Constellation Quality Health

Molina Healthcare of South Carolina

2024 External Quality Review

Submitted: July 19, 2024

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2024 External Quality Review (EQR) that Constellation Quality Health (Constellation), formally The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Molina Healthcare of South Carolina (Molina) since the 2023 Annual Review.

The goals and objectives of the review are to:

- Determine if the health plan is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2023 Annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

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

Summary and Overall Findings

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

- 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

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

Molina develops policies and procedures to guide health plan activities and the functions of internal departments. Policies and procedures are reviewed annually and are housed in a policy repository for staff access. Molina is centralizing and standardizing the documents to include a separate policy, procedure, and state addendum (when needed). Policies and procedures inconsistently reference applicable state addenda.

Molina's Executive Organizational Chart, Organizational Chart Companion Matrix, and Key Personnel and Additional Staff Time Grid reflect appropriate and sufficient staffing to conduct all health plan activities and to ensure required services are provided to members.

Processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse (FWA) are addressed in various documents, including the Molina Healthcare Compliance Plan, the Compliance Plan South Carolina

Addendum, the Fraud, Waste, and Abuse Plan, and related policies and procedures. The Code of Business Conduct and Ethics and the Supplier Code of Conduct communicate expectations for appropriate conduct and business behavior. Compliance training is mandatory for all employees at employment and annually. Staff are educated about compliance, FWA, the importance of reporting noncompliance and FWA, reporting methods, etc. Methods are in place to allow anonymous and confidential reporting, and Molina maintains a non-retaliation policy for those making reports.

Policy MHI PHARM 07, Pharmacy Lock-In Program, provides guidance to staff about the criteria, processes, and requirements for the Pharmacy Lock-in Program. The related State Addendum specifies South Carolina-specific requirements for the Pharmacy Lock-in Program. A discrepancy was noted in documentation of the emergency supply of medication that can be provided to members in the Pharmacy Lock-in Program when comparing the State Addendum to Policy MHI PHARM 07 and the South Carolina Medicaid Pharmacy Lock-in Program Instructions document.

Information Systems Capabilities Assessment documentation indicates Molina can meet contractual requirements. Policies and procedures adhere to industry best practices and are reviewed regularly. Molina has separate risk assessment, business continuity, and disaster recovery plans, and recently conducted successful business continuity and disaster recovery tests.

Provider Services

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

Processes for initial and ongoing credentialing are documented in policies, procedures, and related state addenda; however, organizational provider appeal rights related to credentialing denials were not included. The Professional Review Committee (PRC) uses a peer review process to make recommendations about participation in the network, and membership includes practitioners with a range of specialties. No issues were found in the sample of initial credentialing and recredentialing files reviewed for this EQR. Appropriate processes are in place for monitoring providers for sanctions, exclusions, and quality of care and for addressing identified issues.

New provider orientation and ongoing provider education are conducted through a variety of mechanisms. Resources for providers include Molina's website and Provider Manual. Concerns with the Provider Manual include lack of complete information about member benefits and members' abilities to self-refer.

Molina adopts and educates providers about clinical practice and preventive health guidelines, disseminates the guidelines to providers, and makes the guidelines available on Molina's website and in paper form upon request. It was noted that a policy incorrectly states the frequency for

reviewing the guidelines. Providers are educated about medical record documentation and maintenance requirements and assessed for compliance with the requirements through annual medical record audits. Providers are also educated about ensuring continuity and coordination of care with an annual compliance assessment conducted. Through these processes, Molina identifies opportunities for improvement and implements related interventions.

Constellation conducted a validation review of Molina's provider network following the CMS protocol titled, "*EQR Protocol 4: Validation of Network Adequacy*." Molina's provider network was found to be adequate and consistent with the requirements of the CMS protocol.

Geographic and appointment access standards for providers and processes for monitoring access are addressed in policies and procedures. It was found that Molina uses appropriate geographic access standards to assess the network and no access gaps were noted. For appointment availability, the annual survey revealed issues with primary care provider (PCP) compliance in several appointment categories. Opportunities for improvement and interventions were identified. Molina also monitors its network's ability to serve members with special needs and cultural requirements and develops and implements action plans to address identified concerns. Issues were discussed related to difficulty in accessing cultural competency information on Molina's website.

Molina maintains a printed (PDF) Provider Directory and the website offers an online directory that includes the ability to search for providers. The PDF Provider Directory (page five) does not include dispensing pharmacies and users are required to create an account/sign in to an external website to access pharmacy information. The online Provider Directory does not include the required statement that "Enrolled families may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs."

For the Telephone Provider Access Study conducted by Constellation, the successful answer rate was 59%. For calls not successfully answered, the majority were because the physician was no longer practicing at the location.

Member Services

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

Member rights and responsibilities are included in Molina's policies and procedures, the Member Handbook, website, and in the Welcome Kit Quick Start Guide. The Welcome Kit is provided to new members within 14 calendar days from the date Molina receives their eligibility file. Members are provided with information to address a variety of needs in the Member Handbook and website.

The Member Handbook and website contain a benefit grid that describes core benefits, covered services, prior approval requirements, and limitations. The lack of information found regarding the services provided through the Developmental Evaluation Centers in the Member Handbook was discussed onsite. Constellation recommended additional information should be included in the

Member Handbook to clarify service eligibility and reimbursement information. The Member Handbook provides information about selecting a PCP.

Molina provides members with resources to address chronic health conditions and disease management. Molina reported that digital outreach to members is being expanded to augment current electronic text and email communications methods.

Constellation conducted a validation of the member satisfaction surveys conducted by Press Ganey, a certified CAHPS survey vendor. The Adult survey resulted in improvement for four measures and ten measures showed decline. For the Child survey, six measures showed improvement. For Children with Chronic Conditions, 12 measures improved, and three measures declined. Molina presented the survey results to the Quality Improvement and Health Equity Transformation Committee for discussion and implementation of interventions to improve member satisfaction.

Molina's policies describe processes for filing, acknowledging, and resolving verbal and written grievances. Definitions of grievance terminology, grievance filing options, and associated timeframes are consistent in policy, the Member Handbook, Provider Manual, and website. Performance analysis addressing barriers, strengths, and opportunities for improvement are reported quarterly to the Health Care Services Committee, as evidenced in quarterly meeting minutes.

A sample of grievance files was selected and reviewed for this EQR. All were acknowledged, investigated, and resolved timely with appropriately documented correspondences to members.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Molina developed a Quality Improvement (QI) Program aimed to reduce and eliminate health disparities, address social determinants of health, and improve health outcomes. Their QI Program description provided detailed information about the program, committee structure, roles, functions, and responsibilities of each committee involved in overseeing and implementing the program. It also outlines the various components and activities of the program. Molina actively engages stakeholders in the QI Program by involving them in decision-making, seeking their feedback and input, fostering collaborations and partnerships, providing education and training, and maintaining transparent communication channels.

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 the goal was noted as met for this activity.

The Quality Improvement and Health Equity Transformation Committee (QIHETC), formerly known as the Quality Improvement Committee, is responsible for the implementation, oversight, and ongoing monitoring of the QI Program. This committee is co-chaired by the Chief Medical Officer and the Quality Lead. Other members of this committee include representatives of various departments and positions within Molina, including plan leadership, healthcare services, network/operations, government contracts, compliance, behavioral health, community engagement, contact center, quality leadership, and delegation oversight. External network physicians and practitioners, such as primary care physicians and medical specialists, are also members of the committee.

Molina evaluates the effectiveness of the QI Program by reviewing the key components. This includes evaluating the adequacy of resources, such as staffing, data and other information, to ensure that the program has the necessary support to collect, analyze, and integrate data for quality improvement. Molina also evaluates the committee structure, practitioner participation, and leadership involvement in the quality program to ensure that there is active engagement and oversight. Additionally, Molina conducts ongoing program activity monitoring to assess the program's impact on health plan members and practitioners. The evaluation process includes a review of clinical, service, and operational initiatives and trends. Through this evaluation, Molina identifies barriers and opportunities for improvement and implements interventions to address them.

Performance Measure Validation: Molina produces HEDIS rates using software from an NCQA-certified measure vendor. The performance measure validation found that Molina was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

All relevant HEDIS PMs for the current measure year 2022, the previous measure year 2021, and the change from 2021 to 2022 are reported in the QI section of this report. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial rate increases or decreases from 2021 to 2022. Rate changes shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%). Substantial changes in year-over-year trending were found in four measures.

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	34.48%	52.89%	18.41%
Continuation and Maintenance (C&M) Phase	45.5%	62.65%	17.15%
Follow-Up After Emergency Department Visit for Substance Abuse (FUA)			
Total - 30-Day Follow-Up	16.25%	28.63%	12.38%
Substantial Decrease in Rate (>10% decrease)			
Pharmacotherapy for Opioid Use Disorder (POD)			
Total	52.55%	33.78%	-18.77%

Performance Improvement Project Validation: The validation of the 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.

Molina submitted three PIPs for validation. Topics included: Improving Encounters Acceptance Rates, Child and Adolescent Well-Care Visits, and Immunizations for Adolescents. The validation found the three PIPs met all the requirements and received scores within the "High Confidence in Reported Results Range." A summary of each PIP's status and the interventions is included in the following tables.

Table 2: Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates	
The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from 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 workgroup, as they transition their current encounter system to avoid unintended issues.	
Previous Validation Score	Current Validation Score
79/79=100% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
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.

Table 3: Child and Adolescent Well-Care Visits PIP

Child and Adolescent Well-Care Visits	
The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed improvement in the Child and Adolescent Well-Care Visits (Total) rate from 44.40% to 49.32%, which exceeded the goal of 44.57%.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Table 4: Immunizations for Adolescents PIP

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. 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.	
Previous Validation Score	Current Validation Score

Immunizations for Adolescents	
73/74=99% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• 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.	

Utilization Management

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

Molina's Health Care Services Program Description and various policies outline the staff responsibilities, scope, and objectives for physical and behavioral health services. Also, the Pharmacy Program Description outlines the objectives and procedures of the pharmacy program. The Chief Medical Officer provides oversight of the UM program. The Behavioral Health Medical Director and Pharmacy Director provide clinical oversight and daily operational management over their respective programs.

The UM Reviewers are clinicians that hold a current licensure in their respective healthcare professions. The UM Reviewers use external and internal clinical guidelines to determine medical necessity and appropriateness of requested services. Appropriate timeframes are followed for standard, expedited, and retrospective authorizations. Also, pharmacy requests are processed within 24 hours. Molina conducts annual Inter-Rater Reliability (IRR) testing and monthly audits to ensure consistency in the application of clinical criteria. Constellation's review of a sample of approval and denial files found that determinations were made by appropriate clinical reviewers and that requests were completed and communicated timely.

The process for handling appeal requests is described in policies, the UM Program description, the Member Handbook, the Provider Manual, and found on Molina's website. Molina's standard appeal process procedure and the appeal request form attached to several letter templates incorrectly states a verbal appeal must be followed up with a written request. The was an issue previously identified during the 2023 EQR and not corrected.

The sample of appeal files reviewed reflected timely acknowledgement, determinations made by appropriate reviewers, and timely notification of the appeal determination. Constellation found no issues with the appeal file review.

Molina's Health Care Services Program Description and numerous policies outline the Integrated Care Management (ICM) and Care Transitions Programs. Members are informed of the components of the program through various methods. Several assessments and predictive modeling systems are used to stratify members to the most appropriate level for care management. Care management activities are provided to members to address any medical and/or behavioral needs.

Targeted Care Management Services and specialized programs are also offered to ensure that special populations have access to needed medical, educational, social, and other services. Transition of Care Services are provided to ensure continuity of care for members. Annually, Molina conducts a member experience survey and the results aid in identifying strengths and opportunities for improvement.

Review of the sample of care management files demonstrated that appropriate care coordination activities were implemented and conducted for members based upon their identified acuity level and needs.

Delegation

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

Policies and procedures specify processes and requirements for delegation of health plan activities to subcontractors. The policies and procedures include pre-delegation activities, written agreements, and delegation oversight, such as annual evaluations and ongoing monitoring. The requirement that delegates obtain prior written consent from Molina to subdelegate any delegated activities was not addressed in any policy or procedure.

Molina provided documentation of the oversight activities conducted for all delegates, reflecting timely annual oversight. For one delegate, the review revealed incorrect scoring and failure to conduct call monitoring for the 2023 annual audit, due to information technology issues. 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.

Mental Health Parity

Constellation is required to conduct a Mental Health Parity assessment to determine if Molina met the Mental Health Parity requirements outlined in the Federal Parity Act. 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 limits on the scope or duration of benefits.

For the NQTLs, Constellation reviewed Molina's 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. The NQTL assessment found the mental health services comply with parity requirements of comparability and stringency.

Two templates were provided to Molina to complete the QTL assessment. The templates allowed the plan to enter information based on copay, session limits, day limits, etc. This information was used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There are two steps required to conduct this review: first, Constellation determined if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject. The files submitted demonstrated a service limitation for outpatient services. The outpatient service limitation is consistent for medical/surgical and behavioral health services. Thus, the findings show appropriate parity for mental health services in relation to medical services.

Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation Quality Health requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. Technical assistance is provided until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which Molina implemented the actions to address deficiencies identified during the previous EQR and found the deficiency related to appeals was still an issue. The appeal process still requires a member who files an appeal verbally to follow up with a written appeal request. Details regarding the 2023 QIP can be found in *Attachment 4: Assessment of Quality Improvement Plans from Previous EQR*.

Conclusions

Overall, Molina met of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Molina's compliance scores specific to each of the 14 *Subpart D* and QAPI standards above.

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

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. C 2	1	1	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	2	2	100%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	12	10	83%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	38	97%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	19	95%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	3	3	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D	9	8	89%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	16	16	100%

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

As noted in *Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards*:

- For Availability of Services and Assurances of Adequate Capacity and Services, the printed Provider Directory does not include dispensing pharmacies and requires users to create an account on an external website to access pharmacy information. The online Provider Directory/provider search tool did not include the required statement that "Enrolled families may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs." For the Telephone Provider Access Study conducted by Constellation, there was no improvement in the successful answer rate from the previous year's study.
- For Provider Selection, Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, did not address provider rights related to overall credentialing as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7*, and incompletely documented provider appeal rights related to credentialing denials.
- For Practice Guidelines, Policy and Procedure MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines documented an incorrect frequency for reviewing the guidelines.
- Molina's appeal process still requires a member who files an appeal verbally to follow-up with a written appeal request.

Table 6: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2023 review. For 2024, 210 out of 218 standards received a score of "Met." There were six standards scored as "Partially Met," and two standards received a "Not Met" score.

Table 6: Scoring Overview

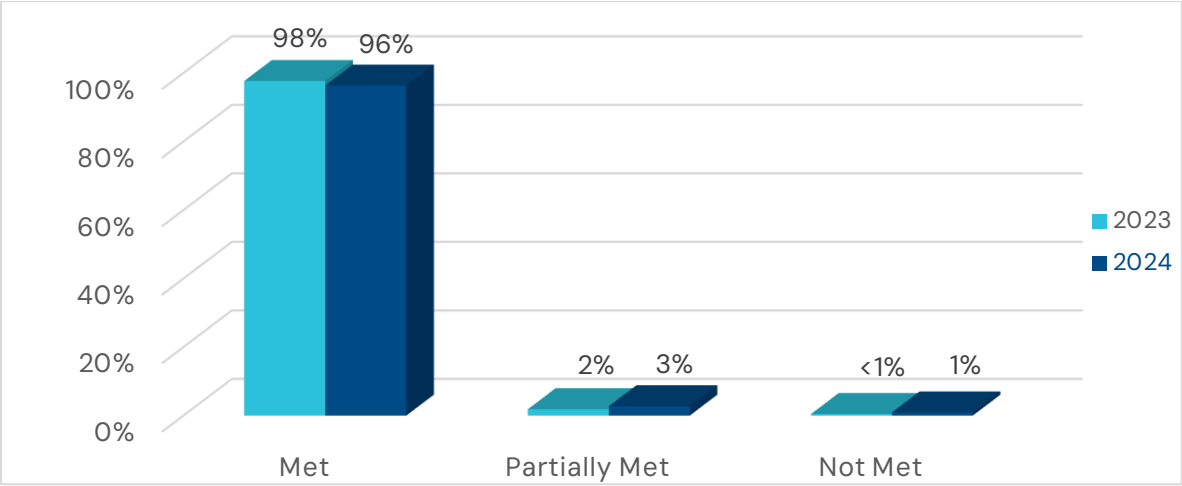
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	40	0	0	0	0	40	100%
2024	39	1	0	0	0	0	98%
Provider Services							
2023	75	1	0	0	0	76	99%
2024	72	5	1	0	0	78	92%
Member Services							
2023	33	0	0	0	0	33	100%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2024	33	0	0	0	0	33	100%
Quality Improvement							
2023	14	0	0	0	0	14	100%
2024	16	0	0	0	0	16	100%
Utilization							
2023	43	3	0	0	0	46	93%
2024	45	0	1	0	0	46	98%
Delegation							
2023	2	0	0	0	0	2	100%
2024	3	0	0	0	0	3	100%
Mental Health Parity							
2024	2	0	0	0	0	2	100%
Totals							
2023	210	4	1	0	0	215	98%
2024	210	6	2	0	0	218	96%

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

The 2024 Annual EQR shows that Molina achieved "Met" scores for 96% of the standards reviewed. The following chart provides a comparison of the current review results to the 2023 review results. Areas of the review not meeting all the standards included Administration, Provider Services, and Utilization Management.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 7: Strengths Related to the Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Molina has appropriate processes in place for new policy development and annual policy review.	✓	✓	
Molina is currently centralizing and standardizing all policies to include separate policy, procedure, and state addendum (when needed) documents.	✓		
Appropriate and sufficient staffing is in place to conduct all health plan activities and to ensure required services are provided to members.	✓		✓
The Executive Organizational Chart displays the health plan's reporting structure and indicates staff who are at or above manager level and corporate partners. Vacant positions are also designated; however, there were few vacant positions noted.	✓		
The Compliance Plan, SC Compliance Plan Addendum, and FWA Plan provide an overview of processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to FWA. Detailed information is included in policies, procedures, and applicable state addenda.	✓		
Molina has implemented a Pharmacy Lock-in Program to manage members with inappropriate prescription utilization.	✓		✓
The expectation for staff to maintain the confidentiality of protected information is documented throughout policies, procedures, etc.	✓		
Disaster recovery and business continuity plans have been successfully tested to ensure they can meet the organization's recovery objectives.	✓		

Strengths	Quality	Timeliness	Access to Care
Thorough information systems policies, procedures, and plans adhere to best practices and are updated regularly.	✓	✓	
Molina has a detailed and up-to-date cybersecurity plan which communicates the organization's overall all security posture.	✓		
Provider Services			
The Professional Review Committee meets monthly and uses a peer review process to make recommendations for credentialing decisions.	✓		
Membership of the Professional Review Committee includes practitioners with a range of specialties.	✓		✓
No issues were noted in the initial credentialing and recredentialing files for practitioners and organizational providers.			✓
Molina contracts with all required Status 1 and Status 2 provider types.			✓
Provider access is evaluated by monitoring and measuring network availability, assessing cultural and linguistic needs, analyzing member and practitioner demographics, and implementing improvements or corrective actions as needed.			✓
Molina monitors its network's ability to serve members with special needs and cultural requirements by collecting and analyzing data to identify network gaps and takes action to address identified gaps.			✓
Initial provider education is conducted within 30 days of a provider's contract effective date, an ongoing provider education is provided through multiple forums, including provider site visits, faxed information, newsletters, electronic communications, webinars, and the MCO website. Additionally, annual Provider Office Manager meetings and quarterly regional provider training sessions are conducted.	✓	✓	
Molina adopts and educates providers about clinical practice and preventive health guidelines to provide current treatment and diagnostic information and to reduce variation in care between providers.	✓		✓
Annual medical record audits are conducted to assess provider compliance with medical record documentation, maintenance, storage, and confidentiality requirements.	✓		
Member Services			
A clear definition of a grievance is provided for members, along with helpful examples of grievances, in the Member Handbook.	✓		
Of the grievance files selected and reviewed for the 2024 EQR, all were acknowledged, investigated, and resolved timely with appropriately documented correspondence to members.		✓	
Quality Improvement			
Molina actively engages stakeholders in the QI Program by involving them in decision-making, seeking their feedback and input, fostering collaborations and partnerships, providing education and training, and maintaining transparent communication channels.	✓		
Molina tracks member and provider compliance with EPSDT services. This includes provider reporting and following up on members who do not receive services, as well as tracking when a member did not receive recommended assessments and/or treatments.	✓		
The health plan was found to be compliant with the HEDIS technical specifications for rate calculations.	✓		

Strengths	Quality	Timeliness	Access to Care
The performance improvement projects received a score in the High Confidence Range and met all the validation requirements.	✓		
Utilization Management			
Molina's Substance Use Navigators undergo specialized training to improve efficiency in conducting clinical reviews for substance use members and ensuring that members receive the most appropriate level of care.	✓		
The Behavioral Health, Prior Authorization, Inpatient UM Clinicians, and Medical Directors received passing scores of 90% or higher in Inter-Rater Reliability testing.	✓		
Monthly inpatient and prior authorization case audits exceeded the target goal of 90%.	✓		
Molina's turnaround time compliance was 100% for prior authorizations and 95% or higher for expedited requests, exceeding the target goals.		✓	✓
Molina offers specialized programs such as Sickle Cell, Adult and Preventative Rehabilitative Services for Primary Care Enhancement to aid in addressing specialized needs for members.			✓
Overall, the Member Experience with Care Management surveys identified that members were satisfied with the care management services provided and exceeded the target goal.	✓		
The appeal files reviewed for this EQR, all were acknowledged and resolved timely and by appropriately credentialed reviewers.		✓	✓
Delegation			
Policies and procedures have been developed to guide the delegation of health plan activities to external entities.	✓		
Molina conducts timely annual oversight for all delegates.		✓	
Written delegation agreements specify the delegated activities, health plan and delegate responsibilities, performance expectations, and possible consequences for substandard performance.	✓		
Mental Health Parity			
Mental Health Parity assessment showed mental health services are aligned with medical surgical financial and treatment limitations.			✓
Access and availability parity is achieved; Provider Network analysis and implementation plans are robust and responsive down to the local level.			✓
Utilization Management Criteria and Processes achieve parity.			✓
IRR incorporates both mental health/substance use disorder and medical/surgical cases.	✓		
Mental health parity was demonstrated in assessment of copays and financial limitations.			✓

Table 7: Weaknesses Related to the Quality, Timeliness, and Access to Care

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Administration				
Policies and procedures inconsistently reference applicable state addendums.	*Recommendation: Revise policies and procedures to include a reference to state-specific addendums when applicable.*	✓		
The Contract Manager position is filled according to contractual requirements; however, the Organizational Chart Companion Matrix incorrectly lists the staff member who fills this position.	*Recommendation: Update the Organizational Chart Companion Matrix to correctly document the staff member who serves as the Contract Manager.*	✓		
Page two of the Executive Organizational Chart lists a staff member in the role of MCS CMO Behavioral Health Region 1 (SC-Charleston). Onsite discussion revealed this information is incorrect.	*Recommendation: Revise page two of the Executive Organizational Chart to reflect correct information for the noted position.*	✓		
Page two of the State Addendum to Policy C-01.4, Effective Lines of Communication, lists incorrect phone numbers for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance. It also lists an incorrect address for the SC Department of Insurance.	*Recommendation: Correct the phone numbers for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance and the address for the SC Department of Insurance on page 2 of the State Addendum to Policy C-01.4, Effective Lines of Communication.*	✓		
Page seven of the SC Compliance Plan Addendum includes a heading of "Audit Work Plan" and states, "There are no Texas-specific requirements for the Audit Work Plan."	*Recommendation: Remove the statement regarding Texas-specific requirements from the SC Compliance Plan Addendum.*	✓		
Page five of the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, indicates the requirement for a quorum for the health plan's Compliance Committee is, "A simple majority which equals to five (5) voting members…" However, there are six voting members of the committee, and the Compliance Officer votes to break tie votes, so a simple majority is four voting members.	*Recommendation: Clarify the requirement for a quorum for the health plan's Compliance Committee on page five of the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight.*	✓		
A discrepancy was noted in documentation of the emergency supply of medication that can be	*Quality Improvement Plan: Determine the correct duration of the emergency supply of medication provided to members in the*		✓	✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
provided to members in the Pharmacy Lock-in Program.	*Pharmacy Lock-in Program and correct the applicable document.*			
Provider Services				
Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers did not include all provider appeal rights required by SCDHHS.	*Quality Improvement Plan: Revise Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, include the provider rights required by the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7, and to clearly document that organizational providers have no appeal rights related to credentialing denials.*	✓		✓
Policy and Procedure MHSC-PC-004, Provider Panel Closure, addresses methods for monitoring PCP panel status to ensure adequate PCP availability, but does not address conducting this monitoring for specialists. The *SCDHHS Contract, Section 6.2.3.1.2* requires that the MCO ensure each member has access to specialists with an open panel.	*Recommendation: Revise Policy and Procedure MHSC-PC-004, Provider Panel Closure, to address methods for monitoring specialist panel status to ensure adequate specialty availability. Ensure the process for monitoring specialist panel status is then implemented.*	✓		✓
The PDF Provider Directory does not include dispensing pharmacies, and when accessing the hyperlink provided on page five, the user is required to create an account and sign in to an external website to access pharmacy information.	*Quality Improvement Plan: Revise the PDF Provider Directory to include dispensing pharmacies, as required by the SCDHHS Contract, Section 3.12.3.3.*			✓
The PDF Provider Directory includes a statement that "Enrolled families 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 statement was not found in the online provider search tool.	*Quality Improvement Plan: Update the online provider search tool to include the explanation 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. Refer to the SCDHHS Contract, Section 3.12.3.10.*			✓
For the Telephone Provider Access Study conducted by Constellation, there was no improvement in the successful answer rate from the previous year's study.	*Quality Improvement Plan: Provide documentation of the methods in place to ensure PCPs are updating their contact information in a timely manner.*			✓
The Provider Manual, page 10, refers the reader to the Member Handbook on Molina's website for a complete list of member benefits and covered services. However, the	*Quality Improvement Plan: Include full member benefit information, including limitations, restrictions, and other requirements about member benefits in the Provider Manual.*	✓		✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Member Handbook does not appear to provide complete and sufficient information for providers to fully understand benefits and related limitations, requirements for authorization, etc.				
The Provider Manual informs that members may obtain referrals for behavioral health services or may self-refer by calling the Contact Center. However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Also, the Provider Manual does not indicate members may self-refer for care other than behavioral health services, although Molina staff confirmed that members may self-refer for both medical and behavioral health care.	*Quality Improvement Plan: Revise the Provider Manual to indicate that members may self-refer for medical care and to clarify the statement that members may self-refer to behavioral health care by calling the Contact Center.*			✓
Issues were noted related to the frequency of reviewing the CPGs and PHGs in Policy MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.	*Quality Improvement Plan: Revise Policy and Procedure MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines to include the correct frequency for reviewing CPGs and PHGs. Alternatively, develop and implement a state-specific addendum to Policy and Procedure MHI-QUAL-018 to specify the frequency of CPG and PHG review for Molina SC Medicaid.*	✓	✓	
Member Services				
The Member Handbook lacked information regarding the services provided through the Developmental Evaluation Centers .	*Recommendation: Revise the Member Handbook to describe the services provided through the Developmental Evaluation Centers, eligibility requirements and reimbursement information.*			✓
Response rates declined for the Adult and Child with Chronic Conditions surveys for this EQR.	*Recommendation: Continue innovative methods (other than oversampling) to improve response rates and achieve a representative sample of the populations surveyed.*	✓		
Quality Management				
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.	*Recommendation: Ensure the QI Work Plan is updated frequently and correct the discrepancies noted regarding the results for each activity.*	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
However, on the Evaluation and Analysis page the goal was noted as met for this activity.				
The meeting minutes for the Quality Improvement and Health Equity Transformation Committee did not reflect the correct committee name.	*Recommendation: Update the Quality Improvement and Health Equity Transformation Committee meeting minutes to reflect the correct name for the committee*	✓		
The Immunizations for Adolescents PIP showed a slight decline in the administrative rate.	*Recommendation: Adding additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.*	✓		
Utilization Management				
Procedure MHSC-MRT-002, Standard Appeal Process and the Appeal Request form incorrectly state a verbal appeal must be followed up by a written request. This was an issue identified during the 2023 EQR and not corrected.	*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.*	✓		✓
Delegation				
The requirement that delegates must obtain approval prior to sub-delegating any delegated activities was not located in any policy or procedure.	*Recommendation: Revise applicable policies to address the requirement that delegated entities cannot sub-delegate the performance of any delegated activities without the prior written consent from Molina.*	✓		
Issues were noted in documentation of the annual oversight for Infomedia Group, Inc., d/b/a Carenet Healthcare Services.	*Recommendation: Correct the 2023 Infosys_Carenet Annual Audit Summary to reflect the correct overall score for the 2023 audit. For future oversight of Infomedia Group, Inc., d/b/a Carenet Healthcare Services, ensure that the oversight includes audit of live or recorded calls received by the Nurse Advice Line and the Behavioral Health Crisis Line.*	✓		✓
Mental Health Parity				
Molina uses internally developed criteria. This poses a risk to parity, both in comparability and stringency.	*Recommendation: Continue to ensure there is parity in internally developed utilization management criteria.*			✓

METHODOLOGY

The process Constellation used for the EQR activities was based on protocols CMS developed for the EQR of a Medicaid MCO/PIHP and focuses on the four federally mandated EQR activities of compliance determination, validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On May 6, 2024, Constellation sent notification to Molina that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Molina to ask questions regarding the EQR process and the requested desk materials. On May 8, 2024, a teleconference was held with Constellation and Molina staff to address questions regarding the requested materials. Constellation provided an overview of the Mental Health Parity Assessment process and answered questions. Molina requested a one-week extension for submitting the documents needed to conduct the Mental Health Parity assessment. Constellation agreed with this request.

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

The second segment was a virtual onsite review conducted on June 20th and 21st. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Molina's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between the health plan and SCDHHS. Strengths, Weaknesses, and Recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet in each section.

A. Administration

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

The Administration review includes policy and procedure development and ongoing management, health plan staffing, information management systems, compliance and program integrity, and confidentiality.

Molina develops policies and procedures to guide health plan activities and departmental functions. Policies and procedures note the line of business and department to which they apply, the effective date, and subsequent review and revision dates. Molina reviews policies and procedures at least annually and updates as needed to ensure compliance with contractual, regulatory, and/or accreditation requirements, with final approval of new/revised policies given by the Administrative and Policy Committee. During the onsite, Molina discussed an ongoing initiative to centralize and standardize policies to include separate policy, procedure, and state addendum (when needed) documents. Constellation's review of policies and procedures revealed the documents inconsistently reference applicable state addenda.

Review of Molina's Executive Organizational Chart and Organizational Chart Companion Matrix, along with the Key Personnel and Additional Staff Time Grid, reveals sufficient staffing to conduct all health plan activities and to ensure required services are provided to members. The Executive Organizational Chart displays the health plan's reporting structure and uses a color key to indicate corporate partners and staff who are at or above manager level. Vacant positions are designated; however, few vacant positions were noted, and onsite discussion revealed the vacant positions have either been filled or are in recruitment. It was found that the Organizational Chart Companion Matrix incorrectly lists the staff member filling the Contract Manager position. Also, the Executive Organizational Chart lists a staff member in the role of MCS - Medical Director (CMO Behavioral Health Region 1 (SC-Charleston) that was revealed to be incorrect during onsite discussion.

The Molina Healthcare Compliance Plan 2023 (Compliance Plan), 2023 Compliance Plan South Carolina Addendum (SC Compliance Plan Addendum), and Molina Healthcare of South Carolina, Inc. SFY 2024 Fraud, Waste, and Abuse Plan (FWA Plan) give an overview of processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse (FWA). Related policies and procedures provide detailed information about compliance preventing, detecting, and responding to FWA. The policies include references to regulatory resources, related policies and procedures, and additional supporting documentation.

Molina's Code of Business Conduct and Ethics (Code of Conduct), which is an attachment to the FWA Plan, communicates expectations for appropriate conduct and business behavior for all employees. The Supplier Code of Conduct states these expectations for vendors and suppliers

doing business with Molina. The Code of Conduct is provided to all employees at the time of employment and then annually.

Molina's Compliance Committee is chaired by the Compliance Officer. This committee supports and oversees the Compliance Program, assists in the development and implementation of compliance policies and procedures, and assists in identifying and managing risks. Membership of the committee includes senior leadership selected by the compliance officer with input from the Board of Directors. Meetings are held at least quarterly. Based on the number of voting members of the committee (six voting members plus the committee chair, who votes to break ties), the quorum for the Compliance Committee is unclear in the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, which states the requirement for a quorum for the health plan's Compliance Committee is, "A simple majority which equals to five (5) voting members…"

Molina provides mandatory compliance training for all employees within 30 days of employment and annually. This training is required before staff are granted access to protected information. Through compliance training and related documents, policies, and procedures, staff are educated about the importance of reporting noncompliance, unethical behavior, and FWA, and are provided with information about various reporting methods. Molina employs a third-party compliance reporting system that allows anonymous/confidential reporting, and Molina maintains a non-retaliation policy for those making reports. It was noted that page two of the State Addendum to Policy C-01.4, Effective Lines of Communication, lists incorrect phone numbers and addresses for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance.

Molina conducts Compliance Risk Assessments that consider the type, implication, probability, impact, and severity of risks by functional area, and uses results to determine resource allocation, to enhance the monitoring structure, and to identify the need for corrective action and/or process improvements to lessen risk. Additional monitoring and auditing activities are addressed in the FWA plan. These activities are also addressed in various policies and procedures. The Special Investigation Unit (SIU) conducts objective investigations of FWA focusing on providers and members. These investigations include reviewing documentation, billing patterns, payment history, and other resources to determine the likelihood of fraud. The SIU implements corrective action based on findings.

Policy MHI PHARM 07, Pharmacy Lock-In Program, provides guidance to staff about the criteria, processes, and requirements for the Pharmacy Lock-in Program. The State Addendum to Policy MHI PHARM 07 specifies South Carolina requirements for the Pharmacy Lock-in Program. A discrepancy was noted in documentation of the emergency supply of medication that can be provided to members in the Pharmacy Lock-in Program when comparing the State Addendum to

Policy MHI PHARM 07, which states a 72-hour supply of medication will be provided in case of an emergency, to the South Carolina Medicaid Pharmacy Lock-in Program Instructions document, which states the emergency supply is a five-day supply.

Molina has established a detailed set of policies and procedures that address expectations for maintaining the confidentiality of member health information. The policies address topics such as privacy and confidentiality of protected health information (PHI), use and disclosure of PHI, and tracking disclosure of PHI.

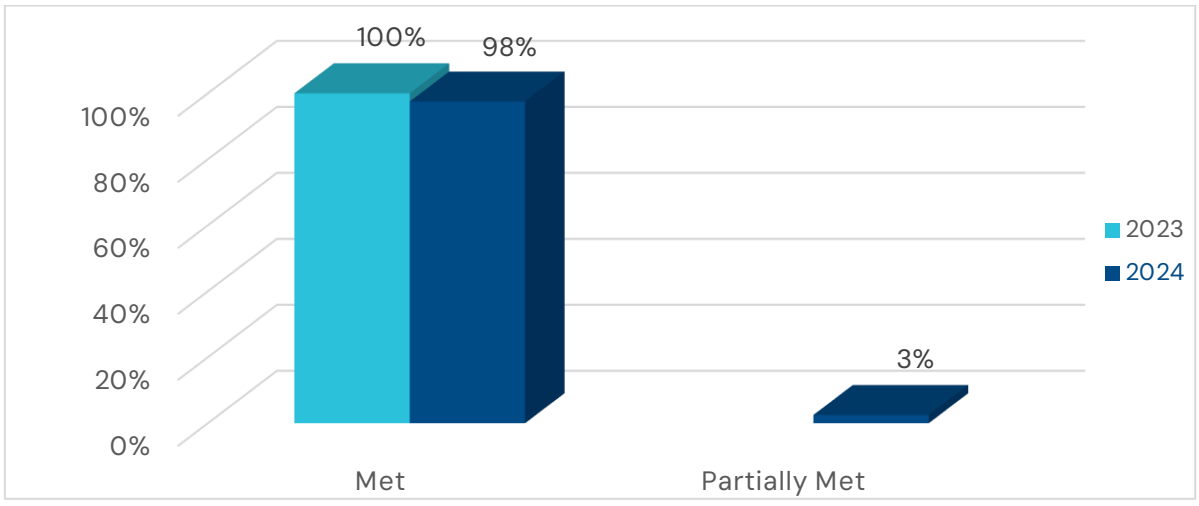
Information Management Systems Assessment

42 CFR § 438.242, 42 CFR § 457.1233 (d)

Molina's Information Systems Capabilities Assessment (ISCA) documentation indicates that the MCO can meet the requirements of the SCDHHS Contract. Policies and procedures adhere to industry best practices and are reviewed regularly to ensure they are valid/applicable. Specifically, Molina should be commended for having risk assessment, business continuity, and disaster recovery plans. Many organizations combine some aspects of these three documents into a more generic single plan. To ensure the plans are sound, Molina recently performed a business continuity test and disaster recovery test. Both had successful results. Industry security best practices were documented throughout Molina's ISCA documentation.

As illustrated in *Figure 2: Administration Findings*, Molina achieved scores of "Met" for 98% of the standards for the Administration review. Strengths, weaknesses, recommendations, and quality improvement plans are documented in the tables below.

Figure 2: Administration Findings



Percentages may not total 100% due to rounding

Table 8: Administration Comparative Data

Section	Standard	2023 Review	2024 Review
Compliance / Program Integrity	The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 9: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Molina has appropriate processes in place for new policy development and annual policy review.	✓	✓	
Molina is currently centralizing and standardizing all policies to include separate policy, procedure, and state addendum (when needed) documents.	✓		
Appropriate and sufficient staffing is in place to conduct all health plan activities and to ensure required services are provided to members.	✓		✓
The Executive Organizational Chart displays the health plan's reporting structure and indicates staff who are at or above manager level and corporate partners. Vacant positions are also designated; however, there were few vacant positions noted.	✓		
The Compliance Plan, SC Compliance Plan Addendum, and FWA Plan provide an overview of processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to FWA. Detailed information is included in policies, procedures, and applicable state addenda.	✓		
Molina has implemented a Pharmacy Lock-in Program to manage members with inappropriate prescription utilization.	✓		✓
The expectation for staff to maintain the confidentiality of protected information is documented throughout policies, procedures, etc.	✓		
Disaster recovery and business continuity plans have been successfully tested to ensure they can meet the organization's recovery objectives.	✓		
Thorough information systems policies, procedures, and plans adhere to best practices and are updated regularly.	✓	✓	
Molina has a detailed and up-to-date cybersecurity plan which communicates the organization's overall all security posture.	✓		

Table 10: Administration Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policies and procedures inconsistently reference applicable state addendums.	*Recommendation: Revise policies and procedures to include a reference to state-specific addendums when applicable.*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The Contract Manager position is filled according to contractual requirements; however, the Organizational Chart Companion Matrix incorrectly lists the staff member who fills this position.	*Recommendation: Update the Organizational Chart Companion Matrix to correctly document the staff member who serves as the Contract Manager.*	✓		
Page two of the Executive Organizational Chart lists a staff member in the role of MCS CMO Behavioral Health Region 1 (SC-Charleston). Onsite discussion revealed this information is incorrect.	*Recommendation: Revise page two of the Executive Organizational Chart to reflect correct information for the noted position.*	✓		
Page two of the State Addendum to Policy C-01.4, Effective Lines of Communication, lists incorrect phone numbers for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance. It also lists an incorrect address for the SC Department of Insurance.	*Recommendation: Correct the phone numbers for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance and the address for the SC Department of Insurance on page 2 of the State Addendum to Policy C-01.4, Effective Lines of Communication.*	✓		
Page seven of the SC Compliance Plan Addendum includes a heading of "Audit Work Plan" and states, "There are no Texas-specific requirements for the Audit Work Plan."	*Recommendation: Remove the statement regarding Texas-specific requirements from the SC Compliance Plan Addendum.*	✓		
Page five of the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, indicates the requirement for a quorum for the health plan's Compliance Committee is, "A simple majority which equals to five (5) voting members…" However, there are six voting members of the committee, and the Compliance Officer votes to break tie votes, so a simple majority is four voting members.	*Recommendation: Clarify the requirement for a quorum for the health plan's Compliance Committee on page five of the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight.*	✓		
A discrepancy was noted in documentation of the emergency supply of medication that can be provided to members in the Pharmacy Lock-in Program.	*Quality Improvement Plan: Determine the correct duration of the emergency supply of medication provided to members in the Pharmacy Lock-in Program and correct the applicable document.*		✓	✓

I. ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Processes and requirements for policy development and ongoing review are found in Policy and Procedure MHSC-AD-02, Annual Policy Review. Molina develops policies and procedures to guide health plan activities and departmental functions. State-specific addenda are used to document state-specific requirements that differ from those listed in the policies and procedures. The policies and procedures note the department and line of business to which they apply, the effective date, and subsequent review and revision dates. Molina reviews policies and procedures at least annually and updates as needed to ensure compliance with contractual, regulatory, and/or accreditation requirements. Final approval of new and revised policies is obtained from the Administrative and Policy Committee. Molina houses policies, procedures, and state addenda in Compliance Central, a policy repository, for staff access. Staff are educated about new and revised policies and procedures by department management.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						During onsite discussion, Molina confirmed that policies and procedures are being centralized and standardized to include a separate policy, procedure, and state addendum (when needed) document. Molina staff confirmed this is nearing completion. Review of various policies and procedures revealed that the documents inconsistently reference applicable state addenda. For example, Policy and Procedure MHI-Pharm-03, Prescription Drug Benefit Services, includes references to the state-specific addendum, while Policy and Procedure CR01, Credentialing and Recredentialing Practitioners, do not include references to the state addendum. *Recommendation: Revise policies and procedures to include a reference to state-specific addenda when applicable.*
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					
1.2 Chief Financial Officer (CFO);	X					
1.3 *Contract Manager;	X					The Contract Manager position is filled according to contractual requirements; however, the Organizational Chart Companion Matrix incorrectly lists the employee who fills this position. *Recommendation: Update the Organizational Chart Companion Matrix to correctly document the staff member who serves as the Contract Manager.*
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					
1.5.1 Pharmacy Director,	X					
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					
1.7.1 Provider Services Staff,	X					
1.8 *Member Services Manager;	X					
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					The Executive Organizational Chart lists the Chief Medical Officer and additional Medical Directors for Molina Healthcare of SC. However, page two of the Executive Organizational Chart lists a staff member in the role of MCS – Medical Director (CMO Behavioral Health Region 1 (SC-Charleston)). Onsite discussion revealed this information is incorrect. *Recommendation: Revise page two of the Executive Organizational Chart to reflect correct information for the position noted above.*
1.10 *Compliance Officer;	X					
1.10.1 *Program Integrity Coordinator;	X					
1.10.2 Compliance/ Program Integrity Staff;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10.3*Program Integrity FWA Investigative/Review Staff;	X					Program Integrity/Fraud, Waste, and Abuse Investigative/Review staff include staff that are located in SC, including: • Two Registered Nurses with a history of Certified Professional Coder (CPC) designation and/or CPC program completion • A Certified Program Integrity Professional (CPIP) • A Certified Coding Specialist Additional staff outside of SC include a Certified Insurance Fraud Investigator and an Accredited Health Care Fraud Investigator.
1.11 *Interagency Liaison;	X					
1.12 Legal Staff;	X					
1.13 *Behavioral Health Director.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					Molina's Executive Organizational Chart displays staffing and the reporting structure and indicates through color-coding staff who are at or above Manager level and Corporate Partners. Vacant positions are also designated. The Key Personnel and Additional Staff Time Grid lists staff filling each of the required Key Personnel positions, required FTEs, in-state requirements for the positions, and designated the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						percentage of time dedicated to SC Medicaid for each of the positions.
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Molina's 30-day claims processing performance (99% complete) exceeds the contractual requirements of 90% within 30 days and matches the contract requirements for 90 days.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Molina presently processes 99% of its claims electronically and 1% in paper form. Claims and encounters are required to use industry standard forms. Additionally, Molina uploads claims in HIPAA 837 format to its EDI system for processing.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Molina has established processes to monitor and track the integrity of enrollment and demographic data throughout its claims processing systems. Claims systems generate logs and error reports which are analyzed to ensure data integrity. Non-compliant data is rejected and reviewed to determine the issue.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					HEDIS and HEDIS-like reports are created with Molina's Claim Sphere HEDIS software. To ensure the accuracy and integrity of HEDIS data and reports, Molina has processes to perform validation testing, interim reporting, volume tracking, data completeness analyses, and primary source validation between the HEDIS data repository and production systems.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Molina has policies, procedures, and processes in place to address the contractual requirements for data security. The MCO's systems include timestamps, audit logs, and reports to track data and conduct audits. Access to facilities that house data is restricted to authorized staff, and Molina routinely audits the physical security of its facilities.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Molina practices the principle of least privilege for access to data and information systems. To consistently apply access controls, Molina grants employee access based on their company role. Multifactor authentication is required for all systems containing sensitive data. Molina has updated security policies to address the organization's access control requirements.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Molina has both a business continuity plan and a disaster recovery plan. These plans have been recently reviewed and updated to support the organization's current uptime requirements. Testing exercises have been performed recently for both the business continuity and disaster recovery plans. Both tests resulted in the organization successfully achieving the goals specified in the respective plans.
I D. Compliance/Program Integrity						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Molina provided copies of the Molina Healthcare Compliance Plan 2023 (Compliance Plan), 2023 Compliance Plan South Carolina Addendum (SC Compliance Plan Addendum), and Molina Healthcare of South Carolina, Inc. SFY 2024 Fraud, Waste, and Abuse Plan (FWA Plan). These documents provide an overview of processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse (FWA). Policy C-01.0, Compliance Program, provides an overview of the Compliance Program and includes references to regulatory resources, related policies and procedures, and additional supporting documentation.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Corporate Compliance Plan references the Code of Business Conduct and Ethics (Code of Conduct), an employee resource that communicates expectations for all employees, and the Supplier Code of Conduct, which states expectations for vendors/suppliers doing business with Molina. As noted in the Corporate Compliance Plan, the Code of Conduct is provided to all employees at the time of employment and then annually. The SC Compliance Plan Addendum also

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addresses expectations for Molina employees to comply with the Code of Conduct, federal and state requirements, and Molina policies. The Code of Conduct is an attachment of the FWA Plan.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan, the SC Compliance Plan Addendum, and the FWA Plan address the roles of the Chief Compliance Officer and Program Integrity Coordinator.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The SC Compliance Plan Addendum addresses the role and functions of the Regulatory Compliance Committee.
2.5 Compliance training and education;						Compliance training and education activities and topics are addressed in Procedure C-01.3, Effective Training and Education, the Corporate Compliance Plan, and the SC Compliance Plan Addendum. Compliance training is mandatory for all employees and is considered in employee performance evaluations. New employees must complete the compliance training within 30 days of employment and annually. Onsite discussion confirmed the training is completed prior to staff having access to protected information. Board members are required to complete training within 30 days of appointment and then annually.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Lines of communication;						The SC Compliance Plan Addendum discusses the importance of reporting non-compliance and unethical behavior and provides methods for reporting incidents, including by telephone, online, email, etc. Additionally, a third-party Compliance Reporting System, AlertLine, allows anonymous or confidential reporting. Staff are informed of methods for reporting concerns through the Code of Conduct, the Compliance Plan, human resources policies and procedures, and Molina's intranet site. Molina ensures clear and open communication between the SC Compliance Officer and employees and maintains a non-retaliation policy for those making reports. The FWA Plan addresses reporting of suspected FWA, provides information about anonymous and confidential reporting mechanisms, and provides tips for information to include when making a report. As noted in the FWA Plan, Molina places posters with the Compliance Hotline number throughout its offices. Policy C-01.4, Effective Lines of Communication, provides additional information about lines of communication, including reporting options and related telephone numbers, website addresses, and/or email

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addresses. It also describes whistleblower protections afforded to those making reports. However, page 2 of the State Addendum to this policy lists incorrect phone numbers for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance. It also lists an incorrect address for the SC Department of Insurance. *Recommendation: Correct the phone numbers for the Office of the SC Attorney General Medicaid Fraud Control Unit and the SC Department of Insurance and the address for the SC Department of Insurance on page 2 of the State Addendum to Policy C-01.4, Effective Lines of Communication.*
2.7 Enforcement and accessibility;						As noted in Procedure C-01.5, Well-Publicized Disciplinary Standards, Molina communicates disciplinary standards in human resources policies and procedures. Staff are required to review and attest to their understanding of the policies and procedures and the Code of Conduct. Noncompliance or misconduct may result in disciplinary action, up to and including termination.
2.8 Internal monitoring and auditing;						As noted in the SC Compliance Plan Addendum, Molina conducts Compliance Risk Assessments that consider the type, implication, probability, impact, and severity of risks

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by functional area. The risk assessment also considers actions already taken to mitigate risks. Results are used to determine where and how to allocate resources, whether to initiate corrective action, to enhance the monitoring structure, and to identify process improvements and other actions reduce risk. Page seven of the SC Compliance Plan Addendum includes a heading of "Audit Work Plan" and states, "There are no Texas-specific requirements for the Audit Work Plan." *Recommendation: Remove the statement regarding Texas-specific requirements from the SC Compliance Plan Addendum.* Per the FWA Plan, Molina conducts a range of monitoring and auditing activities with a goal of preventing and detecting FWA in the administration and delivery of services. Activities include but are not limited to: • Credentialing and verifying provider licensure. • Monthly sanctions reviews of employees, providers, and subcontractors. • Monitoring for aberrant service patterns, over- and underutilization,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						changes in provider behavior, and improper billing schemes. • Claims data matching and analysis and use of claims edits. • Review of pharmacy encounters • Member services verification of whether billed services were received and billed appropriately. Procedure C-01.6, Routine Monitoring, Auditing, and Identification of Compliance Risks, provides detailed information about the risk assessments, internal and external compliance audits, and ongoing monitoring. Procedure C-01.9, Verification of Services, describes processes for verifying services by sending letters to a random sample of members within 45 calendar days of claim payment. The letters outline recent medical services identified as provided to the member and asks the member to contact the health plan if there are any discrepancies.
2.9 Response to offenses and corrective action;						Per the SC Compliance Plan Addendum, Molina promptly implements corrective action for violations and program deficiencies. Activities of the Compliance Officer include: • Timely investigation of potential compliance matters. • Initiation and validation of corrective action plans to minimize the risk of recurrence.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Oversight and reporting of corrective actions to the Compliance Committee and Board of Directors. Per the FWA Plan, the Special Investigation Unit (SIU) conducts objective investigations of FWA focusing on providers and members involved in illegal activities. The investigations include reviewing documentation, billing patterns, payment history, and other resources to determine the likelihood of fraud. The SIU requests additional records when necessary, and takes corrective action based on findings.
2.10 Data mining, analysis, and reporting;						Per the FWA Plan, data mining is used to identify potential FWA. This includes data matching, trending, and statistical and claims data analysis. Required reporting to SCDHHS, the Medicaid Fraud Control Unit, etc., is also addressed in the FWA Plan.
2.11 Exclusion status monitoring.						Molina conducts exclusion status monitoring for providers and subcontractors to ensure they are not excluded or debarred from participating in Medicare, Medicaid, or any other federal health care programs. Monthly monitoring includes: • List of Excluded Individuals and Entities (LEIE) • SCDHHS lists of excluded and terminated providers • System for Award Management (SAM)

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Social Security Death Master File (SSDMF) Molina also conducts these screenings for any person with an ownership or control interest, or who is an agent or managing employee, of the health plan. If a match is found, Molina notifies the SCDHHS Division of Program Integrity and takes necessary follow-up actions. Policy C-03.0, Prohibited Affiliations, describes processes for ensuring Molina does not contract with, employ, or pay for services provided by persons or entities with criminal convictions, suspensions, debarments, or exclusions from participation in state and federal health care programs. The associated procedure addresses prevention, ongoing monitoring activities, reporting, and disclosures. Policy C-04.0, Written Disclosures, addresses circumstances and processes for self-disclosure or self-referral to regulatory agencies or external customers.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					Molina's Compliance Committee is chaired by the Compliance Officer. This committee supports and oversees the Compliance Program, assists in the development and implementation of compliance policies and procedures, and assists in identifying, managing, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						escalating risks. Membership of the committee includes senior leadership selected by the compliance officer with input from the Board of Directors. Meetings are held at least quarterly. Page five of the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight, indicates the requirement for a quorum for the health plan's Compliance Committee is, "A simple majority which equals to five (5) voting members…" However, there are six voting members of the committee, and the Compliance Officer votes to break tie votes, so a simple majority is four voting members. *Recommendation: Clarify the requirement for a quorum for the health plan's Compliance Committee on page five of the State Addendum to Procedure C-01.2, Compliance Officer, Compliance Committee, and High-Level Oversight.*
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Policies and procedures, as well as the Compliance Plan, SC Compliance Plan Addendum, and FWA Plan detail Molina's processes and activities to prevent and detect potential or suspected fraud, waste, and abuse. Additionally, individual policies and procedures are in place that address

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						topics not addressed in other standards.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Procedure C-01.7, Prompt Response (Investigation and Corrective Action) to Compliance Issues, outlines procedures for investigating and taking corrective action in response to compliance issues. The procedure addresses investigations, corrective action, self-monitoring, validation of corrective actions, and closing corrective action plans. Policy MHI-SIU-102, Opening and Conducting Investigations, provides detailed information about processes for opening and conducting preliminary and full investigations by the SIU for FWA complaints/allegations. The policy provides examples of complaints within the SIU's scope include billing fraud, misrepresentation of services, and allegations of product substitution. Appendix 17 includes information specific to processes for South Carolina. Processes for referring potential FWA cases to regulatory and law enforcement agencies for further action are found in Policy MHI-SIU-107, Referral to a Law Enforcement or Regulatory Agency. These referrals are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						made when there is credible evidence of improper billing, false claims, etc.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy MHI-SIU-101, Administrative Actions, addresses processes for taking administration actions, including provider overpayment and recovery processes and payment suspensions. It also addresses SIU Initiated Prepayment Review.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).		X				Policy MHI PHARM 07, Pharmacy Lock-In Program, provides guidance to staff about the criteria, processes, and requirements for the Pharmacy Lock-in Program. The State Addendum to Policy MHI PHARM 07 specifies South Carolina specific requirements for the Pharmacy Lock-in Program. A discrepancy was noted in documentation of the emergency supply of medication that can be provided to members in the Pharmacy Lock-in Program: • The State Addendum to Policy MHI PHARM 07 states a 72-hour supply of medication will be provided in case of an emergency. • The South Carolina Medicaid Pharmacy Lock-in Program Instructions document states the emergency supply is a five-day supply. *Quality Improvement Plan: Determine the correct duration of the emergency supply of medication provided to members in the*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Pharmacy Lock-in Program and correct the applicable document.
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Molina has established a detailed set of policies and procedures that address expectations for maintaining the confidentiality of member health information. The policies address topics including but not limited to: • Privacy and confidentiality of protected health information (PHI) • Use and disclosure of PHI • Members' rights to access, amend, and be informed of disclosure of PHI • Tracking disclosure of PHI • Identifying, reporting, managing, investigating, and responding to privacy incidents

B. Provider Services

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

The Provider Services review includes credentialing and recredentialing processes and file review, provider education processes, preventive health and clinical practice guidelines, continuity of care, processes for assessing provider compliance with medical record documentation standards, and a validation of network adequacy.

Provider Credentialing and Selection

Processes for initial and ongoing credentialing are documented in Policy and Procedure CR01, Credentialing and Recredentialing Practitioners, and Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers. Each of these has an addendum to specify state-specific requirements that differ from the requirements documented in the policies and procedures. It was found that Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, do not address provider rights required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7*, and incompletely document provider appeal rights related to credentialing denials.

Using a peer review process, Molina's Professional Review Committee (PRC) makes final recommendations about practitioner participation or continued participation in the Molina network. A Medical Director chairs the PRC, and the PRC meets monthly and as needed and reports to the National Quality Improvement Committee (NQIC). Provider representation on the PRC includes six internal practitioners and five external practitioners with a range of specialties. Only licensed medical/professional members of the PRC have voting privileges. A quorum is established with the presence of four voting practitioners, two of whom must be participating network practitioners. Submitted documentation confirmed the presence of a quorum at each of the monthly PRC meetings.

A review of initial credentialing and recredentialing files for practitioners and organizational providers was conducted. All the files were compliant with credentialing processes and requirements.

Processes for conducting monthly monitoring of providers are documented in policies. Through ProviderTrust, an exclusion monitoring vendor, providers are monitored at least monthly against the OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), the Social Security Death Master File, National Plan and Provider Enumeration System (NPPES), and state Medicaid exclusion lists. ProviderTrust also monitors state licensure/certification and sanctions as well as provider DEA numbers.

The Quality Improvement Department investigates potential quality of care issues, documents the results of the Medical Director's review, implements, and tracks any resulting quality improvement plans, and provides applicable reporting to the appropriate quality committee. The Medical Director, along with the PRC, determines quality improvement plans, which may include off-cycle review by the PRC, provider counseling or education, staff education, policy and procedure revision and submission, ongoing monitoring, etc.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Provider Services Managers, Supervisors, and/or Representatives conduct new provider orientation at the initiation of a provider's contract. The orientation covers a variety of topics, including but not limited to the provider portal and online resources, the Provider Manual, standards for access to care, billing, and claims, FWA, and member rights and responsibilities. The Medicaid Provider Orientation is available for provider access on Molina's website. Ongoing provider education is provided through provider site visits, periodic communication such as newsletters, annual Provider Office Manager Meetings, and quarterly regional provider training sessions. Staff maintain records of provider education activities, including program title, name/title of the person conducting the program, location, date, time, and a copy of an attendance sheet signed by attendees.

The "Resources & Training" page on Molina's provider website includes downloadable information about various topics. The "Opioid Safety Provider Education Resources" page on the website provides an array of resources and information applicable to this topic. Additionally, the Provider Manual is a resource for network providers, however, issues with the Provider Manual were identified, including:

- The Provider Manual refers providers to the Member Handbook on Molina's website for a complete list of member benefits and covered services. It was noted that the Member Handbook does not appear to provide sufficient information for providers to fully understand benefits and related limitations, requirements for authorization, etc.
- The Provider Manual provides incorrect and incomplete information about members' abilities to self-refer for care. For behavioral health care, it states members may obtain referrals for behavioral health services or may self-refer by calling the Contact Center. Onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Also, the Provider Manual does not indicate members may self-refer for care other than behavioral health services, although Molina staff confirmed that members may self-refer for both medical and behavioral health care.

Molina adopts Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) to provide current treatment and diagnostic information to providers and reduce variation in care between providers. Providers are educated about the CPGs and PHGs through provider orientation materials, the Provider Manual, newsletters, mailings, fax blasts, etc. The guidelines are available on Molina's website and in paper form upon request. Onsite discussion confirmed that adopted CPGs and PHGs are reviewed monthly, as stated in the Provider Manual. However, Policy MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines, incorrectly states the frequency of the review as both quarterly (pages two and three) and quarterly after being in effect for 2 years (pages eight and 15).

Molina educates providers about requirements for medical record documentation, maintenance, storage, and confidentiality. Provider compliance with these requirements is assessed through an annual medical record audit, as described in Policy MHI-QUAL-003, Standards of Medical Record Documentation. For the 2023 medical record audit, scores ranged from 91.16% to 100%, and all the sampled providers received a passing score.

Molina also conducts an annual assessment of coordination and continuity of care between practitioners and across different care settings. From this analysis, Molina identifies opportunities for improvement and develops and implements interventions to address the identified opportunities.

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 Molina's provider network following the Centers for Medicare and Medicaid Services (CMS) protocol titled, *EQR Protocol 4: Validation of Network Adequacy*. This protocol validates the health plan's provider network to determine if the MCO meets network standards defined by the State. To conduct this validation, Constellation requested and reviewed the following:

- 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, 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.

Molina's provider network was found to be adequate and consistent with the requirements of the CMS protocol, "Validation of Network Adequacy." The following is an overview of the results for each activity conducted to assess network adequacy.

Provider Network File Questionnaire

The Provider Network File Questionnaire was reviewed. Molina utilizes an interdepartmental structure, primarily including credentialing, provider information management, and provider configuration management personnel for collecting, storing, and analyzing provider enrollment data. Several mechanisms are in place for updating provider files including HiLabs, provider change forms, and the NPI junction file. The provider directory file is updated monthly, and the time/distance analyses are run quarterly for all provider types.

Availability of Services

Policy and Procedure MHSC-PC-011, Availability of Health Care, defines the geographic access standards for PCPs, specialists, and hospitals. This policy and procedure also describe processes for evaluating provider access by monitoring and measuring network availability. Molina uses GeoAccess software to measure compliance with standards quarterly. As noted in the 12.20.2023 Network Report _ Medicaid, appropriate time and distance parameters were used to measure geographic access to PCPs, specialists, and hospitals, and the standards were met for all providers. This report also confirms Molina contracts with all required Status 1 and Status 2 provider types.

Molina defines appointment access standards in Policy MHSC-PS-005, Provider Availability Standards, and includes them in the Provider Manual and Member Handbook. Procedure MHSC-PS-005, Provider Availability Standards, addresses processes for assessing provider compliance with appointment access standards for providers within the network through annual surveys for primary care, specialty care, and behavioral healthcare. For the survey conducted in January 2023, issues with PCP compliance were noted related to urgent care, emergent care, and after-hours messaging. Opportunities for improvement were noted along with interventions, including provider re-education.

In addition to monitoring the geographic adequacy and appointment access, Molina monitors its network's ability to serve members with special needs and cultural requirements by collecting and analyzing member and provider data, language services, and complaints/grievances about

member cultural and linguistic needs. Action plans are developed and implemented when gaps are identified.

Section 6 of the Provider Manual gives an overview of cultural competency and language services and instructs that providers may obtain additional information by visiting Molina's website or by contacting Provider Services. A hyperlink provided on page 29 of the Provider Manual takes the user to the Molina website home page. From the home page, it is difficult to navigate to the cultural competency information. When using the search functionality of the home page to search the term "cultural competency," results included "Cultural Competency Provider Training Resources and Links." However, the two hyperlinks associated with this search result return the user to the home page. Once located, the Culturally and Linguistically Appropriate Resources / Disability Resources page on the website includes multiple provider trainings and tools related to cultural competency, communication, and a Molina Provider Education Series covering the Americans with Disability Act, Members who are Blind or have Low Vision, Service Animals, and Tips for Communicating with People with Disabilities & Seniors.

Policy and Procedure MHSC-PC-004, Provider Panel Closure, addresses methods for monitoring PCP panel status to ensure adequate PCP availability, but does not address conducting this monitoring for specialists. The *SCDHHS Contract, Section 6.2.3.1.2* requires that the MCO ensure each member has access to specialists with an open panel.

Molina maintains a printed (PDF) Provider Directory and the website offers an online directory that includes the ability to search for providers. The review found that the PDF Provider Directory (page five) states the directory lists "Dentists, vision care providers and pharmacies." However, page five also provides a hyperlink to find pharmacy locations. It was found that the PDF Provider Directory does not include dispensing pharmacies, and when accessing the hyperlink provided on page five of the document, the user is required to create an account and sign in to an external website to access pharmacy information. The online Provider Directory does not include the required statement that "Enrolled families may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs."

Provider Access and Availability Study

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

As part of the annual EQR process for Molina, a provider access study focusing on primary care providers was conducted. From a list of current providers supplied by Molina, a population of 2,433 PCPs was found, and a random sample of 205 PCPs was selected for the provider access study. Attempts were made to contact the sample of providers to ask a series of questions regarding access members have with the providers. For the Telephone Provider Access Study conducted by Constellation, calls were successfully answered 59% of the time (114 out of 192)

when omitting 13 calls answered by personal or general voicemail messaging services. When compared to last year's results of 62%, this year had a decrease in successful calls (p=.658). See *Table 11*.

Table 11: Telephonic Access Study Answer Rate Comparison

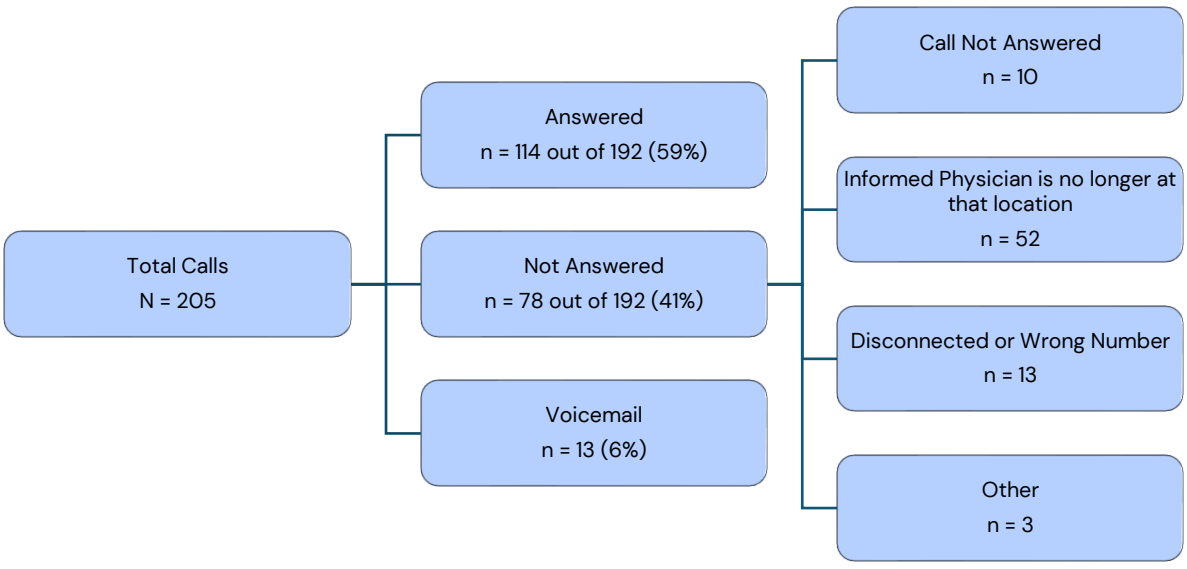
Review Year	Sample Size	Answer Rate	Fisher's Exact p-value
2023 Review	144	62%	.658
2024 Review	205	59%	

Of the 192 total calls (omitting voicemail), 114 (59%) revealed the provider was actively practicing at the location called and were considered successful. Of the 114 providers, 93 (82%) indicated that they accept Molina. Of the 93 that accept Molina, 52 (56%) are accepting new patients, and for those 52, an appointment was available within contractual requirements for 81% (42 out of 52 providers). The remaining 11 respondents (21%) were unable to give a specific date due to requirements such as new patient paperwork or previous PCP referral.

For calls not successfully answered (n= 78 calls), the majority (n = 52, 67%) were because the physician was no longer practicing at the location.

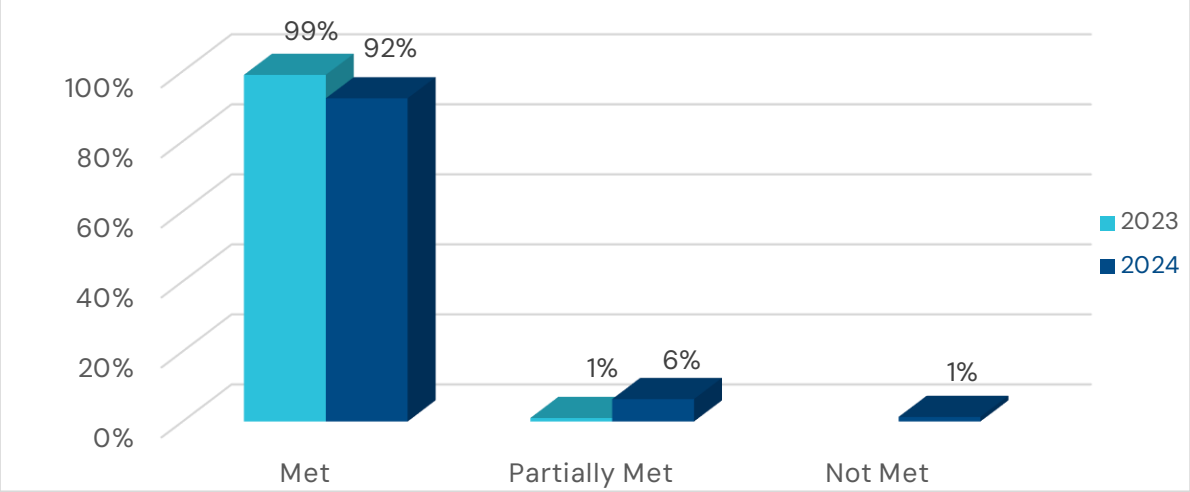
Results of the call study are displayed in *Figure 3: Telephonic Provider Access Study Results*.

Figure 3. Provider Access Study Results



As noted in *Figure 4: Provider Services Findings*, 92% of the standards in the Provider Services section were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 12: Provider Services Comparative Data

Section	Standard	2023 Review	2024 Review
Credentialing and Recredentialing	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	Partially Met
Adequacy of the Provider Network	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met
	The MCO regularly maintains and makes available a Provider Directory that includes all required elements	Met	Partially Met
	The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results	Met	Not Met

Section	Standard	2023 Review	2024 Review
Provider Education	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met
	Procedure for referral to a specialist	Met	Partially Met
Preventive Health and Clinical Practice Guidelines	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	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 13: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
The Professional Review Committee meets monthly and uses a peer review process to make recommendations for credentialing decisions.	✓		
Membership of the Professional Review Committee includes practitioners with a range of specialties.	✓		✓
No issues were noted in the initial credentialing and recredentialing files for practitioners and organizational providers.			✓
Molina contracts with all required Status 1 and Status 2 provider types.			✓
Provider access is evaluated by monitoring and measuring network availability, assessing cultural and linguistic needs, analyzing member and practitioner demographics, and implementing improvements or corrective actions as needed.			✓
Molina monitors its network's ability to serve members with special needs and cultural requirements by collecting and analyzing data to identify network gaps and takes action to address identified gaps.			✓
Initial provider education is conducted within 30 days of a provider's contract effective date, an ongoing provider education is provided through multiple forums, including provider site visits, faxed information, newsletters, electronic communications, webinars, and the MCO website. Additionally, annual Provider Office Manager meetings and quarterly regional provider training sessions are conducted.	✓	✓	
Molina adopts and educates providers about clinical practice and preventive health guidelines to provide current treatment and diagnostic information and to reduce variation in care between providers.	✓		✓
Annual medical record audits are conducted to assess provider compliance with medical record documentation, maintenance, storage, and confidentiality requirements.	✓		

Table 14: Provider Services Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers did not include all provider appeal rights required by SCDHHS.	*Quality Improvement Plan: Revise Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, include the provider rights required by the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7, and to clearly document that organizational providers have no appeal rights related to credentialing denials.*	✓		✓
Policy and Procedure MHSC-PC-004, Provider Panel Closure, addresses methods for monitoring PCP panel status to ensure adequate PCP availability, but does not address conducting this monitoring for specialists. The *SCDHHS Contract, Section 6.2.3.1.2* requires that the MCO ensure each member has access to specialists with an open panel.	*Recommendation: Revise Policy and Procedure MHSC-PC-004, Provider Panel Closure, to address methods for monitoring specialist panel status to ensure adequate specialty availability. Ensure the process for monitoring specialist panel status is then implemented.*	✓		✓
The PDF Provider Directory does not include dispensing pharmacies, and when accessing the hyperlink provided on page five, the user is required to create an account and sign in to an external website to access pharmacy information.	*Quality Improvement Plan: Revise the PDF Provider Directory to include dispensing pharmacies, as required by the SCDHHS Contract, Section 3.12.3.3.*			✓
The PDF Provider Directory includes a statement that "Enrolled families 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 statement was not found in the online provider search tool.	*Quality Improvement Plan: Update the online provider search tool to include the explanation 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. Refer to the SCDHHS Contract, Section 3.12.3.10.*			✓
For the Telephone Provider Access Study conducted by Constellation, there was no improvement in the successful answer rate from the previous year's study.	*Quality Improvement Plan: Provide documentation of the methods in place to ensure PCPs are updating their contact information in a timely manner.*			✓
The Provider Manual, page 10, refers the reader to the Member Handbook on Molina's website for a complete list of member benefits and covered services. However, the Member Handbook does not appear to provide complete and sufficient information	*Quality Improvement Plan: Include full member benefit information, including limitations, restrictions, and other requirements about member benefits in the Provider Manual.*	✓		✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
for providers to fully understand benefits and related limitations, requirements for authorization, etc.				
The Provider Manual informs that members may obtain referrals for behavioral health services or may self-refer by calling the Contact Center. However, onsite discussion confirmed that members are not required to call the Contact Center to self-refer for behavioral health services. Also, the Provider Manual does not indicate members may self-refer for care other than behavioral health services, although Molina staff confirmed that members may self-refer for both medical and behavioral health care.	*Quality Improvement Plan: Revise the Provider Manual to indicate that members may self-refer for medical care and to clarify the statement that members may self-refer to behavioral health care by calling the Contact Center.*			✓
Issues were noted related to the frequency of reviewing the CPGs and PHGs in Policy MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines.	*Quality Improvement Plan: Revise Policy and Procedure MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines to include the correct frequency for reviewing CPGs and PHGs. Alternatively, develop and implement a state-specific addendum to Policy and Procedure MHI-QUAL-018 to specify the frequency of CPG and PHG review for Molina SC Medicaid.*	✓	✓	

II. PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Molina submitted credentialing and recredentialing policies and procedures including but not limited to: • Policy and Procedure CR01, Credentialing and Recredentialing Practitioners • Addendum CR01 – South Carolina Addendum to CR01 • Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers • Addendum CR02 – South Carolina Addendum to CR02 Issues identified in Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, include: • Provider rights required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7*, are not addressed. • Provider appeal rights are incompletely documented. As stated in the document, providers who are administratively denied or administratively terminated do not have the right to submit an appeal. The document does not address appeal rights for non-administrative denials. Onsite discussion

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						confirmed organizational providers have no appeal rights related to credentialing denials. *Quality Improvement Plan: Revise Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers, to include the provider rights required by the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7, and to clearly document that organizational providers have no appeal rights related to credentialing denials.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					Procedure CR01, Credentialing and Recredentialing Practitioners, discusses the roles, responsibilities, functions, and composition of the Professional Review Committee (PRC). A Medical Director chairs the PRC, which reports to the National Quality Improvement Committee (NQIC) and meets monthly and as needed. Using a peer review process, the PRC makes recommendations for credentialing decisions. Provider representation on the PRC includes at least four contracted and participating practitioners from a range of specialties. Only licensed medical/professional members of the PRC have voting privileges. A quorum is established with the presence of four voting practitioners, two of whom must be participating network practitioners. Submitted documentation confirmed monthly meetings with the presence of a quorum at each meeting. The 2024 Credentialing and Professional Review Committee Matrix indicates current PRC membership includes six internal practitioners

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and five external practitioners with a range of specialties.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						No issues were noted in the initial practitioner credentialing files.
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
of Examiners for the specific discipline);						
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.15 Additional Requirements for Nurse Practitioners.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						No issues were noted in the practitioner recredentialing files.
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.14 Additional Requirements for Nurse Practitioners.	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Detailed information about processes for responding to potential quality of care concerns are found in Policy MHI-QUAL-008, Potential Quality of Care, Serious Reportable Adverse Events and Never Events. The Quality Improvement Department investigates potential quality of care (QOC) issues, documents the results of the Medical Director's review, implements and tracks any resulting quality improvement plans, and reports to the appropriate quality committee. The Medical Director, along with the PRC, determines quality improvement plans, which may include off-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						cycle review by the PRC, provider counseling or education, staff education, policy and procedure revision and submission, ongoing monitoring, etc. Procedure MHSC-PS-11, Investigation and Resolution Process for Reporting Provider Issues, addresses: • Receiving, recording, and investigating provider-related reports of issues • Assigning a severity index for the issue • Review by the Professional Review Committee for confirmation of the severity level and recommendations for further course of action • Corrective action plan implementation based on PRC recommendations • Tracking and monitoring CAP status and conducting ongoing monitoring Procedure CR01 indicates the PRC may recommend provider summary suspension or termination. For unprofessional conduct and quality of care issues, the provider will be notified certified letter and email. The notice will include the reasons for the action, process for appealing the determination, and the termination effective date. The provider will be reported to the NPDB, State licensing board, and the Plan Government Contracts Department, and will be reported to the NPDB.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Processes for conducting monthly monitoring of providers are documented in various policies, including: • Policy and Procedure CR01, Credentialing and Recredentialing Practitioners • Policy and Procedure CR02, Assessment and Re-assessment of Organizational Providers • Policy CR 04, Ongoing Monitoring Policy • Procedure CR 04 – 01, OGM - Sanctions Monitoring Procedure • Procedure CR 04 – 02, OGM - Sanctions Monitoring Ownership and Control Procedure • Procedure CR 04 – 05, OGM - NPDB Continuous Query Procedure • Procedure CR 04 – 06, OGM - SSA Death Master File Procedure
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1. The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy and Procedure MHSC-PC-011, Availability of Health Care, defines PCPs as family/general medicine, pediatrics, internal medicine, and FQHC/RCH providers, and states the access standard for all PCPs is 90% of members with access to a PCP within 30 miles/45 minutes for both rural and metro areas. The 12.20.2023 Network Report_ Medicaid indicates the appropriate time and distance parameters were used to measure geographic access to PCPs. All

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers met the time/distance standards and 100% of members have the required access. Policy and Procedure MHSC-PC-004, Provider Panel Closure, states the Provider Contracting Department maintains providers' panel status within the Provider Directory and monitors and reviews the number of PCPs who are accepting new members to ensure adequate availability. Molina sets internal targets for the number of PCPs who will accept new members by both county and provider. If the target is not met, or if member grievances reveal an access issue, Molina develops and implements an action plan to contract with additional PCPs or contacts providers with closed panels to ensure there are enough providers accepting new members. Molina provided a copy of the "Closed Panel PCP Providers" report that indicates a total of 1679 providers have closed panels.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy and Procedure MHSC-PC-011, Availability of Health Care, states the access standard for all specialists as 90% of members with access to a specialist within 50 miles/75 minutes for both rural and metro areas. For hospitals, the standard is specified as 1 hospital within 50 miles/75 minutes. The 12.20.2023 Network Report_Medicaid confirms Molina contracts with all required Status 1 and Status 2 provider types. The report indicates the appropriate time and distance parameters were used to measure geographic

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						access specialists and hospitals and all providers met the time/distance standards. Policy and Procedure MHSC-PC-004, Provider Panel Closure, addresses methods for monitoring PCP panel status to ensure adequate PCP availability, but does not address conducting this monitoring for specialists. The *SCDHHS Contract, Section 6.2.3.1.2* requires that the MCO ensure each member has access to specialists with an open panel. *Recommendation: Revise Policy and Procedure MHSC-PC-004, Provider Panel Closure, to address methods for monitoring specialist panel status to ensure adequate specialty availability. Ensure the process for monitoring specialist panel status is then implemented.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy and Procedure MHSC-PC-011, Availability of Health Care, indicates Molina evaluates provider access by monitoring and measuring network availability, assessing cultural and linguistic needs, analyzing member and practitioner demographics, and implementing improvements or corrective actions as needed. Molina uses GeoAccess software to measure compliance with standards quarterly. The policy and procedure indicate Molina develops an annual availability evaluation/plan to maintain an adequate network of practitioners. The evaluation includes reviewing network availability against required standards, assessing the cultural, racial, and linguistic needs of members, evaluating recruitment

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						efforts, etc. Information that Molina submits its provider network to SCDHHS quarterly was noted.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					As noted in Policy MHI-QUAL-011, Practitioner Network Cultural Responsiveness, Molina monitors its network's ability to serve members with special needs and cultural requirements by collecting and analyzing data, including: • Practitioner race/ethnicity and language information through the credentialing process and provider satisfaction surveys. • Member race/ethnicity and language information from internal systems, the U.S. Census Bureau, and/or Member Satisfaction Surveys. • Language services offered by practices in the network. • Complaints related to the cultural and linguistic needs of the membership. Molina analyzes and compares the member and provider data to identify network gaps. Action plans are developed and implemented when gaps are identified. Section 6 of the Provider Manual gives an overview of cultural competency and language services and instructs that providers may obtain additional information by visiting Molina's website or by contacting Provider Services. Page 29 of the Provider Manual states, "Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com…" However, the hyperlink

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						included on page 29 of the Provider Manual takes the user to the Molina website home page. From there, it is difficult to navigate to the cultural competency information. When using the search functionality of the home page to search the term "cultural competency," results included "Cultural Competency Provider Training Resources and Links." However, the two hyperlinks associated with this document return the user to the home page. The information was located after extensive navigation by the user. The Culturally and Linguistically Appropriate Resources / Disability Resources page on the website includes provider trainings and tools, including: • Building Culturally Competent Healthcare: Training for Healthcare Providers and Staff • A Physician's Practical Guide to Culturally Competent Care • Industry Collaborative Effort (ICE) – Better Communication, Better Care • Molina Provider Education Series (Americans with Disability Act, Members who are Blind or have Low Vision, Service Animals, and Tips for Communicating with People with Disabilities & Seniors) The 2023 Health Equity and Cultural Competency Program Description was found in Appendix E in the 2023 Quality Improvement Program Description.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					As noted in the Molina Healthcare of South Carolina Medicaid – Network Planning/ Adequacy document, Molina reviews GeoAccess reports to analyze the adequacy of the network. Molina acts to address gaps identified through this analysis or as a result of provider terminations to ensure member needs are met by: • Making efforts to provide multiple options for care in every region. • Redirecting members to alternate network providers when a provider terminates. • Executing single case agreements with non-participating providers when no alternate options are available and targeting these providers for recruitment. • Attempting to recruit providers to fill gaps immediately upon provider termination notice.
1.6 The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. Molina utilizes an interdepartmental structure, primarily including credentialing, provider information management, and provider configuration management personnel, for collecting, storing, and analyzing provider enrollment data. Several mechanisms are in place for updating provider files including HiLabs, provider change forms, and the NPI junction file. The provider directory file is updated monthly, and the time/distance analyses are run quarterly for all provider types.
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy MHSC-PS-005, Provider Availability Standards, the Provider Manual, and the Member Handbook appropriately define appointment access standards for PCPs and specialists.
2.2 The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					Molina conducts annual surveys to evaluate provider availability for primary care, specialty care, and behavioral healthcare. Providers with performance below the standard are identified and an action plan is developed for provider education. Procedure MHSC-PS-005, Provider Availability Standards, addresses Molina's processes for assessing provider compliance with appointment access standards for providers within the network. Appendix J of the Quality Improvement Program 2022 Annual Evaluation includes the Accessibility of Services Analysis. The document is labeled as 2022 but indicates the survey was conducted from 1/10/23 through 1/30/23 by the Quality Program Management and Performance Department. The analysis indicates the correct parameters were used to assess appointment availability for PCPs and specialists. Issues were documented with PCP compliance related to urgent care, emergent care, and after-hours messaging. Opportunities for improvement were noted in the document along with interventions, including provider re-education. Onsite discussion confirmed this re-education is provided through quarterly provider communications, fax blasts,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						newsletters, and a standing agenda item for provider education sessions.
2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.		X				Molina provided a copy of the South Carolina All Regions Provider Directory – 2024 (PDF). Additionally, the website offers the ability to search for providers. The PDF Provider Directory and the online directory include all required practitioner elements. The online directory includes all required provider types. It was noted that page five of the PDF Provider Directory states the directory lists "Dentists, vision care providers and pharmacies." However, page five also provides a hyperlink to find pharmacy locations. The PDF Provider Directory does not include dispensing pharmacies, and when accessing the hyperlink provided on page five, the user is required to create an account and sign in to access pharmacy information on an external website. *Quality Improvement Plan: Revise the PDF Provider Directory to include dispensing pharmacies, as required by the SCDHHS Contract, Section 3.12.3.3.* As noted in Policy MHSC-PNA-01, POD Validation, the online provider directory is updated at least once every seven calendar days and printed directories are updated at least quarterly. Both the PDF and the online Provider Directory include a statement that "Some providers may

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						choose not to perform certain services based on religious or moral beliefs." The PDF Provider Directory includes a statement that "Enrolled families 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 statement was not found in the online provider search tool. *Quality Improvement Plan: Update the online provider search tool to include the explanation 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. Refer to the SCDHHS Contract, Section 3.12.3.10.*
2.4 The MCO conducts appropriate activities to validate Provider Directory information.	X					Policy MHSC-PNA-01, POD Validation, addresses processes for Provider Directory validation. The processes are the responsibility of the Provider Services and Provider Information Management Departments. These activities include: • Quarterly provider data validation reviews prioritizing PCPs but including other providers as needed. • Provider Directory Reviews of reports from the online Provider Directory. • Provider surveys to verify the accuracy of information in the online Provider Directory.
2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.			X			Molina submitted a Provider File that contained a population of 2,433 providers. From that population, a random sample of 205 PCPs was selected for the provider access study. Attempts were made to contact the sample of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers to ask a series of questions regarding access members have with the contracted providers. For the Telephone Provider Access Study conducted by Constellation, calls were successfully answered 59% of the time (114 out of 192) when omitting 13 calls answered by personal or general voicemail messaging services. When compared to last year's results of 62%, this year had a decrease in successful calls (p=.658). A total of 205 calls were completed and 13 were answered by voicemail. The voicemail calls were omitted, resulting in a denominator of 192. For calls not successfully answered (n= 78 out of 192 calls), the majority (n = 52, 67%) were because the physician was no longer practicing at that location. Of the 192 calls (omitting voicemail), a total of 114 revealed the provider was actively practicing at the location called and were considered successful (59%). Of the 114 providers, 93 (82%) indicated that they accept Molina. Of the 93 that accept Molina, 52 (56%) are accepting new patients, and for those 52, an appointment was available within contract requirements for 81% (42 out of 52 providers), and the other 11 respondents (21%) were unable to give a specific date due to requirements such as new patient paperwork or previous PCP referral.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Provide documentation of the methods in place to ensure PCPs are updating their contact information in a timely manner.
2.6 The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					SCDHHS has defined the time/distance requirements for primary care, OB/GYN, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Enterprise Services GeoAccess software. Internal audits are conducted to maintain accurate provider directories.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy and Procedure MHSC-PS-010, Provider and Practitioner Education, outline processes and requirements for initial provider education conducted at the initiation of the provider's contract by the Provider Services Manager, Supervisor, and/or Representatives. The training covers a variety of topics, including but not limited to: • Online resources and the web portal • Provider Manual highlights • Access to care standards • Billing and claims submission • FWA and HIPAA • Cultural competency • Care Coordination • Behavioral health services • Appeals and grievances • Member rights and responsibilities

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Records are maintained for provider education sessions, including program title, location, and attendance. The Medicaid Provider Orientation document was located on Molina's website. Additionally, the Provider Manual is a resource for network providers.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				The Provider Manual, page 10, refers the reader to the Member Handbook on Molina's website for a complete list of member benefits and covered services. However, the Member Handbook does not appear to provide complete and sufficient information for providers to fully understand benefits and related limitations, requirements for authorization, etc. For example: • There is no information about post-stabilization care in the Member Handbook. • There is no information about Targeted Care Management services in the Member Handbook. Note: Some information about these services is found in the Provider Manual, but there is a concern that the provider may not check

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Manual because they have been referred to the Member Handbook to obtain information. • Restrictions on and requirements for hysterectomy and sterilization are not included in the Member Handbook. *Quality Improvement Plan: Include full member benefit information, including limitations, restrictions, and other requirements in the Provider Manual.*
2.4 Procedure for referral to a specialist;		X				The Provider Manual indicates PCPs can refer members to in-network specialists for consultation and treatment without a referral request to Molina and indicates members may obtain referrals for behavioral health services or may self-refer by calling the Contact Center. However, onsite discussion revealed that members are not required to call the Contact Center to self-refer for behavioral health services. Molina staff stated that this was included in the Provider Manual so that members may obtain a list of participating providers if needed. Also, the Provider Manual does not indicate members may self-refer for care other than behavioral health services, although Molina staff confirmed that members may self-refer for both medical and behavioral health care. *Quality Improvement Plan: Revise the Provider Manual to indicate that members may self-refer for medical care and to clarify the statement that members may self-refer to*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						behavioral health care by calling the Contact Center.
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					The Provider Manual addresses recommended EPSDT services and general preventive health guidelines. Molina provides coverage for services recommended by the U.S. Preventive Services Task Force, Bright Futures/American Academy of Pediatrics, and Centers for Disease Control and Prevention.
2.7 Medical record handling, availability, retention, and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					Information about Pharmacy coverage and processes is found in Section 10 of the Provider Manual. The information addresses the Pharmacy and Therapeutics Committee, pharmacy network, the drug formulary, etc. The Provider Manual directs the reader to Molina's website to view the Preferred Drug List (PDL). It was noted that Molina's website includes a notification that "Beginning July 1, 2024, all MCO plans will use the same list of outpatient drugs covered under the pharmacy benefit. This list is called a Single Preferred Drug List (SPDL). Members can expect changes to their

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medications and pharmacy products because of the new SPDL."
2.10 Reassignment of a member to another PCP;	X					As noted in the Provider Manual, PCPs may request dismissal of a member from his/her panel due to the member's documented behavior except when the behavior is a result of a physical or behavioral health condition. Appropriate reasons for requesting member dismissal include continued noncompliance with the recommended plan of care and behavior that is disruptive, unruly, abusive, or uncooperative so that it seriously impairs the provider's ability to furnish services to the member or other patients.
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Procedure MHSC-PS-010, Provider and Practitioner Education, describes processes for ongoing provider education and training provided through: • Provider site visits conducted routinely, as needed, and upon request • Periodic communications including but not limited to face-to-face presentations, faxed information, newsletters, electronic communications, webinars, and the MCO website • Annual Provider Office Manager Meetings • Quarterly regional provider training sessions Staff maintain records of provider education activities, including program title, name/title of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the person conducting the program, location, date, time, and a copy of an attendance sheet signed by attendees. The Molina provider website "Resources & Training" page includes downloadable information about various topics, such as site of care infusions, the Provider Services Representative Map, clinical coverage guideline availability, claim status, etc. Additionally, the "Opioid Safety Provider Education Resources" page on the website provides an array of resources and information applicable to this topic.
II D. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. 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.		X				Molina adopts Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) to provide current treatment and diagnostic information to providers and reduce variation in care between providers. The National Quality Improvement and Health Equity Transformation Committee (NQIHETC) holds responsibility for selecting and approving CPGs and PHGs, which are evidence-based and recommended by national clinically based organizations. CPGs are reviewed for relevance to Molina's population, with a focus on high-risk or high-cost subsets. PHGs include age- and condition-specific recommendations relevant to Molina's population. Local health plans are notified of the guidelines approved by the NQIHETC so that they may be reviewed and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						approved by the health plan's QIC. These processes are described in Policy and Procedure MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines. Onsite discussion confirmed that after approval and adoption, the CPGs and PHGs are reviewed monthly, as stated in the Provider Manual. Issues were noted related to the frequency of reviewing the CPGs and PHGs in Policy MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines: • Pages two and three of the policy incorrectly indicate the guidelines are reviewed quarterly. • Pages eight and 15 of the procedure indicate the guidelines are reviewed quarterly after they have been in effect for two years. *Quality Improvement Plan: Revise Policy and Procedure MHI-QUAL-018, Development, Review, Adoption and Distribution of Clinical Practice Guidelines and Preventive Health Guidelines to include the correct frequency for reviewing CPGs and PHGs. Alternatively, develop and implement a state-specific addendum to Policy and Procedure MHI-QUAL-018 to specify the frequency of CPG and PHG review for Molina SC Medicaid.*
2. The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members.	X					Molina employs a multi-faceted approach to ensure the CPGs and PHGs are disseminated to and easily accessible by practitioners. The guidelines are distributed to appropriate

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						practitioners through provider orientation materials, the Provider Manual, newsletters, mailings, fax blasts, on Molina's website, and in paper form upon request. The Provider Manual provides hyperlinks to the adopted PHGs and CPGs and explains the importance of using the guidelines to meet targeted State and Federal standards. It further states, "Molina expects Providers to deliver preventive care and encourage Molina Members to obtain services in accordance with preventive health guidelines for children, adolescents and adults."
3. The guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.7 Behavioral health services.	X					
II E. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Molina's process for monitoring continuity of care between PCPs and other providers is detailed in Procedure MHI-QUAL-004, Monitoring Continuity of Care. At least annually, Molina collects and analyzes data to assess coordination and continuity of care between practitioners and across different care settings. The data sources include but are not limited to claims, encounters, pharmacy data, laboratory data, utilization management and case management information, Healthcare Effectiveness Data and Information Set (HEDIS) data, and provider satisfaction surveys. Procedure MHI-QUAL-003, Standards of Medical Record Documentation, indicates medical record reviews also contribute to the evaluation of continuity and coordination of care among providers. Upon completion of the analysis, Molina identifies at least four opportunities for improvement, and develops and implements interventions to address the identified opportunities. The results of data analysis and planned interventions are reported to the appropriate committees, with interim updates regarding the progress of interventions reported, as necessary.
II F. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy MHI-QUAL-003, Standards of Medical Record Documentation, defines the standards for medical record documentation, maintenance, and confidentiality. The policy also describes the medical record review process to assess provider compliance with these standards.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Addendum 14 to Procedure MHI-QUAL-003, Standards of Medical Record Documentation, defines the specific medical record documentation for the SC Medicaid network. The documented elements are compliant with the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.9 (O).* The Provider Manual addresses the importance of keeping complete and accurate medical records, providing medical records in support of Molina's quality programs and initiatives, maintaining the confidentiality of medical records and appropriate medical record-keeping practices, and retaining records for at least 10 years for adult patients and at least 13 years for minors.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The "State Specific Policies and Procedures" section of Policy MHI-QUAL-003, Standards of Medical Record Documentation, describes the process for conducting annual medical record audits. The annual audit is conducted from a sample of PCPs with a minimum of five records reviewed for each provider included in the sample. The record reviews are conducted by

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						QI medical record review specialists using the standard medical record audit tool. Final review scores of 90% or above are considered passing scores. For providers who do not meet the passing score of 90%, Molina provides re-education. Final review scores of less than 90% require an over-read, and for providers who do not meet the 90% threshold on over-read, a re-audit must be conducted six months after review and approval by the Quality Improvement Health Equity Transformation Committee. The 2023 MHSC Standard Medical Record Review Analysis document reflects that the medical record audit was conducted on a sample of 150 records from 30 providers. 100% of the providers received a passing score, with scores ranging from 91.16% to 100%.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

C. Member Services

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

All member rights and responsibilities are included in Procedure MHSC-ME-04, Member Bill of Rights and Responsibilities, the Member Handbook, and found on Molina's website. New members receive a Welcome Kit within 14 calendar days from the date Molina receives their eligibility file as described in Policy and Procedure ME-01, New Medicaid Member Outreach and Education.

The Member Handbook and website contain a benefit grid that describes core benefits, covered services, and any limitations. Prior approval is not required for family planning services, emergency visits, or behavioral health services. Members are informed of their right to obtain a second opinion, which requires prior approval if the member chooses to go to an out-of-network provider. The lack of information found in the Member Handbook regarding the services provided through Developmental Evaluation Centers was discussed onsite. Constellation recommended additional information should be included in the Member Handbook to clarify service eligibility and reimbursement information.

Members are provided with information to address a variety of needs in the Member Handbook and on Molina's website. The Nurse Advice Line telephone number is listed on the Member ID Card and in the Member Handbook and the Nurse Advice Line is available 24 hours a day. Emergent, urgent, and routine services are clearly described with specific information about accessing each. The Member Handbook informs members that interpreter services are available by contacting the Member Services Contact Center. Policy MHSC-ME-02, Advanced Directives, provides information about a member's right to implement an advance directive, including a description of applicable state laws. Steps to file grievances and appeals and to report fraud, waste, and abuse are clearly indicated in the Member Handbook.

The Member Handbook provides information about the steps to select a PCP. s. Member Services staff are available for members if more information or assistance is needed. Procedure MHSC-ME-05, Medicaid Member Disenrollment, and the Member Handbook describe processes for member disenrollment.

Program information and educational materials are made available to members to address chronic health conditions and disease management. The member Quick Start Guide, Member Handbook, and My Health My Life Newsletters provide helpful resources and supports to members. Molina reported during the onsite discussion that digital outreach to members is being expanded for the upcoming year to augment current electronic text and email communications methods.

Member Satisfaction Survey

Molina contracts with Press Ganey, a certified CAHPS survey vendor, to conduct both the child and adult surveys. Constellation conducted a validation of the satisfaction surveys following the CMS protocol titled, *EQR Protocol 6: Administration or Validation of Quality of Care Surveys*.

The Adult survey had 239 responses out of 2,015 surveys, resulting in a response rate of 11.9%,which is a decline from the previous year's rate of 14.5%. Improvement occurred for four measures, with the largest improvement reported for Discussing Cessation Medications (+3.9%). Ten measures showed a decline with the largest being a 7.4% decline for Rating of Health Care.

For the Child survey, there were 429 out of 4,094 responses, yielding a 10.5% response rate, which is an improvement over last year's rate of 9.7%. Improvement occurred for six measures, with the largest improvement in the Coordination of Care rate (+8.2%). The largest decline was for Getting Needed Care (-6.6%).

For Children with Chronic Conditions (CCC), 425 surveys were completed out of 4,586 sampled, resulting in a 9.3% response rate. This is a decline from the previous year's rate of 9.9%. Improvement occurred for 12 measures, with the largest improvement being 7.3% for Customer Service. Three measures showed a decline, and the largest decline occurred for Access to Prescription Medicines (-2.5%).

Constellation noted the response rates were below the NCQA target of 40% and recommended Molina continue innovative methods (other than oversampling) to improve response rates and achieve a representative sample of the populations surveyed.

The survey results were presented to the Quality Improvement and Health Equity Transformation Committee and shared with Providers. Documentation regarding the committee meetings and analysis was submitted in the desk materials. Molina is working on implementing interventions to improve member satisfaction.

Grievances

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

Policy and Procedure MHSC-MRT-001, Grievance Disposition Process, describes processes for filing, acknowledging, and resolving verbal and written grievances. Members are informed of this process in the Member Handbook and on Molina's website. The definition of a grievance, filing options, and associated timeframes are consistently documented across the documents reviewed. Information about the use of an authorized representative for member assistance was described clearly in the Member Handbook and on the website. Grievances are resolved within 90

calendar days from the date Molina received the grievance. An extension may be requested for up to 14 calendar days by the member or health plan.

A performance analysis for grievances, including barriers, strengths, and opportunities for improvement, is documented quarterly in the Health Care Services (HCS) Committee, a sub-committee of the Quality Improvement and Health Equity Transformation Committee, as evidenced in quarterly meeting minutes. Of the grievance files selected and reviewed for the 2024 EQR, all were acknowledged, investigated, and resolved timely with appropriately documented correspondence to members.

Molina met all the requirements in the Member Services section for the 2024 EQR.

Figure 5: Member Services Findings

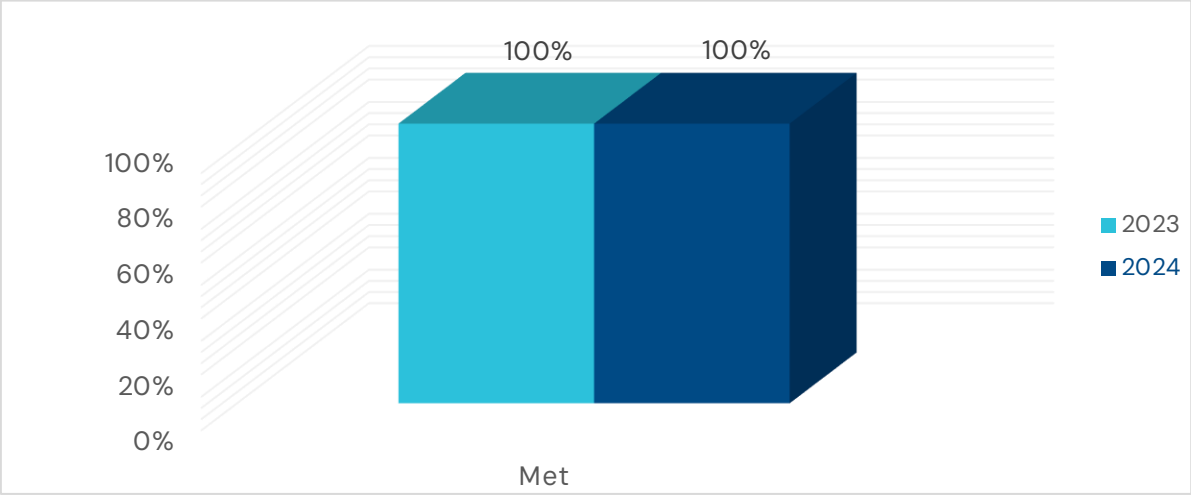


Table 15: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
A clear definition of a grievance is provided for members, along with helpful examples of grievances, in the Member Handbook.	✓		
Of the grievance files selected and reviewed for the 2024 EQR, all were acknowledged, investigated, and resolved timely with appropriately documented correspondence to members.		✓	

Table 16: Member Services Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The Member Handbook lacked information regarding the services provided through Developmental Evaluation Centers.	*Recommendation: Revise the Member Handbook to describe the services provided through the Developmental Evaluation Centers, eligibility requirements and reimbursement information.*			✓
The response rates declined for the Adult and Child with Chronic Conditions surveys for this EQR.	*Recommendation: Continue innovative methods (other than oversampling) to improve response rates and achieve a representative sample of the* populations surveyed.	✓		

III. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Member rights and responsibilities are described in Procedure MHSC-ME-04, Member Bill of Rights and Responsibilities, the Member Handbook, and on Molina's website.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					
1.1 Benefits and services included and excluded in coverage;						The Member Handbook lacked information regarding the services provided through the Developmental Evaluation Centers. *Recommendation: Revise the Member Handbook to describe the services provided through the Developmental Evaluation Centers, eligibility requirements and reimbursement information.*
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						Members are informed of their right to obtain a second opinion in the Member Handbook. Prior approval is required if the member chooses to go to an out-of-network provider.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The Member Handbook and Molina's website detail services that require prior authorization. Prior approval is not required for family planning services, emergency visits, or behavioral health services.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Members are informed that the Nurse Advice Line is available 24 hours a day, seven days a week. The contact information is included in the Member Handbook and on the Member's ID card.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Handbook and Molina's website include the toll-free number to reach the Member Services Department.
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						Information about the member's right to implement an Advance Directive and Living Willis made available in the Member Handbook.
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Instructions for selecting a PCP and obtaining assistance with selecting a providers are included in the Member Handbook.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Procedure MHSC-ME-05, Medicaid Member Disenrollment, describes processes for member disenrollment. Disenrollment steps are also provided in the Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					
2. The MCO identifies children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Molina contracts with Press Ganey, a certified CAHPS survey vendor, to conduct the Adult, Children with Chronic Conditions (CCC), and Child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Press Ganey reports, summarizes, and details all results from the three surveys. The QI Evaluation, Appendix C, displayed an analysis of the data and action steps needed to achieve higher scores for member satisfaction. It was noted the response rates were below the NCQA target of 40%. *Recommendation: Continue innovative methods (other than oversampling) to improve response rates and achieve a representative sample of the populations surveyed.*
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The QIHETC minutes for Q3 2023 and Q4 2023 present objectives related to member satisfaction and initiated action plans to address problematic measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The 2023 Q3 Palmetto Partners Provider Newsletter provides Member Satisfaction Survey results to providers.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The CAHPS Outcome report was presented to the QIC.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy and Procedure, MHSC-MRT-001, Grievance Disposition Process, the Member Handbook, Provider Manual, and the website, describe processes for filing, acknowledging, and resolving grievances.
1.1 The definition of a grievance and who may file a grievance;	X					A clear definition of a grievance is provided for members, along with helpful examples of grievances in the Member Handbook.
1.2 Procedures for filing and handling a grievance;	X					Molina consistently informs members that grievances may be filed verbally in person, by telephone, in writing, by fax, or electronically. An authorized representative may file or assist members with the filing of grievances.
1.3 Timeliness guidelines for resolution of a grievance;	X					Grievances are resolved within 90 calendar days from the date Molina receives the grievance. An extension may be requested for up to 14 calendar days by the member or health plan.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Policy MHSC-MRT-001, Grievance Disposition Process, indicates that grievances are logged, tracked, and analyzed each quarter.
2. The MCO applies grievance policies and procedures as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievance performance analyses addressing barriers, strengths, and opportunities for improvement are documented quarterly in the Health Care Services Committee, a sub-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						committee of the Quality Improvement and Health Equity Transformation Committee.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					Of the grievance files selected and reviewed for the 2024 EQR, all were acknowledged, investigated, and resolved timely with appropriately documented correspondences to members.

D. Quality Improvement

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

The Molina Healthcare of South Carolina Quality Improvement Program Description 2023 was received and reviewed. The aim of the program is to reduce and eliminate health disparities, address social determinants of health, and improve health outcomes. The document provided detailed information about the committee structure, roles, functions, and responsibilities of each committee involved in overseeing and implementing the program. It also outlines the various components and activities of the program. Molina actively engages stakeholders in the Quality Improvement (QI) Program by involving them in decision-making, seeking their feedback and input, fostering collaborations and partnerships, providing education and training, and maintaining transparent communication channels.

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 the goal was noted as met for this activity.

The Quality Improvement and Health Equity Transformation Committee (QIHETC), formerly known as the Quality Improvement Committee, is responsible for the implementation, oversight, and ongoing monitoring of the QI Program. This committee is co-chaired by the Chief Medical Officer and the Quality Lead. Other members of this committee include representatives of various departments and positions within Molina. External network physicians and practitioners, such as primary care physicians, and medical specialists are also members of the committee. The Recorder, who is a Quality Specialist, serves as the meeting coordinator and is responsible for preparing the agenda, drafting the meeting minutes, and conducting various activities related to the committee's meetings. The meeting minutes provided with the desk materials were complete and included feedback, discussion, and decisions made by the committee. The name change for the committee was reported to the committee members in March 2023. However, the meeting minutes did not reflect the new name.

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. Policy MHI-QUAL-016, Communication of Quality Improvement Performance Results, addressed this process. Procedure 103.01, Early Periodic Screening, Diagnostic and Treatment (EPSDT), describes how Molina tracks member and provider compliance with EPSDT services. This includes provider

reporting and following up on members and families who do not receive services, as well as tracking members who did not receive recommended assessments and/or treatments.

Molina evaluates the effectiveness of the QI Program by reviewing key components of the program. This includes evaluating the adequacy of resources, such as staffing, data and other information, to ensure that the program has the necessary support to collect, analyze, and integrate data for quality improvement. Molina also evaluates the committee structure, practitioner participation, and leadership involvement in the program to ensure that there is active engagement and oversight. Additionally, Molina conducts ongoing program activity monitoring to assess the program's impact on health plan members and practitioners. The evaluation process includes a review of clinical, service, and operational initiatives and trends. Through this evaluation, Molina identifies barriers and opportunities for improvement and implements interventions to address them.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation conducted a validation review of the HEDIS measures following the CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. Molina uses Cognizant, a certified software, for the calculation of HEDIS rates based on the specifications and eligibility criteria, which are defined in the software. The performance measure validation found that Molina was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

As part of the review, Constellation examined the roadmap, the data sources, the audit report, and conducted a trend analysis to assess for substantial declines or increases in the rates. All relevant HEDIS performance measures (PMs) for the current measure year (2022), the previous measure year (2021), and the change from 2021 to 2022 are reported in *Table 17: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial improvement (>10%) and the rates shown in red indicate a substantial decrease (>10%).

Table 17: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	70.56%	70.07%	-0.49%
Counseling for Nutrition	58.88%	58.15%	-0.73%
Counseling for Physical Activity	56.2%	55.23%	-0.97%

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Childhood Immunization Status (CIS)			
DTaP	64.96%	64.23%	-0.73%
IPV	82.73%	83.45%	0.72%
MMR	82.97%	83.21%	0.24%
HiB	76.4%	78.10%	1.70%
Hepatitis B	80.78%	79.32%	-1.46%
VZV	80.29%	82.48%	2.19%
Pneumococcal Conjugate	67.4%	68.61%	1.21%
Hepatitis A	79.81%	81.02%	1.21%
Rotavirus	69.34%	65.69%	-3.65%
Influenza	35.28%	28.47%	-6.81%
Combination #3	58.88%	58.15%	-0.73%
Combination #7	53.28%	51.34%	-1.94%
Combination #10	25.79%	19.95%	-5.84%
Immunizations for Adolescents (IMA)			
Meningococcal	66.67%	68.37%	1.70%
Tdap/Td	77.37%	84.18%	6.81%
HPV	29.44%	33.58%	4.14%
Combination #1	66.42%	68.13%	1.71%
Combination #2	28.95%	32.36%	3.41%
Lead Screening in Children (LSC)	67.4%	58.42%	-8.98%
Breast Cancer Screening (BCS)	52.36%	52.60%	0.24%
Cervical Cancer Screening (CCS)	62.53%	56.20%	-6.33%
Colorectal Cancer Screening (COL)			
Total	NR	39.63%	NA
Chlamydia Screening in Women (CHL)			
Total	57.78%	58.78%	1.00%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
Total	71.59%	78.29%	6.70%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	25.66%	22.22%	-3.44%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	65.36%	72.78%	7.42%
Bronchodilator	78.01%	79.25%	1.24%
Asthma Medication Ratio (AMR)			
Total	63.15%	61.81%	-1.34%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	59.85%	52.31%	-7.54%

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	68.18%	71.43%	3.25%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
Received Statin Therapy - Total	82.21%	82.32%	0.11%
Statin Adherence 80% - Total	54.53%	56.26%	1.73%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	2.65%	3.65%	1.00%
Cardiac Rehabilitation - Engagement1 (Total)	5.31%	5.11%	-0.20%
Cardiac Rehabilitation - Engagement2 (Total)	4.87%	1.46%	-3.41%
Cardiac Rehabilitation - Achievement (Total)	3.1%	0.00%	-3.10%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (CDC)			
HbA1c Poor Control (>9.0%)	45.5%	43.07%	-2.43%
HbA1c Control (<8.0%)	46.72%	47.93%	1.21%
Eye Exam (Retinal) Performed	51.58%	53.28%	1.70%
Blood Pressure Control for Patients With Diabetes (BPD)	NR	63.02%	NA
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (Total)	24.79%	28.31%	3.52%
Statin Therapy for Patients With Diabetes (SPD)			
Received Statin Therapy	64.14%	63.53%	-0.61%
Statin Adherence 80%	49.73%	50.40%	0.67%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (Total)	NR	25.96%	NA
Antidepressant Medication Management (AMN)			
Effective Acute Phase Treatment	47.18%	46.66%	-0.52%
Effective Continuation Phase Treatment	30.82%	28.32%	-2.50%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	34.48%	52.89%	18.41%
Continuation and Maintenance (C&M) Phase	45.5%	62.65%	17.15%
Follow-Up After Hospitalization for Mental Illness (FUH)			
Total - 30-Day Follow-Up	59.68%	55.59%	-4.09%
Total - 7-Day Follow-Up	38.22%	32.61%	-5.61%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Total - 30-Day Follow-Up	57.95%	56.33%	-1.62%
Total - 7-Day Follow-Up	42.19%	43.00%	0.81%
Diagnosed Substance Use Disorders (DSU)			
Diagnosed Substance Use Disorders - Alcohol (Total)	NR	1.66%	NA

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Diagnosed Substance Use Disorders - Opioid (Total)	NR	1.78%	NA
Diagnosed Substance Use Disorders - Other (Total)	NR	2.96%	NA
Diagnosed Substance Use Disorders - Any (Total)	NR	5.05%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Total - 30-Day Follow-Up	36%	43.84%	7.84%
Total - 7-Day Follow-Up	25.2%	29.35%	4.15%
Follow-Up After Emergency Department Visit for Substance Abuse (FUA)			
Total - 30-Day Follow-Up	16.25%	28.63%	12.38%
Total - 7-Day Follow-Up	11.31%	19.75%	8.44%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	79.97%	80.72%	0.75%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	66.82%	66.67%	-0.15%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	93.75%*	73.68%*	NA*
Pharmacotherapy for Opioid Use Disorder (POD)			
Total	52.55%	33.78%	-18.77%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	64.03%	67.14%	3.11%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood glucose testing - Total	51.21%	50.96%	-0.25%
Cholesterol Testing - Total	28.64%	30.05%	1.41%
Blood glucose and Cholesterol Testing - Total	26.94%	28.37%	1.43%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.57%	0.45%	-0.12%
Appropriate Treatment for Children With URI (URI)			
Total	88.28%	88.31%	0.03%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
Total	50.62%	59.03%	8.41%
Use of Imaging Studies for Low Back Pain (IBP)	68.69%	66.87%	-1.82%
Use of Opioids at High Dosage (HDO)	1.74%	1.16%	-0.58%
Use of Opioids From Multiple Providers (UOP)			
Multiple Prescribers	23.24%	21.27%	-1.97%
Multiple Pharmacies	1.96%	1.31%	-0.65%
Multiple Prescribers and Multiple Pharmacies	1.39%	1.04%	-0.35%
Risk of Continued Opioid Use (COU)			
Total - >=15 Days covered	4.1%	3.82%	-0.28%
Total - >=31 Days covered	2.6%	2.49%	-0.11%

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Total	79.16%	76.41%	-2.75%
Initiation and Engagement of AOD Dependence Treatment (IET)			
Initiation of AOD Treatment: Total	41.83%	42.06%	0.23%
Engagement of AOD Treatment: Total	12.27%	11.72%	-0.55%
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	87.83%	84.91%	-2.92%
Postpartum Care	75.67%	77.86%	2.19%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
Total	54.5%	57.00%	2.50%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	57.31%	58.43%	1.12%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	69.27%	68.44%	-0.83%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	44.11%	44.40%	0.29%
Antibiotic Utilization for Respiratory Conditions (AXR)			
Antibiotic Utilization for Respiratory Conditions (Total)	NR	23.16%	NA

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

A substantial improvement of 10% or more was noted for the Initiation and Continuation Phase for Follow-up Care for Children Prescribed ADHD Medication rate, and the 30-day Follow-up After ED Visit for Substance Abuse rate. A decline of more than 10% occurred for the Pharmacotherapy for Opioid Use Disorder.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population

- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Molina submitted three PIPs for validation. Topics included Improving Encounters Acceptance Rates, Child and Adolescent Well-Care Visits, and Immunizations for Adolescents. The validation found the three PIPs met all the requirements and received scores within the "High Confidence in Reported Results Range." The tables that follow provides a summary of each PIP's status and the interventions underway.

Table 18: Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates	
The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from 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 workgroup, as they transition their current encounter system to avoid unintended issues.	
Previous Validation Score	Current Validation Score
79/79=100% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
Interventions	
• 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.	

Table 19: Child and Adolescent Well-Care Visits PIP

Child and Adolescent Well-Care Visits
The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed improvement in the Child and Adolescent Well-Care Visits (Total) rate from 44.40% to 49.32%, which exceeded the goal of 44.57%.

Child and Adolescent Well-Care Visits	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Health Educator Team – Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Member Incentive Mailing – Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Table 20: Immunizations for Adolescents PIP

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. 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.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• 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.	

The Immunizations for Adolescents PIP showed a slight decline in the administrative rate. Constellation provided the following recommendation.

Table 21: PIP RECOMMENDATION

Project	Section	Reason	Recommendation
Immunizations for Adolescents	Was there any documented, quantitative improvement in processes or outcomes of care?	The baseline rate was 28.95% with a slight decline in the administrative rate as of 1/20/23 to 28.35%. The goal is 31.19% for the annual improvement goal.	Additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers

Details of the validation of the PMs and PIPs can be found in the Constellation Quality Health *EQR Validation Worksheets, Attachment 3*.

For this EQR, Molina met all the requirements in the Quality Improvement section as demonstrated in the graph that follows.

Figure 6: Quality Improvement Findings

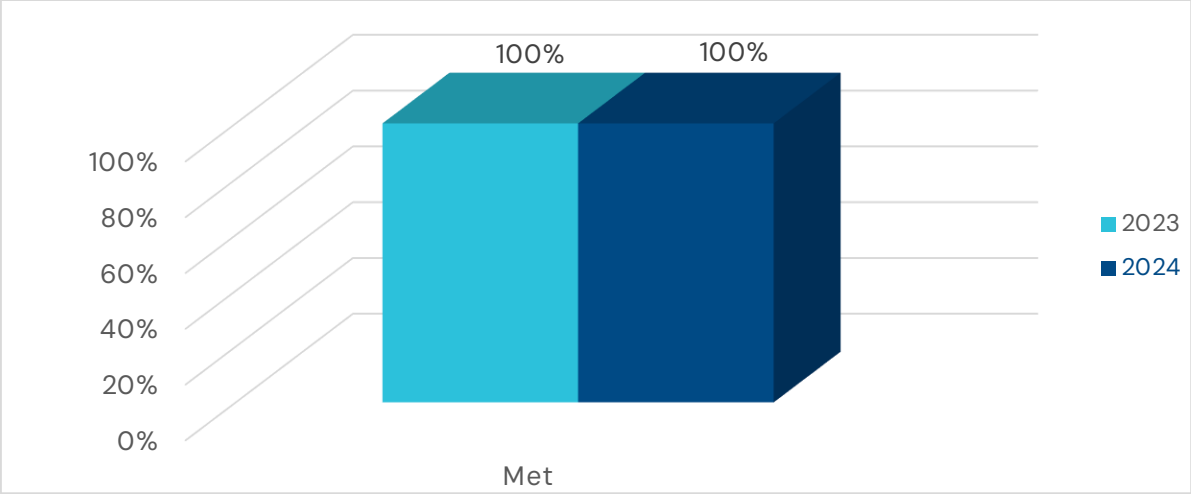


Table 22: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Molina actively engages stakeholders in the QI Program by involving them in decision-making, seeking their feedback and input, fostering collaborations and partnerships, providing education and training, and maintaining transparent communication channels.	✓		
Molina tracks member and provider compliance with EPSDT services. This includes provider reporting and following up on members who do not receive services, as well as tracking when a member did not receive recommended assessments and/or treatments.	✓		
The health plan was found to be compliant with the HEDIS technical specifications for rate calculations.	✓		
The performance improvement projects received a score in the High Confidence Range and met all the validation requirements.	✓		

Table 23: Quality Improvement Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
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 the goal was noted as met for this activity.	*Recommendation: Ensure the QI Work Plan is updated frequently and correct the discrepancies noted regarding the results for each activity.*	✓		
The meeting minutes for the Quality Improvement and Health Equity Transformation Committee did not reflect the correct committee name.	*Recommendation: Update the Quality Improvement and Health Equity Transformation Committee meeting minutes to reflect the correct name for the committee*	✓		
The Immunizations for Adolescents PIP showed a slight decline in the administrative rate.	*Recommendation: Adding additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.*	✓		

IV. QUALITY IMPROVEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The Molina Healthcare of South Carolina Quality Improvement Program Description 2023 was received and reviewed. The aim of the program is to reduce and eliminate health disparities, address social determinants of health, and improve health outcomes. The document provided detailed information about the committee structure, roles, functions, and responsibilities of each committee involved in overseeing and implementing the program. It also outlines the various components and activities of the program. Molina actively engages stakeholders in the QI Program by involving them in decision-making, seeking their feedback and input, fostering collaborations and partnerships, providing education, and training, and maintaining transparent communication channels.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Molina conducts ongoing monitoring and analysis of utilization reports and case review data to identify potential over- and under-utilization of services. They review practitioner medical, pharmacy, and utilization data to assess patterns and trends. This analysis helps identify potential gaps in care, areas for improvement, and opportunities to optimize the utilization of healthcare services. The QI Program

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						uses these findings to develop interventions and initiatives aimed at improving the quality and appropriateness of care provided to health plan members.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Molina 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 the goal was noted as met for this activity. *Recommendation: Ensure the QI Work Plan is updated frequently and correct the discrepancies noted regarding the results for each activity.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement and Health Equity Transformation Committee (QIHETC), formerly known as the Quality Improvement Committee, is responsible for the implementation, oversight, and ongoing monitoring of the QI Program.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIHETC is co-chaired by the Chief Medical Officer and the Quality Lead. Other members of this committee include representatives of various departments and positions within Molina. External network physicians and practitioners, such as primary care physicians, and medical specialists are also members of the committee.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The committee charter defines a quorum as at least 51% of the committee members, with no less than half of the network provider participants. All vote outcomes are determined by a simple majority of the quorum. If a voting member is unable to attend a meeting, a substitute may be appointed in their absence.
3. The QI Committee meets at regular quarterly intervals.	X					The meeting frequency of the QIHETC is quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					The Recorder, who is a Quality Specialist, serves as the meeting coordinator and is responsible for preparing the agenda, drafting the meeting minutes, and conducting various activities related to the committee's meetings. The meeting minutes provided with the desk materials were complete and included feedback, discussion and decisions made by the committee. The name change for the QIHETC was reported to the committee members in March 2023. However, the meeting minutes for meetings held in 2023 did not reflect the new name for this committee. *Recommendation: Update the Quality Improvement and Health Equity Transformation Committee meeting minutes to reflect the correct name for the committee.*
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					Molina uses Cognizant, a certified software, for the calculation of HEDIS rates based on the specifications and eligibility criteria, which are defined in the software. As part of the review,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Constellation examined the roadmap, the data sources, the audit report, and conducted a trending analysis to assess for substantial declines or increases in the rates. Substantial was defined as a 10% change in the rate. For this EQR, a substantial improvement of 10% or more was noted for Initiation and Continuation Phase for Follow-up Care for Children Prescribed ADHD Medication, and the 30-day Follow-up After ED Visit for Substance Abuse. A decline was noted for the Pharmacotherapy for Opioid Use Disorder. The performance measures were validated using the CMS protocol for validation of performance measures. Constellation found the performance measures met the validation requirements.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Molina submitted three PIPs for validation. Topics included Improving Encounters Acceptance Rates, Child and Adolescent Well-Care Visits, and Immunizations for Adolescents.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					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. For the acceptance rate, there was an improvement from 97.30% in 2022 to 98.69% in 2023. The 837P rejection rate declined from 2.70% to 1.31% which exceeded the goal of 2%. The Well Care PIP showed improvement in the Child and Adolescent Well-Care Visits (Total) rate from

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						44.40% to 49.32%, which exceeded the goal of 44.57%. The Immunizations 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. The validation found the three PIPs met all the requirements and received scores within the "High Confidence in Reported Results Range." The Immunizations for Adolescents showed a slight decline in the administrative rate. *Recommendation: Adding additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Per policy MHI-QUAL-016, Communication of Quality Improvement Performance Results, 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.
3. The MCO tracks provider compliance with						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 Administering required immunizations;	X					
3.2 Performing EPSDTs/Well Child Visits.	X					Procedure 103.01, Early Periodic Screening, Diagnostic and Treatment (EPSDT), describes how Molina tracks member and provider compliance with EPSDT services. This includes provider reporting and following up on member and families who do not receive services, as well as tracking when members did not receive recommended assessments and/or treatments.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Molina evaluates the effectiveness of the QI Program by reviewing key components of the program. This includes evaluating the adequacy of resources, such as staffing, data and other information, to ensure that the program has the necessary support to collect, analyze, and integrate data for quality improvement. Molina also evaluates the committee structure, practitioner participation, and leadership involvement in the quality program to ensure that there is active engagement and oversight. Additionally, Molina conducts ongoing program activity monitoring to assess the program's impact on health plan members and practitioners. The evaluation process includes a review of clinical, service, and operational initiatives and trends. Through this evaluation, Molina identifies barriers and opportunities for improvement and implements interventions to address them.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					The Quality Improvement Program 2022 Annual Evaluation was reviewed and approved by the QIHETC and the Board of Directors on 11/16/2023.

E. Utilization Management

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

Constellation conducted a review of Molina's Health Care Services Program Description, policies, and a sample of approval, denial, appeal, and case management files. The staff responsibilities, scope, and objectives for physical and behavioral health services are outlined in the Molina's Health Care Services Program Description. Also, the Pharmacy Program Description outlines the program objectives and procedures of the pharmacy program.

Molina's Chief Medical Officer provides oversight of the UM program. The Chief Medical Officer's responsibilities include, but are not limited to, strategic planning, implementation of clinical practice guidelines, second level reviews, etc. The Behavioral Health Director serves as the behavioral health practitioner that oversees the implementation of behavioral health services that entails conducting clinical reviews, policy development, etc. Molina's Pharmacy Director has an unrestricted pharmacist license and is responsible for oversight of the Drug Utilization Review process, the review of pharmacy requests, and providing education as needed regarding the pharmacy programs.

Coverage and Authorization of Services

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

The UM Reviewers are clinicians that hold a current licensure in their respective healthcare professions. Additionally, Molina's Substance Use Navigators are specialized substance use clinicians that conduct substance use reviews to ensure members are receiving the most appropriate level of care.

The UM Reviewers use external and internal clinical guidelines such as Milliam Clinical Guidelines, Hayes Technology Assessment, American Society of Addition Medicine, etc. to determine medical necessity and appropriateness of services. Medical Directors or their delegates may modify or waive specific review criteria if necessary to accommodate an individual member's needs.

To ensure that UM Reviewers are using up to date clinical guidelines, the Clinical Policy Committee and Pharmacy & Therapeutics Committee conduct an evaluation of new technology and update the guidelines accordingly. Clinical guidelines and criteria are available to providers upon request by contacting the Health Care Services Department.

Standard authorizations are processed within 14 calendar days of receipt, urgent authorizations are processed within 72 hours, and retrospective requests are processed within 30 calendar days. Also, pharmacy requests are processed within 24 hours.

Molina conducts annual Inter-Rater Reliability (IRR) testing and monthly audits for physicians and clinical reviewers to ensure consistency in the application of clinical criteria. Based upon

the IRR results, the Prior Authorization Clinicians, NICU, Behavioral Health, Inpatient Clinicians, and Medical Directors received a passing score. The pharmacy technicians did not receive a passing score. Additional training was provided, and retesting was conducted.

The Pharmacy Program Description and various policies provide an overview of Molina's Pharmacy Program. Molina provides coverage for medications through their Pharmacy Benefit Manager. The Pharmacy and Therapeutics Committee is responsible for developing and updating the pharmacy formulary, managing the preferred drug list, and many other oversight responsibilities.

Constellation's review of a sample of approval files indicated that determinations were made by appropriate clinical reviewers. Individual member circumstances were considered when making clinical determinations. The denial files reviewed demonstrated that the decisions were timely, and the reason for the adverse benefit determination was clearly documented in each member notice, along with the process for filing an appeal.

Appeals

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

Processes for handling standard and expedited appeals are described in Policy MHSC-MRT-002, Standard Appeal Process, Policy MHSC-MRT-003, Expedited Appeal Process, the UM Program Description, the Member Handbook, the Provider Manual, and found on Molina's website. Molina provides a clear definition for an appeal, associated timeframes, and examples of an adverse benefit determination in the Member Handbook. Appeals may be filed verbally or in writing. Molina's standard appeal process procedure (Procedure MHSC-MRT-002, Standard Appeal Process) and the appeal request form attached to several letter templates incorrectly states a verbal appeal must be followed up with a written request. The was an issue previously identified during the 2023 EQR and not corrected.

The sample of appeal files reviewed reflected timely acknowledgement, determinations made by appropriate reviewers, and timely notification of the appeal determination. Constellation found no issues with the appeal file review.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

Molina's Health Care Services Program Description and numerous policies outline the health plan's Integrated Care Management (ICM) and Care Transitions Programs. Members are informed of the components of the program through member newsletters, in-person visits, Molina's website, etc. The identification of at-risk members is analyzed through various data such as pharmacy claims, practitioner referrals, historical member data, encounter forms, hospital census, etc. Once a referral is initiated, a pre-call review and health risk assessment are

completed to aid in further identifying the member's needs and link the member to the most appropriate level of care.

For special populations, Targeted Care Management Services are provided to ensure that members have access to needed medical, educational, social, and other services. Transition of Care Services is provided for members to ensure continuity of care for members discharged from the hospital, entering the health plan, pregnant, or in the appeal process.

Molina conducts an annual member experience survey. The results aid in identifying strengths and opportunities for improvement in Care Management Services. Based upon the results of the member experience survey, members receiving Level II and Level III Care Management reported an overall positive experience with the care management services provided.

Review of the sample care management files demonstrated that appropriate assessments, treatment planning, and care coordination activities were implemented for members based upon their identified acuity level and needs.

Ninety eight percent of the standards in the Utilization Management received a "Met" score. The procedures for handling appeals were found to be out of compliance.

Figure 7: Utilization Management Findings

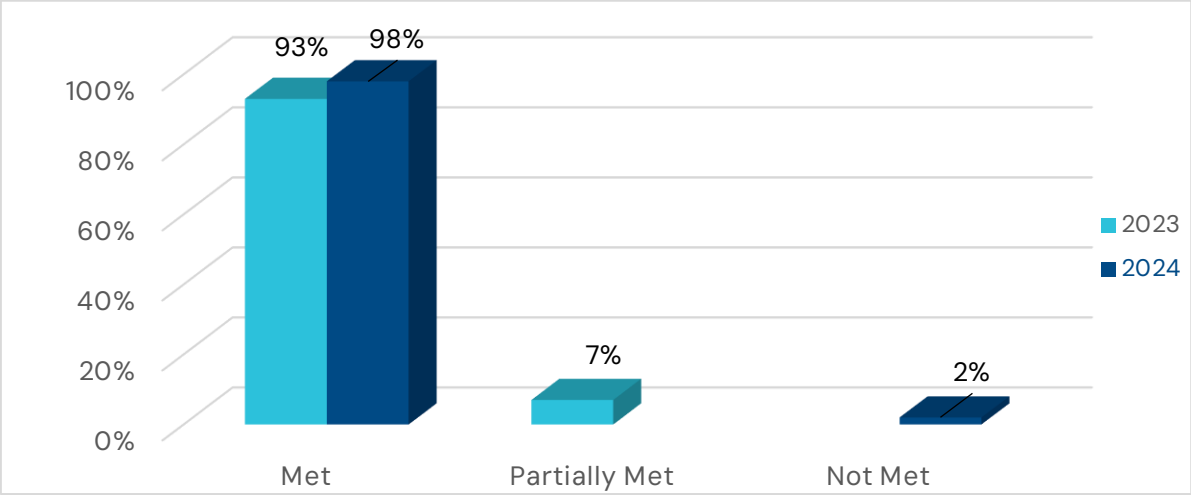


Table 24: Utilization Management Comparative Data

Section	Standard	2023 Review	2024 Review
Medical Necessity Determinations	Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Partially Met	Met

Section	Standard	2023 Review	2024 Review
Appeals	The procedure for filing an appeal	Partially Met	Not Met
Care Management and Coordination	Care management and coordination activities are conducted as required.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 25: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Molina's Substance Use Navigators undergo specialized training to improve efficiency in conducting clinical reviews for substance use members and ensuring that members receive the most appropriate level of care.	✓		
The Behavioral Health, Prior Authorization, Inpatient UM Clinicians, and Medical Directors received passing scores of 90% or higher in Inter-Rater Reliability testing.	✓		
Monthly inpatient and prior authorization case audits exceeded the target goal of 90%.	✓		
Molina's turnaround time compliance was 100% for prior authorizations and 95% or higher for expedited requests, exceeding the target goals.		✓	✓
The appeal files reviewed all were acknowledged and resolved timely by the appropriately credentialed reviewers.		✓	✓
Molina offers specialized programs such as Sickle Cell, Adult and Preventative Rehabilitative Services for Primary Care Enhancement to aid in addressing specialized needs for members.			✓
Overall, the Member Experience with Care Management surveys identified that the members were satisfied with the care management services provided and exceeded the target goal.	✓		

Table 26: Utilization Management Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Procedure MHSC-MRT-002, Standard Appeal Process and the Appeal Request form incorrectly state a verbal appeal	*Quality Improvement Plan: Update all documents related to the process for filing an appeal and remove the*	✓		✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
must be followed up by a written request. This was an issue identified during the 2023 EQR and not corrected.	*requirement that a standard request for an appeal received verbally must be followed by a written request.*			

V. UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V. A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The staff responsibilities, scope, and objectives for physical and behavioral health services are outlined in the Molina's Health Care Services Program Description. Molina's Pharmacy Program Description outlines the program objectives and procedures of the pharmacy program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					Molina's Chief Medical Officer provides oversight of the UM program. The Pharmacy Director and Behavioral Health Medical Director provide oversight of their respective programs. The UM Reviewers are clinicians that hold current licensure in their respective healthcare professions. Molina's Substance Use Navigators are specialized substance use clinicians that conduct substance use reviews to ensure substance use members are receiving the most appropriate level of care. Staff meetings, monthly audits, and supervision occur to ensure accountability.
1.3 guidelines / standards to be used in making utilization management decisions;	X					Molina's Health Care Services Program Description, Policy HCS-303.01, Inpatient/Concurrent Review, and Policy HCS-365.01, Clinical Criteria for Utilization Management Decision Making, describe that UM Reviewers use external and internal clinical

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines such as Milliam Clinical Guidelines (MCG), Hayes Technology Assessment, American Society of Addition Medicine (ASAM), etc. for making decisions concerning medical necessity and appropriateness of services. Medical Directors or their delegates may modify or waive specific review criteria if necessary to accommodate an individual member's needs.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Standard authorizations are processed within 14 calendar days of receipt, urgent authorizations are processed within 72 hours, and retrospective requests are processed within 30 calendar days as described in the 2024 Molina Health Care Services Program Description. Pharmacy requests are processed within 24 hours as described in the Pharmacy Program Description.
1.5 consideration of new technology;	X					Molina's Clinical Policy Committee and Pharmacy & Therapeutics Committee conduct an evaluation of new technology to ensure up to date compliance with guidelines for determining coverage criteria through evidence-based decision making, as described in the Health Care Services Program Description. This evaluation entails a review of evidence-based standards, peer literature review, recommendations from professional societies, etc.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Policy MHSC-HCS-UM-364, Appropriate Professionals Making UM Decisions, and Molina's Health Care Services Program Description outline the roles of the Chief Medical Officer, including strategic planning, committee participation, second level reviews, etc. The Behavioral Health Director oversees the implementation of behavioral health services, including conducting clinical reviews, policy development, etc. Molina's Pharmacy Director has an unrestricted pharmacist license and is responsible for oversight of the Drug Utilization Review process, the review of pharmacy requests, and providing education as needed regarding the pharmacy programs.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V. B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Molina's UM Program Description, Policy HCS-303.01, Inpatient/Concurrent Review, and Policy 365.01, Clinical Criteria for Utilization Management Decision Making, indicate UM Reviewers use external and internal guidelines such Milliman Clinical Guideline, Official Disability Guidelines, Hayes Technology Assessments, Inpatient Hospital Services Coverage Requirements, and State Guidelines to determine medical necessity and appropriateness of services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of a sample of approval files reflected that the UM reviewers used appropriate clinical criteria when making UM determinations.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					UM Reviewers consulted with physicians appropriately and individual member circumstances were considered when making determinations.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Annually, Molina conducts Inter-Rater Reliability (IRR) testing for physicians and clinical reviewers to ensure consistency in the application of clinical criteria. During onsite discussion, it was shared that the Pharmacy Department conducts IRR monthly for quality assurance purposes. Based upon the IRR results, the Prior Authorization Clinicians, NICU, Behavioral Health, Inpatient Clinicians, and Medical Directors received passing scores of over 90%. However, the pharmacy technicians did not receive passing scores. Retraining was conducted and the pharmacy technicians received a passing score after retesting. During onsite discussion, it was shared that monthly audits occur with a designated Clinical Services Auditor wherein feedback is provided to individual staff and a trends analysis is conducted to identify any strengths and opportunities for improvement. Results of the monthly inpatient and prior authorization case audits yielded a score of 93% or more, exceeding the target goal of 90%.
6. Pharmacy Requirements						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Molina provides coverage for medications through their Pharmacy Benefit Manager. The Pharmacy and Therapeutics Committee is responsible for developing and updating the pharmacy formulary or the preferred drug list. The committee's oversight also includes prior authorization criteria, pharmaceutical classes, step therapy, quantity limits, and restrictions as outlined in various policies and the Pharmacy Program Description. Any issues with potential fraud, waste, and abuse are reported to the health plan's compliance committee as described in various policies and Molina's Health Care Services Program Description.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					As outlined in Molina's Health Care Services Program Description, Policy MHI-HCS-302.01, Post Stabilization Services Addendum, and Policy HCS-304, Non-Par Provider Emergency and Post Stabilization Services, emergency and post stabilization services are offered at no cost to members.
8. Utilization management standards/criteria are available to providers.	X					The clinical guidelines and criteria are available to providers upon request by contacting Molina's Health Care Services Department as described in the Provider Manual, Molina's Health Care Services Program Description, and in the Denial Letter Template.
9. Utilization management decisions are made by appropriately trained reviewers.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the approval files reflected timely notification of approval. Molina's compliance with the turnaround time was 100% for prior authorizations and 95% for expedited requests, exceeding the target goals.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Constellation' s review of the sample UM denial files reflect that the adverse benefit determinations were made by appropriate physician specialists.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of the sample UM denials demonstrated the reason for the adverse benefit determination was promptly communicated and clearly documented in the member notices, along with the process for filing an appeal.
V. C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Processes for handling appeals are provided in Policy MHSC-MRT-002, Standard Appeal Process, Policy MHSC-MRT-003, Expedited Appeal Process, the Member Handbook, the Provider Manual, and on Molina's website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeal terminology definitions, along with clear examples, were provided to members in the Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing an appeal;			X			The following documents incorrectly state a verbal appeal must be followed by a written request: • Procedure MHSC-MRT-002, Standard Appeal Process (page one and page two). • The Guidelines for Appealing a Medical Denial and the Appeal Request form in the Progeny Adverse Benefit Determination Letter (page five and seven). • The Guidelines for Appealing a Medical Denial and the Appeal Request form in the Pharmacy Adverse Benefit Determination Letter (page three and five). *Quality Improvement Plan: Update all documents related to the process for filing an appeal and remove the requirement that a standard request for an appeal received verbally must be followed by a written request.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy and Procedure MHSC-MRT-003, Expedited Appeal Process, describes Molina's steps to manage expedited appeals.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					The sample of appeal files reviewed reflected timely acknowledgement, determinations made by appropriate reviewers, and timely notification of the appeal determination. Constellation found no issues with the appeal file review.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Performance analysis addressing barriers, strengths, and opportunities for improvement are documented quarterly in the Health Care Services Committee.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					Molina's Health Care Services Program Description and numerous policies outline the health plan's Integrated Care Management and Care Transitions Programs.
2. The MCO has processes to identify members who may benefit from care management.	X					As described in Molina's Health Care Services Program Description, members are informed of the components of the Integrated Care Management Program through member newsletters, in-person visits, websites, etc. At-risk members are identified through analysis of various data such as pharmacy claims, practitioner referrals, historical member data, encounter forms, hospital census, etc. Once a referral is initiated, a pre-call review and health risk assessment are also completed to aid in further identifying the member's needs and link to the most appropriate level of care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					As described in Molina's Health Care Services Program Description, Targeted Care Management Services are provided to special populations such as children in foster care, chronically mentally ill adults, etc. to ensure the members have access to needed medical, educational, social, and other services. Additionally, Molina's Care Managers coordinated a special program with the state for members diagnosed with sickle cell disease. The Sickle Cell, Adult and Preventative Rehabilitative Services for Primary Care Enhancement is designed for maintenance, improvement, or protection of the member's health with direct involvement of the primary care physician to provide oversight and aid in development of a health care plan.
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					An interdisciplinary approach is provided to members with behavioral health needs. Members are identified through various methods and behavioral health specific assessments are used to develop a plan of care for targeted interventions in collaboration with the behavioral health care manager, nurse, physician, and any other community partners.
6. Care Transitions activities include all contractually required components.						
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					Molina's Health Care Services Program Description and various policies provide an overview of when continuity of care is provided for the members who are entering the health plan, pregnant, in the appeal process, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					Molina conducts an annual member experience survey. The results aid in identifying strengths and opportunities for improvement in Care Management Services. Based upon the results of the member experience survey, members receiving Level II and Level III Care Management reported an overall positive experience with services provided.
8. Care management and coordination activities are conducted as required.	X					Review of the sample care management files demonstrated that appropriate assessments, treatment planning, and care coordination activities were implemented for members based upon their identified acuity level and needs.
V. E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					The Over and Under Utilization Reports analyze emergency room utilization, acute hospital admission rates, pharmacy usage, etc. and the quarterly report is presented at the Health Care Services committee and discussed annually.

F. 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, Molina reported 19 delegation agreements, as shown in *Table 27: Delegated Entities and Services*.

Table 27: Delegated Entities and Services

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

Molina has established processes for delegation of health plan activities to subcontractors, as documented in Policy MHI-DO – 01, Delegation Oversight Program, Procedure MHI- DO -1.1, Delegation Oversight Program, Procedure DO-1.001, Addendum 01 South Carolina, Delegation Oversight, and Procedure MHI-DO-01.2, Delegate Corrective Action Plan. These policies and procedures address pre-delegation activities for potential delegates, implementation of written agreements with approved delegates, annual evaluations, and ongoing monitoring for all delegates. It was found that although the Molina Healthcare of South Carolina Inc. Delegation

Services Addendum addresses the requirement that delegates obtain prior written consent from Molina to subdelegate any delegated activities, this requirement was not addressed in any policy or procedure.

Written agreements with delegates outline the specific services and activities that are being delegated. Molina provided a copy of the Molina Healthcare of South Carolina Inc. Delegation Services Addendum and the South Carolina Program Requirements attachment. The Delegation Services Addendum addresses general terms and conditions, remedies for non-performance, information security, and requirements for the activities that are delegated.

Molina provided documentation of the oversight activities conducted for all delegates. The documentation reflected Molina conducted timely annual oversight of all delegates. The only issues noted were 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.

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

Figure 8: Delegation Findings

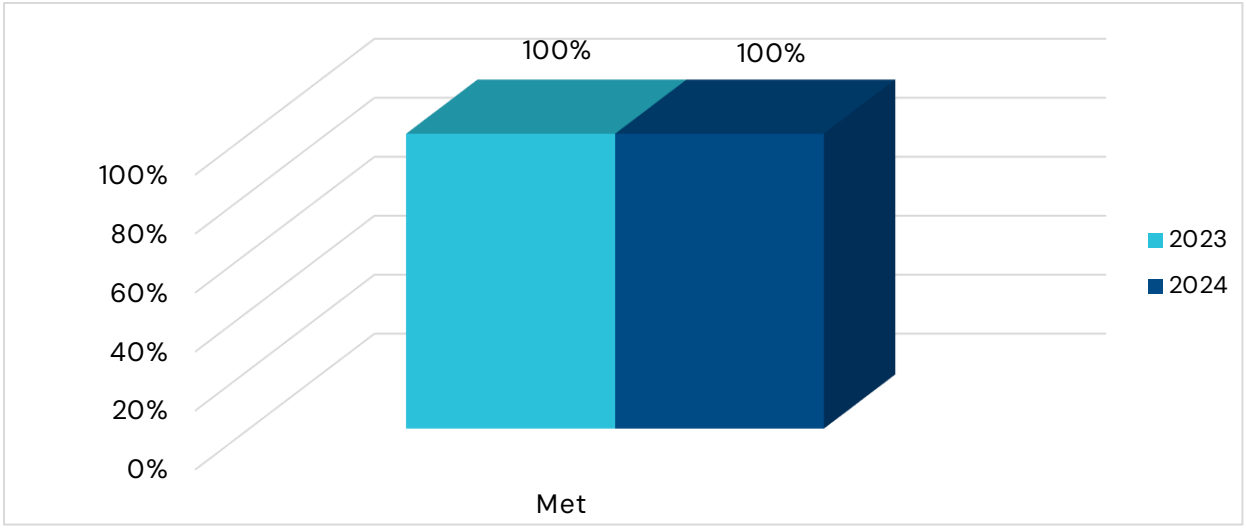


Table 28: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Policies and procedures have been developed to guide the delegation of health plan activities to external entities.	✓		
Molina conducts timely annual oversight for all delegates.		✓	
Written delegation agreements specify the delegated activities, health plan and delegate responsibilities, performance expectations, and possible consequences for substandard performance.	✓		

Table 29: Delegation Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The requirement that delegates must obtain approval prior to sub-delegating any delegated activities was not located in any policy or procedure.	*Recommendation: Revise applicable policies to address the requirement that delegated entities cannot sub-delegate the performance of any delegated activities without the prior written consent from Molina.*	✓		
Issues noted in documentation of annual oversight for Infomedia Group, Inc., d/b/a Carenet Healthcare Services. For the annual audit was conducted in March 2023: • Page one of the 2023 Infosys_Carenet Annual Audit Summary document indicates an Overall Score of 100% and no CAP. However, page two lists a score of 93% and page three lists a score of 95%. If averaged, this would result in an overall score of 94%. • Also, the call review tool included for the 2023 Infosys/Carenet Annual Audit was incomplete. Molina explained that for the 2023 audit, it was discovered that the CareNet call repository was unable to be accessed via the Molina Portal due to systemic issues identified by Molina IT. IT continues to work on correcting access issues, noting that calls are only available for 30 days and then they are deleted." Molina further explained that as of June 23, 2024, the "call portal issues have been	*Recommendation: Correct the 2023 Infosys_Carenet Annual Audit Summary to reflect the correct overall score for the 2023 audit. For future oversight of Infomedia Group, Inc., d/b/a Carenet Healthcare Services, ensure that the oversight includes audit of live or recorded calls received by the Nurse Advice Line and the Behavioral Health Crisis Line.*	✓		✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
corrected, with continued work on adding naming conventions in order to identify calls via market and lines of business. For the 2024 audit, calls will be reviewed for both the NAL and BH Crisis line beginning in August 2024."				

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Processes for delegation of health plan activities are found in: • Policy MHI-DO – 01, Delegation Oversight Program • Procedure MHI- DO -1.1, Delegation Oversight Program • Procedure DO-1.001, Addendum 01 South Carolina, Delegation Oversight • Procedure MHI-DO-01.2, Delegate Corrective Action Plan Article One, Section 1.5 (A), of the Molina Healthcare of South Carolina Inc. Delegation Services Addendum addresses requirements for sub-delegation and informs that delegated entities cannot subdelegate the performance of any delegated activities without the prior written consent from Molina. If the sub-delegation is approved, the delegate continues to hold accountability for the performance of delegated activities and is responsible for ensuring the sub-delegate fulfills all obligations. The requirement that delegates must obtain approval prior to subdelegating any delegated activities was not located in any policy or procedure. *Recommendation: Revise applicable policies to address the requirement that delegated entities*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						cannot sub-delegate the performance of any delegated activities without the prior written consent from Molina.
2. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Procedure MHI- DO -1.1, Delegation Oversight Program, page one, states, "…prior to the delegation, National/State Network Contracting or Procurement must have the vendor enter into a written agreement with Molina which includes a delegation services addendum that outlines the specific delegated activities and reporting responsibilities." Molina provided a copy of the Molina Healthcare of South Carolina Inc. Delegation Services Addendum and a document titled on page one as "South Carolina Program Requirements." The Delegation Services Addendum addresses general terms and conditions, remedies for non-performance, information security, and requirements for the activities that are delegated. Article Two of the Molina Healthcare of South Carolina Inc. Delegation Services Addendum addresses revocation or termination of delegation, or take other actions, if the health plan believes the delegate is not compliant with the terms of the Delegation Services Addendum.
3. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Issues noted in documentation of the annual oversight for Infomedia Group, Inc., d/b/a Carenet Healthcare Services. The annual audit was conducted in March 2023: • Page one of the 2023 Infosys_Carenet Annual Audit Summary document indicates an Overall Score of 100% and no CAP. However, page two

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						lists a score of 93% and page three lists a score of 95%. If averaged, this would result in an overall score of 94%. • Also, the call review tool included in the 2023 Infosys_Carenet Annual Audit Tool was incomplete. Molina explained that for the 2023 audit, Molina discovered that the CareNet call repository was unable to be accessed via the Molina Portal due to systemic issues identified by Molina IT. IT continues to work on correcting access issues, noting that calls are only available for 30 days and then they are deleted." Molina further explained that as of June 23, 2024, the "call portal issues have been corrected, with continued work on adding naming conventions in order to identify calls via market and lines of business. For the 2024 audit, calls will be reviewed for both the NAL and BH Crisis line beginning in August 2024." *Recommendation: Correct the 2023 Infosys_Carenet Annual Audit Summary to reflect the correct overall score for the 2023 audit. For future oversight of Infomedia Group, Inc., d/b/a Carenet Healthcare Services, ensure that the oversight includes audit of live or recorded calls received by the Nurse Advice Line and the Behavioral Health Crisis Line.*

G. 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 (SUD) and medical/surgical benefits equally. Constellation is required to conduct a Mental Health Parity assessment to determine if Molina 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 limits on the scope or duration of benefits.

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

Constellation reviewed Molina's 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.

Review Criteria: Molina uses MCG as their Medical and Behavioral Health criteria. ASAM is used for substance use disorders. Molina does have internally developed criteria as well, to address requests not covered by established criteria.

UM Reviews: Molina performs reviews internally for Medical, Behavioral Health, and substance use disorder requests. Molina's goal of <10 claims/thousand for Out-of-Network utilization was met for both Medical and Behavioral claims.

The internal goal for appeals is <5 appeals per thousand members (appeals/k), and this goal was met throughout the review period for both medical and behavioral health service requests. The medical appeals rate was 0.73/K and behavioral health appeals rate was 0.03%. By comparing overturn rates for medical appeals and mental health/substance use disorder (MH/SUD) appeals, Constellation can make an inference about stringency. If the appeal overturn rates are higher for MH/SUD than for medical benefits, it could mean that criteria are being applied more stringently. Administrative denials could indicate a discrepancy in comparability while medical necessity could indicate a discrepancy in stringency. Although Molina did not supply medical and behavioral health appeal overturn rates, the denial and appeal rates were low and comparable.

The Provider Network follows State and Federal regulations as well as NCQA guidance when credentialing medical, mental health, and SUD providers and practitioners. All time and distance access requirements for behavioral health service providers and medical health care service

providers were met, and appointment standards exceeded the 90% goal in all categories. For Case Management, Molina identifies members with a serious and persistent mental illness and has developed a program to impact outpatient follow up after admission.

The NQTL assessment found the mental health services comply with parity requirements of comparability and stringency.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to Molina to complete the mental health parity assessment. The templates allowed the plan to enter information based on copay, session limits, day limits, etc. This information was used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There are two steps required to conduct this review: First, Constellation determined if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject. *Table 30: Mental Health Parity Quantitative Treatment Limitations Assessment Steps* provides an overview of the results.

Table 30: Mental Health Parity Quantitative Treatment Limitations Assessment Steps

Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
Inpatient	N/A	N/A	Met
Outpatient	N/A	32 sessions per year minimum; 6 per day minimum for relevant services	Met The equivalent Mental Health outpatient services are 32 sessions per year minimum and 6 per day minimum
Pharmacy	N/A	N/A	Met
Emergency Services	N/A	N/A	Met

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.

The files submitted demonstrated a service limitation for outpatient services. The outpatient service limitation is consistent for medical/surgical and behavioral health services. Thus, the findings show appropriate parity for mental health services in relation to medical services.

Molina met all the requirements for the Mental Health Parity Assessment as shown in the figure that follows.

Figure 9: Mental Health Parity Findings

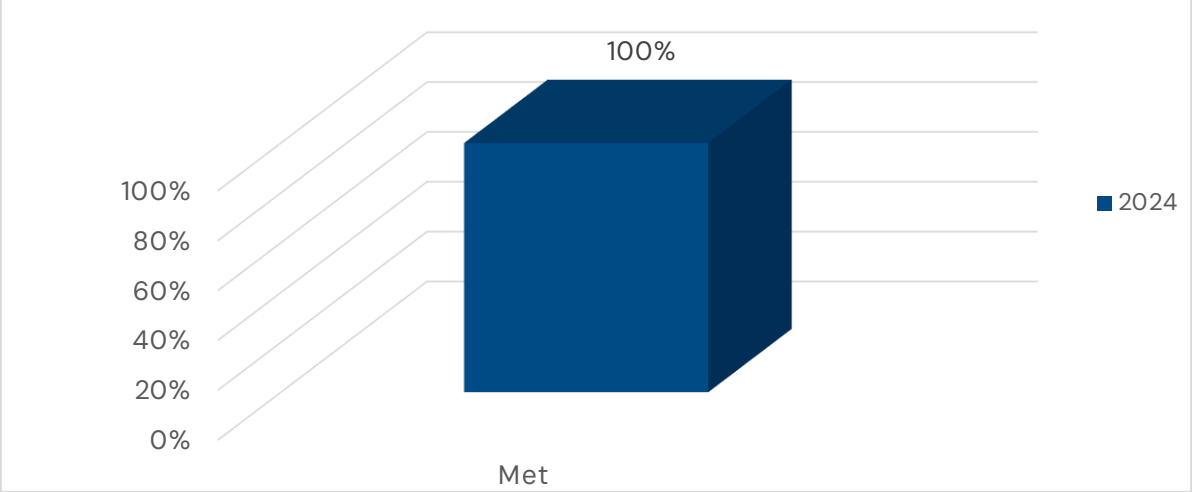


Table 31: Mental Health Parity Strengths

Strengths	Quality	Timeliness	Access to Care
Mental Health Parity assessment showed mental health services are aligned with medical surgical financial and treatment limitations.			✓
Access and availability parity is achieved; Provider Network analysis and implementation plans are robust and responsive down to the local level.			✓
Utilization Management Criteria and Processes achieve parity.			✓
IRR incorporates both MH/SUD and medical/surgical cases.	✓		
Mental health parity was demonstrated in assessment of copays and financial limitations.			✓

Table 32: Mental Health Parity Weakness

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Molina uses internally developed criteria. This poses a risk to parity, both in comparability and stringency.	*Recommendation: Continue to ensure there is parity in internally developed utilization management criteria.*			✓

VII. MENTAL HEALTH PARITY

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. MENTAL HEATLH PARITY						
1. The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations.	X					Constellation reviewed Molina's 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. Review Criteria – Molina uses MCG as their Medical and Behavioral Health criteria. ASAM is used for substance use disorders. Molina does have internally developed criteria as well, to address requests not covered by established criteria. UM Reviews: Molina performs reviews internally for Medical, Behavioral Health, and substance use disorder requests. Molina's goal of <10 claims/thousand for Out-of-Network utilization was met for both Medical and Behavioral claims. The internal goal for appeals is <5 appeals per thousand members (appeals/k), and this goal was met throughout the review period for both medical and behavioral health service requests. The medical Appeals rate was 0.73/K and Behavioral Health Appeals rate being 0.03%. By comparing medical appeals and MH/SUD appeals overturn rates, Constellation can make an inference about stringency. If the appeal overturn rates are higher for MH/SUD than for medical benefits, it could mean that criteria are being applied more stringently. Administrative denials could indicate a discrepancy in comparability while medical necessity

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						could indicate a discrepancy in stringency. Although Molina did not supply appeal overturn rates for Medical and Behavioral Health, the denial and appeal rates were low and comparable. The Provider Network follows State and Federal regulations, as well as NCQA guidance when credentialing medical, mental health, and SUD providers and practitioners. All time and distance access requirements for behavioral health service providers and medical health care service providers were met, and appointment standards exceeded the 90% goal in all categories. For Case Management, Molina identifies members with a serious and persistent mental illness and has developed a program to impact outpatient follow up after admission. *Recommendation: Continue to ensure there is parity in internally developed utilization management criteria policies.*
2. The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	X					The files submitted demonstrated a service limitation for outpatient services. The outpatient service limitation is consistent for medical/surgical and behavioral health services. Thus, the findings show appropriate parity for mental health services in relation to medical services.

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Assessment of Quality Improvement Plans from Previous EQR

Attachment 1: Initial Notice and Materials Requested for Desk Review

May 6, 2024

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

Dear Ms. Wilson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2024 External Quality Review (EQR) of Molina Healthcare of South Carolina (Molina) is being initiated. An external quality review (EQR) conducted by Constellation Quality Health, formally The Carolinas Center for Medical Excellence, is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Healthy Connections Medicaid recipients.

The methodology used by Constellation Quality Health to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review, onsite visit and will address all contractually required services as well as follow-up of any areas of weakness identified during the previous review. The Constellation Quality Health EQR team plans to conduct the virtual onsite on June 20th and 21st. In preparation for the desk review, the items on the enclosed desk materials list should be provided to Constellation Quality Health no later than May 20, 2024.

To help with submission of the desk materials, we have set up a secure file transfer site to allow health plans under review to submit desk materials directly to Constellation through the site. The file transfer site can be found at: https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Project Manager, External Quality Review

cc: SCDHHS

External Quality Review 2024/2025

MATERIALS REQUESTED FOR DESK REVIEW

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

2. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, and key managers responsible for the functions. For all positions required in the SCDHHS Contract, Section 2, Exhibit 1 and Exhibit 2, indicate whether the staff are in-state, the number of FTEs, and any required designations. For contractually required key positions, provide the portion of time allocated to each Medicaid contract as well as all other lines of business.

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

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base. Please include the following:
    a. Geographic access assessments
    b. Network development plans
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios (PCP and specialist)
    f. Analysis of in-network and out-of-network utilization data
    g. Provider identified limitations on panel size considered in the network assessment

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

Excel Spreadsheet Format

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

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

7. A completed Provider Network File Questionnaire.

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

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

10. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Program Descriptions.

11. The Quality Improvement work plans for 2023 and 2024.

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

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

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

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

16. Any data collected for the purposes of monitoring the utilization (over and under) of health care services. Please provide the over and underutilization summary report(s) and the quarterly or monthly monitoring reports.

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

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

19. A complete list of all members enrolled in the case management program from March 2023 through April 2024. Please include open and closed case management files, the member's

name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

20. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for March 2023 to April 2024. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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

22. A report of findings from the most recent member satisfaction survey (i.e., CAHPS and ECHO), a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of March 2023 through April 2024.

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

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

    . Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    a. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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

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

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

30. A copy of the provider handbook or manual.

31. A sample provider contract.

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

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

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

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

35. Results of the most recent annual evaluation and ongoing monitoring activities for all delegated entities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.
36. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen;

hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;

c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates.
i. Please include the point value, and index scores for the SCDHHS withhold measures.

37. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of March 2023 through April 2024. Include any medical information and physician review documentation used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of March 2023 through April 2024, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeal, Grievance, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to Constellation Quality Health.

38. Copies of the following documents needed to complete the Mental Healthy Parity Assessment.
    - Program Descriptions:
        i. Utilization Management
        ii. Mental Health/Substance Use Disorder (MH/SUD)
        iii. Medical/Surgical (MS)
        iv. Quality
    - Reports:
        i. M/S Denial - denial rates, administrative and clinical (IP, OP, ER, RX)
        ii. M/S Appeal – overturn rates (IP, OP, ER, RX)
        iii. M/S Pharmacy Denials - -denial rates, administrative and clinical (IP, OP, ER, RX)
        iv. M/S Pharmacy Appeals - -overturn rates (IP, OP, ER, RX)
        v. MH/SUD Denials- denial rates, administrative and clinical (IP, OP, ER, RX)
        vi. MH/SUD Appeals - overturn rates (IP, OP, ER, RX)
    - Authorization Report
        i. Out of Network Utilization (M/S)
        ii. Out of Network Utilization (MH/SUD)
        iii. Network Access Reports (M/S)
        iv. Network Access reports (MH/SUD)
    - Parity Tools
        i. Benefit Map (Appendix B)
        ii. NQTL List (Appendix C)
        iii. NQTL Comparison Chart (Appendix D)
        iv. QTL List (Appendix E)
        v. QTL Tool (Excel Spreadsheets)

These materials:

- should be organized and uploaded to the secure Constellation Quality Health's EQR File Transfer site at: https://eqro.thecarolinascenter.org

Attachment 2: Materials Requested for Onsite Review

Molina Healthcare of SC

External Quality Review 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. An organization chart or listing of the program integrity staff / reviewers / investigators for SC Medicaid, along with their credentials. Please indicate the staff that are located in SC.
3. Copies of the Staff Training and Compliance tracking reports referenced in Procedure 103.01, Early Periodic Screening, Diagnostic and Treatment (EPSDT).
4. A copy of the letter used to notify members of inclusion in the Pharmacy Lock-in Program.
5. A copy of policy and procedure EMU-CM-009.01, Unable to Reach and Member Locating Procedure (MMP).
6. A copy of the South Carolina Network Adequacy Report for 2023.
7. A copy of a policy addressing processes for validating information in the Provider Directory.
8. A copy of the 2023 Continuity and Coordination of Medical Care report.
9. A copy of policy and procedure MHSC-HCS-CM-068-MMP, Molina Transitions of Care (MMP).
10. A copy of the 2023 MHSC Standard Medical Record Review Audit Results.

Materials should be uploaded to the secure Constellation Quality Health EQR File Transfer site at: https://eqro.thecarolinascenter.org

Attachment 3: EQR Validation Worksheets

EQR PIP Validation Worksheet

Plan Name:	Molina Healthcare of SC
Name of PIP:	Improving Encounters Acceptance Rates
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was based on analysis of encounters acceptance and rejection rates.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of study were reported.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	PIP addressed key aspects of non-clinical information.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	Relevant populations were included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Indicators were defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measured changes in systems related to processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? (1)	MET	The sources of data were clearly identified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Project has a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	PIP involved qualified personnel.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were analyzed annually.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements were documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	For the acceptance rate, there was improvement from 97.30% in 2022 to 98.69% in 2023. The

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		goal is 100%. The 837P rejection rate declined from 2.70% to 1.31% which is an improvement. The goal is 2% and thus, the most recent rate has exceeded the goal.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement was a result of interventions in place.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR PIP Validation Worksheet

Plan Name:	Molina Healthcare of SC
Name of PIP:	Immunizations for Adolescents
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was based on analysis of immunizations rates.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of study were reported.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	PIP addressed key aspects of clinical information.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	Relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling was not conducted for latest reported rate- Administrative rates were reported.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling was not conducted for latest reported rate- Administrative rates were reported.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not conducted for latest reported rate- Administrative rates were reported.
Step 5: Review Selected PIP Variables and Performance Measures		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Indicators were defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measures related to processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were specified in the report.
6.2 Did the study design clearly specify the sources of data? (1)	MET	The sources of data were clearly identified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Project has a systematic method to collect data using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments used allow for consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was reported.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	PIP involved qualified personnel.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were analyzed annually.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements were documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The report included hybrid rates for baseline and remeasurement 1, with the administrative rate for remeasurement 2. There was a decline from 2022 at 32.36% to 2023 at 28.12%. The goal for 2023 was 34.67%. *Recommendation: Additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Improvement was not reported based on available data as of report.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Statistical analysis was not applied based on varied methodologies applied.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	73
Project Possible Score	74
Project Rating Score	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR PIP Validation Worksheet

Plan Name:	Molina Healthcare of SC
Name of PIP:	Well Care Visits
Reporting Year:	2023
Review Performed:	2024

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specified data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data was being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to planned methods.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel involved in the data collection and their qualifications were mentioned.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements were documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The Well Care PIP showed improvement in the HEDIS WCV Total administrative rate from 44.40% to 49.32%, which exceeded the goal of 44.57%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement was a result of interventions in place.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR Performance Measure Validation Worksheet

Plan Name:	Molina Healthcare of SC
Name of PM:	All HEDIS measures
Reporting Year:	MY2022
Review Performed:	2024

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2022 Volume 2 Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	Met	Data sources and programming logic were documented.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	Calculation of rates adhered to numerator specifications.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	Met	Documentation and tools were found to be compliant.
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	Met	Integration methods were found to be compliant.
N5 Numerator - Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	Met	Methods were reported to be compliant.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1 Sampling	Sample treated all measures independently.	Met	Sampling was conducted according to specifications.
S2 Sampling	Sample size and replacement methodologies met specifications.	Met	Replacements were conducted and found compliant.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1 Reporting	Were the state specifications for reporting performance measures followed?	Met	HEDIS specifications were followed and found compliant.
Overall Assessment			Plan uses NCQA certified software Cognizant for calculations. Audit report noted compliance for HEDIS measures.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	75
Possible Measure Score	75
Validation Findings	100%

Audit Designation
Fully Compliant

Audit Designation Possibilities	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

EQR Network Adequacy Validation Worksheet

Plan Name:	Molina Healthcare of SC
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	Score	Comments
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the MCO to the EQRO? (1)	MET	Data sources were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? (1)	MET	All variables to evaluate State standards were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? (1)	MET	Missing data was addressed.
1.4 Do the MCO's data enable valid, reliable, and timely calculations of the indicators? (1)	MET	Data allowed valid and reliable calculations.
1.5 Did the MCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? (1)	MET	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the MCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? (1)	MET	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? (1)	MET	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? (1)	NA	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the MCO include appropriate calculations and sound methodology? (5)	MET	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
2.1 Are the methods selected by the MCO appropriate for the state? (10)	MET	Methods aligned with State standards.
2.2 Are the methods selected by the MCO appropriate to the state Medicaid and CHIP population(s)? (10)	MET	Methods aligned with populations.
2.3 Are the methods selected by the MCO adequate to generate the data needed to calculate the indicators according to the State's expectations? (10)	MET	Methods generated required data for NA assessment.
2.4 Does the MCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? (1)	MET	Provider network file questionnaire indicated appropriate provider

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
		classification per State guidelines.
2.5 If the MCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? (1)	MET	Sound sampling methods were applied, wherein necessary.
2.6 If the MCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? (1)	MET	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. (1)	MET	Random sampling was utilized where required.
2.8 Does the MCO's approach for measuring time/distance indicators match the state's expectation? (1)	MET	Approach for time/distance aligned with State requirements.
2.9 Does the MCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? (1)	MET	Ratio calculations for PCPS and specialists were conducted according to State requirements.
2.10 Does the MCO's approach for determining the maximum wait time for an appointment match the state's expectation? (1)	MET	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? (10)	MET	Methods are objective and use of third-party vendors were used wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? (10)	MET	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF MCO NETWORK ADEQUACY RESULTS		
Component / Standard (Total Points)	Score	Comments
3.1 Did the MCO produce valid results? (10)	MET	Results were judged to be valid.
3.2 Did the MCO produce accurate results? (10)	MET	Results were judged to be accurate.
3.3 Did the MCO produce reliable and consistent results? (10)	MET	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the MCO accurately interpret its results? (10)	MET	Findings were interpreted and analyzed by MCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

Step	Points Possible	Points Earned
Step 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	1	NA
1.9	5	5
Step 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Step 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	100	99

Points Earned	99
Possible Score	100
Validation Findings	100%

Audit Designation
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR Survey Validation Worksheet

Plan Name	Molina
Survey Validated	CAHPS MEMBER SATISFACTION- ADULT
Validation Period	2023
Review Performed	2024

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience identified in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey tested for validity. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey tested for reliability. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For MY2022, adult response rate was 11.9% (239 out of 2,015) which is a decline from last year's response rate of 14.5%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022 *Recommendation: In addition to oversampling, other methods to increase response rates should be incorporated into the survey administration.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to then work plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

EQR Survey Validation Worksheet

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

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. *Documentation:* Press Ganey Child CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 10.5% (429 out of 4,094 surveys) which is an increase over last year's rate of 9.7%. However, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2022 *Recommendation: In addition to oversampling, other methods to increase response rates should be incorporated into the survey administration.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	Molina
Survey Validated	CAHPS MEMBER SATISFACTION- CHILD (CCC)
Validation Period	2023
Review Performed	2024

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey was tested for validity. *Documentation:* Press Ganey CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey was tested for reliability. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. *Documentation:* Press Ganey CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability was documented. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. *Documentation:* Press Ganey CCC CAHPS Report MY2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey CCC CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* Press Ganey CCC CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Child with CCC response rate was 9.3% (425 out of 4,586), which is a decline from the previous year's rate of 9.9%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey CCC CAHPS Report MY2022 *Recommendation: In addition to oversampling, other methods to increase response rates should be incorporated into the survey administration.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey CCC CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey CCC CAHPS Report MY2022

Attachment 4: Assessment of Quality Improvement Plans from Previous EQR

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. 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	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
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. *Quality Improvement Plan: Update Procedure MHSC HCS-UM-365, Clinical Criteria for Utilization Management Decision Making and remove the reference to InterQual Criteria.*	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.	✓	
V. C. Appeals			

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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: • For seven files, there was no identified note or date provided on the creation of the Individualized Care Plan (ICP).	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: For the 2 files, we have submitted documentation of follow up schedule for outreach and progress for Complex CM services.	✓	

Molina Healthcare 2023 EQR Findings	Actions Taken by Molina to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
• 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.*			