Constellation Quality Health

# Molina Healthcare of South Carolina

## Coordinated and Integrated Care for Medicare–Medicaid Recipients

## 2024 External Quality Reivew

Submitted: July 19, 2024

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

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# EXECUTIVE SUMMARY

At the request of the South Carolina Department of Health and Human Services (SCDHHS), Constellation Quality Health (Constellation), formerly The Carolinas Center for Medical Excellence, conducted an External Quality Review (EQR) of Molina Healthcare of South Carolina's (Molina) Coordinated and Integrated Care for Medicare-Medicaid recipients. This review focused on network adequacy for home and community-based service (HCBS) and behavioral health providers, over- and under-utilization, and care transitions.

The goals of the review are to:

- Determine if Molina is following service delivery as mandated in the 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.

## Methodology

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 received from Molina and reviewed in Constellation's offices (see *Attachment 1*) and a virtual onsite visit conducted on June 20th, and 21st, 2024.

## Summary and Overall Findings

An overview of the findings for each section follows and full details are included in the tabular spreadsheet (*Attachment 2*). Constellation classifies areas of review as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), or failing a standard ("Not Met").

### Network Adequacy

Molina is required by the *SCDHHS Contract* to maintain a network of HCBS providers sufficient to provide all enrollees with access to a full range of covered services in each geographic area. SCDHHS established a minimum of at least two providers for each service in each county except Anderson, Charleston, Florence, Greenville, Richland, and Spartanburg. For these larger counties, a minimum of three providers for each service was established. The HCBS services include:

- Adult Day Health
- Case Management
- Home Delivered Meals

- Personal Emergency Response System (PERS)
- Personal Care
- Respite
- Telemonitoring

Constellation requested a complete list of all contracted HCBS providers currently in Molina's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. Of the 322 services across 46 counties, there were no services or counties that did not meet the requirements. Molina received a validation score of 100% for the HCBS network. Refer to *Table 1: HCBS Provider Adequacy Results* for a detailed breakdown by county and service.

This was noted as an improvement over the previous year's score of 87%. See *Attachment 3: Assessment of Quality Improvement Plans from Previous EQR* for information regarding how Molina addressed this deficiency identified during the 2023 EQR.

Table 1: HCBS Provider Adequacy Results

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Abbeville | | | |
| Adult Day Health | 2 | 3 | Met |
| Case Management | 2 | 9 | Met |
| Home Delivered Meals | 2 | 6 | Met |
| PERS | 2 | 21 | Met |
| Personal Care | 2 | 47 | Met |
| Respite | 2 | 12 | Met |
| Telemonitoring | 2 | 3 | Met |
| Aiken | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 8 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 60 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Allendale | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 46 | Met |
| Respite | 2 | 12 | Met |
| Telemonitoring | 2 | 4 | Met |
| Anderson | | | |
| Adult Day Health | 3 | 9 | Met |
| Case Management | 3 | 7 | Met |
| Home Delivered Meals | 3 | 6 | Met |
| PERS | 3 | 22 | Met |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Personal Care | 3 | 72 | Met |
| Respite | 3 | 17 | Met |
| Telemonitoring | 3 | 3 | Met |
| Bamberg | | | |
| Adult Day Health | 2 | 8 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 50 | Met |
| Respite | 2 | 13 | Met |
| Telemonitoring | 2 | 4 | Met |
| Barnwell | | | |
| Adult Day Health | 2 | 5 | Met |
| Case Management | 2 | 5 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 48 | Met |
| Respite | 2 | 14 | Met |
| Telemonitoring | 2 | 4 | Met |
| Beaufort | | | |
| Adult Day Health | 2 | 4 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 47 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Berkeley | | | |
| Adult Day Health | 2 | 9 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 49 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 4 | Met |
| Calhoun | | | |
| Adult Day Health | 2 | 11 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 54 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 4 | Met |
| Charleston | | | |
| Adult Day Health | 3 | 10 | Met |
| Case Management | 3 | 7 | Met |
| Home Delivered Meals | 3 | 5 | Met |
| PERS | 3 | 19 | Met |
| Personal Care | 3 | 56 | Met |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Respite | 3 | 15 | Met |
| Telemonitoring | 3 | 4 | Met |
| Cherokee | | | |
| Adult Day Health | 2 | 4 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 42 | Met |
| Respite | 2 | 12 | Met |
| Telemonitoring | 2 | 4 | Met |
| Chester | | | |
| Adult Day Health | 2 | 8 | Met |
| Case Management | 2 | 5 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 52 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Chesterfield | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 47 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Clarendon | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 10 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 58 | Met |
| Respite | 2 | 18 | Met |
| Telemonitoring | 2 | 3 | Met |
| Colleton | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 43 | Met |
| Respite | 2 | 14 | Met |
| Telemonitoring | 2 | 4 | Met |
| Darlington | | | |
| Adult Day Health Care | 2 | 5 | Met |
| Case management | 2 | 8 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 63 | Met |
| Respite | 2 | 16 | Met |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Telemonitoring | 2 | 3 | Met |
| Dillon | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 9 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 55 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 3 | Met |
| Dorchester | | | |
| Adult Day Health | 2 | 10 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 52 | Met |
| Respite | 2 | 14 | Met |
| Telemonitoring | 2 | 4 | Met |
| Edgefield | | | |
| Adult Day Health | 2 | 4 | Met |
| Case Management | 2 | 8 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 45 | Met |
| Respite | 2 | 13 | Met |
| Telemonitoring | 2 | 3 | Met |
| Fairfield | | | |
| Adult Day Health | 2 | 8 | Met |
| Case Management | 2 | 9 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 68 | Met |
| Respite | 2 | 18 | Met |
| Telemonitoring | 2 | 3 | Met |
| Florence | | | |
| Adult Day Health | 3 | 7 | Met |
| Case Management | 3 | 9 | Met |
| Home Delivered Meals | 3 | 4 | Met |
| PERS | 3 | 20 | Met |
| Personal Care | 3 | 70 | Met |
| Respite | 3 | 16 | Met |
| Telemonitoring | 3 | 3 | Met |
| Georgetown | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 10 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 63 | Met |
| Respite | 2 | 14 | Met |
| Telemonitoring | 2 | 3 | Met |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Greenville | | | |
| Adult Day Health | 3 | 10 | Met |
| Case Management | 3 | 7 | Met |
| Home Delivered Meals | 3 | 6 | Met |
| PERS | 3 | 22 | Met |
| Personal Care | 3 | 80 | Met |
| Respite | 3 | 17 | Met |
| Telemonitoring | 3 | 4 | Met |
| Greenwood | | | |
| Adult Day Health | 2 | 5 | Met |
| Case Management | 2 | 11 | Met |
| Home Delivered Meals | 2 | 6 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 61 | Met |
| Respite | 2 | 17 | Met |
| Telemonitoring | 2 | 3 | Met |
| Hampton | | | |
| Adult Day Health | 2 | 4 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 38 | Met |
| Respite | 2 | 13 | Met |
| Telemonitoring | 2 | 4 | Met |
| Horry | | | |
| Adult Day Health Care | 2 | 7 | Met |
| Case management | 2 | 10 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 65 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 3 | Met |
| Jasper | | | |
| Adult Day Health | 2 | 4 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 39 | Met |
| Respite | 2 | 14 | Met |
| Telemonitoring | 2 | 4 | Met |
| Kershaw | | | |
| Adult Day Health | 2 | 12 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 67 | Met |
| Respite | 2 | 20 | Met |
| Telemonitoring | 2 | 3 | Met |
| Lancaster | | | |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 5 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 60 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Laurens | | | |
| Adult Day Health | 2 | 5 | Met |
| Case Management | 2 | 10 | Met |
| Home Delivered Meals | 2 | 7 | Met |
| PERS | 2 | 22 | Met |
| Personal Care | 2 | 70 | Met |
| Respite | 2 | 17 | Met |
| Telemonitoring | 2 | 4 | Met |
| Lee | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 8 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 59 | Met |
| Respite | 2 | 18 | Met |
| Telemonitoring | 2 | 3 | Met |
| Lexington | | | |
| Adult Day Health | 2 | 10 | Met |
| Case Management | 2 | 12 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 88 | Met |
| Respite | 2 | 19 | Met |
| Telemonitoring | 2 | 4 | Met |
| Marion | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 8 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 65 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 3 | Met |
| Marlboro | | | |
| Adult Day Health | 2 | 5 | Met |
| Case Management | 2 | 6 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 51 | Met |
| Respite | 2 | 14 | Met |
| Telemonitoring | 2 | 3 | Met |
| McCormick | | | |
| Adult Day Health | 2 | 3 | Met |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Case Management | 2 | 9 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 41 | Met |
| Respite | 2 | 12 | Met |
| Telemonitoring | 2 | 3 | Met |
| Newberry | | | |
| Adult Day Health | 2 | 10 | Met |
| Case Management | 2 | 10 | Met |
| Home Delivered Meals | 2 | 5 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 63 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Oconee | | | |
| Adult Day Health | 2 | 5 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 5 | Met |
| PERS | 2 | 21 | Met |
| Personal Care | 2 | 55 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 3 | Met |
| Orangeburg | | | |
| Adult Day Health | 2 | 13 | Met |
| Case Management | 2 | 10 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 75 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 4 | Met |
| Pickens | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 7 | Met |
| Home Delivered Meals | 2 | 6 | Met |
| PERS | 2 | 21 | Met |
| Personal Care | 2 | 69 | Met |
| Respite | 2 | 16 | Met |
| Telemonitoring | 2 | 4 | Met |
| Richland | | | |
| Adult Day Health | 3 | 14 | Met |
| Case Management | 3 | 11 | Met |
| Home Delivered Meals | 3 | 4 | Met |
| PERS | 3 | 19 | Met |
| Personal Care | 3 | 101 | Met |
| Respite | 3 | 21 | Met |
| Telemonitoring | 3 | 4 | Met |
| Saluda | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 10 | Met |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Home Delivered Meals | 2 | 5 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 51 | Met |
| Respite | 2 | 13 | Met |
| Telemonitoring | 2 | 3 | Met |
| Spartanburg | | | |
| Adult Day Health | 3 | 7 | Met |
| Case Management | 3 | 7 | Met |
| Home Delivered Meals | 3 | 6 | Met |
| PERS | 3 | 21 | Met |
| Personal Care | 3 | 79 | Met |
| Respite | 3 | 17 | Met |
| Telemonitoring | 3 | 4 | Met |
| Sumter | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 11 | Met |
| Home Delivered Meals | 2 | 5 | Met |
| PERS | 2 | 20 | Met |
| Personal Care | 2 | 73 | Met |
| Respite | 2 | 19 | Met |
| Telemonitoring | 2 | 3 | Met |
| Union | | | |
| Adult Day Health | 2 | 9 | Met |
| Case Management | 2 | 8 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 55 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 4 | Met |
| Williamsburg | | | |
| Adult Day Health | 2 | 7 | Met |
| Case Management | 2 | 12 | Met |
| Home Delivered Meals | 2 | 4 | Met |
| PERS | 2 | 19 | Met |
| Personal Care | 2 | 59 | Met |
| Respite | 2 | 15 | Met |
| Telemonitoring | 2 | 3 | Met |
| York | | | |
| Adult Day Health | 2 | 6 | Met |
| Case Management | 2 | 5 | Met |
| Home Delivered Meals | 2 | 3 | Met |
| PERS | 2 | 18 | Met |
| Personal Care | 2 | 61 | Met |
| Respite | 2 | 17 | Met |
| Telemonitoring | 2 | 3 | Met |
| Total that Met Minimum (sum of all services across 46 counties with minimum required providers met) | 322 | | |

| County/Services | Minimum Required | Unique Providers | Score |
|---|---|---|---|
| Total Required (sum all of services across 46 counties: 46 counties, 7 services for each county) | 322 | | |
| Percentage Met | 100% | | |
| VALIDATION DECISION | Met | | |

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

CICOs are required to maintain a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services. Plans are required to have a network of BH providers to ensure a choice of at least two providers located within no more than fifty miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older). At least one of the behavioral health providers used to meet the two providers per fifty-mile requirement must be a Community Mental Health Center (CMHC).

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

## Evaluation of Over/Under-Utilization

Over- and under-utilization focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services. Several reports were submitted for the over and under-utilization measures. The documentation showed monitoring and analysis of trended data to ensure resources are applied and interventions are implemented to improve appropriate utilization. *Table 2: Over and Underutilization Data* provides an overview of the utilization data.

Table 2: Over and Underutilization Data

| Measure | Reported Value |
|---|---|
| 30-Day Hospital Readmission | Readmissions declined from 46 in the previous year to 43 in the current year. |
| LOS Inpatient | The length of stay rate increased from 2022 (7.3 days) to 2023 (8.4 days). |

| Measure | Reported Value |
|---|---|
| LOS SNF | For the length of stay for a skilled nursing facility, the rate increased from 18.3 to 18.7 days. |
| ER Utilization | The emergency room utilization rate declined from 865 per thousand to 855 per thousand. This was likely due to the changes in the collaboration program between Transition Coaches and Care Coordinators. |
| BH OP Penetration/BH Inpatient Penetration | The mental health service utilization rate declined from 349 to 304. Efforts continue to address members needing services. |

## Care Transitions

Molina's Healthcare Services (HCS) Program Description for Dual Options / Medicaid and Medicare, Policy EMU-CM-011, Transitions of Care, and Procedure EMU-CM-011.01, Transitions of Care, were provided for review. These documents describe Molina's processes for ensuring coordination and continuity of care as a member's health status changes.

Transitions of Care Coaches and Care Coordinators are responsible for safely and effectively transitioning members from acute/inpatient care to lower levels of care and/or home. They provide assessment, planning, coordination, monitoring, and evaluation of services for members during transitions. Additionally, Molina ensures continuity of care for members in an "active course of treatment" and facilitates the transition of care for members whose benefits have come to an end. Data monitoring and analysis related to transitions of care is conducted to identify trends and recommend interventions to improve the effectiveness of care transitions.

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

Constellation requested a list of any enrollee who was hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days for the period of March 1, 2023, to April 30, 2024. Constellation specified to only include those enrollees readmitted with a

diagnosis that meets the definition of a potentially avoidable hospitalization. These are defined by SCDHHS as: Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers. A list of eleven enrollees that met the above criteria was provided. Constellation requested and Molina provided a copy of the case management files for these 11 enrollees. The initial review findings were discussed with Molina onsite. Additional information was provided; and the following is a summary of the issues identified after reviewing the additional information.

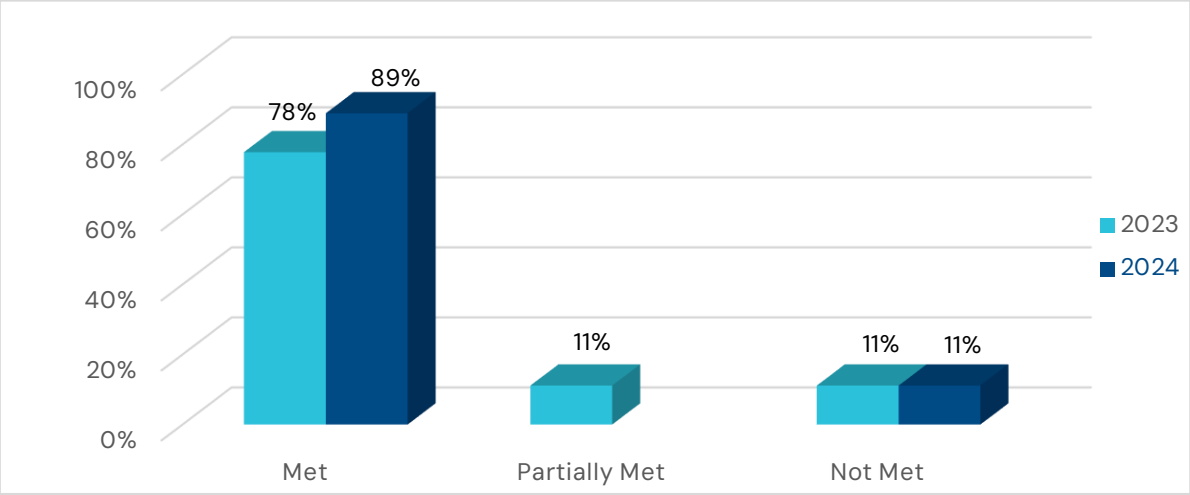
- Six files lacked documentation of collaboration with the facility-based care/case manager or discharge planner.
- Notification and participation of the enrollee's PCP was not found in three files.
- The clinical follow up (phone call or home visit) within 72 hours of transition was not conducted for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

These findings were the same or similar to the findings from the 2022 and 2023 EQRs. In Molina's response to the deficiencies identified during the 2023 EQR, the health plan mentioned implementing a new UM system to improve documentation. This was discussed onsite, and Molina indicated this new system was still in the planning state. For additional information regarding the deficiencies identified during the 2023 EQR, see *Attachment 3: Assessment of Quality Improvement Plans from Previous EQR*.

## Conclusions

The 2024 Annual EQR of Molina shows that 89% of the standards received a "Met" score. The score for the Network Adequacy improved, and Care Transitions continues to not meet the requirements. The chart that follows provides a comparison of the current review results to the 2023 review results.

Figure 1: Annual EQR Comparative Results




*Scores were rounded to the nearest whole number.*

Table 3: Strengths Related to the Quality, Timeliness, and Access to Care

| Strengths | Quality | Timeliness | Access to Care |
|---|---|---|---|
| Molina has a strong network of HCBS and behavioral health providers, ensuring members have access to a choice of providers. | | | ✓ |
| Molina's network meets the minimum provider requirements for each service in each county, ensuring access to necessary services. | | | ✓ |
| Molina has shown improvement in key indicators of over- and under-utilization, such as hospital readmission rates and emergency room utilization. | ✓ | | ✓ |
| Molina has dedicated staff and conducts data monitoring for care transitions, ensuring safe and effective transitions from acute/inpatient care to lower levels of care and/or home. | ✓ | | ✓ |

Table 4: Weaknesses Related to the Quality, Timeliness, and Access to Care

| Weakness | Recommendation or Quality Improvement Plan | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| Procedure HCS-168.01, Transitions of Care, notes for members discharged to a home/community setting, the Care Coach and/or Case Manager will outreach to the member within five business days. However, the *SCDHHS 3-Way Contract, Section 2.6.8.7.1.9* requires a clinical follow-up phone call or home visit within 72 hours of | *Quality Improvement Plan: Correct Procedure HCS-168.01, Transitions of Care, or the state addendum to meet the requirements in the SCDHHS 3-Way Contract, Section 2.6.8.7.1.9.* | ✓ | ✓ | |

| Weakness | Recommendation or Quality Improvement Plan | Quality | Timeliness | Access to Care |
|---|---|---|---|---|
| transition. The state addendum does not address this as a variance. | | | | |
| The review of the sample of care transition files found the same or similar deficiencies to the findings from the 2022 and 2023 EQRs. The following activities were not documented or not conducted:<br><br>• Collaboration with the facility-based care/case manager or discharge planner.<br>• Notification and participation of the enrollee's PCP.<br>• Clinical follow up (phone call or home visit) within 72 hours of transition.<br>• Medication monitoring and adherence required to be performed after the initial 72-hour follow-up.<br>• A reassessment completed following the trigger event (readmission) for five files.<br>• There were no transition activities conducted for one file due to late notification of admission. | *Quality Improvement Plan: Re-evaluate the TOC policies and process and make necessary changes to ensure Molina is in compliance with the requirements for member transitions.* | ✓ | ✓ | ✓ |

## Attachments

- Attachment 1:  Initial Notice and Desk Materials Request List
- Attachment 2:  Data Collection Tool
- Attachment 3:  Assessment of Quality Improvement Plans from Previous EQR

## Attachment 1: Initial Notice and Desk Materials Request List

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's Medicare-Medicaid Plan 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 Medicare-Medicaid recipients.

This review will only include a desk review and will address only the contract requirements specified by SCDHHS which are included in the enclosed standards document.

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 and a teleconference and will address only the contract requirements specified by SCDHHS which are included in the enclosed standards document. The Constellation Quality Health EQR team plans to conduct the teleconference 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 developed a secure file transfer site to allow health plans under review to submit desk materials directly to Constellation Quality Health. 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 schedule an education session (via webinar) 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

### MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of current policies and procedures related to the following areas:
    - Care Transitions;
    - Care Coordination;
    - Over and Underutilization; and
    - Network development and assessment.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. Please include the staffing levels for Case Management, Care Coordination, and Care Transitions.

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

4. Documentation of all HCBS and Behavioral Health provider network geographic assessments (e.g. GeoAccess studies), and any other documentation that support the adequacy of the provider base. The reports must be supplemented with information on providers that serve over age 65 enrollees.

5. Please provide a complete list of all contracted HCBS providers currently in your network in the following format:

| Field | Type | Description |
|---|---|---|
| ProviderName | Character | Provider Name |
| ProviderID | Character | NPI/Legacy ID |
| ServiceType | Character | Contracted Service |
| County | Character | County of Contracted Service |
| ContractDate | Date/Time | Date contract started with provider |
| UnitCost | Numerical | The health plan's reimbursement cost for the service(s) provided, based on expected units in the attached table. |

The file format should be a Microsoft Excel file with a row for each provider / service / county combination that the plan has active contracts with. For example:

| ProviderName | ProviderID | ServiceType | County | ContractDate | UnitCost |
|---|---|---|---|---|---|
| PROVA | 1234 | Nutritional Supplement | Aiken | 5/1/2015 | 33.00 |
| PROVA | 1234 | Nutritional Supplement | Berkeley | 5/1/2015 | 33.00 |
| PROVA | 1234 | Brief – Adult Small | Aiken | 5/1/2015 | 0.57 |
| PROVB | 9876 | Attendant Care | Darlington | 1/1/2015 | 10.52 |

If a provider is contracted to cover more than one county, a row would be created for each county being served by that provider. For example, if the provider is contracted to cover the entire state, 46 rows would be created.

Only those providers contracted to perform the services listed below should be included in the spreadsheet submitted.

**Home and Community Based Service Types and Expected Units**

| Service Types |
|---|
| Adult Day Health Care |
| Adult Day Health Care Transportation |
| Adult Diapers - Extra Large |
| Adult Diapers - Large |
| Adult Diapers - Medium |
| Adult Diapers - Small |
| Adult Wipes |
| Attendant Care |
| Attendant-Backup |
| Bariatric Diapers |
| Brief - Adult Extra Large |
| Brief - Adult Large |
| Brief - Adult Medium |
| Brief - Adult Small |
| Brief - Pediatric Large |
| Brief - Pediatric Small |
| Brief - Youth |
| Case Management Contact |
| Case Management Visit |
| Companion - Agency |
| Diapers - Youth |

| Service Types |
|---|
| Incontinence Pads |
| Meals - Standard/Modified |
| Meals - Therapeutic |
| Med Pads (Chux) |
| Medicaid Nursing Service (LPN) |
| Medicaid Nursing Service (RN) |
| Nutritional Supplement |
| Nutritional Supplement-Diabetic |
| Pediatric Diapers - Large |
| Pediatric Diapers - Small |
| PERS - installation |
| Pers. Emer. Resp. Sys. |
| Personal Care I (Home Mgmt.) |
| Personal Care II |
| Respite (Inst.) |
| Respite (RCF) |
| Respite Care (In-home) |
| Specialized Medical Equipment |
| Specialized Medical Supplies |
| Telemonitoring |

6. For Behavioral Health providers, please submit an excel spreadsheet that includes:
    - County name;
    - Total number of behavioral health providers in that county;
    - Identify adjacent counties; and
    - Number of Behavioral Health Providers in adjacent counties.

Example:

| County | Total Providers | Adjacent County | Providers | Adjacent County | Providers | Adjacent County | Providers |
|---|---|---|---|---|---|---|---|
| Allendale County | | Bamberg | | Colleton | | Hampton | |
| Chester County | | Cleveland | | York | | Union | |
| McCormick County | | Greenwood | | Edgefield | | Columbia | |
| Greenwood County | | Laurens | | Newberry | | Edgefield | |
| Edgefield County | | Saluda | | Aiken | | Richmond | |

7. A description of the Disease Management, Case Management/Care Coordination/Care Transition, and Quality Programs.

8. Committee Minutes for Quality Improvement and Utilization Management from March 2023 through April 2024.

9. The most recent reports summarizing the effectiveness of the Disease Management, Case Management/Care Coordination/Care Transition, and Quality Programs.

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

    - Length of Stay-Hospitalizations;
    - Length of Stay- LTC defined as SNF, intermediate and assisted living;
    - Emergency Room utilization; and
    - Number and percentage of enrollees receiving mental health services.

11. A copy of the monitoring conducted between March 2023 to April 2024, that is used to determine the factors contributing to a readmission/move to a higher level of care and actions taken by the CICO to improve enrollee outcomes. Specifically:
    - The total number of transitions completed in this timeframe;
    - The total number of enrollees in transition in the timeframe; and
    - The total number of enrollees who transitioned back to a higher level of care in this timeframe.

12. The following data regarding any Healthy Connections Prime enrollee who <u>was hospitalized in an acute care setting, discharged, and readmitted to an acute care facility</u> within 30 days.

Include only those enrollees readmitted with a diagnosis that meets the definition of a Potentially Avoidable Hospitalization (PAH): These are defined by SCDHHS as: Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, or Skin Ulcers. Please provide an excel spreadsheet containing the following:

- First Name;
- Last name;
- DOB;
- Date of discharge from initial hospitalization;
- Record ID number
- Initial hospitalization primary diagnosis and diagnosis code;
- Initial hospitalization secondary diagnoses and diagnosis codes;
- Date of readmission;
- Readmission primary diagnosis and diagnosis code; and
- Readmission secondary diagnoses and diagnosis codes.

*Use the timeframe for data collection from March 1, 2023, to April 30, 2024. Note: Based on this information Constellation Quality Health will request a random sample of files for review. The care plans and case management/care transition notes for all enrollees that were extracted for random sampling will be requested.*

These materials:

- Should be organized and uploaded to the secure Constellation Quality Health's EQR File Transfer site at https://eqro.thecarolinascenter.org; and
- Should be submitted in the categories listed.

## Attachment 2: Data Collection Tool

# CICO Data Collection Tool

| | |
|---|---|
| Plan Name: | Molina Healthcare of SC<br>Coordinated and Integrated Care for Medicare-Medicaid recipients |
| Collection Date: | 2024 |

| Standard | Score | | | Comments |
|---|---|---|---|---|
| | Met | Partially Met | Not Met | |
| I. Provider Network Adequacy | | | | |
| 1. The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services. | X | | | Constellation requested a complete list of all contracted HCBS providers currently in Molina's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. Of the 322 services across 46 counties, there were no services or counties that did not meet the requirements. Molina received a validation score of 100% for the HCBS network. This was noted as an improvement over the previous year's score of 87%. |
| 2. The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services. | X | | | Information to assess the BH providers was submitted with the desk materials. The requirements as set forth by SCDHHS were compared to submitted information. The assessment showed 100% of members had access to two BH providers with at least one CMHC included in that access area. Allendale county did not meet the standard of 90% for the opioid treatment clinic nor the psychologist provider group. Bamberg did not meet the 90% standard for the opioid treatment clinic. These results are similar to the previous two years' findings. All counties had 100% of members showing access to at least two types of BH providers. |
| II. Evaluation of Over/Under Utilization | | | | |

| Standard | Score | | | Comments |
|---|---|---|---|---|
| | Met | Partially Met | Not Met | |
| 1. The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to: | | | | Several reports for the over- and under-utilization measures were submitted. The documentation showed monitoring and analysis of trended data to ensure resources are applied and interventions are implemented to improve appropriate utilization. |
| 1.1 30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers); | X | | | Readmissions declined from 46 in the previous year to 43 in the current year. |
| 1.2 Length of stay for hospitalizations; | X | | | The length of stay rate increased from 2022 (7.3 days) to 2023 (8.4 days). |
| 1.3 Length of stay in nursing homes; | X | | | The length of stay for a skilled nursing facility increased from 18.3 to 18.7 days. |
| 1.4 Emergency room utilization; | X | | | The emergency room utilization rate declined from 865 per thousand to 855 per thousand. This was likely due to the changes in the collaboration program between Transition Coaches and Care Coordinators. |
| 1.5 Number and percentage of enrollees receiving mental health services. | X | | | The mental health service utilization rate declined from 349 to 304. Efforts continue to address members needing services. |
| III. Care Transitions | | | | |
| 1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions. | | | X | Molina's Healthcare Services (HCS) Program Description for Dual Options / Medicaid and Medicare, Policy EMU-CM-011, Transitions of Care, and Procedure EMU-CM-011.01, Transitions of Care, were provided for review. These documents describe Molina's processes for ensuring coordination and continuity of care as a member's health status changes. Procedure EMU-CM-011.01, Transitions of Care, states "all members with an acute inpatient admission will be sent a post discharge letter upon notification of discharge." Constellation requested a copy of the discharge letter. Molina explained that the post discharge letter was an automated process, occurring within the new Utilization |

| Standard | Score | | | Comments |
|---|---|---|---|---|
| | Met | Partially Met | Not Met | |
| | | | | Management (UM) system, PEGA, and had not been implemented. Per Molina, this process had been added to the enterprise policies and procedures prematurely. Molina provided an updated policy, procedure and state addendum (HCS-168, Transitions of Care) that indicated the post discharge letter was not applicable for SC. Procedure HCS-168.01, Transitions of Care, notes for members discharged to a home/community setting, the Care Coach and/or Case Manager will outreach to the member within five business days. However, the *SCDHHS 3-Way Contract, Section 2.6.8.7.1.9* requires a clinical follow-up phone call or home visit within 72 hours of transition. The state addendum does not address this as a variance.<br><br>*Quality Improvement Plan: Correct procedure HCS-168.01, Transitions of Care, or the state addendum to meet the requirements in the SCDHHS 3-Way Contract, Section 2.6.8.7.1.9.*<br><br>Constellation requested a list of enrollees who were hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days for the period of March 1, 2023, to April 30, 2024. Constellation specified to only include those enrollees readmitted with a diagnosis that meets the definition of a potentially avoidable hospitalization. These are defined by SCDHHS as: Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, or Skin Ulcers. A list of eleven enrollees that met the above criteria was provided as Constellation requested, and Molina provided a copy of the case management files for these 11 enrollees. The initial review findings were discussed with Molina onsite. Additional information was provided; and the following is a summary of the issues identified after reviewing the additional information.<br>• Six files lacked documentation of collaboration with the facility-based care/case manager or discharge planner. |

| Standard | Score | | | Comments |
|---|---|---|---|---|
| | Met | Partially Met | Not Met | |
| | | | | • Notification and participation of the enrollee's PCP was not found in three files.<br>• The clinical follow up (phone call or home visit) within 72 hours of transition was not conducted for eight files.<br>• Six files did not contain documentation of medication monitoring and adherence required to be performed after the initial 72-hour follow-up.<br>• A reassessment completed following the trigger event (readmission) was not completed for five files.<br>• There were no transition activities conducted for one file due to late notification of admission.<br><br>These findings were the same or similar to the findings from the 2022 and 2023 EQRs. In Molina's response to the deficiencies identified during the 2023 EQR, the health plan mentioned implementing a new UM system to improve documentation. This was discussed onsite, and Molina indicated this new system was still in the planning state.<br><br>*Quality Improvement Plan: Re-evaluate the TOC policies and process and make necessary changes to ensure Molina is in compliance with the requirements for member transitions.* |
| 2. Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes. | X | | | The Healthcare Services (HCS) Program Description for Molina's Dual Options / Medicaid and Medicare discusses the monitoring of data to prevent unnecessary readmissions. A copy of the 2023 Higher Level of Care for Transitions report was provided. This was a quarterly report that broke down the readmissions by the number of admissions and discharges and the total number where the transition resulted in a move to a higher level of care. No information was provided regarding the analysis and evaluation of this data to determine if there were factors that contributed to the change and any interventions to address these factors. This information was requested onsite. Molina provided the Utilization Data Evaluation results. To address readmissions, Molina implemented an enhanced discharge planning program pilot to address |

| Standard | Score | | | Comments |
|---|---|---|---|---|
| | Met | Partially Met | Not Met | |
| | | | | opportunities to increase communication and collaboration with facility case management and discharge planning teams. Outcomes were improved in both LOS and Readmission Rates. Approval of this program for implementation across Molina MMP/Medicare markets was received in May 2024. Project implementation will occur in August 2024. Full implementation is expected by the end of the year in all markets. |

## Attachment 3: Assessment of Quality Improvement Plans from Previous EQR

# ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

## Molina Healthcare of South Carolina MMP 2023 Quality Improvement Plan

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

<table>
<tr><th rowspan="2">Molina Healthcare<br>2023 EQR Findings</th><th rowspan="2">Actions Taken by Molina to Address Findings</th><th colspan="2">2024 EQR Findings</th></tr>
<tr><th>Corrected</th><th>Not Corrected</th></tr>
<tr><td>The SC MMP Care Transition Program Description, Policy MHSC-HCS-CM-068-MMP, Molina Transitions of Care, and the associated procedure describe Molina's care transition process.<br>CCME reviewed a sample of 30-day readmission files submitted by Molina. The initial review findings were discussed with Molina onsite. Additional information was provided, and the following is a summary of the issues identified after reviewing the additional information:<br><br>• Files lack documentation of collaboration with the facility Case Management or Discharge Planning staff to ensure a safe transition. Most of the documentation was the communication to the facility regarding the approval of the admission.<br>• Documentation of any needed clinical and non-clinical supports, transition/aftercare appointments, and any barriers for after-care was lacking in two files.<br>• Three files lacked documentation of outreach to the member to conduct the 72-hour follow-up post discharge. For one of the three files, the attempt to reach the member was documented, however this attempt was outside of the 72-hour window.<br>• Medication monitoring adherence after the initial 72-hour follow-up was not evident in four files.<br>• Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done.<br>These findings were the same or similar to the findings from the 2022 EQR.<br><br>Quality Improvement Plan: Make necessary changes to ensure the requirements for member transitions are met. The TOC files should contain:<br>• Documentation of the collaboration with the facility Case Management/Discharge Planner.<br>• Any identified clinical and non-clinical support needed, transition/aftercare appointments, and barriers to after-care.</td><td>Facility Collaboration:<br>We met with our Medicare UM Team to discuss ways to improve and better document collaboration with facilities for transition of care activities. Efforts include: 1) moving facility outreach responsibility to the Concurrent Review staff, 2) CM outreach to Hospital CM offices once members appear on our census report. This outreach is documented in our Case Management system. This approach still presents a challenge as we are finding they rarely take our calls or respond to our emails. However, we will continue to attempt to reach hospital CM in efforts to ensure our members obtain any needed post-discharge services.<br>A new UM system will be implemented in late August and Molina plans to leverage that system to improve documentation of facility outreach and communication.<br>Clinical Supports and Barriers:<br>The Enterprise TOC Assessment, which was rolled out mid-2022, asks about many TOC-related barriers and includes a comprehensive evaluation of post-discharge needs. Following this review, we realized that the printed version of the new eTOC Assessment does not show all of the branching logic that is available in the electronic version. It also does not print out all of the options that were not answered in the affirmative by the member. Please see the submitted full text version of the eTOC assessment. This blank assessment form shows that barriers, needed supports and medication issues are clearly evaluated, if they are present.<br>72-Hour calls:<br>We are committed to making attempts to reach the members within 72 hours for the discharge. As highlighted below, when members are readmitted within 24 hours, the Plan doesn't have an opportunity to complete this activity. Since contacts with members while they are inpatient do not meet this requirement, we did attempt to reach the member or caregiver following the second discharge.<br><table><tr><td></td><td>DC 1</td><td>DC 2</td></tr><tr><td>Case 1</td><td>Readmitted < 24h</td><td>Call completed</td></tr><tr><td>Case 2</td><td>Call completed</td><td>Call Day 4 after dc (Mon)</td></tr><tr><td>Case 3</td><td>Call completed</td><td>Call completed</td></tr><tr><td>Case 4</td><td>Readmitted < 24h</td><td>Deceased within 72h</td></tr></table>In Case 2, the Plan had no knowledge of the 2nd discharge within the 72-hour timeframe. The CM had called on Wednesday and was told that the member was going to be transferred to a SNF later in the week, there was no mention of discharge. The CM was able to reach the caregiver on the following Monday to inquire about the transfer and was notified then that the member had been discharged the previous Thursday afternoon. The CM learned of the discharge from the caregiver that morning and assisted them with DC needs. The facility notified Molina on Tuesday, five days after the discharge, of the discharge event.<br>In Case 4, the member was discharged on Hospice and died within the first 72 hours.</td><td></td><td>✓</td></tr>
</table>

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