investment in sustaining improvements and addressing disparities in care delivery across key populations.

The following tables provide a summary of the validation results, project performance overtime, and interventions for each of the PIPs. An arrow pointing up (↑) indicates that project's performance on the measure is improving. The down arrows (↓) indicate the project's performance on the measure is declining. Cells highlighted in green indicate a statistically significant improvement in performance. The yellow highlighted cells indicate a statistically significant decline in performance. Cells without highlighting indicate the change was not statistically significant.

ATC submitted three PIPs that focused on reducing hospital readmissions, improving prenatal care timeliness, and increasing adult access to preventive health care. The plan achieved gradual improvements in readmission rates and maintained strong performance in prenatal care. Interventions were multifaceted, involving transition-of-care teams, discharge planning enhancements, telehealth support, and comprehensive outreach strategies. The results of the validation for those PIPS follow.

Table 27: ATC PIP Performance Findings

PIP Topic	Validation Score	Performance Measure	Performance Measure Results				
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)
Hospital Readmissions	80/80=100% High Confidence in Reported Results	The percentage of readmissions that occurred within 30 calendar days of discharge from the initial admission to the same or different acute care facility. *Lower Rate is better	18.0% (2019)	15%	*16.2% ↓ (2020)	*15.5% ↓ (2021)	*15.3% ↓ (2022)
Timeliness of Prenatal Care	93/93=100% High Confidence in Reported Results	The percentage of members who had a prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment	84.43% (2022)	88.32%	N/A	N/A	N/A
Adult Access to Preventive Health Care	74/75=99% High Confidence in Reported Results	The percentage of members who had an ambulatory or preventive care visit in the measurement year	77.28% (2020)	78.08%	78.18% ↑ (2021)	72.46% ↑ (2022)	N/A

Statistically significant improvement in performance Statistically significant decline in performance

R1 – Remeasurement 1, R2 – Remeasurement 2, R3 – Remeasurement 3, N/A = not applicable as no remeasurement has been conducted

Table 28: PIP Interventions – ATC

Interventions
Hospital Readmissions
• Transition of Care team assesses members upon discharge and reviews the discharge summary, assists members with scheduling appointments within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • The multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meets quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. • Utilization Management Manager pulls a daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members' needs are met.
Timeliness of Prenatal Care
• Tablets are distributed to women in rural areas to allow them to participate in telehealth services. • The pay-for-performance incentives were expanded to encourage adherence to prenatal HEDIS recommendations. • Disparity analysis is used to identify areas where disparities exist to improve health equity and assist those members with accessing prenatal care.
Adult Access to Preventive Health Care
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well-versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • Eliza application for scheduling appointments and member outreach. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.

Humana submitted PIPs that focused on Human Papillomavirus Vaccine (HPV) vaccination rates and prenatal/postpartum care. While the performance for prenatal care measure remained high, postpartum care rates declined, highlighting a continued area of opportunity. Interventions included case management restructuring, bilingual outreach, incentive programs, and use of data dashboards to track service gaps. The results of the validation for those PIPS follow.

Table 29: Humana PIP Performance Findings

PIP Topic	Validation Score	Performance Measure	Performance Measure Results				
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)
Human Papillomavirus Vaccine	80/80=100% High Confidence in Reported Results	The percentage of adolescents 13 years of age who have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	11.5% (2022)	35.4%	16.4%↑ (2023)	N/A	N/A
Prenatal and Postpartum	100/100=100% High Confidence in Reported Results	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	85.89% (2023)	84.55%	84.13%↓	N/A	N/A
		The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	79.08% (2023)	80.23%	61.48%↓	N/A	N/A

Statistically significant improvement in performance Statistically significant decline in performance

R1 – Remeasurement 1, R2 – Remeasurement 2, R3 – Remeasurement 3, N/A = not applicable as no remeasurement has been conducted

Table 30: PIP Interventions - Humana

Interventions
Human Papillomavirus Vaccine
• HEDIS metric monitoring dashboard to include data monitoring and tracking towards goals. • Clinical dashboard with HEDIS alerts to prompt Case Management staff to educate members on missing preventive services, including vaccines. • Targeted outreach campaigns specific to EPSDT program offerings.

Interventions
• Well child visit text campaign to support well-child visits with an effort to increase chances of positive provider-member relationship. • Member and Provider newsletters educating providers on HPV vaccine uptake importance. • Member Incentives. • Provider Newsletter education related to same day, same way campaign.
Prenatal and Postpartum
• Implemented Case Management staffing structure to include a bi-lingual prenatal nurse and reminders. • Data monitoring through Cotiviti at a monthly cadence. • Targeted outreach campaigns specific to Humana Beginnings program offerings. • Provider newsletter educating providers on 12-month postpartum extended coverage. • Value Added Benefits for pregnant members that included car seats and cribs.

Molina's PIPs centered around encounter data quality, child and adolescent well-care visits, and adolescent immunizations. The plan demonstrated significant progress in encounter acceptance rates and modest gains in well-care visit measures. Interventions featured provider training, member education campaigns, transportation support, and the use of gap reports and incentive mailings.

Table 31: Molina PIP Performance Findings

PIP Topic	Validation Score	Performance Measure	Performance Measure Results				
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)
Improving Encounters Acceptance Rates	79/79=100% High Confidence in Reported Results	Initial Professional Encounter Acceptance Rate	97.5% (2020)	100%	96.9%↓ (2021)	97.30%↑ (2022)	98.69% ↑ (2023)
		837P Taxonomy Related Rejections *Lower rate is better	2.63% (2020)	2%	2.82%↑ (2021)	2.70%↓ (2022)	1.31%↓ (2023)
Child and Adolescent Well-Care Visits	80/80=100% High Confidence in Reported Results	HEDIS – WCV – Child and Adolescent Well-Care Visits – Administrative Data The percentage of enrolled members 3–21 years of age who had at least one comprehensive well-care visit with a PCP	44.11% (2021)	55.08%	44.40%↑ (2022)	49.32%↑ (2023)	N/A

PIP Topic	Validation Score	Performance Measure	Performance Measure Results				
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)
		or an OB/GYN practitioner during the measurement year.					
Immunizations for Adolescents	73/74=99% High Confidence in Reported Results	HEDIS – IMA – Immunizations for Adolescents – Hybrid Data The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	28.95% (2021)	40.88%	32.36%↑ (2022)	28.12%↓ (2023)	N/A

Statistically significant improvement in performance Statistically significant decline in performance

R1 – Remeasurement 1, R2 – Remeasurement 2, R3 – Remeasurement 3, N/A = not applicable as no remeasurement has been conducted

Table 32: PIP Interventions - Molina

Interventions
Improving Encounters Acceptance Rates
• Refining the internal logic that determines which taxonomy to select and compare it against the crosswalks. to help determine if an encounter will get accepted on the initial submission. • Adjustments to the encounter logic to match SCDHHS' current listing of provider types where the encounter does not require a rendering provider NPI and only the billing NPI is needed. • Add more provider NPI's to the NON-PAR exception file. • Outreach to providers noted to have an incorrect provider registration. • A review of provider contracts to determine if providers are being paid for services that will not be accepted on encounters and updated if needed. • Open dialogue with the SCDHHS Encounter team to proactively identify issues before they become large scale.
Child and Adolescent Well-Care Visits
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP.

Interventions
• Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Member Incentive Mailing – Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.
Immunizations for Adolescents
• Member education regarding the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Assistance with member transportation. • Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • A HEDIS Missing Services Report/Gaps in Care Report was placed on the Provider Portal for easy access. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members. • Collaboration with the MUSC Adolescent Immunization Van. • Implementation of a Provider Enhanced Fee for immunizations. • Text Message Reminder Campaign for members.

Select Health submitted PIPs that focus on diabetes outcome measures and foster care well-care visit access. The plan saw improvements in diabetes control and well-child visits in certain age groups but experienced performance fluctuations in other areas. Interventions emphasized data-sharing initiatives, provider engagement, clinical rounds, gap reports, and member incentive programs.

Table 33: Select Health PIP Performance Findings

PIP Topic	Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
Diabetes Outcomes Measures	100/100=100% High Confidence in Reported Results	Hemoglobin A1c Control for Patients With Diabetes (HBD) The percentage of members 18–75 years of age with diabetes (Types 1 and 2)	35.71% (2019)	44.96%	36.98%↑ (2020)	42.82%↑ (2021)	42.09%↓ (2022)	50.12% ↑ (2023)

PIP Topic	Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
		whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • HbA1c poor control (>9.0%).						
		Comprehensive Diabetes Care (CDC) Blood Pressure Control <140/90	57.68% (2019)	66.17%	53.04%↓ (2020)	63.02%↑ (2021)	61.31%↓ (2022)	61.56%↑ (2023)
Well Care Visits for the Foster Care Population	74/75 = 99% High Confidence in Reported Results	Adolescent Well-Care Visits (AWC) The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	69.30% (2019)	70.98%	71.11%↑ (2020)	69.59%↓ (2021)	66.75%↓ (2022)	N/A
		Well-Child Visits in the First 15 Months of Life (W15) The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits. • One well-child visit. • Two well-child visits. • Three well-child visits. • Four well-child visits. • Five well-child visits. • Six or more well-child visits	57.79% (2019)	59.32%	54.78%↓ (2020)	58.16%↑ (2021)	54.93%↓ (2022)	53.96%↓ (2023)
		Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	76.24% (2019)	85.05%	81.45%↑ (2020)	83.38%↑ (2021)	83.68%↑ (2022)	N/A

PIP Topic	Validation Score	Performance Measure	Performance Measure Results					
			Baseline (MY)	Goal	R1 (MY)	R2 (MY)	R3 (MY)	R4 (MY)
		Well-Child Visits in the First 30 Months of Life (W30) The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	54.78% (2020)	59.32%	58.16%↑ (2021)	54.93%↓ (2022)	53.96%↓ (2023)	N/A
		2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	85.53% (2020)	91.12%	89.33%↑ (2021)	87.01%↓ (2022)	84.0%↑ (2023)	N/A
		Child and Adolescent Well-Care Visits (WCV) The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year: 3–11-year-olds	76.26% (2020)	78.97%	77.42%↑ (2021)	76.30%↓ (2022)	76.82%↑ (2023)	N/A
		12–17-year-olds	75.71% (2020)	77.54%	76.02%↑ (2021)	72.22%↓ (2022)	71.16%↓ (2023)	N/A
		18–21-year-olds	46.41% (2020)	39.23%	38.46% ↓ (2021)	43.54%↑ (2022)	43.25%↓ (2023)	N/A
		Total	73.87% (2020)	74.98%	73.51%↓ (2021)	71.47%↓ (2022)	71.31%↓ (2023)	N/A

Statistically significant improvement in performance Statistically significant decline in performance

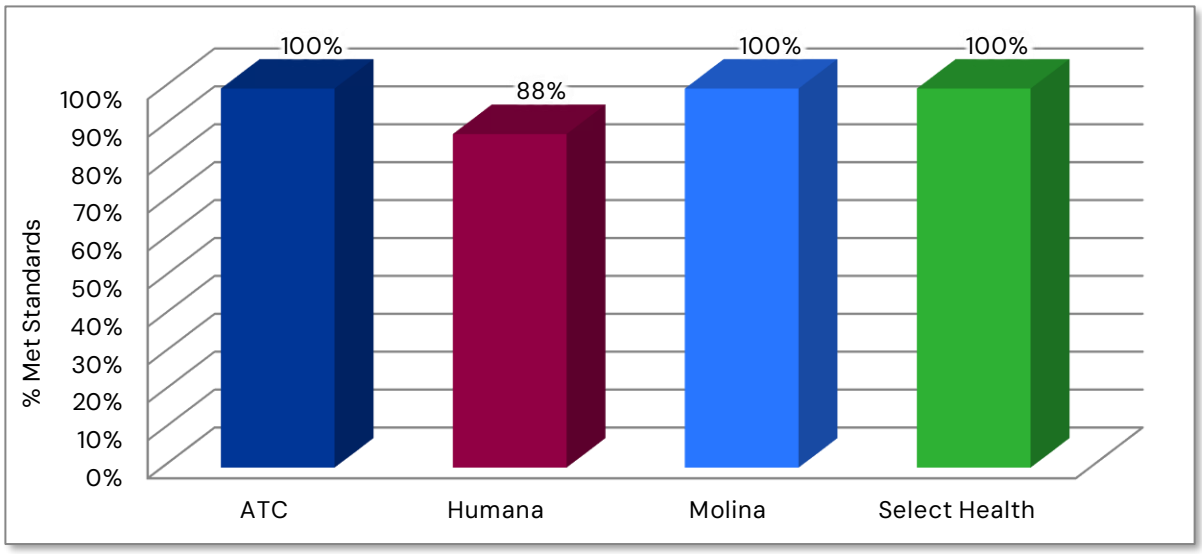
R1 – Remeasurement 1, R2 – Remeasurement 2, R3 – Remeasurement 3, N/A = not applicable as no remeasurement has been conducted

Table 34: PIP Interventions – Select Health

Interventions
Diabetes Outcomes Measures
• Data sharing by direct electronic medical record access • Year-round medical record review • Value based payment programs • Member incentives • Provider education • Newsletters
Well Care Visits for the Foster Care Population
• Data sharing • Care management calls to new members • Monthly gaps in care reports • Clinical rounds • Weekly appointment reports • Provider education • A texting campaign • The Take Flight Program • Member incentives

All the requirements were met for the MCOs except for Humana. Humana met 88% of the standards in the Quality Improvement section as noted in *Figure 10: Quality Improvement Findings*.

Figure 10: Quality Improvement Findings



Scores were rounded to the nearest whole number.

Table 35: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The QI Programs addressed a wide range of areas including clinical care, preventive health, emergency care, chronic care, behavioral health, customer service, network operations, and social determinants of health. It integrates quality improvement activities across all departments and care settings, ensuring a holistic approach to member health and service quality.	✓		
Health plans submitted detailed QI Program Descriptions that integrate quality assurance, management, and improvement into daily operations with defined performance metrics and accountability.	✓		
Providers receive information about their performance through various methods, including population health management reporting, comparative data reports, provider newsletters, and direct feedback via provider report cards.	✓		
Health plans evaluate the effectiveness of the QI Programs annually, outlining accomplishments, analyzing data and outcomes compared to goals, and providing conclusions and recommendations for the upcoming year.	✓		
Most plans, particularly ATC and Select Health, demonstrated strong or improved rates across multiple immunization series (DTaP, MMR, VZV, Hepatitis A, etc.). Humana and Molina also reported gains in select components.	✓		
Breast, cervical, and colorectal cancer screening rates increased for multiple plans, particularly ATC and Select Health.	✓		

Strengths	Quality	Timeliness	Access to Care
Most plans showed positive performance in prescribing statins for diabetes and cardiovascular disease populations, with some improvement in adherence levels.	✓		
ATC, Select Health, and Humana performed well in adult access measures and well-child visit rates, with a generally positive trend in utilization of primary care.	✓		
All health plans consistently emphasize member outreach and education. Strategies include reminder systems, targeted outreach calls and texts, educational newsletters, and member incentives. These efforts are designed to increase preventive service utilization and encourage timely health care visits across various populations.	✓		
Provider engagement and education is a shared priority across all plans. Health plans support providers through newsletters, training sessions, provider town halls, and tip sheets. These resources help align provider practices with quality standards and improve compliance with key performance metrics.	✓		
Each plan demonstrates a commitment to data-driven performance monitoring. This includes the use of internal dashboards, HEDIS alert systems, gap analysis reports, and performance tracking tools. These systems enable real-time identification of care gaps and allow for targeted intervention strategies.	✓		
A multidisciplinary, team-based approach is used by all plans to improve care coordination. Care Management, Utilization Management, Quality Improvement, Pharmacy, and Medical Affairs staff are involved in collaborative efforts to enhance patient outcomes and streamline service delivery.	✓		

Table 36: Quality Improvement Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Humana's QI work plan was not updated timely and did not note when the timeframe for completing and reporting the continuity and coordination of care activity was not met. This was an issue identified during the 2024 EQR and not corrected.	*Develop a process to ensure the QI work plan is updated timely. Include the party responsible for making the change(s).*	✓		
Humana's Quality Assurance Committee meeting minutes did not include information about when a proxy representative is used for absent voting members. This was an issue identified during the 2024 EQR and not corrected.	*Update the Quality Assurance Committee meeting minutes template to ensure a proxy representative and the voting member the proxy represents is clearly noted in the meeting minutes.*	✓		
Follow-up rates after hospitalization or ED visits for mental illness or substance use disorder remain low or declined across several plans.	*Strengthen care coordination and case management processes at discharge; consider incentives for follow-up visits within 7 and 30 days.*	✓		
Although the initiation of AOD treatment rates showed some gains, engagement remains low across all plans, especially for Molina and ATC.	*Expand access to behavioral health integration in primary care; pilot peer support models and contingency management programs.*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Most of the health plans showed increases or stagnant rates in opioid-related overuse and inappropriate antibiotic prescribing, especially Humana.	*Implement clinical decision support tools and provider education programs focused on guideline-concordant prescribing and diagnostics.*	✓		
Inconsistent performance improvement over time in key measures such as adolescent well-care visits, postpartum care, and diabetes management. Some plans show early gains that later decline or plateaued.	*Strengthen sustainability strategies through continuous quality improvement cycles, enhance performance accountability structures, and integrate follow-up audits to maintain gains.*	✓		
Lower-than-target rates in adolescent immunizations (HPV, Tdap, Meningococcal) persist across multiple plans, despite outreach efforts and incentives.	*Enhance adolescent engagement strategies by incorporating school-based health programs, mobile immunization units, and provider-level incentives specifically tied to adolescent vaccination completion.*	✓		✓
Limited documentation of measurable equity-focused interventions beyond basic disparity analysis, particularly in rural or underserved populations.	*Expand health equity initiatives with specific, measurable interventions—such as community partnerships, targeted social determinant support services, and equity dashboards to monitor disparities more effectively.*	✓		✓

Table 37: Quality Improvement Comparative Data

Standard	ATC	Humana	Molina	Select Health
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*				
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	Met	Met	Met	Met
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met
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	Met	Met
Quality Improvement Committee				
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met
The composition of the QI Committee reflects the membership required by the contract	Met	Met ↑	Met	Met

Standard	ATC	Humana	Molina	Select Health
The QI Committee meets at regular quarterly intervals	Met	Met	Met	Met
Minutes are maintained that document proceedings of the QI Committee	Met	Partially Met	Met	Met
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*				
Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met	Met	Met
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*				
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Met	Met	Met	Met
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Met	Met	Met
Provider Participation in Quality Improvement Activities				
The MCO requires its providers to actively participate in QI activities	Met	Met	Met	Met
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met
The MCO tracks provider compliance with: Administering required immunizations	Met	Met	Met	Met
Performing EPSDTs/Well Child Visits	Met	Met	Met	Met
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*				
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met ↑	Met	Met
The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors	Met	Met	Met	Met

Utilization Management

42 CFR § 438.210(a–e), 42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260, 42 CFR § 208, 42 CFR § 457.1230 (c),

Constellation evaluated each health plan's Utilization Management (UM) program by reviewing policies, the UM Program Description, Provider Manual, Member Handbook, and a sample of approval, denial, appeal, and case management files.

The health plans have detailed program descriptions, policies, and guidelines that clearly outline the implementation of utilization management (UM) services across physical health, behavioral health, and pharmaceutical services for members. These documents effectively define the purpose, scope, goals, and objectives of the UM Programs as well as related staff responsibilities. Each plan has a Chief Medical Officer that provides clinical oversight of the UM Program. Additional Medical Directors, Behavioral Health Medical Directors, Pharmacy Directors, and other

licensed clinicians support the UM Managers. These leaders ensure effective day-to-day program operations, including staff supervision, training, consistent application of UM criteria, and adequate documentation.

Coverage and Authorization of Services

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

The UM Program Descriptions, along with the associated policies, outline specific guidelines that focus on timely determination of UM decisions. Each health plan under the program adheres to its own set of policies, which cover key aspects such as clinical criteria, timeliness, and communication standards. These policies are managed and overseen by licensed healthcare professionals, ensuring that all decisions meet appropriate clinical and regulatory standards.

To maintain a high level of consistency and quality in decision-making, annual inter-rater reliability reviews are conducted. These reviews assess the performance of reviewers to ensure that their decisions align with the established benchmarks. If a reviewer's performance falls below the target consistency rate of 90%, corrective actions are implemented, including additional training or other measures to improve accuracy and adherence to established policies. This continuous monitoring and improvement process is designed to ensure that UM determinations are made in a timely, reliable, and clinically appropriate manner, ultimately supporting the best outcomes for patients.

Standard authorizations are typically processed within 14 calendar days, while urgent requests are given priority and processed within a more expedited timeframe of three days. The UM program employs a two-tiered approach to medical necessity reviews to ensure that decisions are made appropriately and in a timely manner. Level I reviews are designed to assess requests without resulting in denials or reductions in coverage. Level II reviews are more in-depth and may result in adverse determinations, which could lead to the denial or reduction of coverage. Adverse determinations are made by a Medical Director or an appointed designee, ensuring that all decisions are based on sound clinical judgment.

When a denial decision is made, members are promptly notified and informed of their right to appeal the decision or request a State Fair Hearing, depending on the specific circumstances. Additionally, peer-to-peer reviews are available upon request, offering an opportunity for healthcare providers to engage in discussions with medical professionals from the health plan to resolve concerns regarding the medical necessity of a request.

While most of the health plans offer a Preferred Provider Program, ATC was unable to provide comprehensive details regarding the structure and operation of their specific program. Key aspects, such as how providers are notified about the program, how preferred provider status is granted, and how this status is tracked and monitored within the plan, were not available. This lack of information prevents a clear understanding of how ATC's Preferred Provider Program is implemented, communicated to providers, and managed over time.

Appeals

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

Processes for handling member appeals are described in policies, Member Handbooks, Provider Manuals, UM Program Descriptions, and are found on health plan websites. Appeal terminology is defined, along with steps for filing an appeal by the member, a legal guardian, authorized representative, or service provider. Timeframes associated with standard and expedited appeals are clearly documented for appeal acknowledgment, resolution, and extension, if needed, for each health plan.

Constellation found the following issues with the appeal process.

- Humana's appeal policy does not indicate that members may file a grievance when they disagree with a 14-day extension request. This was an issue identified in the previous (2024) EQR and not corrected.
- Molina's policy/procedure and appeal request form incorrectly stated a verbal appeal must be followed by a written request. This was identified during the 2023 EQR and was not corrected.
- *SCDHHS Contract, Section 9.1.6.3.1.1* requires the appeal resolution notification be sent to the member via certified mail with return receipt requested. Select Health removed this requirement from the appeal policy. The sample appeal files reviewed did not include evidence that the notices had been sent to the member via certified mail.

Appeals are logged, categorized, and analyzed for trends and any potential quality improvement opportunities. The random sample of appeal files reviewed demonstrated the appeal process was completed timely and determinations were made by appropriate credentialed reviewers.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

Each of the health plans offers care coordination, transitional care, disease management programs, and specialized care management services for its members. Select Health also provides specialized foster care management.

Members are referred to care management services through various referral resources. Once referred, outreach is initiated to conduct the initial assessment and to stratify the member's risk level. The health plans provide integrated care management for their members wherein members are assigned a dedicated point of contact based on their identified medical or behavioral needs. The primary Care Manager is supported by a multidisciplinary Care Team that provides support for the members.

Performance and satisfaction with care management services are measured through various metrics such as member satisfaction survey data and health outcome data. Constellation's review

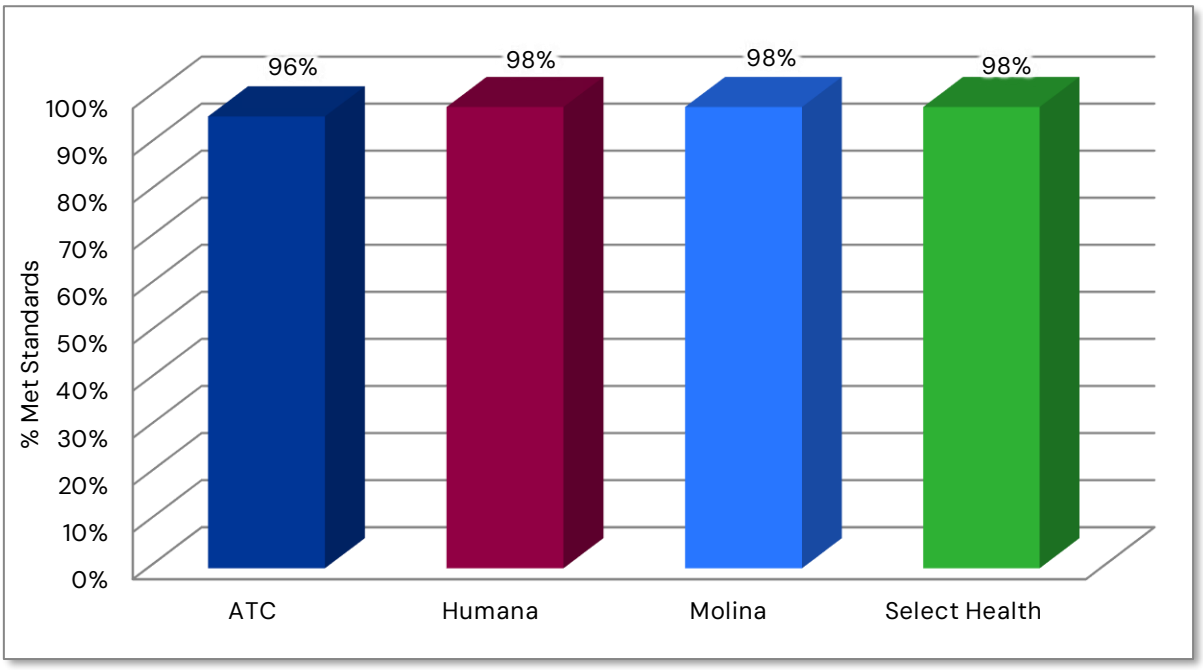
of the sample care management files found that care management activities were conducted as required, including completing assessments, treatment planning, and linkage to appropriate community resources. ATC did not follow its policy in three files regarding contact guidelines.

Over- and Underutilization

All four MCOs successfully met the standards for detecting, monitoring, and analyzing over- and underutilization of medical services, as required by contract and regulatory guidance. Each plan demonstrated that mechanisms are in place to track utilization trends, supported by regular data analysis and reporting. ATC uses detailed quarterly tracking with expected thresholds and action plans for each metric, further strengthened by a newly implemented reporting template. Humana follows a structured policy with quarterly reporting including both quantitative data and qualitative analysis to guide corrective actions. Molina reviews covered key service areas such as ER and pharmacy utilization and hospital admissions, with findings presented regularly to oversight committees. Select Health's integrated approach involved collaboration between Quality and Utilization Management teams, using KPIs and data-driven interventions to identify risks and promote evidence-based care. Overall, all MCOs demonstrated strong performance in this area, with robust tracking and monitoring systems to support appropriate utilization management.

For Humana, Molina, and Select Health, 98% of the standards in the Utilization Management section were scored as "Met." ATC received "Met" scores for 96% of the standards. Refer to *Figure 11*.

Figure 11: Utilization Management Findings



Scores were rounded to the nearest whole number.

Table 38: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
The UM Program Descriptions are comprehensive and appropriately describe the goals, scope, and structure of each UM Program.	✓		✓
The sample approval and denial files indicated reviews were completed in a timely manner according to contractual standards for all health plans. Criteria and procedures for the evaluation of medical necessity of services for members were applied consistently.	✓		✓
Of the random appeal files reviewed for each EQR, all were addressed timely and were reviewed by appropriately credentialed staff.		✓	✓
Appeal acknowledgement and resolution letters for each MCO were clear with appropriate information needed specific to determination or next steps as applicable.	✓		✓
Some of the health plans offer specialized programs such as Sickle Cell and Adult and Preventative Rehabilitative Services for Primary Care Enhancement to aid in addressing specialized needs for members.	✓	✓	✓
All MCOs have formal policies and structured processes in place to detect and monitor over- and underutilization.	✓		
Quarterly reporting mechanisms include data analysis, threshold monitoring, and clearly documented action plans.	✓		
Oversight and accountability are evident through regular committee reviews, integrated departmental collaboration, and use of KPIs to guide interventions.	✓		

Table 39: Utilization Management Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
ATC was unable to provide details regarding the structure of their Preferred Provider Program, how providers are informed about it, or how preferred provider status is identified and tracked within the plan. This issue was identified during the previous EQR for ATC and was not corrected.	*Develop and implement a Preferred Provider Program in accordance with SCDHHS Contract, Section 8.5.2.8 and include the specifics for the program in respective policies.*	✓		
Humana's appeal policy does not indicate that members may file a grievance when they disagree with a 14-day extension request. This was an issue identified in the previous (2024) EQR and not corrected.	*Update policies to indicate that a grievance can be filed if the filer disagrees with a request for an extension.*		✓	✓
Molina's policy/procedure and appeal request form incorrectly stated a verbal appeal must be followed by a written request. This was identified during the 2023 EQR and was not corrected.	*Update all documents related to the process for filing an appeal and remove the requirement that a standard request for an appeal received verbally must be followed by a written request.*			✓
SCDHHS Contract, Section 9.1.6.3.1.1 requires the appeal resolution notification	*Revise the process for sending the appeal resolution notifications to the member via*	✓		✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
be sent to the member via certified mail with return receipt requested. Select Health revised and removed this requirement in the appeal policy. The sample appeal files reviewed did not include evidence that the notices had been sent to the member via certified mail.	*certified mail with return receipt requested as required by the SCDHHS Contract, Section 9.1.6.3.1.1 9. Comply with contractual requirements to ensure appeal resolution notices are sent via certified mail.*			
ATC's case management files demonstrated staff were not following ATC's policy when a case manager was unable to reach a member.	*Reeducate staff on the unable to reach process and ensure adherence to the established policy standards.*	✓		✓

Table 40: Utilization Management Comparative Data

Standard	ATC	Humana	Molina	Select Health
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:	Met	Met	Met	Met
Structure of the program and methodology used to evaluate the medical necessity	Met	Met	Met	Met
Lines of responsibility and accountability	Met	Met	Met	Met
Guidelines / standards to be used in making utilization management decisions	Met	Met	Met	Met
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met ↑	Met	Met	Met
Consideration of new technology	Met	Met	Met	Met
The absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met
The mechanism to provide for a preferred provider program.	Not Met ↓	Met	Met	Met ↑
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met
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	Met	Met	Met	Met
Medical Necessity Determinations *42 CFR § 438.210 (a–e), 42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.1228*				

Standard	ATC	Humana	Molina	Select Health
Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met	Met↑	Met
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Met	Met	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met
Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Met	Met	Met↑
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Met	Met	Met
Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met
Utilization management standards/criteria are available to providers	Met	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met
Denials 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	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met ↑	Met ↑	Met	Met
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260*				
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:	Met	Not Met ↓	Met	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met	Met
The procedure for filing an appeal	Met	Met	Not Met ↓	Met
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	Met	Met	Met	Met

Standard	ATC	Humana	Molina	Select Health
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Met	Met	Met
Written notice of the appeal resolution as required by the contract	Met	Met	Met	Met
Other requirements as specified in the contract	Met	Met	Met	Met
The MCO applies the appeal policies and procedures as formulated	Met	Met	Met	Not Met ↓
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met
Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*				
The MCO formulates policies and procedures that describe its care management/care coordination programs	Met	Met	Met	Met
The MCO has processes to identify members who may benefit from care management	Met	Met	Met	Met
The MCO provides care management activities based on the member's risk stratification	Met	Met	Met	Met
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met
The MCO conducts required care management activities for members receiving behavioral health services	Met	Met	Met	Met
Care Transitions activities include all contractually required components The MCO has developed and implemented policies and procedures that address transition of care	Met	Met	Met	Met
The MCO has a designated Transition Coordinator who meets contract requirements	Met	Met	Met	Met
The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary	Met	Met	Met	Met
Care management and coordination activities are conducted as required	Partially Met ↓	Met	Met ↑	Met
Evaluation of Over/ Underutilization				
The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract	Met	Met	Met	Met
The MCO monitors and analyzes utilization data for over- and under-utilization	Met	Met	Met	Met

Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates.

For this review, ATC provided a list of delegates with the desk materials. ATC reported delegation agreements with 23 subcontractors. As noted in *Table 41: Delegated Entities and Services – ATC*, the delegated services include pharmacy services, utilization management, care management, vision services, and credentialing.

Table 41: Delegated Entities and Services – ATC

Delegated Entities	Delegated Services
Centene Pharmacy Services	Pharmacy – Claims, Credentialing, Network Management
Centene Vision	Claims/Payments, Provider Payment Appeals, Credentialing – Practitioners Utilization Management
Evolent – National Imaging Associates (NIA)	Customer Service Utilization Management, Utilization Management – Member Appeals
Evolent – New Century Health (NCH)	Utilization Management
Express Scripts, Inc. (ESI)	Care Management – Medication Therapy Management, Pharmacy Services – Claims, Credentialing, Network Management
Focus Behavioral Health	Utilization Management – Peer Review Services Behavioral Health
Medical Review Institute of America, Inc	Utilization Management, Utilization Management – Member Appeals
• AnMed Health • AU Medical Center • Bon Secours Ambulatory Services • CVS Health Minute Clinic • Health Network Solutions • LCH Group Inc. and Subsidiaries • Lexington County Health Services District • Medical University of South Carolina • Novant Choice Health • Preferred Care of Aiken • Prisma Palmetto USC • Regional Health Plus Spartanburg • Roper St. Francis Physicians Network • Self Regional Health Care • St. Frances Physician Services • United Physician	Credentialing and Recredentialing

ATC evaluates the delegate's capacity before entering into a delegation agreement and conducts an annual evaluation of the delegate's programs and performance, with a summary presented to the appropriate committee. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

Last year (2023), ATC was not reporting the oversight to the Credentialing Committee. ATC provided a Quality Improvement Plan for this issue. During the current EQR, Constellation found the Quality Improvement Plan had been implemented, and the delegation oversight reports were presented to the Credentialing Committee.

Humana reported delegation agreements with 20 entities, as shown in *Table 42: Delegated Entities and Services – Humana*.

Table 42: Delegated Entities and Services – Humana

Delegated Entities	Delegated Services
Block Vision, dba Superior Vision Benefit Management	Vision Network Management, Claims Processing, Credentialing
Censeo Health, dba Signify Health	Credentialing, Health Risk Assessments
Focus Health, dba Focus Behavioral Health	Behavioral Health Utilization Management, Appeals
Modivcare Solutions	Non-emergent transportation services, Claims Processing
Network Medical Review Company	Utilization Management, Appeals
• ANMED Health • ChoiceHealth Inc. • Hanger Prosthetics & Orthotics • HCN Physicians and the subsidiaries of Tenet Healthcare • Lexington Health, Inc. dba Lexington Medical Center • Lifestance Health • Medical University Hospital Authority/MUSC Medical Center • Prisma Health • Regional Health Plus • Roper St. Francis • Self Regional Healthcare • South Carolina Department of Mental Health • St. Francis Physician Services • United Physicians • UWH of the Carolinas, PLLC	• Credentialing

Humana's policy for delegating functions emphasizes Humana's responsibility for the performance and compliance of delegated functions and includes detailed requirements for audits, corrective actions, and legal agreements to ensure compliance with federal, state, and accreditation standards. Humana's Delegation Compliance department performs a pre-delegation audit prior to any function being delegated to a prospective entity. The pre-delegation audit includes an evaluation of a prospective delegate's compliance and performance capacity against state, federal, accreditation, and Humana's standards. Results of the pre-delegation audit are reported to the appropriate committee. A delegation service agreement is executed upon approval of delegation. This agreement describes the activities and responsibilities of Humana and the delegated entity. A delegate's failure to perform or comply with the terms of the delegation agreement and or unacceptable performance may result in termination of the delegation. An annual delegation audit is conducted to evaluate all delegates' continued ability to meet the delegation compliance and performance capacity. If a delegate's audit score falls below the target goal, a corrective action plan is implemented to address the deficiencies and ensure compliance. For this EQR Humana submitted copies of the pre-delegation and annual audit results. Corrective action plans were implemented as needed.

Molina reported 19 delegation agreements, as shown in *Table 43: Delegated Entities and Services – Molina*.

Table 43: Delegated Entities and Services – Molina

Delegated Entities	Delegated Services
• AccordantCare • HealthMAP • Progeny	Case Management
Infomedia Group, Inc., d/b/a Carenet Healthcare Services	Member Call Center
Progeny	Utilization Management
March Vision	• Claims, Member Call Center, Credentialing
• AnMed Health • Aperture • Atrium Health (formerly known as Managed Health Resources) • Augusta University formerly Georgia Regents • Bon Secours St. Francis • Inovalon • Lexington Health • Medical University of South Carolina (MUSC) • Prisma Health-Upstate (formerly Greenville Health Systems)	Credentialing

Delegated Entities	Delegated Services
• Prisma Midlands (formerly Palmetto Health USC Medical Group) • Regional Health Plus (RHP) • Roper St. Francis • Tenet Physicians	

Molina has established processes for delegation of health plan activities to subcontractors, as documented in policies. These policies address pre-delegation activities for potential delegates, implementation of written agreements with approved delegates, annual evaluations, and ongoing monitoring for all delegates.

Molina provided documentation of the oversight activities conducted for all delegates which reflected timely annual oversight of all delegates. An issue was identified related to incorrect scoring for the March 2023 annual audit for Infomedia Group, Inc., d/b/a Carenet Healthcare Services. Also, it was found that due to inability to access the Carenet Healthcare Services call repository, Molina was unable to conduct an audit of recorded calls for the 2023 annual audit. Molina reported that the issue with accessing the recorded calls has been corrected and the 2024 annual audit will include a review of recorded calls for both the Nurse Advice Line and the Behavioral Health Crisis Line.

Select Health reported 15 delegation agreements, as shown in *Table 44: Delegated Entities and Services – Select Health*.

Table 44: Delegated Entities and Services – Select Health

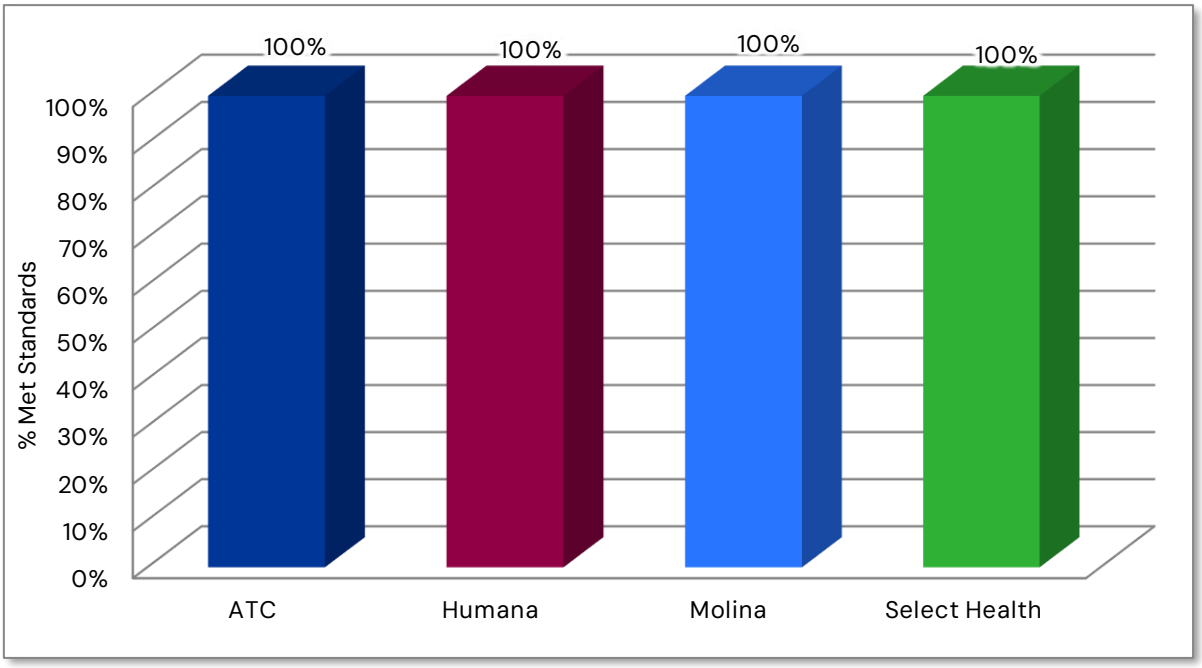
Delegated Entities	Delegated Services
National Imaging Associates (NIA)	Radiology Utilization Management
BHM Health Solutions	Behavioral Health Decision Reviews on Assigned Cases
PerformRx	Pharmacy
Infomedia Group dba Carenet Health Solutions	24/7 Nurse Triage Line
• AnMed Health • AU Medical Center • Health Network Solutions (HNS) • Lexington Health, Inc. • Medical University of South Carolina (MUSC) • Prisma Health • PSG Delegated Services • Regional Health Plus (RHP)	Credentialing/Recredentialing

Delegated Entities	Delegated Services
• Roper St. Francis (RSF) • Self Regional Healthcare • St. Francis Physician Services (SFPS)	

Select Health's policy outlines the process for oversight of delegates. Select Health requires any new delegate to pass a pre-delegation audit prior to performing any activities. An annual audit is conducted for each delegate that includes a comprehensive review of the delegate's processes and a file review, where applicable, to ensure compliance with Select Health's established thresholds and criteria. If a delegate does not pass the pre-delegation assessment or the annual assessment, Select Health may terminate part or all of the delegation agreement. The delegation agreement and policy do not allow any delegate to sub-delegate any activities without written approval. Select Health provided documentation of the annual oversight audits conducted for all non-credentialing and credentialing delegates. Results of the credentialing delegate audits are presented to the Credentialing Committee, and the non-credentialing monitoring results are presented to the Quality of Service Committee. There were no issues identified with the monitoring.

As noted in *Figure 12: Delegation Findings*, the MCOs achieved "Met" scores for 100% of the Delegation standards.

Figure 12: Delegation Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, and recommendations are detailed in *Table 45: Delegation Strengths*.

Table 45: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
The Delegation Oversight Program for each MCO includes pre-delegation assessments, ongoing monitoring, and comprehensive annual audits.	✓		
The MCOs require all third-party entities to enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights.	✓		
Policies and procedures have been developed to guide the delegation of health plan activities to external entities.	✓		
Clear thresholds have been set and corrective action plans implemented as needed to ensure delegates meet the MCOs' standards and regulatory requirements.	✓		
Delegates are required to undergo ongoing monitoring and periodic reporting to help maintain continuous compliance and performance standards.	✓		

Table 46: Delegation Comparative Data

Standard	ATC	Humana	Molina	Select Health
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*				
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	Met	Met	Met	Met
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	Met↑	Met↑	Met	Met

Mental Health Parity

The *Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008* requires health plans to cover behavioral health/substance use disorder and medical/surgical benefits equally. Constellation is required to conduct a Mental Health Parity assessment to determine if the MCOs met the Mental Health Parity requirements outlined in the *Federal Parity Act*. This assessment is conducted as a two-step process. Step one involves assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs), such as medical management standards, provider network

admission standards and reimbursement rates, policies, and other limitations on the scope or duration of benefits. The Mental Health Parity assessment was conducted for ATC, Humana, Molina, Select Health, and Health Blue. Healthy Blue is in the first year of operation and does not yet have a full data set for reporting purposes.

The MCOs provided Program Descriptions, various utilization and network access reports, Member and Provider Handbooks, benefit maps, satisfaction survey results, NQTL lists and comparison charts, and QTL lists and assessment tools. Each document provided a comparison of services for medical/surgical and mental health/substance use disorder (MH/SUD) and the information was used to determine overall compliance with the *Federal Parity Act*. The following is a summary of this assessment.

Mental Health Parity Non-Quantitative Treatment Limitations (NQTL) Assessment

Constellation reviewed supporting documentation to assess both elements of NQTL Parity: comparability and stringency. Compliance with these two factors depends on a parity of process, policy, and practice.

Leadership/Corporate Structure – Parity is reflected in the corporate structure by the inclusion of Behavioral Health licensed clinicians in positions of leadership. Each of the plans was able to demonstrate this within their organizations.

Review Criteria – All health plans were noted to use evidence-based criteria to determine medical necessity. Humana, Healthy Blue, and Molina use Milliman Care Guidelines (MCG) as their medical and behavioral health criteria for authorizations. Molina also has internal criteria for services not covered in MCG. Select Health and ATC use InterQual. All plans use the industry standard assessment American Society of Addiction Medicine (ASAM) for substance use disorder services.

Clinical Auditing – Behavioral Health specific questions are used for inter-rater reliability (IRR) testing with clinicians completing behavioral health authorizations. Scores were found to be comparable for MH/SUD clinicians and medical/surgical clinicians for Humana, Molina, and Select Health. IRR scores indicating disparity and the need for additional training were noted for ATC. For Healthy Blue, Constellation observed training post IRR with subsequent re-testing and improved scores on behavioral health standards.

Quality—Constellation noted a higher percentage of quality-of-care concerns for Select Health's MH/SUD population. Select Health implemented interventions to address this, both internally and with provider documentation requirements. Humana reports minimal to no quality-of-care concerns for MH/SUD. ATC reported no MH/SUD quality of care concerns for the prior year. Quality of care incidents were not differentiated between medical and behavioral for Molina.

Utilization Management (UM) Review Process– Humana Utilization Management completes first level reviews and has delegated their mental health adverse determinations and appeals to FOCUS. Monthly Joint Operational Committee meetings are continuing due to ongoing communication and system compatibility complications between Humana and FOCUS. No potential disparity issues were noted for ATC, Select Health, and Healthy Blue in terms of UM.

Provider Network – Out of network (OON) requests and geographic access to provider goals were assessed for comparability. Molina met their goal of <10 claims/thousand for OON utilization for both medical/surgical and MH/SUD. Healthy Blue reported lower levels of OON requests for MH/SUD compared to medical/surgical, while Select Health and ATC report higher rates. It was suggested that plans separate MH from SUD to assist in identifying a root cause or a specific area to target intervention. Member satisfaction with the provider network and provider availability were also compared. Survey results for ATC and Humana indicate lower satisfaction in terms of getting treatment quickly. Healthy Blue did not provide results from a behavioral health specific satisfaction survey, such as the ECHO, for comparison purposes. Select Health reported positive movement in accessibility of services both for MH/SUD prescribers and non-prescribers. Provider time and distance goals were met for Molina. Humana had 100% geographic access for psychiatrists, nurse practitioners, and SUD treatment, but did not meet geographic access goals in three counties for inpatient psychiatric services, which for medical inpatient was 100% in all counties. Healthy Blue had a lower level of psychiatric hospital access compared to medical hospital access although this rate may be higher if the plan were to include psychiatric beds in acute care hospitals in addition to free-standing psychiatric hospitals. Select Health had 100% access to behavioral health prescribers and non-prescribers.

Appeals and Denials – By examining appeal overturn rates between medical/surgical appeals and MH/SUD appeals, Constellation can make an inference about stringency. If the appeal overturn rates are higher for MH/SUD than they are for medical/surgical benefits, it could mean that criteria are being applied more stringently. Healthy Blue has a significantly higher inpatient denial rate for MH/SUD, but a comparable rate for outpatient denials. Select Health and Humana have comparable denial rates overall. Molina and ATC report a significantly lower level of denials for MH/SUD. Healthy Blue and Humana reports no overturned BH/SUD appeals. Molina did not supply appeal overturn rates for comparison. Select Health reports a higher overturned appeal rate, especially for outpatient services. ATC has a higher rate of MH/SUD overturned appeals percentage wise, but that number does not indicate a significant parity issue due to the low number of denials.

Pharmacy – Constellation compares pharmacy appeals and denials when this data is available. However, because of the nature of this information, plans are not always able to distinguish between MH/SUD and medical/surgical in their pharmacy data reports. Humana reports no overturned BH pharmacy appeals but has a slightly higher BH pharmacy denial percentage. Select

Health reports a slightly lower pharmacy overturn rate for MH/SUD. Pharmacy data for ATC was not separated between MH/SUD and medical/surgical, and no information was available for Healthy Blue.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to each health plan to complete the mental health parity assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. for medical/surgical and mental health benefits. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. For all health plans, there were no financial requirements for mental health benefits that exceeded the financial requirement predominant value for medical/surgical benefits, thus, parity was met. Table 47: Mental Health Parity Quantitative Treatment Limitations Assessment Steps provides an overview of the QTL assessment results.

Table 47: Mental Health Parity Quantitative Treatment Limitations Assessment Steps

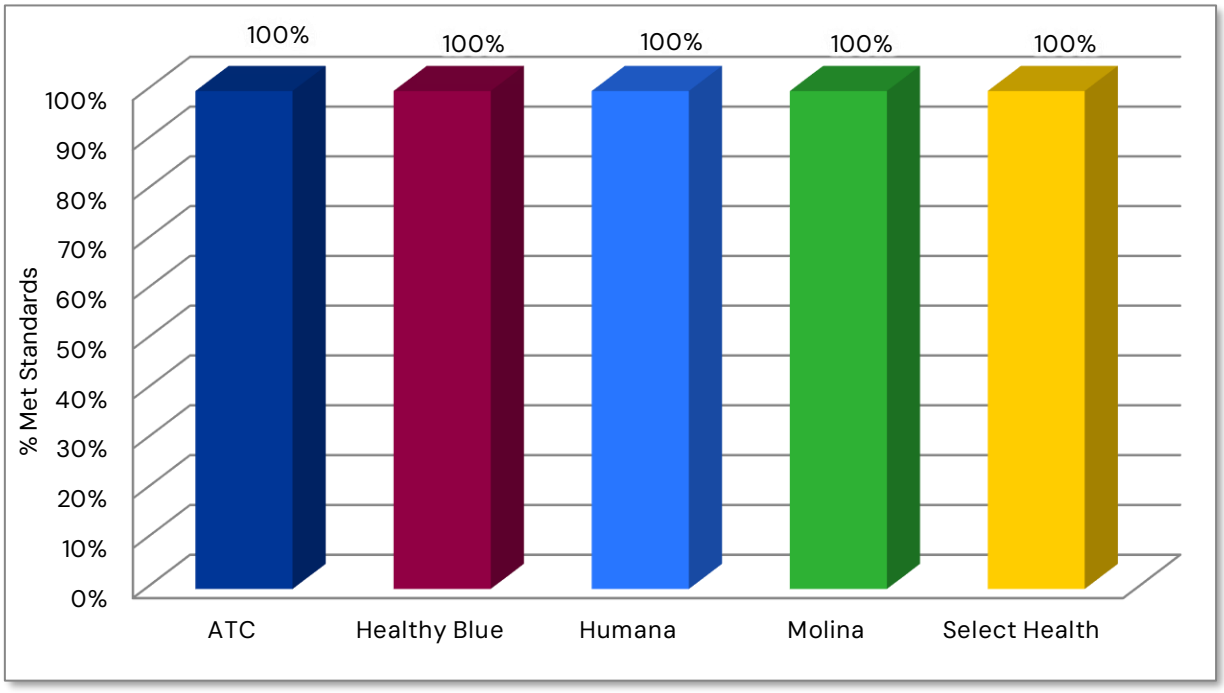
Plan Name	Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
ATC	Inpatient	N/A	N/A	Accepted
	Outpatient	N/A	N/A	Accepted
	Pharmacy	N/A	N/A	Accepted
	Emergency Services	N/A	N/A	Accepted
Healthy Blue	Inpatient	N/A	N/A	Accepted
	Outpatient	N/A	N/A	Accepted
	Pharmacy	N/A	N/A	Accepted
	Emergency Services	N/A	N/A	Accepted
Humana	Inpatient	N/A	N/A	Accepted
	Outpatient	N/A	N/A	Accepted
	Pharmacy	Y	Copay $3.40	Accepted
	Emergency Services	N/A	N/A	Accepted
Molina	Inpatient	N/A	N/A	Accepted
	Outpatient	N/A	N/A	Accepted
	Pharmacy	N/A	N/A	Accepted
	Emergency Services	N/A	N/A	Accepted
Select Health	Inpatient	Y	Copay $25.00	Accepted

Plan Name	Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
	Outpatient	Y	Copay $3.30	Accepted
	Pharmacy	Y	Copay $3.40	Accepted
	Emergency Services	N/A	N/A	N/A

Note. N/A – As directed by SCDHHS, effective 7/1/2024, there will be no copays for service classification based on a memo sent to the managed care plan on May 6, 2024.

Figure 13: Mental Health Parity Findings indicate all plans met the requirements for the Mental Health Parity assessment.

Figure 13: Mental Health Parity Findings



Scores were rounded to the nearest whole number.

Table 48: Mental Health Parity Strengths and *Table 49: Mental Health Parity Weaknesses and Recommendations* note the strengths, weaknesses, and recommendations for the Mental Health Parity assessments.

Table 48: Mental Health Parity Strengths

Strengths	Quality	Timeliness	Access to Care
All plans use industry standard criteria for determination of MH/SUD approvals and denials.	✓		✓
MH/SUD specific questions are used for inter-rater reliability testing of utilization management staff.	✓		
Polices and standards are generally equivalent among each plan	✓		
BH licensed staff are represented in positions of leadership within the corporate structure of each plan.	✓		
Four of the five plans have comparable denial rates between MH/SUD and MS authorization requests.			✓
The MH/SUD Provider Networks meet geo access standards with a few exceptions.			✓
Mental Health Parity assessment showed mental health services are aligned with medical surgical financial and treatment limitations.			✓
All health plans demonstrated compliance with mental health parity requirements, ensuring that financial requirements and treatment limitations for mental health and substance use disorder benefits are no more restrictive than those for medical/surgical benefits.	✓		✓

Table 49: Mental Health Parity Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
For ATC, a higher rate of out-of-network authorization requests for MH/SUD services was noted compared to medical/surgical services.	*Separate data for MH from SUD to help determine root cause.*			✓
For ATC, a lower level of satisfaction with getting routine and urgent care MH/SUD appointments was noted than the level of satisfaction for medical/surgical routine and urgent care appointments.	*Separating MH and SUD data could help pinpoint specifically which subset of this population is having the issue of accessing care.*			✓
Healthy Blue administers a CAHPS survey annually, but no corresponding survey for MH members.	*Conduct a survey of member satisfaction with mental health services (i.e., ECHO).*	✓		✓
For Healthy Blue, there was no appeals data present for denials, which are a significantly higher proportion of service requests than for medical/surgical requests.	*Continue to track MH and SUD separately in order to pinpoint opportunities more readily. Ensure any inquiries about clinical denials made to member services that are resolved on the call (if any) are categorized appropriately.*	✓		✓
There is limited geographic access to inpatient psychiatric care in three counties for Humana.	*Review system to ensure configuration does not deny out of network services for inpatient psychiatric care in counties where access is limited.*			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
For Humana, provider availability for MH/SUD services is lower than for medical/surgical primary care and specialty services.	*Continued monitoring of ECHO scores and out-of-network utilization to identify network opportunities.*			✓
Molina uses internally developed criteria. This poses a risk to parity, both in comparability and stringency.	*Continue to ensure there is parity in internally developed utilization management criteria.*			✓
For Select Health, out-of-network requests for MH/SUD services are more than triple those for medical/surgical services.	*Continue network expansion to all available providers until improved provider to member ratio and provider accessibility scores in deficit areas*			✓
Select Health's appeal overturn rates were higher for MH/SUD than medical/surgical services.	*Separate MH from SUD to help identify root cause.*			✓

Table 50: Mental Health Parity Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Mental Health Parity					
The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations	Met	Met	Met	Met	Met
The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	Met	Met	Met	Met	Met

SC Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. Constellation's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement (QI) and Care Coordination/Case Management Programs.

Standards were scored as meeting all requirements ("Met"), acceptable but needing improvement ("Partially Met"), or failing a standard ("Not Met"). An overview of the findings for each section follows. The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) indicates the score for that standard improved from the previous review, and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate there was no change in the score from the previous review.

Administration

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457.1233 (d)

Solutions has established processes for policy development, management, and ongoing review and demonstrates the importance of creating and maintaining written policies and procedures critical for compliance with contractual obligations and accreditation standards. Solutions reviews its policies annually and makes revisions as needed. Policies are housed in a location that allows staff access and leaders disseminate the policies to staff and oversee their implementation.

Solutions' Chief Medical Officer/Executive Director oversees day-to-day operations and is responsible for clinical oversight and decision-making. A Medical Advisor provides clinical consultation for the Care Coordinators and providers. Program staffing levels were appropriate, and vacant positions were filled. To ensure all nursing staff employed in Care Management clinical positions have valid and active professional credentials, Solutions conducts initial credentialing of clinical staff at employment and conducts routine recredentialing activities. These activities include licensure and/or certification validation, and all licensed personnel are required to report any adverse changes in licensure or certification designation within three business days. Review of a sample of employee files found that the required checks and validations were conducted. Documentation was also provided to demonstrate compliance with employee HIPAA, Fraud, Waste, and Abuse, and annual training.

Solutions' 2024 Compliance Program Description provided an overview of the Compliance Program, which encompasses employee education about compliance topics, mechanisms for reporting of potential problems, and processes for conducting internal inquiries and implementing corrective action when indicated. The Compliance Officer oversees and manages compliance issues, and develops, operates, and monitors the Compliance Program. Comprehensive compliance training is provided to employees at employment and annually. Solutions enforces a non-retaliation policy for those reporting compliance issues.

Information Management Systems Assessment

Information Systems Capabilities Assessment (ISCA) documentation details Solutions' policies and procedures to safeguard protected health information. Security and privacy administrative policies are in place to ensure data is protected both electronically and physically, and the policies are regularly reviewed and updated. A business continuity plan is in place to provide guidance for maintaining operations and/or restoring operations if a disruptive incident occurs. The ISCA documentation shows Solutions performed a successful tabletop Disaster Recovery exercise in October 2023 and reflected good communication with staff and the State before, during, and after a hurricane that affected SC.

All standards were "Met" for the Administration review for Solutions, as noted in *Table 51: Solutions Administration Findings*.

Table 51: Solutions Administration Findings

Standard	Score
General Approach to Policies and Procedures	
Policies and procedures are organized, reviewed, and available to staff	Met
Organizational Chart / Staffing	
The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities: Administrative oversight of day-to-day activities of the organization	Met
Pre-assessment	Met
Care coordination and enhanced case management	Met
Provider services and education	Met
Quality assurance	Met
Designated compliance officer	Met
The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, the following are included: Criminal background checks are conducted on all potential employees	Met
Verification of nursing licensure and license status	Met
Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs	Met
Ensuring Care Coordinators and Pre-Admission Screening staff meet all contract requirements	Met
Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a participant's Person-Centered Service Plan	Met
Employee personnel files demonstrate compliance with contract and policy requirements	Met
Governing Board/Advisory Board	
The Organization has established a governing body or Advisory Board	Met
The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined	Met
Contract Requirements	
The organization carries out all activities and responsibilities required by the contract, including but not limited to: Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday	Met
Adherence to contract requirements for holidays and closed days	Met
Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS	Met

Standard	Score
Organization and participant record retention and availability as required by the contract	Met
Participant materials written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages	Met
Processes are in place to ensure care coordination services are available statewide	Met
Confidentiality	
The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy	Met
Data Systems/Security	
Policies, procedures and/or processes are in place for addressing data, system, and information security and access management	Met
The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented	Met
Compliance and Program Integrity	
The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following: Written policies, procedures, and standards of conduct comply with federal and state standards and regulations	Met
A compliance committee that is accountable to senior management	Met
Employee education and training that includes education on the False Claims Act, if applicable	Met
Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers	Met
Enforcement of standards through well-publicized disciplinary guidelines	Met
Provisions for internal monitoring and auditing	Met
Provisions for prompt response to detected offenses and development of corrective action initiatives	Met
A system for training and education for the Compliance Officer, senior management, and employees	Met
Processes for immediate reporting of any suspicion or knowledge of fraud and abuse	Met
The organization reports immediately any suspicion or knowledge of fraud or abuse	Met

Provider Services

The Provider Services review focused on provider education processes. Solutions addressed provider orientation and ongoing education processes for all network providers, as well as disseminating provider updates as needed, in policy. The policy stated formal re-education is conducted every three years at recredentialing for all providers and that providers are given, at

minimum, annual updates of any program changes. However, the policy provided only a high-level overview of provider education processes and lacked detailed information about methods for conducting training, how providers are notified of the required training, how Solutions verifies and/or tracks provider education, etc. The review and onsite discussion revealed that Solutions was not conducting provider education for all providers and was not disseminating the required annual provider updates. Solutions staff reported that a provider hub was being planned to house provider training materials and attestation forms in the future. Providers will be able to complete the training through this hub and return the attestation of completion to Solutions.

The 2024 Enhanced Provider Network Orientation document was comprehensive and gave an overview of the MCCW, participant eligibility, requirements for physician participation in the network, program objectives, care coordination, etc. The 2024 MCCW Provider Manual addressed topics such as Enhanced Primary Care Case Management, provider responsibilities, team conferences, primary care provider accessibility, medical record documentation and maintenance requirements, etc. Both the 2024 Enhanced Provider Network Orientation document and the Provider Manual were available on Solutions' website. Additionally, the "Providers" page on Solutions' website gave information about the MCCW, use of the Medicaid guidelines and the SCDHHS Preferred Drug List, information about reporting Fraud, Waste, and Abuse, the Notice of Non-discrimination, contact information for free language services, and links to the credentialing application, the SCDHHS website, and the list of SCDHHS Provider Manuals.

For Provider Services, 80% of the Provider Services standards were scored as "Met." *Table 52: Provider Services Findings* shows the scoring for each of the standards reviewed.

Table 52: Provider Services Findings

Standard	Score
Provider Services	
The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Met
Initial provider education includes: Organization structure, operations, and goals	Met
Medical record documentation requirements, handling, availability, retention, and confidentiality	Met
How to access language interpretation services	Met
The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Partially Met↓

Quality Improvement

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

Solutions' Quality Improvement (QI) Program was described in the 2024 Strategic Quality Plan. The Strategic Quality Plan (SQP) defines the company's commitment to a culture of quality throughout

the organization, with the Board of Directors (BOD) overseeing the SQP and delegating day-to-day management to the Compliance & Quality Management Committee (CQMC). The SQP included the program's goals, objectives, and structure. The QI Program uses a systematic process for quality management, including planning and standards development, identification and prioritization of improvement opportunities, use of performance measures, clinical care standards and practice guidelines, data collection methodology, monitoring and analysis, performance improvement, follow-up, and reporting.

Solutions had two performance improvement projects underway. Topics for those projects include Annual Visit and Initial Monthly Summary Reports and the Enhanced Provider Network. The aim of the Annual Visit and Initial Monthly Summary Reports project is to improve PCP involvement in the care process. The measures, sub measures, and goals were added to the project document as recommended by Constellation during the previous EQR. Most of the established goals for this project have been met or exceeded. Solutions indicated they would re-evaluate the project in October following the remeasurement or reporting period. The aim of the Enhanced Provider Network project was unclear. This project lacked background or specific baseline data that supports the need for the project. The measures, goals, and the data collection plan were also missing.

The 2023 and 2024 Quality Work Plans were submitted for review. These documents contain various activities related to emergency preparedness, case audits, program material revision, quality improvement plans, policy and procedure review, quality management committee meetings, and Utilization Review Accreditation Commission (URAC) accreditation. The start dates, estimated completion dates, and quarterly updates were included in the work plans.

The CQMC is responsible for the development and implementation of the QI Program within the organization. The CQMC oversees all aspects of the QI Program, ensuring that quality improvement activities align with the organization's strategic goals. The committee directs and reviews quality improvement initiatives, monitors implementation and compliance of program-specific requirements, and evaluates project recommendations and areas of concern in the provision of healthcare services. The CQMC also facilitates the development and monitoring of corrective action plans, identifies improvement opportunities, and coordinates quality management activities across all departments and functional areas.

Solutions conducts a formal evaluation of the program annually. The Quality and Performance Improvement Annual Report for Calendar Year 2023 was received. The purpose of this report is to provide an overview of the quality and performance improvement activities undertaken by Solutions during the calendar year 2023. It outlines the various components of the care management program, satisfaction measures, compliance with accreditation and program integrity, quality assessment and performance improvement, and highlights the continued

success and future goals. The report aims to communicate the efforts, initiatives, successes, and opportunities for improvement within the organization's quality management program. The Annual Report was approved by the Chief Medical Officer, the Corporate Officer, the CQMC, and the Board of Directors.

The Annual Report did not include the following information:

- Pages five and six mentioned the projects that are underway in 2023 and included several goals for the projects and the analysis. The information and/or the format for how this information was presented needed clarity. It was unclear what analysis and goals were connected to one another and if the goal for each measure was met.
- Page eight included the Program Integrity Compliance section, which referenced the monthly monitoring of the LEIE, SAM, and the NPDB. This section did not include the monthly monitoring of the SC Excluded Providers List.
- The Annual Report did not include reporting or results for the Emergency/Disaster Preparedness activity and the case audits conducted.

Solutions met all the requirements in the Quality Improvement section for this EQR.

Table 53: Quality Improvement Standards and Findings

Standard	Score
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*	
The organization 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 participants	Met
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Met
Quality Improvement Committee	
The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met
The QI Committee meets at regular intervals	Met
Minutes are maintained that document proceedings of the QI Committee	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
The annual report of the QI program is submitted to the QI Committee	Met

Care Coordination/Case Management

42 CFR § 438.208

Solutions offers a comprehensive approach to care coordination and case management for participants. The program is overseen by Solutions' Chief Medical Officer, who also serves as the Executive Director, ensuring effective daily operations. Care coordination is provided by Registered Nurses with a minimum of three years of experience working with pediatric patients with medically complex or chronic conditions. As of May 2024, Licensed Practical Nurses with similar pediatric experience were incorporated into the care model to serve as additional Care Coordinators, operating within the scope defined by the SC Nurse Practice Act.

The Solutions' Care Coordination model has a team-based approach, with Registered Nurses conducting assessments and developing Person-Centered Service Plans. Each Person-Centered Service Plan is tailored to the unique needs, goals, and preferences of the participant and their family, with input from all parties involved.

Care Coordinators serve as liaisons between families, medical providers, and community services, ensuring continuity of care, particularly during transitions from hospital to home or stable care environments. Care Advocates assist by providing administrative support, while a dedicated Durable Medical Equipment Team addresses all equipment and supply needs. Additionally, a Parent Advocate offers guidance to both newly enrolled and existing families seeking further assistance.

Materials provided to members are available in both English and Spanish, with Solutions working alongside SCDHHS to ensure all forms are accessible in Spanish. Additionally, participant materials include multiple complaint filing phone numbers, categorized by issue type, and the health plan acknowledged the need to update these contact numbers for accuracy.

A review of case management files confirmed that assessments, monthly follow-ups, and quarterly and yearly in-home visits were conducted appropriately, with no issues identified in the file sample reviewed. Table 54 offers an overview of the scores for the Care Coordination/Case Management section.

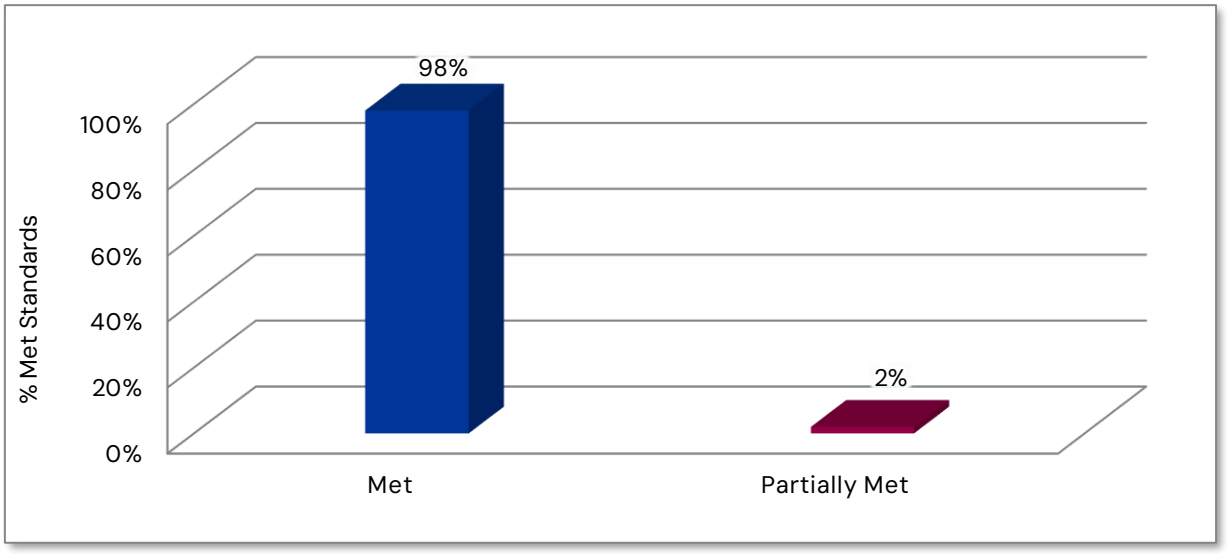
Table 54: Care Coordination/Case Management Findings

Standard	Score
Care Coordination/Case Management *42 CFR § 438.208*	
The organization formulates written policies and procedures and/or a program description that describes its care coordination and case management programs	Met
Policies and procedures and/or the program description address the following: Structure of the program	Met
Lines of responsibility and accountability	Met

Standard	Score
Goals and objectives of Care Coordination/Case Management	Met
Intake and assessment processes for Care Coordination/Case Management	Met
Providing required information to participants at the time of enrollment	Met
Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable	Met
Processes to develop, implement, coordinate, monitor, and update individual Person-Centered Service Plans	Met
Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plan	Met
Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Met
Processes for reporting suspected abuse, neglect, or exploitation of a participant	Met
A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Met
The organization provides a written, formal evaluation of the Person-Centered Plan to SCDHHS every 6 months or upon request	Met
The organization conducts Care Coordination and Case Management functions as required by the contract	Met

Overall, Solutions met 98% of the standards for the 2024 EQR as noted in *Figure 14: SC Solutions Overall Findings*.

Figure 14: SC Solutions Overall Findings



Scores were rounded to the nearest whole number.

Solutions' specific strengths, weaknesses, and recommendations are displayed in Tables 55 and 56.

Table 55: Solutions' Strengths

Strengths	Quality	Timeliness	Access to Care
Administration			
The sample personnel files reviewed showed evidence of the required auto insurance, driver's license, drug screening, nursing license, and background checks. Documentation was also provided to demonstrate compliance with employee HIPAA, FWA, and annual training.	✓		
Following a hurricane in 2023, Solutions provided records demonstrating good communication with staff and the State before, during, and after the storm specific to data management.	✓		✓
Provider Services			
Solutions' provides its Enhanced Provider Network Orientation document and MCCW Provider Manual on its website.	✓		✓
Solutions' website includes information about the MCCW, Medicaid guidelines, the SCDHHS Preferred Drug List, reporting FWA, contact information for free language services, and links to the SCDHHS website, and list of SCDHHS Provider Manuals.	✓		✓
Quality Improvement			
Solutions actively engages in quality improvement projects and corrective action plans. These projects aim to enhance the quality of care and address any identified areas for improvement.	✓		
Solutions strives to improve health outcomes for its members and provide more effective and efficient healthcare services.	✓		
The program demonstrates a commitment to compliance and accreditation. Solutions ensures compliance with state and federal regulations. The program also has written compliance guidelines, leadership oversight, training and education, effective communication channels, and monitoring and auditing processes in place to maintain program integrity.	✓		
Care Coordination/Case Management			
Chart audits are conducted for Care Coordinators, Durable Medical Equipment Team, and Care Advocates to ensure quality assurance.	✓		
Care Management activities have reportedly decreased care costs. Re-hospitalization rates for MCCW Enhanced Provider Network participants within 30 days of discharge was 7%, and re-hospitalization within 72 hours of discharge was 1% in 2023.	✓		✓

Table 56: Solutions' Weaknesses and Recommendations

Weakness	Recommendation	Quality	Timeliness	Access to Care
Provider Services				
Solutions did not include detailed information about processes for conducting initial and ongoing provider education and providing annual updates in policy.	*Ensure health plan policies include detailed information about all processes.*	✓	✓	
The review confirmed Solutions was not in compliance with policy requirements for providing annual provider updates and conducting required provider training.	*Ensure compliance with policy requirements for disseminating provider updates and conducting provider training.*	✓	✓	
Quality Improvement				
The aim for the Enhanced Provider Network project was unclear. This project lacked documentation regarding the following: • the background or reason for conducting the project • the specific baseline data that supports the need for the project • the measures and goals the data collection plan	*Review and revise the Enhanced Provider Network project document and include the background or reason for conducting the project, the baseline data, the measures, goals, and the data collection plan.*	✓		
The Annual Report was missing the following information: • Pages five and six mentioned the projects underway in 2023, including several goals for the projects and the analysis. The information and/or the format for how this information was presented needed clarity. It was unclear what analysis and goal were connected to one another and if the goal for each measure was met. • Page eight included the Program Integrity Compliance section, which references the monthly monitoring of the LEIE, SAM, and the NPDB. This section does not include the monthly monitoring of the SC Excluded providers list. • The Annual Report did not include reporting or results for the Emergency/Disaster Preparedness activity, and the case audits conducted.	*Update the format for the Annual Report and consider reporting the analysis under each measure. Include information regarding if the goal for the measure was met or not met. If the goal was not met, include a barrier analysis and interventions implemented to address these barriers.* *Include the results for all QI activities noted in the QI Work Plan.*	✓		

Coordinated and Integrated Care Organizations Annual Review

Constellation conducted an EQR of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those plans include Wellcare, Molina, and Select Health. As directed by SCDHHS, this review was a compliance review that focused on network adequacy for home and community-based services (HCBS), behavioral health providers, over- and underutilization, and care transitions.

SCDHHS did not require the CICOs to conduct performance improvement projects or collect performance measures during this reporting period. However, the CICOs were required to report specific CMS core measures. As requested by SCDHHS, the results of the CICOs performance data currently available are included as an attachment to this report. Refer to *Attachment 2: SC Medicare-Medicaid Plan Core Measures Performance Data*. This data shows the CICOs performance on quality measures during 2022 and the results of surveys of MMP enrollees conducted in 2022 or 2023. These measures were not validated by Constellation and only included as information.

For the EQR activities, Constellation used a process based on the CMS *Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations*. To conduct the review, Constellation requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over- and underutilization data, and care transition files.

Standards were scored as meeting all requirements ("Met"), acceptable but needing improvement ("Partially Met"), or failing a standard ("Not Met"). An overview of the findings for each section follows. The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) indicates the score for that standard improved from the previous review, and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate there was no change in the score from the previous review.

Provider Network Adequacy

The CICOs are required by contract to maintain a network of HCBS providers that is sufficient to provide all enrollees with access to a full range of covered services in each geographic area. The CICOs are also required to have a network of Behavioral Health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard.

SCDHHS established minimums for HCBS of at least two providers for each service in each county except Anderson, Charleston, Florence, Greenville, Richland, and Spartanburg counties. For these

larger counties, the minimum was established as three providers for each service. The minimum number of required providers for each active county was calculated and compared to the number of current providers for seven different services:

- Adult Day Health
- Case Management
- Home Delivered Meals
- Personal Care
- Personal Emergency Response System (PERS)
- Respite
- Telemonitoring

Constellation requested a complete list of all contracted HCBS providers currently in each health plan's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services.

For Molina, of the 322 services across 46 counties, there were no services or counties that did not meet the requirements. Molina received a validation score of 100% for the HCBS network. This was noted as an improvement over the previous year's score of 87%.

Select Health had services documented for providers in 46 counties. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. Of the 322 services across 46 counties, there were no services or counties that did not meet the requirements. Select Health received a validation score of 100% for the HCBS network.

Wellcare's network was evaluated and of the 322 services across 46 counties, Aiken County only had one unique provider for Adult Day Health services. The minimum number of providers for Adult Day Health in Aiken County is two. Wellcare received a validation score of 99.7% for the HCBS network. This was discussed during the onsite and Wellcare acknowledged this gap and has continued efforts to contract with additional providers to cover the Adult Day Health services in Aiken County.

Table 57: HCBS Provider Adequacy Results provides an overview of the network adequacy results for each CICO.

Table 57: HCBS Provider Adequacy Results

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Abbeville				
Adult Day Health	2	3	2	3
Case Management	2	9	15	3
Home Delivered Meals	2	6	5	4

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
PERS	2	21	17	18
Personal Care	2	47	41	30
Respite	2	12	10	13
Telemonitoring	2	3	3	3
Aiken				
Adult Day Health	2	7	4	1
Case Management	2	8	12	6
Home Delivered Meals	2	4	5	3
PERS	2	18	16	18
Personal Care	2	60	51	23
Respite	2	16	13	6
Telemonitoring	2	3	3	2
Allendale				
Adult Day Health	2	6	3	2
Case Management	2	6	12	5
Home Delivered Meals	2	3	4	2
PERS	2	18	16	17
Personal Care	2	46	43	17
Respite	2	12	11	7
Telemonitoring	2	4	4	3
Anderson				
Adult Day Health	3	9	9	4
Case Management	3	7	11	3
Home Delivered Meals	3	6	6	3
PERS	3	22	19	19
Personal Care	3	72	76	39
Respite	3	17	15	17
Telemonitoring	3	3	4	3
Bamberg				
Adult Day Health	2	8	3	3
Case Management	2	7	13	5
Home Delivered Meals	2	4	5	3
PERS	2	18	17	19
Personal Care	2	50	44	18
Respite	2	13	11	6
Telemonitoring	2	4	4	4
Barnwell				
Adult Day Health	2	5	2	3
Case Management	2	5	11	5
Home Delivered Meals	2	3	4	4
PERS	2	18	17	19
Personal Care	2	48	42	19
Respite	2	14	11	6
Telemonitoring	2	4	4	4

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Beaufort				
Adult Day Health	2	4	2	3
Case Management	2	6	11	4
Home Delivered Meals	2	3	4	3
PERS	2	18	16	18
Personal Care	2	47	40	19
Respite	2	16	13	7
Telemonitoring	2	3	3	4
Berkeley				
Adult Day Health	2	9	6	4
Case Management	2	7	12	6
Home Delivered Meals	2	4	5	3
PERS	2	19	16	18
Personal Care	2	49	46	21
Respite	2	15	15	8
Telemonitoring	2	4	5	4
Calhoun				
Adult Day Health	2	11	8	4
Case Management	2	7	12	4
Home Delivered Meals	2	3	5	4
PERS	2	19	17	19
Personal Care	2	54	48	21
Respite	2	15	13	6
Telemonitoring	2	4	4	4
Charleston				
Adult Day Health	3	10	6	6
Case Management	3	7	12	6
Home Delivered Meals	3	5	6	4
PERS	3	19	16	18
Personal Care	3	56	53	25
Respite	3	15	15	10
Telemonitoring	3	4	5	4
Cherokee				
Adult Day Health	2	4	5	3
Case Management	2	6	9	4
Home Delivered Meals	2	4	4	2
PERS	2	18	17	18
Personal Care	2	42	47	22
Respite	2	12	11	8
Telemonitoring	2	4	4	4
Chester				
Adult Day Health	2	8	6	6
Case Management	2	5	10	3
Home Delivered Meals	2	3	4	3

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
PERS	2	18	17	18
Personal Care	2	52	53	25
Respite	2	16	16	11
Telemonitoring	2	3	3	3
Chesterfield				
Adult Day Health	2	6	3	2
Case Management	2	7	11	3
Home Delivered Meals	2	4	5	5
PERS	2	19	16	18
Personal Care	2	47	45	20
Respite	2	16	16	7
Telemonitoring	2	3	3	3
Clarendon				
Adult Day Health	2	7	4	4
Case Management	2	10	15	6
Home Delivered Meals	2	4	6	3
PERS	2	20	16	19
Personal Care	2	58	57	22
Respite	2	18	16	8
Telemonitoring	2	3	3	3
Colleton				
Adult Day Health	2	7	4	5
Case Management	2	6	11	5
Home Delivered Meals	2	4	5	4
PERS	2	19	16	18
Personal Care	2	43	39	22
Respite	2	14	12	9
Telemonitoring	2	4	4	4
Darlington				
Adult Day Health	2	5	2	2
Case Management	2	8	11	5
Home Delivered Meals	2	4	4	2
PERS	2	20	16	18
Personal Care	2	63	55	25
Respite	2	16	14	8
Telemonitoring	2	3	3	2
Dillon				
Adult Day Health	2	6	3	2
Case Management	2	9	12	4
Home Delivered Meals	2	4	5	3
PERS	2	20	16	21
Personal Care	2	55	53	21
Respite	2	15	14	7
Telemonitoring	2	3	3	3

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Dorchester				
Adult Day Health	2	10	7	3
Case Management	2	7	12	5
Home Delivered Meals	2	4	5	2
PERS	2	19	16	17
Personal Care	2	52	48	23
Respite	2	14	14	10
Telemonitoring	2	4	5	3
Edgefield				
Adult Day Health	2	4	2	2
Case Management	2	8	14	3
Home Delivered Meals	2	4	5	3
PERS	2	19	17	18
Personal Care	2	45	46	19
Respite	2	13	11	7
Telemonitoring	2	3	3	2
Fairfield				
Adult Day Health	2	8	7	5
Case Management	2	9	14	4
Home Delivered Meals	2	4	5	4
PERS	2	18	17	19
Personal Care	2	68	59	29
Respite	2	18	14	10
Telemonitoring	2	3	3	3
Florence				
Adult Day Health	3	7	5	3
Case Management	3	9	15	5
Home Delivered Meals	3	4	5	4
PERS	3	20	16	21
Personal Care	3	70	62	28
Respite	3	16	17	8
Telemonitoring	3	3	3	3
Georgetown				
Adult Day Health	2	7	5	4
Case Management	2	10	12	6
Home Delivered Meals	2	3	4	3
PERS	2	19	16	19
Personal Care	2	63	56	22
Respite	2	14	15	7
Telemonitoring	2	3	3	3
Greenville				
Adult Day Health	3	10	10	5
Case Management	3	7	14	4
Home Delivered Meals	3	6	6	4

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
PERS	3	22	19	20
Personal Care	3	80	84	42
Respite	3	17	15	20
Telemonitoring	3	4	4	5
Greenwood				
Adult Day Health	2	5	2	3
Case Management	2	11	15	6
Home Delivered Meals	2	6	5	3
PERS	2	20	17	18
Personal Care	2	61	63	33
Respite	2	17	14	15
Telemonitoring	2	3	3	2
Hampton				
Adult Day Health	2	4	2	3
Case Management	2	6	11	5
Home Delivered Meals	2	3	4	3
PERS	2	18	16	18
Personal Care	2	38	34	17
Respite	2	13	11	6
Telemonitoring	2	4	4	4
Horry				
Adult Day Health	2	7	6	3
Case Management	2	10	13	7
Home Delivered Meals	2	3	4	2
PERS	2	19	16	19
Personal Care	2	65	56	23
Respite	2	15	15	7
Telemonitoring	2	3	3	2
Jasper				
Adult Day Health	2	4	2	3
Case Management	2	6	11	4
Home Delivered Meals	2	3	4	3
PERS	2	18	16	18
Personal Care	2	39	35	19
Respite	2	14	11	8
Telemonitoring	2	4	3	4
Kershaw				
Adult Day Health	2	12	9	6
Case Management	2	7	14	5
Home Delivered Meals	2	4	5	3
PERS	2	20	16	20
Personal Care	2	67	64	31
Respite	2	20	17	12
Telemonitoring	2	3	3	3

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Lancaster				
Adult Day Health	2	7	4	3
Case Management	2	5	10	3
Home Delivered Meals	2	3	4	2
PERS	2	19	17	17
Personal Care	2	60	52	25
Respite	2	16	16	14
Telemonitoring	2	3	3	2
Laurens				
Adult Day Health	2	5	4	3
Case Management	2	10	15	6
Home Delivered Meals	2	7	6	4
PERS	2	22	17	19
Personal Care	2	70	74	40
Respite	2	17	15	17
Telemonitoring	2	4	4	4
Lee				
Adult Day Health	2	6	2	5
Case Management	2	8	14	5
Home Delivered Meals	2	4	5	3
PERS	2	20	17	19
Personal Care	2	59	53	21
Respite	2	18	15	9
Telemonitoring	2	3	3	3
Lexington				
Adult Day Health	2	10	6	6
Case Management	2	12	16	6
Home Delivered Meals	2	3	4	3
PERS	2	18	17	19
Personal Care	2	88	78	40
Respite	2	19	17	14
Telemonitoring	2	4	4	4
Marion				
Adult Day Health	2	6	2	3
Case Management	2	8	12	6
Home Delivered Meals	2	3	4	3
PERS	2	19	17	20
Personal Care	2	65	58	26
Respite	2	15	14	7
Telemonitoring	2	3	3	3
Marlboro				
Adult Day Health	2	5	3	2
Case Management	2	6	8	3
Home Delivered Meals	2	3	4	3

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
PERS	2	20	16	19
Personal Care	2	51	47	22
Respite	2	14	13	7
Telemonitoring	2	3	3	3
McCormick				
Adult Day Health	2	3	2	2
Case Management	2	9	15	3
Home Delivered Meals	2	4	5	4
PERS	2	19	17	19
Personal Care	2	41	43	23
Respite	2	12	10	9
Telemonitoring	2	3	3	3
Newberry				
Adult Day Health	2	10	8	10
Case Management	2	10	13	6
Home Delivered Meals	2	5	6	5
PERS	2	19	17	19
Personal Care	2	63	58	31
Respite	2	16	13	10
Telemonitoring	2	3	3	3
Oconee				
Adult Day Health Care	2	5	5	2
Case Management	2	7	10	2
Home Delivered Meals	2	5	5	3
PERS	2	21	19	19
Personal Care	2	55	56	27
Respite	2	16	13	10
Telemonitoring	2	3	3	3
Orangeburg				
Adult Day Health	2	13	9	6
Case Management	2	10	14	7
Home Delivered Meals	2	3	5	3
PERS	2	18	16	19
Personal Care	2	75	65	27
Respite	2	15	15	11
Telemonitoring	2	4	4	4
Pickens				
Adult Day Health	2	6	6	3
Case Management	2	7	14	3
Home Delivered Meals	2	6	6	3
PERS	2	21	19	19
Personal Care	2	69	72	38
Respite	2	16	14	18
Telemonitoring	2	4	4	4

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Richland				
Adult Day Health	3	14	9	8
Case Management	3	11	15	6
Home Delivered Meals	3	4	4	4
PERS	3	19	17	19
Personal Care	3	101	87	45
Respite	3	21	17	16
Telemonitoring	3	4	4	4
Saluda				
Adult Day Health	2	7	4	2
Case Management	2	10	16	3
Home Delivered Meals	2	5	5	4
PERS	2	19	16	19
Personal Care	2	51	52	26
Respite	2	13	11	8
Telemonitoring	2	3	3	3
Spartanburg				
Adult Day Health	3	7	7	6
Case Management	3	7	12	5
Home Delivered Meals	3	6	6	3
PERS	3	21	18	19
Personal Care	3	79	81	40
Respite	3	17	14	20
Telemonitoring	3	4	4	5
Sumter				
Adult Day Health	2	7	6	7
Case Management	2	11	16	6
Home Delivered Meals	2	5	7	3
PERS	2	20	16	19
Personal Care	2	73	70	29
Respite	2	19	17	11
Telemonitoring	2	3	3	2
Union				
Adult Day Health	2	9	8	7
Case Management	2	8	9	4
Home Delivered Meals	2	4	4	3
PERS	2	18	17	18
Personal Care	2	55	55	31
Respite	2	15	14	14
Telemonitoring	2	4	4	4
Williamsburg				
Adult Day Health	2	7	5	4
Case Management	2	12	15	7
Home Delivered Meals	2	4	5	4

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
PERS	2	19	16	19
Personal Care	2	59	53	22
Respite	2	15	15	8
Telemonitoring	2	3	3	3
York				
Adult Day Health	2	6	3	4
Case Management	2	5	9	3
Home Delivered Meals	2	3	4	2
PERS	2	18	17	17
Personal Care	2	61	56	25
Respite	2	17	17	13
Telemonitoring	2	3	3	2
Total that Met Minimum (Sum of all services across the total number of counties with minimum required providers met)		322	322	321
Total Required (Sum all of services across the total number of counties)		322	322	322
Percentage MET		100%	100%	99.7%
VALIDATION DECISION		Met	Met	Met

Validation Decision Categories: Met = 91% or higher; Partially Met = 51% -90%; Not Met = ≤50%

The CICOs are also required to have a network of Behavioral Health (BH) providers to ensure a choice of at least two providers located no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older), and at least one of the behavioral health providers used to meet the two providers per 50-mile requirement must be a Community Mental Health Center (CMHC). The CICOs met these requirements. The following is an overview of the findings.

Molina - Information to assess the BH providers was submitted with the desk materials. The requirements set forth by SCDHHS were compared to submitted information. The assessment showed 100% of members had access to two BH providers with at least one CMHC included in the access area. Allendale County did not meet the standard of 90% for the opioid treatment clinic nor did the psychologist provider group. Bamberg did not meet the 90% standard for the opioid treatment clinic. These results are similar to the previous two years' findings. All counties had 100% of members showing access to at least two types of BH providers.

Select Health - Information on BH providers was submitted to the desk materials. The requirements set forth by the State were compared to submitted information. The Metro analysis showed 99.9% of members have access to an inpatient BH provider, 99.6% have access to an

outpatient BH provider, and 100% have access to CMHCs. Micro-level geographic areas showed 100%.

Wellcare provided information on their in-network behavioral health providers. The requirements set forth by the State were compared to the information submitted. The October 2024 GeoAccess Network Analysis report provided by Quest Analytics showed that 99.1% of members have access to a psychiatrist; 98.6% have access to a psychologist; 99.8% have access to a social worker; and 99.9% have access to a CMHC. The analysis was conducted for large metro, metro, micro, rural, and counties with extreme access considerations. All counties had 100% of members with access to at least two types of BH providers.

Table 58: Provider Network Adequacy Comparative Data provides an overview of each plan's score for the Provider Network Adequacy section.

Table 58: Provider Network Adequacy Comparative Data

Standard	Molina	Select Health	Wellcare
Provider Network Adequacy			
The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met ↑	Met	Met
The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Met	Met

Evaluation of Over- and Underutilization

The CICOs are required to monitor and analyze utilization data to look for trends or issues that may provide opportunities for quality improvement. The over- and underutilization monitoring focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services.

The documentation shows monitoring and analysis of trended data to ensure resources are applied and interventions are implemented to improve appropriate utilization.

The CICOs conducted an analysis of utilization data to evaluate the effectiveness of program interventions and to identify any opportunities to modify and improve these programs. The documentation showed monitoring and analysis of trended data to ensure resources are applied and interventions are implemented to improve appropriate utilization. *Table 59: CICO Over- and Underutilization Data* provides the data each CICO reported for over- and underutilization.

Table 59: CICO Over- and Underutilization Data

CICO	Measure	Reported Value
Molina	30-Day Hospital Readmission	Readmissions declined from 46 in the previous year to 43 in the current year.
	LOS Inpatient	The length of stay rate increased from 2022 (7.3 days) to 2023 (8.4 days).
	LOS SNF	For the length of stay for a skilled nursing facility, the rate increased from 18.3 to 18.7 days.
	ER Utilization	The emergency room utilization rate declined from 865 per thousand to 855 per thousand. This was likely due to the changes in the collaboration program between Transition Coaches and Care Coordinators.
	BH OP Penetration/BH Inpatient Penetration	The mental health service utilization rate declined from 349 to 304. Efforts continue to address members needing services.
Select Health	30-day hospital readmission	13.3%
	LOS Inpatient	11.0%
	LOS Skilled Nursing Facility (SNF)	13.8%
	ER Utilization	937 (as of May 2024)
	BH Outpatient Penetration/BH Inpatient Penetration	2.09 per 1000 members/1.21 per 1000 members
Wellcare	Inpatient Length of Stay	The inpatient LOS is at 7.9, which is above the expected value of 6.5.
	Readmissions	Readmissions are at 16.2%, which is above the expected rate of 14.5%.
	Skilled Nursing Facility Length of Stay	Skilled Nursing Facility LOS was at 23 overall for 2023.

The CICOs met the requirements for evaluating over- and under-utilization as shown in *Table 60: Evaluation of Over/Under Utilization Comparative Data*.

Table 60: Evaluation of Over/Under Utilization Comparative Data

Standard	Molina	Select Health	WellCare
Evaluation of Over/Under Utilization			
The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement.	Met	Met	Met
Length of stay for hospitalizations	Met	Met	Met
Length of stay in nursing homes	Met	Met	Met
Emergency room utilization	Met	Met	Met
Number and percentage of enrollees receiving mental health services	Met	Met	Met

Care Transitions

Constellation reviewed each CICO's Program Descriptions and policies related to care transitions. The CICOs were required to submit a file of enrollees who were hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. The CICOs were directed to only include those enrollees readmitted with a diagnosis that met the definition of a potentially avoidable hospitalization. These were defined by SCDHHS as Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers. Based on the file received from each CICO, a random sample of files was requested for review. An overview of the findings for Care Transitions follows.

Molina - Molina's Healthcare Services (HCS) Program Description for Dual Options / Medicaid and Medicare, Policy EMU-CM-011, Transitions of Care, and Procedure EMU-CM-011.01, Transitions of Care describes processes for ensuring coordination and continuity of care as a member's health status changes. Procedure EMU-CM-011.01, Transitions of Care states "all members with an acute inpatient admission will be sent a post discharge letter upon notification of discharge." Constellation requested a copy of the discharge letter. Molina explained that the post discharge letter was an automated process, occurring within the new Utilization Management (UM) system, PEGA, and had not been implemented. Per Molina, this process had been added to the enterprise policies and procedures prematurely. Molina provided an updated policy, procedure, and state addendum (HCS-168, Transitions of Care) that indicated the post discharge letter was not applicable for SC. Procedure HCS-168.01, Transitions of Care, notes for members discharged to a home/community setting, the Care Coach and/or Case Manager will outreach to the member within five business days. However, the *SCDHHS 3-Way Contract, Section 2.6.8.7.1.9* requires a clinical follow-up phone call or home visit within 72 hours of transition. The state addendum does not address this as a variance.

Constellation reviewed case management files for 11 enrollees provided by Molina. The initial review findings were discussed with Molina onsite. Additional information was provided; and the following is a summary of the issues identified after reviewing the additional information.

- Six files lacked documentation of collaboration with the facility-based care/case manager or discharge planner.
- Notification and participation of the enrollee's PCP was not found in three files.
- The clinical follow up (phone call or home visit) within 72 hours of transition was not conducted for eight files.
- Six files did not contain documentation of medication monitoring and adherence required to be performed after the initial 72-hour follow-up.
- A reassessment completed following the trigger event (readmission) was not completed for five files.
- There was no transition activities conducted for one file due to late notification of admission.

These findings were the same or similar to the findings from the 2022 and 2023 EQRs. In Molina's response to the deficiencies identified during the 2023 EQR, the health plan mentioned implementing a new UM system to improve documentation. This was discussed onsite, and Molina indicated this new system was still in the planning stage. For additional information regarding the deficiencies identified during the 2023 EQR, see *Attachment 1: Assessment of Quality Improvement Plans from Previous EQR*.

Select Health - The First Choice VIP Care Plus by Select Health of South Carolina Population Health/Care Management Program Description and policies address care transitions detailing the involvement of the Care Coordinators to ensure appropriate care and support before, during, and after transitions. This includes identifying suitable housing options, coordinating resources, and facilitating the transition process.

Constellation reviewed case management files and found several files that did not reflect attempts to contact the facility's Case Management/Discharge Planning staff or the member's primary care physician (PCP), did not include a completed assessment or reassessment, or did not document the medication monitoring performed after the 72-hour follow up. These were issues identified during the 2023 EQR. Select Health provided additional information following the onsite and indicated that most of these issues occurred prior to the implementation of the quality improvement plan (QIP) developed following the 2023 EQR. However, these were the same issues identified in 2022, 2023, and for this EQR (2024). Details regarding the 2023 QIP can be found in *Attachment 1: Assessment of Quality Improvement Plans from Previous EQR*. Constellation reviewed the additional information submitted after the onsite and found the following:

- There were no attempts to contact the facility's Case Management/Discharge Planning for four files.
- Notification of the member's PCP regarding the transition was not found in seven files.
- Documentation of the scheduling or follow-up with the member regarding an after-care appointment was missing in three files.
- The clinical follow up within 72 hours of transition was missing in 10 files.
- Documentation of the medication monitoring performed after the 72-hour follow-up was missing in three files.
- Reassessments were not completed for three files.
- There was no transition activities conducted for one file due to late notification of admission.
- The identification of clinical and non-clinical support needs and any barriers to after care was missing in one file.

Wellcare also provided a program description and polices that emphasizes the importance of early discharge planning and coordination to avoid preventable readmissions. Wellcare's Care Coordinators and Interdisciplinary Care Team work together to ensure that all necessary services and supports are in place to facilitate a smooth transition and reduce the risk of readmission.

Wellcare conducts an annual analysis of transition of care events to understand and improve collaboration with providers. The analysis showed care transitions were categorized into three categories: Category I (lower to higher level of care), Category II (higher to lower level of care), and Category III (clinically equivalent transitions). The analysis noted that out of 918 transitions, 66 (7.2%) were to a higher level of care. A detailed review of those 66 cases was conducted and found potential issues in nine cases (13.6% of Category I transitions). Actions taken included enhancing specialized teams for in-depth analysis, monitoring trends, collaborating with providers for training, and involving multidisciplinary teams for process improvement. Wellcare's goal was to reduce readmissions, ensure proper care, and continuously improve processes for better health outcomes.

Wellcare provided a sample of care management files for enrollees that met the readmission criteria. Overall, Constellation noted an improvement in the documentation in the case management files when compared to the 2023 EQR of the case management files. Two enrollees had multiple admission where outreach to the facility was not documented.

Table 61 provides an overview of the CICOs scores for the Care Transitions section.

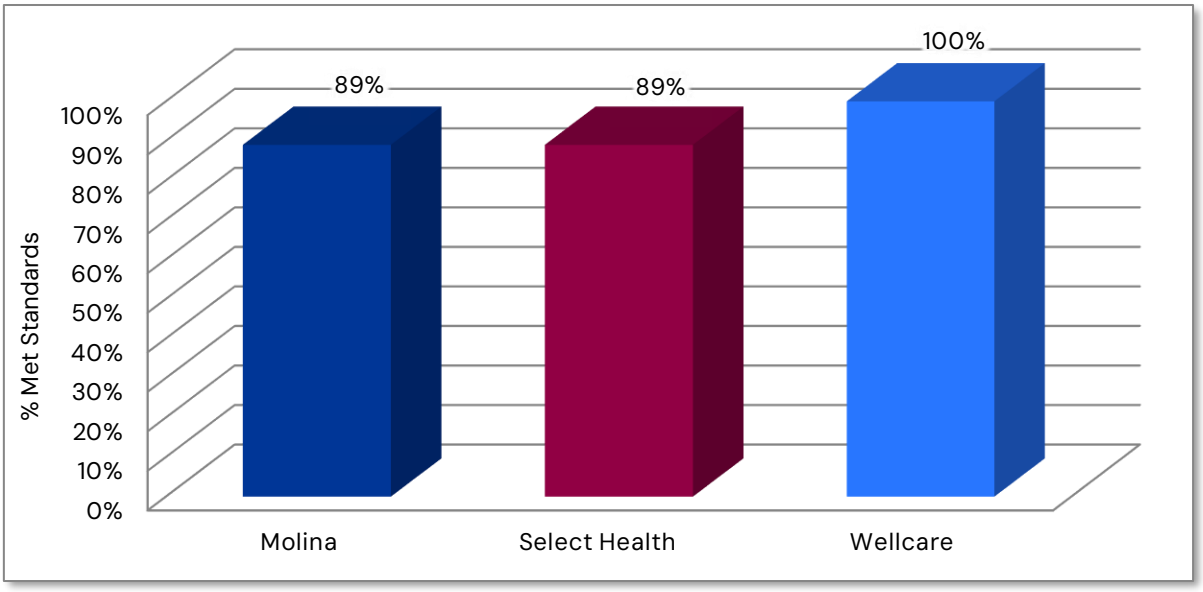
Table 61: Care Transitions Comparative Data

Standard	Molina	Select Health	WellCare
Care Transitions			
The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions	Not Met	Not Met ↓	Met ↑
Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes	Met	Met	Met

Conclusions

The 2024 - 2025 Annual EQR of the CICOs found that Molina and Select Health received "Met" scores for 89% of the standards. Care Transitions were the area not meeting the requirements. Wellcare received "Met" scores for 100% of the standards. The assessment of the CICOs strengths and weaknesses are included in tables 62 and 63.

Figure 15: CICO's Percentage of Met Standards



Scores were rounded to the nearest whole number.

Table 62: CICO Strengths

Strengths	Quality	Timeliness	Access to Care
The health plans have a strong network of HCBS and behavioral health providers, ensuring members have access to a choice of providers.			✓
The documentation shows monitoring and analysis of trended utilization data to ensure resources are applied and interventions are implemented to improve appropriate utilization.	✓		
Improvement was noted in the documentation in the case management files for Wellcare. Timely outreach to the facility regarding discharge planning, to the member following discharge, and to the primary care provider was well documented.	✓	✓	✓

Table 63: CICO Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Molina and Select Health are not conducting the appropriate care transitions functions as required by the contract to minimize unnecessary complications.	Develop a plan to audit a sample of case management files to assess compliance with contract requirements. Include additional staff training as needed.	✓		

FINDINGS SUMMARY

Table 64: Scoring Overview provides an overview of the scoring for each section of the EQR. The percentages highlighted in green indicate the health plan sustained or showed an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings.

Table 64: Scoring Overview

	Met	Partially Met	Not Met	Not Applicable	Total Standards	*Percentage Met Scores
Administration						
ATC	38	2	0	0	40	95%↓
Humana	38	2	0	0	40	95%
Molina	39	1	0	0	40	98%↓
Select Health	39	1	0	0	40	98%↓

	Met	Partially Met	Not Met	Not Applicable	Total Standards	*Percentage Met Scores
Solutions	30	0	0	0	30	100%
Provider Services						
ATC	73	4	1	0	78	94% ↓
Humana	73	4	1	0	78	94% ↓
Molina	72	5	1	0	78	92% ↓
Select Health	75	2	1	0	78	96% ↓
Solutions	4	1	0	0	5	80% ↓
Member Services						
ATC	33	0	0	0	33	100% ↑
Humana	31	1	1	0	33	94%
Molina	33	0	0	0	33	100%
Select Health	33	0	0	0	33	100%
Quality Improvement						
ATC	16	0	0	0	16	100%
Humana	14	2	0	0	16	88% ↑
Molina	16	0	0	0	16	100%
Select Health	16	0	0	0	16	100%
Solutions	7	0	0	0	7	100%
Utilization Management						
ATC	44	1	1	0	46	96% ↑
Humana	45	0	1	0	46	98% ↑
Molina	45	0	1	0	46	98% ↑
Select Health	45	0	1	0	46	98% ↑
Solutions (Care Coordination/Case Management)	14	0	0	0	14	100%
Delegation						
ATC	3	0	0	0	3	100% ↑
Humana	3	0	0	0	3	100% ↑
Molina	3	0	0	0	3	100%
Select Health	3	0	0	0	3	100%

	Met	Partially Met	Not Met	Not Applicable	Total Standards	*Percentage Met Scores
Mental Health Parity						
ATC	2	0	0	0	2	100% ↑
Humana	2	0	0	0	2	100%
Molina	2	0	0	0	2	100%
Select Health	2	0	0	0	2	100%
Totals						
ATC	209	7	2	0	218	95%
Humana	206	9	3	0	218	95% ↑
Molina	210	6	2	0	218	96% ↓
Select Health	213	3	2	0	218	98%
Solutions	55	1	0	0	56	98% ↓

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

Table 65: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons displays a comparison of the total percentage of standards scored as "Met" for the Part 438 Subpart D and QAPI Standards for the 2024—2025 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction from the MCO's prior review. Up (↑) and down (↓) arrows are included to further illustrate the change from the previous reviews.

Table 65: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons

Federal Standards	ATC			Humana			Molina			Select Health		
	2024	2023	2022	2025	2024	2023	2024	2023	2022	2024	2023	2022
Disenrollment Requirements and Limitations *(§ 438.56)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enrollee Rights Requirements *(§ 438.100)*	100%↑	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency and Post-Stabilization Services *(§ 438.114)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	75%	75%	100%	75%↓	92%	87.5%	83%↓	88%	87.5%	83%↓	92%	75%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	89%↓	100%	100%	100%	100%	100%	100↑%	89%	100%	100%	100%	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	100%↑	92%	100%	100%	100%	92.8%	100%↑	93%	92.8%	100%↑	93%	100%
Provider Selection *(§ 438.214, § 457.1233)*	97%↓	98%	97%	97%↓	98%	100%	97%↓	100%	100%	97%↓	100%	100%

Federal Standards	ATC			Humana			Molina			Select Health		
	2024	2023	2022	2025	2024	2023	2024	2023	2022	2024	2023	2022
Confidentiality *(§ 438.224)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	100%	100%	100%	90%↑	85%	90%	95%	95%	90%	95%	95%	90%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	100%↑	50%	50%	100%↑	50%↓	100%	100%	100%	100%	100%	100%	100%
Practice Guidelines *(§ 438.236, § 457.1233)*	100%	100%	100%	100%	100%	100%	89%↓	100%	100%	100%	100%	100%
Health Information Systems *(§ 438.242, § 457.1233)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	100%	100%	100%	88%↑	75%↓	79%	100%	100%	92.8%	100%	100%	100%

Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100.
***The Standards Not Evaluated were removed from the denominator and numerator*

ATTACHMENTS

- Attachment 1: Assessment of Quality Improvement Plan from Previous EQR
- Attachment 2: SC Medicare–Medicaid Plan Core Measures Performance Data

Attachment 1: Assessment of Quality Improvement Plan from Previous EQR

Constellation Quality Health

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Absolute Total Care 2023 EQR Quality Improvement Plan Response and Review

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
I D. Compliance/Program Integrity			
2. The Compliance Plan and/or policies and procedures address requirements, including: 2.11 Exclusion status monitoring.			
Policy CC.COMP.36, Centene Exclusion Screening Requirements, states Federal and State exclusion screening standards apply to Beneficial Owners, the Board of Directors, employees, contingent workers, and vendors at the time of affiliation or employment. Thereafter, monthly screening of federal and state databases is conducted to determine exclusion status. The policy provides detailed information about the process followed if an individual or entity is found to be possibly ineligible. The policy lists the queried databases as, at minimum: • Office of Inspector General's List of Excluded Individuals/Entities (OIG LEIE) • General Services Administration's System for Award Management (SAM) • State exclusion lists for states in which Centene operates Policy CC.COMP.36 does not address querying the Social Security Death Master File (SSDMF) for subcontractors and persons with ownership or control interest or who are agents or managing	2/01/24 ATC Response The CC.COMP.36 SC Addendum has been revised to include our process for conducting queries of the SSDMF and ensure they are conducted timely. During Centene's Human Resources onboarding process for all employees, the SSDMF is searched and there would not be a need to re-screen employees against the SSDMF. In researching all relevant information regarding this QIP we have discovered conflicting instructions between the SC contract and P&P Section 11.2.10. We believe the language that we have been operating under is that in the P&P. During a previous clean-up of the contract, the reference to Subcontractor was inadvertently changed to Contractor. We would like to get clarification on this if possible. The contract states: 11.2.10. Process to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor, that is not a South Carolina Medicaid Network Provider as well as any person with an ownership or	✓	

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
employees of the MCO. This requirement is noted in the *SCDHHS Contract, Section 11.2.10*. During onsite discussion, the process for conducting queries of the SSDMF was discussed. ATC staff verbalized the process for querying the SSDMF for network providers at initial credentialing and monthly thereafter. However, health plan staff were unable to verbalize the process for conducting SSDMF queries for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. *Quality Improvement Plan: Revise Policy CC.COMP.36, Centene Exclusion Screening Requirements, or develop a South Carolina-specific policy to define the process for conducting queries of the SSDMF for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. Ensure this process is implemented and conducted timely.*	control interest, or who is an agent or managing employee of the CONTRACTOR through routine checks of federal databases. This includes the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the Department or Secretary of Health and Human Services may prescribe (e.g. Department's SC List of Excluded Providers or the SC List of Providers Terminated for Cause. The P&P says: Section 11.2.10 through 11.2.11.1: The MCO will establish written Policies and Procedures adopting routine checks of federal and state databases to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor that is not a South Carolina Medicaid Network Provider, and any person with an ownership or control interest, or an agent, or managing employee of the Provider and/or Subcontractor. This includes checking the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases the Department or the Secretary of Health and Human Services may prescribe (e.g., the South Carolina List of Excluded Providers or the South Carolina List of Providers Terminated for Cause). MCO written Procedures shall include requirements that the MCO shall check federal and state Provider exclusion and termination for cause databases upon contracting or Credentialing the Provider and no less than monthly thereafter. 2/23/24 ATC RESPONSE: ATC is waiting on clarification from SCDHHS to implement the process of SSDMF. 3/22/24 ATC response: The CC.COMP.36 SC Addendum has been revised to include our process for conducting queries of the SSDMF and ensure they are conducted timely.		
PROVIDER SERVICES			

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*			
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.			
The Centene Corporation Credentialing Program Description provides a brief overview of the Credentialing Program. Specific processes and requirements are detailed in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment and Reassessment. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. Policy CC.CRED.01 indicates ATC will process practitioner credentialing applications within 60 calendar days of receipt of a complete application, including all necessary documentation and attachments. However, Policy CC.CRED.09 does not define the timeframe within which ATC will process credentialing applications for organizational providers. *Quality Improvement Plan: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers.*	2/01/24 – ATC Response: Credentialing will revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers. 2/23/24 ATC RESPONSE: The timeframe for processing is found on page 53, number 26 of Policy CC.CRED.09.	✓	
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*			
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* 2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.			
As noted in Policy CC.PRVR.19, Provider Directory – Portico, ATC maintains a searchable, printable, web-based Provider Directory that includes all network providers. The policy lists elements that must be included in the Provider Directory and details processes for maintaining provider information for the directory. Information submitted along with the desk materials for this review indicated that instead of sending members a printed provider directory, ATC sends a letter providing the member with a list of their active	2/01/24 ATC Response: The following statement will be added to the Medicaid Member Home page (https://www.absolutetotalcare.com/members/medicaid.html) under the Member Quick Links icons and before the moral and religious statement AND to the Find a Provider page (https://findaprovider.absolutetotalcare.com/location) before the moral and religious disclaimer.	✓	

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
local providers and instructs them to call ATC or to use the find-a-provider tool on ATC's website to identify additional providers as needed. The *SCDHHS Contract, Section 3.12.5.10*, requires that the Provider Directory include "An explanation to all potential Members that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs." This explanation was not noted in the online Find a Provider tool. *Quality Improvement Plan: Add a statement to the online Find a Provider Tool that when multiple members of a family are enrolled with ATC, they may all choose the same PCP, or they may choose different PCPs for each family member.*	*PCP Choice: Multiple members of a family enrolled with Absolute Total Care may all choose the same PCP or each member may choose a different PCP.* The following statement will be added to the Medicaid Member Handbook under the Choosing Your Primary Care Provider (PCP) heading. *Multiple members of a family enrolled with Absolute Total Care may all choose the same PCP or each member may choose a different PCP.* <u>2/23/24 ATC RESPONSE:</u> 1) Currently our public website is undergoing a migration from AEM to a new cloud version AEM environment to improve both accessibility and usability. The migration process began in the late 2023 and is scheduled to go-live February 27, 2024. Any tickets submitted and worked during the migration are not guaranteed to transfer. Once the migration is final on February 27, 2024 a ticket will been submitted to incorporate the requested language on the find the provider tool to ensure compliance is met. 2) We are currently making multiple updates to the Member Handbook to satisfy guidance released by SCDHHS on 1/1/24 and 2/1/24. To avoid multiple SCDHHS submissions, once all changes are completed, we will submit the Member Handbook to the State for review and approval. Please see current redline* version as evidence that the changes are being implemented to "*Choosing Your Primary Care Provider (PCP)*" heading. <u>3/4/24 ATC Response:</u> The Web migration was completed on 2/27/24 and ticket ID 2246 was submitted. The request has been added to the Minor Enhancements list and is pending a response regarding estimated time to complete. An updated was requested on the status this morning.		
UTILIZATION MANAGEMENT			
V A. The Utilization Management (UM) Program			
1.7 the mechanism to provide for a preferred provider program.			

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Policy SC.UM.54, Preferred Provider Designation, provides an overview of their Preferred Provider process. However, during onsite discussion, ATC was unable to sufficiently describe the Preferred Provider Designation process. ATC stated that once a provider obtains Preferred Provider status that it is communicated to the provider; however, ATC was unable to describe their process for identification and tracking preferred provider status. Also, ATC was not able to describe the health plan's process for making providers aware of the program. *Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy SC.UM.54, Preferred Provider Designation, with a process for making providers aware of the program.*	2/01/24 ATC Response: The process is outlined in SC.UM.05: 1. Any one member on the Utilization Management Committee (UMC) can nominate and propose to designate any Participating Provider (PAR) as a preferred provider, known as the "sponsor" would notify the secretary of the UMC prior to the quarterly UMC to add to the agenda. 2. During the UMC, the sponsor will present two things that are voted on separately. a. First, their nomination and justification why the provider should be designated as a preferred provider and if approved, will then; b. Propose what relaxed or exempt authorization benefits should be approved for this provider. 3. Once both are approved, a future effective date will be decided by Population Health and Clinical Operations (PHCO) and Provider Engagement (PE). PHCO will initiate and complete the necessary ARQ and claims configuration changes. 4. PE will initiate provider notification to include both written notification and scheduled meetings with the appropriate provider rep. 5. PHCO works with PE to incorporate the PPD P&P in the new provider orientation and quarterly town halls. Will also add a section to the provider billing manual and update accordingly with information on the PPD P&P and publish with the next update. Can also work with marketing to create a flyer that can be sent to providers and/or posted on our website 2/23/04 ATC RESPONSE: 1) ATC Mistakenly noted SC.UM.05 in original response. 2) ATC is updating SC.UM.54 Preferred Provider Designation Policy to ensure contract compliance. 3) ATC's Multidisciplinary Leadership team will update and review all future versions. The Preferred Provider Designation policy will be added to the provider manual after updates to the policy. 3/24/24 ATC RESPONSE: Submit the revised policy (SC.UM.54) referenced.		✓

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
11. Denials 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			
Constellation Quality Health's review of a sample of denial decisions demonstrated that adverse benefit determinations were promptly communicated to the provider and member. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, in four sample denial files, the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request. This is no longer a contractual requirement. During onsite discussion, ATC reported they conducted a compliance audit in June 2023 and ensured that the verbiage was removed. *Quality Improvement Plan: Remove from adverse benefit determination notices that a written appeal request is required when an oral request is submitted.*	2/01/24 ATC Response: 1. A project was created to create and update the denial letter to have just one member denial letter that can be used for all adverse determinations. 2. ATC is deactivating all letters that are no longer authorized for use to prevent them from being used accidentally. By February 15, 2024. 2/23/24 ATC RESPONSE: The requested documentation has been uploaded for your review. The deactivation process involves submitting a ticket to the Centene business process team who is responsible for working and completing the ticket. All deactivated letters, once confirmed and approval to deactivate is obtained, require recoding and configuration so they can be archived that prevents a new letter from being generated while also still allowing the ability to access and view previously generated letters. The entire process averages 4 to 8 weeks, depending on certain expected and unexpected factors.	✓	
DELEGATION			
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*			
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.			
ATC provided documentation of oversight conducted for non-credentialing and credentialing delegates. For this EQR, ATC provided the annual evaluation for all entities and no issues were identified. However, Policy CC.CRED.12, Oversight of Delegated Credentialing, Section IV (Annual Evaluation, item E states, "Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval." During the previous EQR, ATC reported that results of the annual	2/01/24 ATC Response: Credentialing will ensure that the Credentialing Committee Minutes reflect review of the credentialing delegation oversight. 2/23/24 ATC RESPONSE: At this time, we do not have the evidence to provide.	✓	

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). However, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of credentialing delegation oversight. A copy of the 2022 – 2023 SC Delegation Report was included in the folder with the Credentialing Committee minutes, however, it was not mentioned in any of the minutes reviewed. *Quality Improvement Plan: Ensure Credentialing Committee Minutes clearly and completely document review and discussion of credentialing delegation oversight activities.*			

Constellation Quality Health

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Humana Healthy Horizons 2024 Quality Improvement Plan

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
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: 1.8 *Member Services Manager			
The *SCDHHS Contract, Section 2*, requires that the health plan have one in-state full-time employee to serve as Member Services Manager. This role is currently filled on an interim basis by Brad Utter, Associate Vice President, Inbound Contacts. He is located in MN, and per Humana staff, has been serving as Interim Member Services Manager for approximately 10 months. This is the second consecutive year Humana has not met the contractual requirement for the Member Services Manager position. During onsite discussion, Humana reported that the position is expected to be filled on a permanent basis by 2/25/24. *Quality Improvement Plan: Hire a full time Member Services Manager located in SC.*	Humana has promoted Tawana Barksdale into the role of Member Services Manager effective 2/26/2024. The organizational chart has been updated to reflect this appointment. 4/3/2024- Humana posted a requisition to backfill the Interagency Liaison position that Tawana Barksdale vacated. As of 4/1/2024, an offer has been made to a candidate to fill the role with a start date of 4/22/2024. The Org chart to reflect the new hire for the Interagency Liaison will be updated after 4/22/2024 and shared with the state and CCME.	✓	
I D. Compliance/Program Integrity			
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).			

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Humana manages members with inappropriate use of certain medications through the Pharmacy Lock-in Program, as described in Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program. The Overutilization Review and Monitoring department manages the program, and members are selected for inclusion based on review of SCDHHS-generated quarterly reports, along with the member's pharmacy claims history, by a pharmacist to determine the appropriateness of inclusion. Policy SC.RX.004 appropriately addresses member requests to select a different pharmacy; however, the information included about appealing the lock-in decision is unclear. Page two of the policy states, "If the member files an appeal, they will be granted a stay of action and removed from the lock in program." Onsite discussion of this finding revealed that the member is only removed from the program until the appeal determination is made. If the member's appeal is denied, the member is included in the program and restricted to one pharmacy. Policy SC.RX.004 addresses circumstances under which a mediation override may be granted but does not include the 72-hour limitation on an emergency supply of medication included in an override. Refer to the *SCDHHS Contract, Section 11.10.3.5* Additionally, Policy SC.RX.004 does not address the process for notifying members when the lock-in restriction is removed, as required by the *SCDHHS Contract, Section 11.10.5*. *Quality Improvement Plan: Revise Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, to include:* • *Full information about the process followed when members appeal inclusion in the lock-in program.* • *The limitation of 72 hours for emergency supply of medication.* • The process for notifying members when they are removed from the lock-in program.	Humana updated SC.RX.004 Pharmacy Lock -In Program to include additional information regarding the process for when a member appeals inclusion, the 72 hours emergency supply of medication and the process for notification once the member is removed from the lock-in program.	✓	
PROVIDER SERVICES			

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
II A. Credentialing and Recredentialing			
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies. 3.1.16 Additional Requirements for Nurse Practitioners.			
Two of the three initial credentialing files for nurse practitioners did not include the collaborative agreement between the nurse practitioner and the collaborating physician. *Quality Improvement Plan: Collect collaborative agreements for nurse practitioners at initial credentialing and include in the credentialing file.*	Humana has revised the process for collecting the required credentialing documents to include and verify the collaborative agreements for nurse practitioners. Humana has also developed a mitigation plan to verify any missing collaborative agreements. Nurse practitioners that have been identified with missing agreements will be outreached to obtain the collaborative agreement. This mitigation plan is expected to be completed by 6/28/2024.	✓	
II B. Adequacy of the Provider Network			
2. Practitioner Accessibility 2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.			
The online "find a doctor" tool and the PDF Provider Directories include all elements required by the *SCDHHS Contract, Section 3.12.5.1.1.* During onsite discussion, Humana was informed that the contractually-required statement that some providers may choose not to perform certain services based on religious or moral beliefs could not be located on the online "find a doctor" tool. Post-onsite, Humana acknowledged this finding. *Quality Improvement Plan: Revise the online 'find a doctor" tool to include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. Refer to the SCDHHS Contract, Section 3.12.5.7.*	Humana has revised the online "find a doctor" tool to include the required statement per the SCDHHS contract, Section 3.12.3.7. The update will go live on 3/27/2024. 4/3/2024- Humana has updated the "find the provider" tool and live link. The required statement has been added to the footer and a screenshot has been placed in the CCME SharePoint site as well. The following is the live link: https://finder.humana.com/finder/medical?customerId=1	✓	
MEMBER SERVICES			
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:			

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
1.2 Procedures for filing and handling a grievance;			
Discrepancies were noted in the timeframe for grievance acknowledgement, as follows: • Policy SC.MCC.005, Member Grievances and Appeals, states the grievance acknowledgement timeframe is 10 calendar days. • Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, does not define the timeframe for grievance acknowledgement. • The Member Handbook and Provider Manual state the grievance acknowledgement timeframe is within five (5) business days from the date of receipt of a grievance. *Quality Improvement Plan: Revise the documents listed above to consistently document the timeframe for grievance acknowledgement. Include the acknowledgement timeframe in Policy SC.GAA.001* Grievance acknowledgement letters do not indicate that a grievance may be filed if the member disagrees with an extension as required by the *SCDHHS Contract, Sections 9.1.6.1.4 and 9.1.6.1.5*. *Quality Improvement Plan: Revise the Grievance acknowledgement letters to indicate that a grievance may be filed if the member disagrees with an extension of a grievance resolution timeframe, as required by the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*	Humana has revised policy SC.MCC.005, Member Grievance and Appeals, and SC.GAA.001 SC Medicaid Grievance and Appeal policy have been updated to reflect the correct acknowledgement timeframe within 5 business days. Additionally, the Grievance acknowledgment letters have been revised to indicate a grievance may be filed if the member disagrees with an extension of a grievance resolution timeframe.		✓
2. The MCO applies grievance policies and procedures as formulated.			

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Three grievance files were closed with significant time remaining, with instructions for the member to contact the health plan to provide further information. *Quality Improvement Plan: Establish processes or training to ensure that grievances are not closed with significant time remaining when additional information is needed.*	Humana has revised the internal Medicaid Outreach Procedure document to include additional steps for member outreach. Please see steps 2 and 3 on page 3 of the procedure document.	✓	
QUALITY IMPROVEMENT			
IV A. The Quality Improvement (QI) Program			
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).			
Humana develops a work plan annually that includes measurable goals and objectives based on the previous year's annual evaluation. The 2022 and 2023 QI Work Plans were provided. The work plans included the quality improvement activities, the goals and objectives for each activity, the responsible party, and the expected completion date. The following errors were identified: • The Nurse Advice Line activity (line 14 of the 2022 workplan) indicated a report for this activity would be submitted to the Quality Assurance Committee. There was no documentation in the committee minutes that this report was provided. • The Quality Assurance Committee was incorrectly referred to as the Quality Assessment Committee and the Quality Assessment and Performance Improvement Committee in the 2022 and 2023 work plans. • In the 2023 work plan, the goal for the NICU activity states, "Track and trend average length of stay." However, the average length of stay is not being reported. The number of NICU admissions and the follow-up provided by Case Management was being reported. • The Performance Improvement Projects, line 26 of the 2023 work plan, is missing the HPV project.	Humana will ensure the Quality Improvement (QI) Work Plan template is updated on a quarterly basis. Humana has revised the following items: • The Nurse Advice Line activity is an active report within the committee and is reported as part of the quarterly sub delegation reporting. This has been notated for clarity in the 2023 and 2024 workplan to align with reporting structure. • The 2022, 2023, and 2024 workplans have been revised to state Quality Assurance Committee. • The long-term goal of average length of stay has been removed. • The HPV project has been added to the 2023 work plan.		✓

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Quality Improvement Project: Correct the errors noted in the QI work plans.			
IV B. Quality Improvement Committee			
2. The composition of the QI Committee reflects the membership required by the contract.			
The Committee Charter includes information about voting and non-voting members of the committee. This committee is chaired by the Chief Medical Officer and co-chaired by the Quality Improvement Lead. Other members of the committee include directors and representatives from the health plan's management staff. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. The committee meeting minutes demonstrated Humana had recruited two network providers, a pediatrician and an OB/GYN provider. The pediatrician attended the meetings held in 2023 and resigned from the committee in January 2024. The OB/GYN physician only attended one meeting (May 2023). During onsite discussion, Humana indicated that a primary care physician had been recruited and will be added to the committee in May 2024. Additional copies of the committee meeting minutes were submitted following the onsite. This additional information did not address the lack of a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.* <u>This was an issue identified during the previous EQR and not corrected.</u> *Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.*	Humana will continue recruitment efforts for in-network provider participation as part of the QAC. Humana is on track to add 4 different physician specialties (Behavioral Health, OB/Gyn, Family Medicine and Pediatrics) as voting members for the 2024 QI committee year beginning in May.	✓	
4. Minutes are maintained that document proceedings of the QI Committee.			

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Minutes are documented for each meeting and presented to the committee for review and approval at the next scheduled meeting. The QAC 2023 Charter indicates a quorum of fifty percent of the voting members plus one must be present for committee action, and voting members are expected to attend each meeting or appoint a representative in their absence. The committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings. Also, the August 2023 meeting minutes indicated the Committee Chair was absent. However, the minutes reflected the meeting was called to order by the Committee Chair. After the onsite, Humana submitted another copy of the QAC meeting minutes for meetings held in 2023. It was noted that for the August 2023 meeting, the voting members' attendance had changed. The Compliance Lead, the Clinical Pharmacy Director, and the OB/GYN external physicians were marked as present in the committee meeting minutes submitted after the onsite. These voting members were noted as absent in the meeting minutes submitted with the desk materials. Also, an external physician (pediatrician) was noted as absent in the meeting minutes submitted after the onsite. There was no documentation indicating why the attendance was changed and the minutes amended. *Quality Improvement Plan: Document in the QAC meeting minutes who has been appointed as the representative for voting members absent during the meetings. Develop a process for how errors or changes in the committee minutes should be documented and reported to the committee.*	Humana will be revising each agenda to clearly identify voting members as well as proxy designees in the absence of voting members. During the review and approval of minutes, errors and changes to meeting minutes will be documented and reported to the committee. Humana has developed a new policy, SC.QLT.012, Quality Improvement Work Plan, to address how errors and changes are documented and reported to the committee.		✓
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.			

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
At least annually, Humana assesses the effectiveness of their quality program. The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation provided the annual analysis of Humana's QI program with barriers, interventions, and conclusions or recommendations for each activity. Constellation Quality Health found the previously identified issues were not corrected in the evaluation received for this EQR. There were issues with missing data or results and incorrect goals being measured. Those included: • The Delegation Oversight activity was not included in the evaluation. • Page 33, Section D, Monitoring and Improving Patient Safety indicates the goal for this activity is set at: o 80% of cases are closed or sent to Peer Review Committee within 90 days o 90% of cases are closed or sent to Peer Review Committee within 120 days However, the goal in the 2022 QI work plan for this activity is listed as 90% of the cases are closed or sent to the Peer Review Committee within 120 days, and 95% within 160 days. • The tables on pages 38 and 39 note there were no complaints, grievances, and appeals for 2022 related to access. However, the Grievance and Appeal section of the evaluation (page 47) noted several grievances in the second, third and fourth quarters of 2022 related to provider access issues. • Page 47 states there were no Behavioral Health grievances or appeals for 2022. However, under the Qualitative Analysis section, grievances related to behavioral health are noted in the second and third quarters of 2022. • The graph on page 86 was upside down. *Quality Improvement Plan: Correct the errors noted in the 2022 QI Program Evaluation and include a summary of the Delegation Oversight activities.*	Humana has re-evaluated the Quality program's 2022 calendar year to include the plan's first 12 months. This re-evaluation was completed in August 2023. Humana is working through the 2023 QI Program Evaluation. Humana will be sure that any incorrect data is reviewed and remediated in the upcoming QI Program Evaluation. Humana will be sure to include a summary of Delegation Oversight activities in the 2023 QI Program Evaluation that will be completed in August 2024.	✓	

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
UTILIZATION MANAGEMENT			
V B. Medical Necessity Determinations			
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.			
Constellation Quality Health's review of a sample of adverse benefit determinations demonstrated that the decisions were promptly communicated to the provider and member. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, the sample of adverse benefit determination letters and the adverse benefit determination letter templates incorrectly informed the member that a written appeal is required when an oral request is submitted. *Quality Improvement Plan: Remove the requirement that a written appeal request must be submitted following an oral request for an appeal in the adverse benefit determination notices.*	Humana has revised the adverse benefit determination notices to remove the following language stating, "You must send an official request in writing."	✓	
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:			
Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, and Policy SC.MCC.005, Member Grievances and Appeals, describe processes for responding to appeals. Appeals information is included in the Member Handbook and Provider Manual. However, Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not indicate that a grievance can be filed if the member disagrees with an extension of the appeal resolution timeframe. *Quality Improvement Plan: Correct Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template to indicate that a grievance can be filed if the filer*	Humana has updated policy SC.MCC.005, Member Grievances and Appeals and the Appeals Acknowledgement Letter to include language that the filer may file a grievance if they disagree with an extension of the appeal resolution timeframe.		✓

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
disagrees with an extension of the appeal resolution timeframe. as required by the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.			
DELEGATION			
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.			
Humana's 2023 Subcontractor and Oversight Monitoring Plan and policy SC.DCO.001, Delegation Policy describes the oversight process for any activity or function that has been delegated to another entity. This process includes a pre-delegation audit conducted prior to any function being delegated. Annual audits are conducted to evaluate all delegates' continued ability to meet the contract requirements and performance standards. Policy SC.DCO.001 includes the specific requirements for sub-delegation. Delegates are required to request approval from Humana to sub-delegate any portion of the delegated functions or activities. However, this policy does not include the requirement to notify SCDHHS of any further delegation by a subcontractor (*SCDHHS Contract, Section 2.5.11*). Humana provided copies of the annual delegation oversight monitoring. The following issues were identified in the audit tools: • The element regarding the CLIA was marked as not applicable for six of the delegates during the file review. • For three of the delegates, the nurse practitioner agreement was not checked during the file review. This element was marked as not applicable. • Hospital admitting privileges were not checked during the file review for one delegate. Following the onsite, Humana responded to these deficiencies and acknowledged the elements were not scored appropriately during the annual audits.	Humana has revised SC.VMT.002 – Subcontractor and Monitoring Plan, SC.DCO.001 – Delegation Policy, and the Delegation Services Addendum to include required language that SCDHHS must be notified of further delegation by Humana. Humana held a Credentialing Delegation team meeting on February 21, 2024, to re-educate staff on CLIA requirements for SC.	✓	

2024 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Quality Improvement Plan: Include the SCDHHS requirement to notify SCDHHS of any further delegation by a subcontractor. Also, ensure this requirement is included in each delegate's contract. *Re-educate staff conducting the annual oversight audits regarding the credentialing and recredentialing requirements that should be checked during the file review.*			

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Molina Healthcare 2023 Quality Improvement Plan

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II B. Adequacy of the Provider Network			
3. Practitioner Accessibility 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.			
Policy MHSC-PS-005, Provider Availability Standards, the Provider Manual, and the Member Handbook appropriately define appointment access standards for PCPs. Requirements for specialty care appointments are found in the *SCDHHS Contract, Section 6.2.3.1.5*. For specialty providers, Policy MHSC-PS-005 does not include the requirements for emergent visits immediately upon referral and urgent medical condition care appointments within 48 hours of referral or notification of the PCP. The Provider Manual, pages 68-69, and the Member Handbook, page 29, include requirements for emergent visits and urgent medical condition care appointments; however, the information is found in table with a heading of "PCPs," so it is not clear that the information applies to specialist appointments. Also, the Provider Manual and Member Handbook define the requirement for routine specialist appointments as 12 weeks; however, this is incomplete.	The correct availability standards for specialty providers were updated in both the Member Handbook and the Provider Manual in July. They are both live on Molina's website and we have submitted both documents for your reference. Policy MHSC-PS-005_Provider Availability Standards was edited to include updated Specialist availability requirements. The redlined version was submitted for review, and the policy will go to the policy committee for approval in August. Policy MHSC-PS-005 Provider Availability Standards has been updated to include 'emergency' and 'urgent' availability requirements. The redlined policy has been submitted and will go to the next policy committee for approval. Page 71 of the manual has been updated to include the requirements for 'emergent' and 'urgent' specialist appointment referrals. Page 29 of the handbook has been updated to include the requirements for 'emergent' and 'urgent' specialist appointment referrals.	✓	

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
As stated in Procedure MHSC-PS-005, Molina conducts annual provider availability and after-hours telephonic surveys of PCP, specialty, and behavioral health providers to evaluate compliance with appointment access standards. Providers who do not meet the standards are re-educated and resurveyed within 3-6 months. *Quality Improvement Plan: Revise Policy MHSC-PS-005, the Provider Manual, and the Member Handbook to clearly state the requirements for specialty appointments. Ensure the information is compliant with the standards defined in the SCDHHS Contract, Section 6.2.3.1.5.*			
Utilization Management			
V. B. Medical Necessity Determinations			
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.			
Molina's UM Program Description and Policy MHSC-HCS-UM-365, Clinical Criteria Utilization Management Decision Making, describe that health practitioners utilize external and internal guidelines such Milliman Clinical Guidelines (MCG), Official Disability Guidelines (ODG), Hayes Technology Assessments, Inpatient Hospital Services Coverage Requirements, and State Guidelines to make clinical coverage decisions. However, Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, continues to identify InterQual as an evidenced based criteria utilized in clinical determinations. This was an issue identified in the previous EQR. During onsite discussion, Molina responded that they have removed the reference to InterQual Criteria to the stated policy and committee approval is pending. After the onsite, the health plan submitted an updated draft policy.	MHSC-HCS-UM-365 was retired on 2/13/2023 and replaced with Molina Policy & Procedure: • HCS-365 Clinical Criteria for UM Decision Making Policy / HCS-365.01 Clinical Criteria for UM Decision Making Procedure • HCS-394 Clinical Determination of Appropriate Level of Care Policy / • HCS-394.01 Clinical Determination of Appropriate Level of Care Procedure In MHI policy 394 it does list InterQual and Milliman because different states use different decision criteria. In order to change MHI P&P to align with SC ADDENDUM HCS-394 Clinical Determination of Appropriate Level of Care Policy was created and approved in HCS Committee on 6/20/2023 to remove InterQual.	✓	

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Quality Improvement Plan: Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making and remove the reference to InterQual Criteria.			
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: 1.2 The procedure for filing an appeal;			
Requirements for filing an appeal are documented in Molina's UM Program Description, policies, and procedures. However, page 50 of Molina's UM Program Description indicates that a standard request for an appeal received verbally must be followed by a written request within 30 days. This was an issue identified in the previous EQR. During onsite discussion, Molina shared that this verbiage has been removed from the UM Program Description and committee approval is pending. Also, the letter template for acknowledging a standard appeal incorrectly informs the member that a written request is needed after an oral request. Lastly, the letter template used to inform a member that an appeal was closed also mentions a written appeal was not received after an oral request. The health plan shared that neither of these letters is currently being utilized. *Quality Improvement Plan: Update all documents related to the process for filing an appeal and remove the requirement that a standard request for an appeal received verbally must be followed by a written request.*	PROGRAM DESCRIPTION: 2023 Program Description was approved before committee on 6/20/2023 with verbiage removed, please see attached copy. Page 52 reads: "Appeals may be expedited or standard. Expedited appeals may be requested verbally or in writing. Standard appeals can also be requested verbally or in writing." APPEAL LETTERS: While appeal letters MIRR-014 and MIRR-016, which contain language requiring a written appeal following an oral request, were still in Molina's system these letters were no longer in use after April 2022. At that time Appeals staff was notified of the change that oral appeals no longer required follow up in writing. These letters were submitted for EQR 2023 in error, as they are defunct and no longer in use. As of today, Molina has had 014 and 016 letters removed from the system. Letters MIRR-001 and MIRR-006 are used for appeals acknowledgement and do not include language related to oral appeals and follow up in writing. These letters have been resubmitted for your reference.		✓
V. D. Care Management and Coordination			
8. Care management and coordination activities are conducted as required.			
A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, the following issues were identified:	DOCUMENTATION OF ICPs: Molina requested a list of applicable files and received 8 members. We have submitted documentation of ICP date, note for consent, and when ICP was created for all 8 members. FOLLOW UP SCHEDULE OF PROGRESS:	✓	

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
• For seven files, there was no identified note or date provided on the creation of the Individualized Care Plan (ICP). • Two files did not have ongoing documentation of notes that entail a follow up schedule or an assessment of the member's progress that were receiving Level III Complex CM services. *Quality Improvement Plan: In Individualized Care Plan development, please ensure to obtain and accurately document the date of the signed acknowledgement and receipt with the member, and that a follow up schedule with documentation of the members' process is appropriately documented.*	For the 2 files, we have submitted documentation of follow up schedule for outreach and progress for Complex CM services.		

Constellation Quality Health

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Select Health 2023 Quality Improvement Plan

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II B. Adequacy of the Provider Network			
2. Practitioner Accessibility 2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.			
As part of the annual EQR process for Select Health Plan, a provider access study was performed focusing on PCPs. A list of current providers was given to Constellation by Select Health, from which a population of 2,802 unique PCPs were found. A sample of 210 providers were randomly selected from this population for the 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. In reference to the results of the Telephone Provider Access Study, conducted by Constellation, calls were successfully answered 55% of the time (107 out of 193) when omitting calls answered by personal or general voicemail messaging services. The success rate declined from last year's rate of 60%. When compared to last year's results of 60%, this year's study rate of 55% was a non-significant decrease in successful calls (p = .317). For those not answered successfully (n= 86 calls), 54 (63%) were due to the physician no longer being active at that location; 28 (33% were due to a wrong number, hold time longer than five minutes, or busy signal, and four were due to call not being answered (5%).	The Select Health of SC's (SHSC) Provider Directory Workgroup will continue to identify a process to review and update provider information. The workgroup will also work on identifying additional opportunities to maintain an accurate listing of providers and reeducate providers on all required appointment access standards. 12/15 *<u>SHSC Response:</u> The Provider Network Account Executives (AEs) are responsible for reviewing a minimum of 30 groups in their respective areas per month. A provider list, based on most current provider directory, is used by the AEs to review with each group. All updates are sent to the provider enrollment team for updating the system. The data reviewed by the AEs includes provider names currently listed in the directory, if there are new are termed providers in the group, address, and phone numbers, accepting new patients and age range of members seen.* *A Provider Directory Validation survey is also completed annually to determine accuracy of provider data. Results from the 2023 survey indicated that all audit elements surveyed exceeded the goal of 85%. Additionally, provider directory data for other provider*		✓

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Of 107 providers successfully contacted, 103 (96%) accepted Select health and four (4%) did not accept Select Health. Of the 103 who are accepting Select Health, 74 (72%) are accepting new patients; 29 (28%) are not accepting new patients. A routine appointment was available within the contract requirements (30 days) for 26 (35%) of the 74 that are accepting new patients and outside the required timeframe for 48 (65%). *Quality Improvement Plan: Continue current processes that are conducted to update and validate provider contact information. Look for additional ways to improve provider contact information, such as increasing the frequency of monitoring and verifying provider contact information. Also, reeducate all providers about required appointment access standards.*	*specialties are reviewed based on business need. For example, all of the Physical Therapy, Occupational Therapy and Speech Therapy providers are in the process of being reviewed to ensure accuracy including data elements such as address, phone number and age of patients seen. Additionally, any data updates submitted through the online provider directory are routed to the assigned AE to review, validate and update as needed. See attached Provider Directory Accuracy Report TAB 02A and Provider Directory Validation Memo TAB 02B.* *In addition, A revised and expanded Provider Directory Workgroup is being established to improve the accuracy of the provider data listed in the provider directory. The first meeting is set up for the week of 12/18/23.* *SHSC RESPONSE: Meeting Agendas with notes have been provided for the Provider Data Workgroup held between the departments Provider Network Operations and Provider Network Management. An agenda has been provided for at least one meeting held within a quarter. See meeting agendas with notes TABS 02C-TAB 02G.* *SHSC RESPONSE: The changes being discussed will be to the revised and expanded workgroup, which the goal of is to establish a timeframe and best approach to survey providers. It will also* identify which providers are most critical for review. The first meeting is scheduled for 12/18/23. *SHSC RESPONSE: The revised and expanded workgroup is working on creating new innovations for maintaining an accurate list of providers. These interventions will involve multiple departments to assist in the process for updating provider data. One of the problematic items that the work group will focus on is providers not communicating when they have moved, changed address, or removed or added a new provider.*		

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	SHSC RESPONSE: The plan will include a notice about provider updates in the provider newsletters and within our provider portal for any reeducation to providers regarding appointment access standards as changes are made. *SHSC RESPONSE: The plan has implemented a quality improvement project to identify provider contact information through the revised Work Group.*		
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: 1.7 the mechanism to provide for a preferred provider program.			
Select Health's Policy UM.318S, Preferred Provider Program, indicated the Preferred Provider Program is designated for providers to have clinical review requirements waived and annually, Medical Directors conduct retrospective chart and claims audits for providers to maintain eligibility within the program. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented such as Contract Exceptions and Primary Care Physician Auto Assignment. Neither of these two processes are communicated to the providers for participation and do not correspond with the processes outlined in Policy UM.318S, Preferred Provider Program. *Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy UM.318S Preferred Provider Program.*	SHSC is evaluating the current policy and process for Preferred providers and will adjust/update to align with the SCDHHS contract requirement and the current processes. The Preferred Provider policy number UM.318S and the process documents will be updated and communicated to providers by the end of 1st quarter 2024.	✓	
V B. Medical Necessity Determinations			
6. Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.			

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. There was no information regarding when the negative PDL changes were published on the website. The *SCDHHS Contract, Sections 4.2.21.2.1* and *4.2.21.3,* requires the health plan's Pharmacy & Therapeutics Committee to approve the PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plan's website at least 30 days prior to implementation. Select Health's changes posted on the website did not appear to meet this requirement. *Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Select Health's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*	SHSC's website includes a copy of the 2023 Preferred Drug List Changes. This list notes the drug changes and the effective date for those changes. Going forward, the date stamp of the posted date will be added to the website. The Pharmacy team is working with the Communications Team. PerformRx, the pharmacy benefit manager for Select Health, reviews and maintains the Preferred Drug List. The Pharmacy & Therapeutics Committee also provides input for the pharmacy program and has met four times this year. The goal of the committee is to approve pharmacy policies, criteria review, and review the preferred drug list changes.	✓	
V C. Appeals			
2. The MCO applies the appeal policies and procedures as formulated.			
The sample of appeal files reviewed found issues with seven files. • For one file, Select Health extended an expedited appeal request without notifying the member as required by the *SCDHHS Contract, Section 9.1.6.1.5* and Policy MMS.100, Member Grievances and Appeals Process. Also, the acknowledgement letter sent to the member incorrectly indicated that the appeal would be resolved within 30 days as opposed to the 14-day extension timeframe. The reason for the extension was not documented in the appeal notes reviewed or conveyed to the member. • The acknowledgement letter was not sent for one standard appeal and five expedited appeal requests. During the onsite, Select Health indicated a verbal acknowledgement is given for expedited appeal requests. However, Policy MMS, 100, Member	All extension cases will be monitored on our dashboard for communication (date and time) with member / provider and extension letters are completed and mailed (date and time). Acknowledgement letters are not sent for expedited cases but instead a verbal notification is provided. We will update this information in our policy for state approval. If the case will not allow us to change this in the policy, we will need to develop a new acknowledgment letter for expedited. The appeals review process has been updated for all letters. Documentation of date and time from Client Letter must be documented in the case and copy of letter uploaded to episode before the cases is closed.	✓	

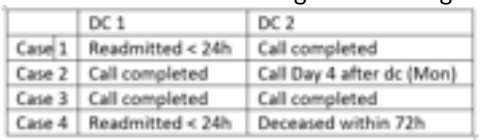
2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Grievances and Appeals Process, Section IV, Expedited Appeals, indicates the Appeals Administrator will create and mail a member's acknowledgment letter. *Quality Improvement Plan: Ensure that acknowledgement letters are sent to members in accordance with Policy MMS.100, Member Grievances and Appeals Process. Develop a process to monitor a sample of appeal files to ensure all the requirements for processing appeals are met. Conduct a root-cause analysis when deficiencies are found so interventions can be developed to address the deficiencies.*			

Constellation Quality Health

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Molina Healthcare of South Carolina MMP 2023 Quality Improvement Plan

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II B. Adequacy of the Provider Network			
1. The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services.			
CCME requested a complete list of all contracted HCBS providers currently in Molina's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. All 46 counties in SC had at least one member in the MMP Member Demographics 2022 file received with the desk materials. Of the 322 services across 46 counties, there were 41 services that did not meet the requirements and 281 that met the minimum requirement. This yielded a validation score of 87% (281/322). Only five counties met the minimum requirements for case management services. *Quality Improvement Plan: Recruit additional case management providers for the 41 counties not meeting the minimum requirements for case management services.*	Please see submitted documents: '2023 EQR Quality Improvement Plan – HCBS case mgmt' and updated HCBS Providers listing with additional contracted providers added.	✓	
CARE TRANSITIONS			
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.			
The SC MMP Care Transition Program Description, Policy MHSC-HCS-CM-068-MMP, Molina Transitions of Care,	Facility Collaboration: We met with our Medicare UM Team to discuss ways to improve and better document collaboration with facilities for transition of care activities. Efforts include: 1) moving		✓

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
and the associated procedure describe Molina's care transition process. CCME reviewed a sample of 30-day readmission files submitted by Molina. The initial review findings were discussed with Molina onsite. Additional information was provided, and the following is a summary of the issues identified after reviewing the additional information: • Files lack documentation of collaboration with the facility Case Management or Discharge Planning staff to ensure a safe transition. Most of the documentation was the communication to the facility regarding the approval of the admission. • Documentation of any needed clinical and non-clinical supports, transition/aftercare appointments, and any barriers for after-care was lacking in two files. • Three files lacked documentation of outreach to the member to conduct the 72-hour follow-up post discharge. For one of the three files, the attempt to reach the member was documented, however this attempt was outside of the 72-hour window. • Medication monitoring adherence after the initial 72-hour follow-up was not evident in four files. • Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done. These findings were the same or similar to the findings from the 2022 EQR. *Quality Improvement Plan: Make necessary changes to ensure the requirements for member transitions are met. The TOC files should contain:* • *Documentation of the collaboration with the facility Case Management/Discharge Planner.*	facility outreach responsibility to the Concurrent Review staff, 2) CM outreach to Hospital CM offices once members appear on our census report. This outreach is documented in our Case Management system. This approach still presents a challenge as we are finding they rarely take our calls or respond to our emails. However, we will continue to attempt to reach hospital CM in efforts to ensure our members obtain any needed post-discharge services. A new UM system will be implemented in late August and Molina plans to leverage that system to improve documentation of facility outreach and communication. Clinical Supports and Barriers: The Enterprise TOC Assessment, which was rolled out mid-2022, asks about many TOC-related barriers and includes a comprehensive evaluation of post-discharge needs. Following this review, we realized that the printed version of the new eTOC Assessment does not show all of the branching logic that is available in the electronic version. It also does not print out all of the options that were not answered in the affirmative by the member. Please see the submitted full text version of the eTOC assessment. This blank assessment form shows that barriers, needed supports and medication issues are clearly evaluated, if they are present. 72-Hour calls: We are committed to making attempts to reach the members within 72 hours for the discharge. As highlighted below, when members are readmitted within 24 hours, the Plan doesn't have an opportunity to complete this activity. Since contacts with members while they are inpatient do not meet this requirement, we did attempt to reach the member or caregiver following the second discharge.  In Case 2, the Plan had no knowledge of the 2nd discharge within the 72-hour timeframe. The CM had called on Wednesday and was told that the member was going to be transferred to a SNF later in the week, there was no mention of discharge. The CM was able to reach the caregiver on the following Monday to inquire about the transfer and was notified then that the member had been discharged the previous Thursday afternoon. The CM learned of the discharge from the caregiver that morning and assisted them with DC needs. The facility notified Molina on Tuesday, five days after the discharge, of the discharge event.		

	DC 1	DC 2
Case 1	Readmitted < 24h	Call completed
Case 2	Call completed	Call Day 4 after dc (Mon)
Case 3	Call completed	Call completed
Case 4	Readmitted < 24h	Deceased within 72h

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
• *Any identified clinical and non-clinical support needed, transition/aftercare appointments, and barriers to after-care.* • *Documentation of contact with the member and/or care giver within 72 hours of the member's discharge.* • *Medication monitoring adherence after the initial 72-hour follow-up.* • *Attempts to conduct post-discharge reassessments for any of the trigger events.*	In Case 4, the member was discharged on Hospice and died within the first 72 hours. Medication Adherence: Medication adherence is assessed every contact with a member regardless of TOC status. We did not submit that evaluation with this file review. We will train CM staff to capture information regarding medication adherence as part of the TOC process and include within the system to support TOC documentation. This training will be completed, and process implemented by September 1st. Reassessment: Members with multiple hospitalizations are categorized as High Risk and are required to complete the Prime Comprehensive Assessment, which is face to face. Going forward, we will refer them for scheduling of this home visit as soon as we are notified of a discharge. This process was in already in place, but was interrupted during the Public Health Emergency. It was not reimplemented until after this audit period due to the public health emergency restrictions still in place. Molina: The HCS team was able to produce a format of the eTOC Assessment that includes imbedded dates that display within the form. We have submitted copies of the full TOC and eTOC Assessments. Text boxes were added to indicate that those were only examples to show all areas addressed, as completed member assessments only display the member affirmative answers. Also included are the dates in which each assessment was valid during 2022. Attached also find a copy of the staff eTOC training invite, which confirms the date of transition to the new eTOC assessment (9/26/22). Molina: During this review, we have discovered that the printed version of the new eTOC does not include the dates the assessment was entered and completed. These dates are captured on our live system, but do not display on the printed version. We are actively working with out Molina IT team to update our system to include this information in the printed version of the assessment. In the interim, we have identified a work-around for this issue. We are able to export the completed assessment that contains all of the relevant information as an excel file, and then convert it to pdf. Please see the submitted updated eTOC assessments. These documents include the relevant dates of assessment completion, as well as the name of the CM who completed it. In the future we will use this method to provide case file documentation until such time that this is updated in our system.		

Constellation Quality Health

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

First Choice VIP Care Plus by Select Health 2023 Quality Improvement Plan

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
CARE TRANSITIONS			
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.			
Constellation Quality Health reviewed a sample of 30-day readmission files submitted by Select Health. Most of the files reflected that the assessments and reassessments were being conducted as required. There were several files (13) that reflected no attempts to contact the facility's Case Management/Discharge Planning staff or the member's PCP, an assessment or reassessment was not completed, and no documentation of the medication monitoring performed after the 72-hour follow-up. These were issues identified during the 2022 EQR. When discussed onsite, Select Health indicated all of these transitions occurred prior to the implementation of the quality improvement plan developed following last year's EQR (2022). However, for the files where the transition occurred <u>after</u> the implementation of the quality improvement plan; Constellation Quality Health noted an improvement in the documentation of collaboration with the facility case managers and the member's PCP. There were still issues with this collaboration for five files. Also, there was no	Policy CM 156-209 Comprehensive Transitional Care was revised to include medication monitoring after the 72-hour follow up. The policy is in draft format and set for review/approval on December 19, 2023. On November 27, 2023 the SC MMP CM leader met with our internal auditing department to outline a plan for auditing a sample of each Coordinator's files to assess the effectiveness of the changes made in the process. The December 2023 audits will reflect the changes related to transitions. Corporate audit policy included: Corporate%20Clinical%20Audit%20Polic On November 29, 2023 a meeting was held with the transition of care (TOC) team to review the results from the audit and provide additional education. Cases were reviewed and Instructions were provided to ensure enhanced communication with the PCP and med monitoring after the 72-hour follow-up. Minutes included:		✓

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
documentation of the medication monitoring performed after the 72-hour follow-up for five files. *Quality Improvement Plan: Develop a plan to audit a sample of each Case Manager's cases/files to assess the effectiveness of the changes made in the process to meet the contract requirements related to transitions. Reevaluate the process for medication monitoring required after the initial 72-hour follow-up.*	 TOC_Meeting_Minutes.docx		

Constellation Quality Health

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Wellcare Prime by Absolute Total Care 2023 Quality Improvement Plan

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
CARE TRANSITIONS			
2. Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes.			
Constellation Quality Health reviewed a sample of 30-day readmission files submitted by Wellcare. Most of the files contained detailed notes regarding the transitions and the outreach to the member, primary care provider and the facility. There were several files that reflected no attempts to contact the facility's Case Management/Discharge Planning staff or the member's PCP, and untimely attempts to contact members/caregivers within 72-hours of discharge. These were issues identified during the 2022 EQR. Wellcare addressed this deficiency with a quality improvement plan and some of these transitions occurred prior to the implementation of that plan. *Quality Improvement Plan: Develop a plan to audit a sample of each Case Manager's cases/files to assess the effectiveness of the changes made in the process to meet the contract requirements related to transitions.*	1. Wellcare Prime leadership team will review Constellation Quality Health's recommendations and current processes with teams to ensure key metrics are met within established parameters. 2. Wellcare Prime leadership will ensure random sampling of each case manager's files to assess metrics adhere to regulatory standards. 3. Senior Case Manager will work closely with manager and director of transition of care department to assess random sampling of each case managers cases monthly. 4. Member-facing FTE's to review cases presented during EQRO with Sr. CM or manager. 5. Member-facing FTEs will receive retraining on key metrics and appropriate timeframes as defined by regulatory standards. 6. Senior leadership will monitor audit results monthly to ensure contract compliance 7. Senior leadership will continue to explore digital programs for more real time receipt of discharge data (Availity, SCHIEX, other integrators, contracted facility data feeds, EMR access)	✓	

Attachment 2: SC Medicare–Medicaid Plan Core Measures Performance Data

South Carolina Medicare-Medicaid Plan Core Measures Performance Data

Introduction

Under the Medicare-Medicaid Financial Alignment Initiative (FAI) capitated model, the Centers for Medicare & Medicaid Services (CMS) is collecting a variety of measures that examine plan performance and the quality of care provided to enrollees. The Medicare-Medicaid Plan (MMP) performance data published here represent currently available data on MMP performance on certain Medicare Parts C and D quality measures as well as select CMS core measures that MMPs are required to report. The data show MMP performance on quality measures during 2022 and the results of surveys of MMP enrollees conducted in 2022 or 2023.

The scope of the measures displayed here is limited, particularly in the area of long term services and supports. Consequently, we urge caution in using any of these data for comparative or MMP selection purposes.

In addition, we note that the differences in MMP eligibility across states participating in the FAI, and the differences in the characteristics of enrollees in particular MMPs, may limit the ability to compare MMP performance across demonstrations. For example, enrollment in MMPs in Massachusetts is limited to individuals under the age of 65 at the time of enrollment, while in South Carolina, only individuals aged 65 or older living in the community can enroll. In the New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration, only individuals with IDD can enroll.

Additional details and technical specifications for each measure can be found in the accompanying MMP Performance Data Technical Notes. Questions about the MMP performance data should be sent to: mmcocapsmodel@cms.hhs.gov.

State Weighted Averages

Within the MMP Performance Data File, state weighted averages are provided for each measure. Depending on the measure type, the averages are weighted by the enrollment of each MMP with valid data for the measure or by the eligible population for the measure as reported for each MMP. More specifically, averages for measures from the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey are weighted using the total number of members enrolled in February 2022 and January 2023, respectively, to align with the timeframe during which each survey's sampling frame was drawn. Averages for the Call Center Foreign Language Interpreter and TTY Availability measures are weighted using the total number of members enrolled in February

2023 to align with the timeframe during which call center monitoring commenced. Averages for all other measures are weighted using each MMP's eligible population for the measure (e.g., the denominator for each MMP).

Differences between the 2023 and 2024 MMP Performance Data File and Technical Notes

There were a few changes between the 2023 and 2024 versions of the MMP Performance Data File and Technical Notes. This section provides a summary of the notable differences.

Revisions:

– Where applicable, measure numbers, measure specifications, and related attachments were updated to comport with the Medicare 2024 Part C & D Star Ratings Technical Notes and Medicare 2024 Part C & Part D Display Measure Technical Notes.

Additions:

– The following measures were added to the MMP Performance Data File and Technical Notes:

  - Transition of Care (C17)
  - Follow-up after Emergency Department Visits for People with Multiple High-Risk Chronic Conditions (C18)

Removals:

– The following measure was removed from the MMP Performance Data File and Technical Notes:

  - Diabetes Care – Kidney Disease Monitoring (C10)

Measure (MY)		Wellcare Prime by ATC	Molina Healthcare of SC	First Choice VIP Care Plus	South Carolina Weighted Averages
Domain 1: Coordination of Care and Long Term Services and Supports	M21: Comprehensive Health Risk Assessment (01/01/2022 – 12/31/2022)	98%	99%	97%	98%
	M32: Care Plan Completion (01/01/2022 – 12/31/2022)	97%	95%	96%	96%

Measure (MY)		Wellcare Prime by ATC	Molina Healthcare of SC	First Choice VIP Care Plus	South Carolina Weighted Averages
	DMC21: Care for Older Adults – Functional Status Assessment (01/01/2022 – 12/31/2022)	66%	68%	55%	62%
Domain 2: Managing Chronic (Long Term) Conditions/Health Outcomes	C06: Care for Older Adults – Medication Review (01/01/2022 – 12/31/2022)	91%	79%	96%	90%
	C07: Care for Older Adults – Pain Assessment (01/01/2022 – 12/31/2022)	79%	79%	73%	76%
	C08: Osteoporosis Management in Women who had a Fracture (01/01/2022 – 12/31/2022)	Not enough data available	Not enough data available	25%	25%
	C09: Diabetes Care – Eye Exam (01/01/2022 – 12/31/2022)	51%	56%	62%	57%
	C10: Diabetes Care – Blood Sugar Controlled (01/01/2022 – 12/31/2022)	70%	74%	72%	72%
	C11: Controlling Blood Pressure (01/01/2022 – 12/31/2022)	62%	64%	61%	62%
	C12: Reducing the Risk of Falling (07/19/2022 – 11/01/2022)	70%	65%	67%	68%
	C13: Improving Bladder Control (07/19/2022 – 11/01/2022)	Not enough data available	38%	43%	41%
	C14: Medication Reconciliation Post-Discharge (01/01/2022 – 12/31/2022)	32%	31%	59%	44%
	C15: Plan All-Cause Readmissions (01/01/2022 – 12/31/2022)	1.27	1.14	1.33	1.25
	C16: Statin Therapy for Patients with Cardiovascular Disease (01/01/2022 – 12/31/2022)	83%	84%	88%	85%
	C17: Transitions of Care (01/01/2022 – 12/31/2022)	28%	27%	41%	34%

Measure (MY)		Wellcare Prime by ATC	Molina Healthcare of SC	First Choice VIP Care Plus	South Carolina Weighted Averages
	C18: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (01/01/2022 – 12/31/2022)	49%	47%	49%	48%
	D08: Medication Adherence for Diabetes Medications (01/01/2022 – 12/31/2022)	83%	83%	82%	83%
	D09: Medication Adherence for Hypertension (RAS antagonists) (01/01/2022 – 12/31/2022)	85%	83%	82%	83%
	D10: Medication Adherence for Cholesterol (Statins) (01/01/2022 – 12/31/2022)	85%	82%	79%	82%
	D11: MTM Program Completion Rate for CMR (01/01/2022 – 12/31/2022)	73%	5%	86%	62%
	D12: Statin Use in Persons with Diabetes (SUPD) (01/01/2022 – 12/31/2022)	87%	89%	88%	88%
	DMC01: Follow-up Visit after Hospital Stay for Mental Illness (within 30 days of discharge) (01/01/2022 – 12/31/2022)	Not enough data available	39%	Not enough data available	39%
	DMC02: Antidepressant Medication Management (6 months) (01/01/2022 – 12/31/2022)	85%	67%	64%	71%
	DMC12: Initiation of Substance Use Disorder Treatment (01/01/2022 – 12/31/2022)	37%	49%	38%	42%
	DMC13: Engagement of Substance Use Disorder Treatment (01/01/2022 – 12/31/2022)	4%	6%	5%	5%
Domain 3: Member Experience with	C19: Getting Needed Care (03/2023 – 06/2023)	80%	84%	85%	83%

Measure (MY)		Wellcare Prime by ATC	Molina Healthcare of SC	First Choice VIP Care Plus	South Carolina Weighted Averages
Integrated Plan and Care Providers	C20: Getting Appointments and Care Quickly (03/2023 – 06/2023)	76%	79%	81%	79%
	C21: Customer Service (03/2023 – 06/2023)	Not enough data available	92%	93%	93%
	C22: Rating of Health Care Quality (03/2023 – 06/2023)	86%	89%	88%	88%
	C23: Rating of Health Plan (03/2023 – 06/2023)	87%	88%	89%	88%
	C24: Care Coordination (03/2023 – 06/2023)	Not enough data available	87%	88%	88%
	OHP5: Satisfaction with Care Coordination (03/2023 – 06/2023)	57%	49%	53%	53%
	CC10: Access to Medical Equipment (03/2023 – 06/2023)	51%	57%	39%	48%
	CC14: Access to Personal Care (03/2023 – 06/2023)	52%	58%	64%	58%
	MH3: Access to Mental Health Treatment (03/2023 – 06/2023)	Not enough data available	Not enough data available	65%	65%
	D05: Rating of Drug Plan (03/2023 – 06/2023)	90%	90%	90%	90%
	D06: Getting Needed Prescription Drugs (03/2023 – 06/2023)	92%	92%	91%	92%
	C01: Breast Cancer Screening (01/01/2022 – 12/31/2022)	64%	59%	60%	61%
	C02: Colorectal Cancer Screening 01/01/2022 – 12/31/2022	49%	54%	45%	49%
	C03: Annual Flu Vaccine (03/2023 – 06/2023)	68%	64%	68%	67%
	C04: Monitoring Physical Activity (07/19/2022 – 11/01/2022)	45%	46%	45%	45%
	C25: Complaints about the Health Plan	0.06	0.04	0.04	0.05

Measure (MY)		Wellcare Prime by ATC	Molina Healthcare of SC	First Choice VIP Care Plus	South Carolina Weighted Averages
	(01/01/2022 – 12/31/2022)				
	C26: Members Choosing to Leave the Plan (01/01/2022 – 12/31/2022)	21%	17%	17%	18%
	C28: Plan Makes Timely Decisions about Appeals (01/01/2022 – 12/31/2022)	Not enough data available	100%	100%	100%
	C29: Reviewing Appeals Decisions (01/01/2022 – 12/31/2022)	Not enough data available	100%	82%	90%
	C30: Call Center – Foreign Language Interpreter and TTY Availability (02/2023 – 05/2023)	100%	98%	94%	97%
	D01: Call Center – Foreign Language Interpreter and TTY Availability (02/2023 – 05/2023)	97%	98%	86%	93%