South Carolina Department of Health and Human Services

Quality Strategy 2019

SCDHHS Division of Quality and Health Outcomes

Healthy Connections

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Section I – Introduction

Managed Care Goals, Objectives and Overview

1. History of the South Carolina Department of Health and Human Services Managed Care Program

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer South Carolina's Medicaid program under Title XIX of the Social Security Act. Similar to the rest of the country, by 1994, South Carolina's health care costs had risen dramatically. In addition to growing costs, SCDHHS had room for improvement in access to care and quality of care. Thus, in 1994, South Carolina Governor Carroll Campbell initiated the Palmetto Health Initiative, a statewide research and demonstration project which included restructuring the fee-for-service delivery system into a managed care delivery system. In 1996, South Carolina began operating a comprehensive risk-based managed care organization (MCO) program, which served certain children, pregnant women and non-dual eligible adults with disabilities, and covered acute, primary and some specialty care services and outpatient behavioral health. Initially, MCOs were available on a voluntary basis.

Between 2006 and 2007, SCDHHS introduced the Medical Homes Network (MHN) program, a statewide Enhanced Primary Care Case Management program (PCCM), that utilized networks of primary care providers to provide and arrange for most Medicaid acute, primary and specialty care and behavioral health for eligible Medicaid participants (excluding those in another managed care program, receiving home and community-based waiver services or residing in an institution). In Sept. 2013, SCDHHS transitioned from the PCCM program to an MCO service delivery system. Enrollment in the managed care program remained limited until 2006, when SCDHHS introduced the Healthy Connections Choices program. This program deployed enrollment counselors to help beneficiaries who were now required to choose one of the three Medicaid delivery models available in the state at that time: an MCO, the new PCCM program or the traditional fee-for-service (FFS) option. That year, SCDHHS also supplemented its primary managed care program by introducing (1) a Program of All-Inclusive Care for the Elderly (PACE), which provides all Medicare and Medicaid services, including long-term care services, to individuals over age 55 who meet a nursing home level of care, and (2) a non-emergency medical transportation (NEMT) program for most Medicaid beneficiaries statewide.

In 2011, SCDHHS further expanded Healthy Connections Choices through mandatory enrollment of Medicaid beneficiaries formerly served in the FFS system in either the MCO program or the MHN program. Children in foster care and with certain disabilities, Medicaid waiver enrollees, certain people served in institutions and dual-eligible beneficiaries remained exempt from mandatory participation in managed care. SCDHHS also recently added or "carved-in" inpatient behavioral health services to the MCO benefit package and, in Oct. 2013, expanded mandatory enrollment in managed care to all children under the age of one. In Jan. 2014, SCDHHS eliminated the PCCM model, or MHN program, and transitioned to a managed care model. SCDHHS

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still administers one MHN, SC Solutions, for individuals that are enrolled in the Medically Complex Children's Waiver program. Currently, there are five MCOs contracted with SCDHHS.

2. Quality Management Structure

The Division of Quality and Health Outcomes is a part of the Office of Health Programs. The division is led by the Director of Quality and Health Outcomes, who reports to the Deputy Director for the Office of Health Programs, who reports directly to the SCDHHS Director, who is appointed by the Governor of South Carolina. There are several additional full-time equivalent positions in the division of Quality and Health Outcomes, the majority of whom are staff dedicated to Quality through Technology and Innovation in Pediatrics (QTIP), a program offering quality improvement strategies and measures for implementation in pediatric practices. The Division of Quality and Health Outcomes designs and implements quality strategy and oversees execution of portions of the MCO contract related to quality, including MCO payments related to Healthcare Effectiveness Data and Information Set (HEDIS) measure performance, MCO alternative payment contracting for quality, the Patient-Centered Medical Home (PCMH) program and the external quality review process, as well as QTIP.

The Division of Quality and Health Outcomes works in concert with SCDHHS medical directors and other agency divisions to set the direction for managed care quality in a thoughtful, balanced manner. In addition, the division collaborates with MCO quality departments regularly on quality improvement initiatives.

SCDHHS also funds and participates in the South Carolina Birth Outcomes Initiative and a statewide PCMH alliance, both of which draw together diverse provider groups and associations from across the state for regular meetings throughout the year.

3. Managed Care Decision

SCDHHS contracted with managed care organizations in 2007 to reduce the cost of health care services for Medicaid members while maintaining quality and access to necessary services.

4. Goal and Objectives

As depicted below, quality is one of the five key pillars in SCDHHS' strategic plan to which our goals and strategies must align.

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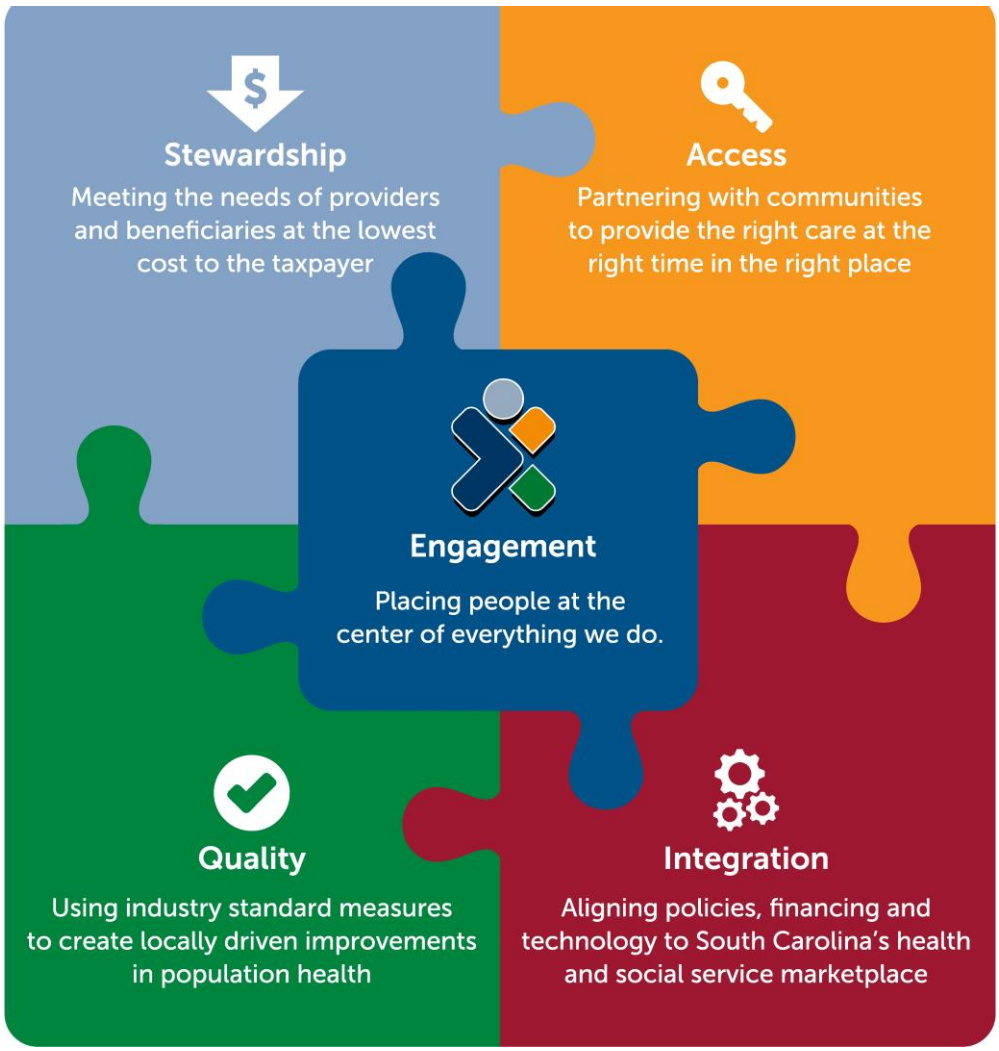

Care. Value. Health.

Agency Value Proposition

In addition to the specific goals laid out in SCDHHS' strategic plan, the quality strategy is aligned with Medicaid's overall National Quality Strategy.

CMS' 2016 Quality Strategy outlined six priorities to advance the Triple Aim of better care, smarter spending, and healthier people and communities. The following table maps how various quality initiatives of SCDHHS align with CMS' six priorities.

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CMS Priority	SCDHHS Requirement/Initiative
1. Make care safer by reducing the harm caused in the delivery of care	• NCQA Accreditation: MCOs are required to be accredited, which necessitates quality of care tracking and reporting mechanisms. • PCMH Incentive: Primary care practices are offered a per-member per-month incentive to become recognized by NCQA as a PCMH, which necessitates quality improvement projects. • BOI: The birth outcomes initiative is aimed at improving care specifically related to births, one of the health topics of greatest impact on the Medicaid population. Focus is ongoingly updated; examples of previous topics include the reduction of elective C- sections to improve the safety of mothers and children.
2. Strengthen person and family engagement as partners in their care	• PCMH Incentive: person-centered care is fundamental to Recognition. • NCQA Accreditation: accreditation requires the scored reporting of the Consumer Assessment of Health Plan Survey, which drives health plans to make member/caregiver satisfaction with care a priority. • Quality Index Withholds and Auto Assignment: 1.5% of claims payments are withheld until they can be earned back by MCOs by hitting HEDIS (clinical outcomes) performance benchmarks. In addition, HEDIS and CAHPS underpin the quality ratings published by NCQA which serves as the factor that determines the weight of auto-assignment of members who have not chosen an MCO. Member and engagement is often vital in clinical outcomes that HEDIS measures, and would be a factor in CAHPS satisfaction scores, so it behooves MCOs to have member and/or provider strategies that strengthen engagement.
3. Promote effective communication and coordination of care	• NCQA Accreditation: MCOs are required to be accredited, which necessitates continuous analysis of opportunities to improve coordination of care. • PCMH Incentive: Primary care practices are offered a per-member per-month incentive to become recognized by NCQA as a PCMH, which necessitates quality improvement projects. • Quality Index Withholds and Auto Assignment: when the lack of coordination of care would lower HEDIS performance, MCOs have an incentive from both levers to close those gaps.

4. Promote effective prevention and treatment of chronic disease	• Quality Index: 1/3 of the 1.5% claims withhold is tied to performance on the Diabetes Quality Index which is made up of four individual comprehensive diabetes care HEDIS measures. • NCQA Accreditation and Auto Assignment: Because these initiatives are tied to HEDIS measures, many of which are about chronic diseases such as diabetes, asthma, and behavioral health these initiatives reinforce effective prevention and effective treatment of chronic disease. • QTIP: Pediatric quality program to provide direct communications with pediatric practices and coordinate data to support best pediatric practices. Focus topics are updated yearly but examples of previous topics include such chronic disease states as asthma.
5. Work with communities to promote best practices to enable healthy living	• Quality Index: 2/3 of the 1.5% claims withhold is tied to performance on the Women's and Children's Quality Indices which include measures of prenatal care, preventive screenings and well visits. • NCQA Accreditation and Auto Assignment: Because these initiatives are tied to HEDIS measures, which include measures related to healthy living such as measuring body mass index, weight counseling, and nutrition for children, and getting annual well visits, these initiatives support the goal of promoting best practices related to lifestyle. • QTIP: Pediatric quality program whose focus topics are updated yearly; examples of previous topics include such practices of healthy living as a body-mass index (BMI) and well-child visits.
6. Make care affordable	• By improving the quality of care, SCDHHS believes that all of the quality initiatives described above contribute to the goal of making care affordable. In addition, SCDHHS, in alignment with CMS's aims with respect to value-based purchasing, has set goals for MCO alternative payment model contracting which increase each year. By tying quality to payment, SCDHHS hopes to get better value for expenditures.

Development & Review of Quality Strategy

5. Quality Strategy Process

The Division of Quality and Health Outcomes, under the leadership of the Deputy Director for Health Programs, develops the quality strategy, first considering CMS' directives and the National Quality Strategy, then gathering input from other divisions of the Office of Health Programs. Key partners and stakeholders will be solicited for feedback through the Medical Care Advisory Committee (MCAC). Then the quality strategy will be submitted to CMS for approval, published for public comment. These comments will be considered and incorporated into the final quality strategy document.

6. Public Comment

The mechanism for soliciting public comment will be through the MCAC. The final quality strategy document

will be posted on SCDHHS' website, www.scdhhs.gov, in the section of the site devoted to quality after the three-year update.

7. Assessment and Update Timeline

The agency examines the MCOs' quality performance through the year and then assesses and updates the quality strategy document accordingly. , If significant changes are needed to the Quality Strategy document, the agency, publishes the quality strategy document for solicitation of public comment for 30 days. Once comments are reviewed, the quality strategy document is revised, if necessary, and the final version is again published on SCDHHS' website.

Section II Assessment

Quality and Appropriateness of Care Procedures

8. Special Health Care Needs Procedures

Quality and appropriateness of care delivered by MCOs, and their contracted networks, are assessed for accreditation by the National Committee for Quality Assurance (NCQA), performance on HEDIS measures and annual external quality reviews.

The MCO contract includes a requirement that MCOs coordinate with organizations to provide targeted case management (TCM) services for the following individuals with special healthcare needs: alcohol and substance abuse individuals, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with an intellectual disability or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Procedures for coordination of TCM for individuals with these special healthcare needs are being assessed through the External Quality Review (EQR) process.

9. Race, Ethnicity and Language Procedures

Information about the race, ethnicity and primary language of applicants is collected at the time of the Medicaid application and can be updated throughout the eligibility process. This information can be gathered online, by telephone or in person by eligibility workers at local Medicaid offices. The information is self-reported by the individual on the application or redetermination form.

10. Disparities in Health Care Efforts

Section 1557 of the Affordable Care Act of 2010 builds on long-standing federal civil rights laws by prohibiting discrimination based on race, color, national origin, sex, age or disability in health programs and activities that receive Federal funds. Former nondiscrimination legislation includes Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

Section 1557 assists populations that have been most vulnerable to discrimination in health care and health coverage, including women, members of the LGBT community, individuals with disabilities and individuals with limited English proficiency. As a result of various parts of this legislation, SCDHHS has renewed its efforts to

reduce disparities in health care by striving for 100% compliance with nondiscrimination legislation.

By way of examples, SCDHHS, through its Civil Rights Division, is currently implementing a bilingual program, which will focus on qualifying bilingual/multilingual employees to effectively interact with limited English speakers (LES), building a glossary of SCDHHS terms to be used with applicants/beneficiaries and providing annual trainings on cultural competence.

SCDHHS also secured an interpretation/translation contract with Telelanguage to eliminate language barriers for applicants/beneficiaries and ensure communication is effective and beneficial.

It is important those with disabilities have access to quality health care. With that said, the Civil Rights Division is conducting site visits to all county eligibility and CLTC offices, SCDHHS headquarters, sponsored worker sites, nursing homes and Medicaid providers to review each site for potential physical barriers to health care. Eliminating physical barriers include ensuring building access for those who use wheelchairs and other mobility aids, educating staff and the public on service animal regulations and establishing policies and procedures for interactions with individuals who are blind, deaf, hard of hearing, cognitively impaired and/or intellectually disabled.

Finally, SCDHHS is reviewing existing nondiscrimination policy for possible updates and amendments.

National Performance Measures

11. Required/Voluntary Performance

SCDHHS strives to achieve consistency in setting expectations for MCOs that align with CMS' expectations and other national performance expectations. SCDHHS draws on a subset of HEDIS measures and provides additional incentives for the MCOs to put forth maximum effort towards achievements to such HEDIS measures as are of particular concern to the Medicaid agency population in South Carolina.

These measures are grouped into four indices measuring improvements in: diabetes management, maternal health, children's health and behavioral health (for reporting year 2018).

SCDHHS also sets expectations that MCOs will accomplish transformation in their payment methodologies with contracted network providers. MCOs are required to reach goals set for percentages of contracts that are tied to value, and those percentages increase over time.

Monitoring and Compliance

12. Monitoring and Evaluation

SCDHHS currently requires all contracted managed care organizations to submit both annual member satisfaction surveys and HEDIS scores to use in SCDHHS quality withhold program. To encourage HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) outcome improvement on an annual basis, 1.5% of premium payments are initially withheld. If an MCO does not meet SCDHHS predetermined quality scoring annually, the withheld funds are added to a bonus pool for redistribution to higher performing

MCOs. To help members compare the quality of MCOs, SCDHHS currently links to the NCQA health plan rating in the quality initiatives portion of its website, as well as displays NCQA star ratings in a plan comparison feature of the member's online application for Medicaid.

In addition to the reports outlined above SCDHHS requires the following reports from the MCOs to ensure they are operating effectively with both their provider networks and their Medicaid membership.

MCO Additional Reporting Used to Assess Compliance with Federal Regulations		
Managed Care Report Name	**Short Description of Report**	**Report Timing**
Call Center Performance	*Call center performance metrics for member English line, member Spanish language line and provider call center.*	*Monthly*
Care Management	*Report of members receiving care management services on an ongoing basis with the MCO.*	*Monthly*
Member Grievance Summary	*Member and provider grievance reporting by MCO. Summary complaint statistics are included in this quarterly report.*	*Quarterly*
Member Appeal Log	*Member appeal reporting by MCO. Formal appeals by the member are included on this quarterly report.*	*Quarterly*
Provider Dispute Log	*Provider dispute reporting by MCO. Provider disputes are received quarterly in this report.*	*Quarterly*
PI Fraud and Abuse Provider	*Form utilized by MCO for reporting to SCDHHS any potential provider abuse and fraud issues.*	*As Necessary*
PI Fraud and Abuse Member	*Form utilized by MCO for reporting to SCDHHS any potential member ongoing fraud and abuse cases.*	*Monthly*
Monthly MCO Fraud and Abuse	*Monthly reporting of potential provider and member ongoing fraud and abuse cases.*	*Monthly*
Termination Denial for Cause	*Monthly reporting of any MCO terminated provider.s*	*Monthly*
Quarterly MCO Fraud and Abuse	*Quarterly reporting of potential MCO fraud and abuse cases.*	*Quarterly*
Claims Payment Accuracy	*A report detailing monthly claim payment by the MCO. Provides SCDHHS with an overall report of claim payments for a month and percentage still not paid by the MCO.*	*Monthly*
Encounter Submission Summary	*A report detailing totals for monthly claims paid, accepted encounters, rejected encounters and completeness percentage.*	*Monthly*
Capitation Rate Calculation Sheet (CRCS)	*A report detailing the units and the amount paid per rate category. Utilize to assess encounter completeness and accuracy on a quarterly basis.*	*Quarterly*

External Quality Review

13. Annual External Independent Quality Review

The contract between SCDHHS and the Carolinas Center for Medical Excellence (CCME) requires an annual comprehensive review of each MCO contracted with SCDHHS. The contractual arrangement expires in 2019 and SCDHHS will bid for a future three-year contract period with two one-year extensions.

Each comprehensive annual review includes the following components:

Validation of performance improvement projects conducted by the health plan during the preceding 12 months:

- Validation of performance measures.
- Compliance review to determine the health plan's compliance with federal and Medicaid contractual requirements.

CCME's process, materials, and worksheets follow the CMS protocol and include:

- Desk review of materials submitted by the health plans.
- Telephone access study.
- Onsite visit at each health plan's office.
- Annual technical report.
- Review of quality improvement plans for health plans failing to meet any standards.
- Technical assistance and education as needed.

Each annual review focuses on the health plan's structure and operation, enrollee rights and protections, access to care, their quality measurement and improvements. The review also focuses on any deficiencies identified during a previous review to ensure corrections were made and recommendations followed.

14. Optional Eternal Quality Review Activities

As part of each health plan's annual review, CCME conducts telephonic provider access studies to ensure compliance with service access standards as specified in the federal regulations and SCDHHS' MCO contracts. The survey questions address correct provider information, appointment availability, scheduling and member access to providers. CCME requests an electronic list of providers in the desk materials for the EQR. A population of primary care providers is derived from this list. Sample size is calculated based on the population size, and then a sample of providers is drawn. A CCME-developed access study tool is used to standardize the data collection process across health plans.

CCME staff members place calls to the practices and ask a series of questions to assess whether the practices accept Medicaid beneficiaries and members from the health plan; whether members have access to appointments within a specified time period; and if providers are screening patients before accepting them into the practice. Results are analyzed and summarized in the annual technical report. The study is also discussed during the onsite review. In addition, a comparison of the study results for each health plan is included in the annual comprehensive technical report.

15. Private/Medicare Accreditation Reviews

The external quality review process for SCDHHS does not utilize the information from private or Medicare accreditation reviews.

16. Dual Eligible Reviews

The external quality review process for MCOs does not utilize information drawn from other reviews conducted for dual eligible programs.

Section III State Standards

Access Standards

17. Availability of Services

The SCDHHS managed care contract has the following availability requirements with citations to the relevant sections of the Code of Federal Regulations (CFR):

1. Provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. 438.206 (b) (2)
2. Provide for a second opinion from a qualified health care professional within the network or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. 438.206 (b) (3)
3. Demonstrate that its providers are credentialed as required by 42 CFR § 438.214. 438.206 (b) (6)
4. The MCO must ensure timely access by:
    - Meeting with and requiring its providers to meet SCDHHS' standards for timely access to care and services, taking into account the urgency of the need for services. 438.206 (c) (1) (i)
    - Ensuring its network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS if the provider serves only members. 438.206 (c) (1) (ii).
    - Ensuring all services included in the contract are made available 24 hours a day, 7 days a week, when medically necessary. 438.206 (c) (2) (iii)
5. The MCO must participate in SCDHHS' efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. 438.206 (c) (2)
6. The MCO's provider network must maintain, through written agreements, an appropriate provider network necessary for the provision of the services. Provider networks must include but are not limited to primary care providers (PCPs), specialty providers, hospitals and other health care service providers as identified by SCDHHS.

18. Assurances of Adequate Capacity and Services

SCDHHS' MCO contract requires that each MCO ensure that each member has access to at least one PCP with an open panel within 30 miles of their place of residence. This primary care network must include at least one federally qualified health center (FQHC) and one rural health clinic (RHC) in the provider network where available. All PCPs must have an appointment system that meets the following access standards:

a. Routine visits scheduled within 4 weeks.
b. Urgent, non-emergent visits within 48 hours.
c. Emergent visits immediately upon presentation at a service delivery site.
d. Waiting times that do not exceed 45 minutes for a scheduled appointment of a routine nature.
e. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

f. Provide 24-hour coverage by direct access or through an arrangement with a triage system.

Each MCO must monitor the adequacy of the providers' appointment processes. Each MCO must contract with specialists defined as status 1 providers in the Provider Network Table that follows. Members must have access to specialists within 50 miles and within 75 minutes or less driving time from their place of residence. MCOs must make available a choice of at least two required contracted specialists and/or subspecialists who are accepting new patients within the geographic area.

For specialists defined as status 3 providers in the chart below labeled, Provider Network Table, the MCO may attest rather than contract with these provider types due to the limited number participating within South Carolina. In these instances, while the time and distance standards do not apply for specialists defined as a status 3. The MCO must have both contracted and attested specialists that can schedule:

a. Emergent visits immediately upon referral.
b. Urgent medical condition care appointments within 48 hours of referral or notification from the primary care physician.
c. Routine care (non-symptomatic) within 4 weeks and a maximum of 12 weeks for unique specialists.

Provider Network Table

Medicaid Service Grouping	**Contract Status** **1=Must be in network (Distance and drive time and contract access requirements apply)** **2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply)** **3=Attestation (Contracting with provider's not required but must meet member needs for service)** **4= Service provision and contracting not required (Additional services non-core managed care services)**
Autism	**2**
Cardiology	**1**
Community Mental Health	**2**
DHEC	**2**
Durable Medical Equipment	**2**

Gastroenterology	**1**
General Surgery	**1**
Hematology and Oncology	**1**
Home Health	**2**
Infectious Disease	**2**
Laboratory/X-ray	**2**
Licensed Mental Health Professionals	**1**
Nephrology	**1**
Neurology	**1**
Occupational Therapy	**1**
OB/GYN	**1**
Optometry	**1**
Orthotics/Prosthetics	**2**
Otolaryngology/Otorhinolaryngology	**1**
Pharmaceutical Services	**2**
Pediatrics	**1**
Physical Therapy	**1**
Primary Care	**1**
Psychologist	**1**
Pulmonary Medicine	**1**
Rehabilitative Behavioral Health	**1**
Substance Abuse Treatment	**2**

Speech and Audiology Therapy	**1**
Psychiatry	**1**
Urology	**1**
Ambulatory Centers	**2**
Anesthesiology	**3**
Allergy and Immunology	**2**
Case Management	**4**
Chiropractor	**2**
Colon and Rectal Surgery	**2**
Dental	**4**
Dermatology	**2**
End-stage Renal Disease (ESRD) Clinic	**3**
Genetics	**3**
Dietitian/Nutrition	**2**
Endocrinology	**2**
Emergency Medicine	**3**
Home and Community Based Services	**4**
Hospice	**4**
Hospitalist	**3**
Midwife	**3**
Medical Transportation	**3**
Nurse Practitioner	**2**
Orthopedic Surgery	**2**
Pain Medicine	**2**
Pathology	**3**
Pediatric Subspecialists	**2**

Plastic Surgery	**3**
Physical Medicine/Rehabilitation	**2**
Physician Assistant	**2**
Podiatry	**3**
Radiology, Diagnostic	**3**
Rheumatology	**2**
Surgery Neurological	**2**
Environmental Medicine	**4**
Phlebology	**4**
Medical Examiner	**4**
Vascular Surgery	**2**
Surgery Oncology	**2**
Surgery	**2**
Therapeutic Radiology	**3**
Thoracic Surgery	**2**

Each MCO must ensure that members have access to at least one hospital within 50 miles of their place of residence.

The MCOs must submit their entire provider network to SCDHHS on a monthly basis. Semi-annually MCOs submit geocoded reporting to SCDHHS that follows the guidelines specified below:

1. Primary Care Physicians: For providers acting in the capacity of a primary care physician (PCP) the standard is 90% of the managed care eligible population in the county must have access to at least 1 PCP within 30 miles and within 45 minutes or less driving time.
2. Required Specialists: For providers acting as specialists the standard is 90% of the managed care eligible population in the county must have access to the required specialist within 50 miles and within 75 minutes or less driving time.
3. OB/GYN: OB's acting as a primary care physician should be included in the PCP section of the GeoAccess report. Also, include all OB/GYN's in the specialty section of the GeoAccess report.
4. FQHC/RHC: For FQHC's and RHC's providers acting as PCP include them in the PCP section of the GeoAccess report. FQHC's and RHC's acting as specialists include them in the appropriate required specialty GeoAccess report.
5. Hospitals: For hospitals, the standard is 90% of the managed care eligible population in the county must have access to a hospital within 50 miles and within 75 minutes or less driving time.

Each MCO is responsible for ensuring that all enrolled providers are eligible to participate in the Medicaid program. If a subMCO (also known as a delegate) is not accepting new Medicaid MCO members, the subMCO must identify why any provider not accepting new members should be included on the GeoAccess report. Additionally, if a PCP or specialist does not have admitting privileges to at least one of the contracted hospital(s)

listed on the report, the MCO must provide a detailed description of the mechanisms that will be used to provide services to Medicaid MCO members.

SCDHHS intends to have independent third-party verification of network adequacy. SCDHHS is currently working with the MCOs and an independent contractor to implement a detailed survey instrument to assess network adequacy. The newly modified verification process, once implemented, will utilize at least semiannual review with the MCOs to ensure network adequacy on an ongoing basis.

19. Coordination and Continuity of Care

SCDHHS' MCO contract requires coordination and continuity of care. As part of the care management system, each MCO is required to be responsible for the management, coordination and continuity of care for all its membership and must develop and maintain a programmatic level of policies and procedures to address care management and coordination of services. Management and coordination is a continuous process for the assessment of a member's physical health, behavioral health and social support service and assistance needs, the identification of physical health services, behavioral health services and other social support services and assistance necessary to meet identified needs and the assurance of timely access to and provision, coordination and monitoring of the identified services associated with physical health, behavioral health and social support service and assistance to help the member maintain or improve his or her health status.

Each MCO's care management program and care coordination activities must conform to the requirements and industry standards stipulated in the NCQA requirements for complex case management and by the *Standards of Practice of Case Management* released by the Case Management Society of America (CMSA). Each MCO is required to:

- Develop a detailed program description for complex case management.
- Have policies and procedures for the assessment of characteristics and needs of its member population (including children/adolescents, individuals with disabilities and individuals with Serious and Persistent Mental Illness (SPMI), and/or Serious Emotional Disorders (SED).
- Have a case management system based on sound evidence. Have a systematic process for identifying members with complex conditions and referring them for case management services.
- Have automated systems to support the case management staff.
- Have a case management system that ensures appropriate documentation and follow-up.
- Have a case management system with processes for initial assessment and ongoing management of members.
- Measure its performance and member satisfaction.
- Have procedures to improve performance when necessary.

Each MCO must stratify its members based on risk. MCOs must classify each member in one of the three risk categories (low, moderate or high) and must provide care management activities based on the member's risk stratification. Each MCO must provide members at high-risk with intensive case management.

Each MCO submits a monthly report of all members receiving care management services to SCDHHS.

The MCOs Care Management Programs and Policies must address coordination of services for physical and behavioral health services the member is receiving from another MCO's health plan or provider.

Each MCO must ensure that continuity of care activities are consistent with 42 CFR § 438.208 and should provide processes for effective interactions between members, in-network and out-of-network providers and identification and resolution of problems if those interactions are not effective or do not occur.

The MCOs are required to assist members in determining the need for services outside the core benefits and refer the members to the appropriate provider.

Each MCO must establish a process to coordinate the delivery of core benefits with services reimbursed on a Medicaid FFS-basis by SCDHHS. In the event of termination of an MCO's provider, the MCO will continue to pay the provider until the member has finished the course of treatment or until the provider releases the member to another provider who is within the MCO's provider network. In accordance with 42 CFR § 430.10(f)(5), the MCO must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

Each MCO must coordinate the referral of members for excluded services available under the Medicaid FFS program from enrolled Medicaid providers. They must also ensure these services are consistent with the outline and definition of covered services in the State Plan. These services include, but are not limited to, transition of care requirements.

Each MCO must develop and implement policies and procedures to address the transition of care consistent with the managed care policy and procedure manual for new members, members who transition between MCOs, members who transition from Medicaid FFS and members still enrolled upon termination or expiration of the contract. Each MCO must designate a person with appropriate training and experience to act as the transition coordinator. This staff person must interact closely with SCDHHS' staff and other MCOs' employees to ensure a safe and orderly transition.

Each MCO must develop a transition plan that provides a detailed description of the process for transferring members from out-of-network providers to the MCO's provider network to ensure optimal continuity of care. The transition plan must include:

- A timeline for transferring members.
- A description of provider clinical record transfers.
- A schedule of appointments.
- Proposed prescription drug protocols.
- Claims approval for existing providers during the transition period.
- Document its efforts relating to the transition plan in the member's records.

Upon notification of enrollment of a new member, the receiving MCO is required to assist the member with requesting copies of the member's medical records from treating providers, unless the member has arranged for the transfer. Transfer of records may not interfere or cause a delay in providing services to the member.

When relinquishing members, the MCO must cooperate with SCDHHS and new treating providers in the receiving MCO's provider network or Medicaid FFS program regarding the course of ongoing care with a specialist or other provider. The relinquishing MCO is responsible for providing timely notification and needed information to SCDHHS, or its designee, regarding pertinent information related to any special needs of transitioning members, if requested. Such information includes but is not limited to the provision of any

transitioning member forms required by SCDHHS, information regarding historical claims paid, and information regarding currently authorized services.

In addition to ensuring appropriate referrals, monitoring, and follow-up to providers within the Network, the MCO must ensure appropriate linkage and interaction with providers outside the Network.

20. Coverage and Authorization of Services

SCDHHS' contract with MCOs defines medical necessity in accordance with 42 CFR 438.210(a)(4).

With regard to the MCO's service authorization systems, the MCO must notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested in accordance with 42 CFR § 438.210(c). Each MCO must also ensure that compensation to individuals or entities that conduct UM and SA activities is not structured to provide incentives for the individual or entity to deny, limit or medically necessary covered services to any member in accordance with 42 CFR § 438.210(e).

Each MCO is required to develop a service authorization process. Service authorization includes, but is not limited to, prior authorization and concurrent authorization and includes requests for the provision of covered services submitted by a provider and includes a request for the provision of service from a member. In addition, each MCO must develop policies and procedures for service authorization procedures consistent with 42 CFR §
438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

- Written policies and procedures for processing requests for initial and continuing authorizations of services.
- Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as CHAPS site.
- Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.
- Provide the authorization number and effective dates for authorization to in-network providers and applicable out-of-network providers through the MCO's service authorization system.
- Have capacity to electronically store and report all service authorization requests, decisions made by the MCO regarding the service requests, clinical data to support the decision and time frames for notification of providers and members of decisions.
  - Provide notification of decisions to the requesting provider and, in cases of an adverse action, also provide written notification to the member, in accordance with 42 CFR § 438.404, and develop a mechanism within the MCO's utilization management policies and procedures to provide for a preferred provider program in which providers may obtain designation based on quality. For purposes of this section, such designation must result in the provider becoming eligible for a service authorization process that recognizes the provider's ability to manage care including but not limited to: exemption from service authorizations, expedited service authorization process; service authorization process that is based on simplified documentation.

Each MCO must have a process for expedited service authorizations in accordance with 42 CFR § 438.210(d).

Structure and Operations Standards

21. Provider Selection

Each member is given the opportunity to choose a specific primary care provider (PCP) within the MCO's provider network. That PCP will be responsible for the provision of primary care services as well as the coordination of all other health care needs in accordance with 42 CFR § 438.208(b). Members who do not choose a PCP by the tenth calendar day of the month in which the member is initially enrolled in the MCO's health plan is contacted by the MCO and assigned a PCP. If the MCO is unable to contact the newly assigned member, the MCO must assign a PCP to the member. If the new member contacts the MCO after being assigned a PCP and selects a different PCP, the MCO must switch the member to the new PCP within five business days.

SCDHHS requires that all contracted MCOs have a written credentialing program that complies with the code of federal regulations. Additionally, SCDHHS requires all MCOs to maintain NCQA accreditation to participate in the Medicaid program. NCQA accreditation requirements include a written credential program as well.

In addition to the contractual language, SCDHHS' Managed Care Policy and Procedure Guidance include the following additional guidance. The MCO's medical director must have overall responsibility for the credentialing committee's activities. The committee must have a broad representation from all disciplines (including mid-level practitioners) and reflect a peer review process.

Credentialing must be completed and approved by the MCO credentialing committee for all Medicaid providers who participate with the MCO prior to serving Medicaid MCO beneficiaries. All MCO providers that have been credentialed as Medicaid MCO contracted providers must be enrolled with SCDHHS. SCDHHS does not consider the provider to be a Medicaid MCO Provider if they are not enrolled with SCDHHS. The MCO will be assessed a penalty as outlined in the MCO contract if they utilize a contracted provider not enrolled with SCDHHS. The provider has a right to review the information submitted to support the credentialing application, to correct erroneous information, receive the status of the credentialing (re-credentialing) application, and to a non- discriminatory review and receive notification of these rights.

SCDHHS uses its External Quality Review and current NCQA accreditation status to assess the MCO's compliance with 438.214(a), 438.214(b)(1), 438.214(b)(2), 438.214(c). 438.214 (d) SCDHHS employs several measures to ensure that MCOs not employ or contract with providers excluded from federal health care programs. SCDHHS' contractual obligations include a requirement that contracted managed care providers be enrolled with SCDHHS. Because of these contractual requirements, SCDHHS and MCOs in the state work from the same provider set. This assists SCDHHS and MCOs in the effort to ensure that all providers operating with the South Carolina Medicaid program are fully eligible and not federally excluded. SCDHHS requires the MCOs to utilize the same disclosure of ownership process and forms that are utilized by the state in the administration of the FFS Medicaid program. SCDHHS' program integrity unit has dedicated personnel that work to ensure any federally-excluded providers are terminated from both the MCO provider network and the Medicaid FFS network. Information is shared real time through a SharePoint network with the MCO's

quality personnel to ensure prompt action is taken on a federally-excluded provider.

22. Enrollee Information

SCDHHS employs the following contractual obligations and policies to ensure that all enrollment notices, informational materials and instructional materials are easily understood. SCDHHS also has mechanisms in place to help enrollees and potential enrollees understand the managed care program and each MCO has mechanisms in place to understand the requirements and benefits of the plan. Contractually all MCOs and SCDHHS's contracted enrollment broker must follow these guidelines reflected below. The member handbook information reflected below applies only to the MCOs since SCDHHS' contracted enrollment broker handles member assignment and enrollment to managed care plans and does not cover actual service provision.

Each MCO must comply with 42 CFR § 438.10(c) as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). All member materials must be in a style and reading level that will accommodate the reading skills of members. In general, the writing should be at no higher than a 6th grade level. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member ID cards, and unless otherwise approved by SCDHHS. The MCO's name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-page marketing materials. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.

Each MCO must develop written policies and procedures for providing language interpreter and translation services to any member who needs such services, including but not limited to, members with limited English proficiency and members who are hearing impaired in accordance with 42 CFR 438.10. The MCO must provide interpreter and translation services free of charge to members. Interpreter services must be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the TTY universal line.

Each MCO must make all written materials available in alternative formats and in a manner that takes into consideration the enrollee's special needs, including those who are visually impaired or have limited reading proficiency. The MCO must notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats. As required by 42 CFR §438.206, each MCO must participate in SCDHHS's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

Each MCO must provide each member with a member handbook. The MCO's member handbook must be updated as needed and the MCO must document the changes on a change control log posted on its website. Each MCO must develop and maintain a member handbook that adheres to the requirements in 42 CFR §438.10 (f)(6). The member handbook and any subsequent changes must be submitted to SCDHHS for review and approval. At a minimum, the member handbook is required include the following information:

1. Table of contents.
2. A general description about how the Medicaid MCO operates, member rights and responsibilities, appropriate utilization of services including emergency room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services.
3. Member's right to dis-enroll from the MCO.
4. Member's right to change providers within the MCO.

5. Any restrictions on the member's freedom of choice among contracted providers.
6. Member's rights and protections, as specified in 42 CFR §438.100.
7. The amount, duration and scope of benefits available to the member under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled.
8. Procedures for obtaining benefits, including prior authorization requirements.
9. Description of the purpose of the Medicaid card and the MCO's Member ID card and why both are necessary and how to use them.
10. The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers.
11. The extent to which, and how, after-hours and emergency coverage are provided, including: What constitutes an emergency medical condition, emergency services and post- stabilization services, as defined in 42 CFR §438.114(a), that prior authorization is not required for emergency services, the process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent, the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services, that, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.
12. The post-stabilization care services rules set forth in 42 CFR 422.113(c);
13. Policy on referrals for specialty care and other benefits not furnished by the member's PCP.
14. Cost sharing, if any.
15. How and where to access any benefits that are available under the Medicaid State Plan but are not covered by the MCO, including any cost sharing.
16. How transportation is provided.
17. How and where to obtain counseling or referral services that the MCO, or a provider under contract with the MCO, does not cover because of moral or religious objections.
18. Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424.
19. Grievance, appeal and fair hearing procedures that include the following for State Fair Hearing.
    a. The right to a hearing.
    b. The method for obtaining a hearing.
    c. The rules that govern representation at the hearing.
    d. The right to file grievances and appeals.
    e. The requirements and timeframes for filing a grievance or appeal.
    f. The availability of assistance in the filing process.
    g. The toll-free numbers that the member can use to file a grievance or an appeal by phone.
    h. The fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
20. Members whose request for a disenrollment for good cause is not approved by SCDHHS or its designee may request a fair hearing of the decision.
21. Advance Directives, set forth in 42 CFR §438.6(i)(2) - A description of Advance Directives which must include, the MCO's policies related to advance directives, which meet the requirements of 42 CFR § 489 SUBPART I; The member's rights under State law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives. Any changes in law must be reflected in the member handbook as soon as possible, but no later than ninety calendar days after the effective date of the change.

22. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.
23. Information that complaints concerning non-compliance with the advance directive requirements may be filed with the State Survey and Certification Agency.
24. Information to call the Medicaid Customer Service Unit toll-free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, county of residence or mailing address changes.
25. How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show."
26. A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services.
27. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.
28. Information about the requirement that a member must notify the MCO immediately of any worker's compensation claim, a pending personal injury or medical malpractice lawsuit, or if the member has been involved in an auto accident.
29. Reporting requirements for the member who has or obtains another health insurance policy, including employer-sponsored insurance. Such situations must be reported to the MCO.
30. Instructions on how to request interpretation and translation services when needed at no cost to the member. This instruction must be included in all versions of the handbook.
31. Information on the member's right to a second opinion at no cost and how to obtain it.
32. Any additional services provided by the MCO.
33. The date of the last revision.
34. Additional information that is available upon request, including the following:
    - Information on the structure and operation of the MCO.
    - Physician incentive plans [42 CFR 438.6(h)].
    - Service utilization policies.

23. Confidentiality

SCDHHS' MCO contract details a number of requirements regarding the safeguarding of confidentiality to ensure that individually identifiable health information is only disclosed in accordance with federal privacy requirements.

The MCO must assure that all material and information, in particular information relating to members or potential members, will be treated as confidential information in accordance with state and federal laws. The MCO may not use any information in any manner other than what is necessary to fulfil its contractual responsibilities.

Members' personal information must be treated as privileged and confidential communications and must not be divulged without the written consent of SCDHHS or the member/potential member. However, summary information or other information that does identify specific individuals may be disclosed. The use or disclosure of member information must only be for purposes directly connected with the MCO's responsibilities in its contract with SCDHHS.

All MCOs must agree to abide by a detailed Business Associate Agreement that governs the handling of protected health information, reporting of breaches, safeguards for vendors or other entities, use of

technology, violations and permissible uses and disclosures.

24. Enrollment and Disenrollment

SCDHHS is solely responsible for the enrollment of Medicaid beneficiaries and managed care eligibles into the Healthy Connections Medicaid program. SCDHHS has established an enrollment process for the Medicaid managed care program with a third-party enrollment broker, called South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for all enrollment and disenrollment activities for potential and enrolled members, in accordance with 42 CFR § 438.10(b). Additional details can be found on the SCHCC website (www.scchoices.com).

The MCOs may not enroll or disenroll potential members. SCDHHS uses an auto-assignment algorithm for eligible members that do not select an MCO. The auto-assignment algorithm is designed to consider factors associated with each MCO's quality and performance measures, its size and ability to optimally serve its membership. The MCO may not discriminate against members on the basis of their health history, health status, need for health care services or adverse change in health status. The MCO must also not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

25. Grievance Systems

By contract, SCDHHS requires each MCO to establish and maintain a Grievance System for members and a separate Provider Dispute System. The Grievance System must comply with S.C. Code Ann. § 38-33-110, 42 CFR § 438.400, and 42 CFR § 431.200 et seq.

The Provider Dispute System must address providers who are not satisfied with the MCO's policies and procedures or a decision made by the MCO. The MCO's Grievance System procedures and Provider Dispute System, and any changes thereto, must be approved in writing by SCDHHS prior to implementation and must include, at a minimum, the requirements set forth herein. The MCO must refer all members who are dissatisfied in any respect with the MCO or its sub-MCO to the MCO's designee authorized to review and respond to grievances and appeals.

Each MCO must have a Grievance System in place for a member that includes a Grievance Process, an Appeal Process, and access to SCDHHS's Fair Hearing system for appeals once the MCO's Appeal Process has been exhausted.

The Grievance Process must address a "Grievance." A "Grievance" is defined as An expression of dissatisfaction about any matter other than an "Action." The Appeal Process must address a request to review an "Action." An "Action" is defined as The denial or limited authorization of a requested service, including the type or level of service; The reduction, suspension, or termination of a previously authorized service; The denial, in whole or in part, of payment for a service; The failure to provide services in a timely manner, as defined by SCDHHS; The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); Or, For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

Access to SCDHHS's Fair Hearing System includes the following requirements:

- Members must exhaust the MCO's appeal process prior to filing for a State Fair Hearing.
- The MCO must inform members how to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal.

Each MCO must allow members and Authorized Representatives, acting on behalf of the member and with the member's written consent, to file grievances, appeals, or State Fair Hearings (42 CFR § 438.402(b)). The following requirements apply to the filing of grievances and appeals.

A member may file a grievance and an MCO level appeal and may request a State Fair Hearing once the MCO's Appeals Process has been exhausted. An Authorized Representative is an individual granted authority to act via SC DHHS Form 1282 ME, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals, who is acting for the Applicant/Beneficiary with the Applicant/Beneficiaries' knowledge and consent and who has knowledge of his circumstances. A Provider may serve as a member's Authorized Representative and act on the behalf of the member with the member's written consent.

Each MCO must adhere to the following timeframes for filing of grievances and appeals:

- Grievance. A grievance may be filed within thirty calendar days of the occurrence.
- Appeal. The member must be sent notice of the MCO's action and allowed at least thirty calendar days from receipt of the notice to file an appeal.

The member or the member's authorized representative may file a grievance with the MCO either orally or in writing. The member or the member's authorized representative may file an appeal with the MCO either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal.

Each MCO must ensure that all its members are informed of SCDHHS's Fair Hearing process and of the MCO's Grievance and Appeal procedures. The MCO's member handbook must include descriptions of the MCO's Grievance and Appeal procedures.

Forms on which members may file grievances, appeals, concerns or recommendations to the MCO must be available through the MCO's website and must be provided upon the members' request.

A copy of an Oral Grievances Log and Records of Disposition of Written Appeals must be retained in accordance with the provisions of S.C. Code Ann. § 38-33-110 (A)(2). Each MCO must provide SCDHHS with a monthly written log of all, active and resolve, grievances/appeals filed by members in a format specified by SCDHHS. The log will include minimum data prescribed by SCDHHS to include, but not be limited to:

- Member's name.
- Medicaid number.
- Summary of grievance and/or appeal.
- Date of filing.
- Current status.
- Resolution.
- Any resulting corrective action.

According to 42 CFR § 438.406, the procedures for grievances and appeals must be governed by the following requirements:

1. Provide members any assistance in completing forms and taking other procedural steps. This includes providing interpreter services and toll-free telephone numbers that have adequate Teletypewriter/Teletypewriter Device for the Deaf (TTY/TTD) and interpreter capability.
2. Acknowledge receipt of each grievance and appeal.
3. Ensure that the individuals who make decisions on grievances and appeals are individuals:
    a. Who were not involved in any previous level of review or decision-making.
    b. Who, if deciding: (1) an appeal of a denial based on lack of medical necessity; (2) a grievance regarding denial of expedited resolution of an appeal; or (3) a grievance or appeal that involves clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by SCDHHS, in treating the member's condition or disease.

The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the member's authorized representative requests expedited resolution. The timeline for the appeal begins with the receipt of the member's initial notification of appeal (oral or written) to the MCO. Written confirmation of all oral requests must be received by the MCO within the timeframe established for the resolution of MCO level appeals or the appeal may be denied by the MCO.
2. Provide the member or the member's authorized representative a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO must inform the member of the limited time available for this in the case of expedited resolution.
3. Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process. Include, as parties to the appeal:
    a. The member and his or her authorized representative.
    b. The legal representative of a deceased member's estate.
    c. The MCO's staff must be educated concerning the importance of the grievance and appeal procedures and the rights of the members and Providers.
    d. The appropriate individual or body within the MCO's Health Plan having decision-making authority, as part of the grievance/appeal procedure must be identified.

Each MCO must give the Medicaid managed care enrollee written notice of any action within the timeframes for each type of action. The Notice of Action must be in writing and must meet the language and format requirements of 42 CFR § 438.10 (c) and (d) to ensure ease of understanding.

- Language and format requirements
- Content of Notice of Action

- The Notice of Action must include specific information about the action. This information must explain the following:
    - The action the MCO or its delegate has taken or intends to take.
    - The reasons for the action.

If the MCO extends the timeframe it must:

- Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.
- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

For service authorization decisions not reached within the timeframes specified, (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three business days after receipt of the request for service. The MCO may extend the three business days' time period by up to fourteen calendar days if the member requests an extension, or if the MCO justifies (to SCDHHS upon request) a need for additional information and how the extension is in the member's interest. SCDHHS must conduct periodic random audits to ensure that members are receiving such notices in a timely manner.

The MCO must dispose of grievances, resolve each appeal, and provide notice as expeditiously as the member's health condition requires, but also within the following specific timeframes:

- For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety calendar days from the day the MCO receives the grievance.
- For the standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty calendar days from the day the MCO receives the appeal. This timeframe may be extended under the *Extension of Timeframes* provisions.
- For the expedited resolution of an appeal and notice to affected parties, the timeframe is established as three business days after the MCO receives the appeal. This timeframe may be extended under the *Extension of Timeframes* provisions.

Each MCO may extend the timeframes by up to fourteen calendar days if:

- The member requests the extension.
- The MCO shows (to SCDHHS's satisfaction, upon its request) that there is a need for additional information and how the delay is in the member's interest. If the MCO extends the timeframes, it must, for any extension not requested by the member, give the member written a notice of the extension and the reason for the delay.

For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide prompt oral notice. The written notice of the resolution must include the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the members. The right to request a State Fair Hearing, and how to do so:
- The right to request to receive benefits while the hearing is pending, and how to make the request.
- An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

If a member has exhausted the MCO's appeal process, the member may request a State Fair Hearing within thirty calendar days of receipt of the MCO's notice of resolution. The MCO must send the MCO's Notice of Resolution to the member via certified mail, return receipt requested. The thirty-calendar day period is counted from the date the member receives the MCO's notice of resolution or MCO receives a failure of delivery notification from the return receipt requested.

- SCDHHS's standard timeframe for reaching its decision will be within ninety calendar days from the date the member filed the appeal with the MCO, excluding any days to file the request for Fair Hearing.
- SCDHHS's timeframe for reaching an expedited state fair hearing decision, when the appeal was heard first through the MCO appeal process, is as expeditiously as the enrollee's health condition requires, but no later than three working days from state receipt of a hearing request for a denial of a service that: (1) Meets the criteria for an expedited appeal process but was not resolved within the MCO's expedited appeal timeframes, or (2) Was resolved within the timeframe for expedited resolution, but the decision was wholly or partially adversely to the enrollee.

The parties to SCDHHS Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.

The MCO must establish and maintain an expedited review process for appeals, where the MCO determines (in response to a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If the MCO denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the timeframe for standard resolution
- Make efforts to give the member prompt oral notice of the denial and follow up within two calendar days with a written notice.

Expedited appeals must be resolved no later than the above-stated timeframes, and all parties must be informed of the MCO's decision. If a determination is not made within the above-stated time frames, the member's request will be deemed approved as of the date upon which a final determination should have been made.

If the final resolution of the Appeal is adverse to the member (i.e., the MCO's Action is upheld), the MCO may recover the cost of the services furnished to the member while the appeal was pending, to the extent that the services were furnished solely because of the requirements of this Section and in accordance with the requirements set forth in 42 CFR § 431.230(b) as specified in 42 CFR § 438.420(d).

The MCO may not submit any encounters information related to the services appeal if it recoups the money from the member.

The MCO must provide the information specified at 42 CFR § 438.10(g)(1) about the Grievance System to all providers and delegates (subMCOs) at the time they enter into a contract with the MCO as follows:

- The enrollee's right to file a grievance and/or appeal, the requirements for filing, and timeframe for filing.
- Availability of assistance with filing grievances and appeals.
- The toll-free number to file oral grievances and appeals.
- The enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing, although the enrollee may be liable for the cost of any continued benefits if the action is upheld.
- Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service.
- Effectuation of Reversed Appeal Resolutions. The MCO may not submit any encounters information related to the services appeal if it recoups the money from the member.

The MCO must provide the information specified at 42 CFR § 438.10(g)(1) about the Grievance System to all providers and delegates (subMCOs) at the time they enter into a contract with the MCO as follows:

- The enrollee's right to file a grievance and/or appeal, the requirements for filing, and timeframe for filing.
- Availability of assistance with filing grievances and appeals.
- The toll-free number to file oral grievances and appeals.
- The enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing, although the enrollee may be liable for the cost of any continued benefits if the action is upheld.
- Any State-determined provider's appeal rights to challenge the failure of the organization to cover a service.
- Effectuation of Reversed Appeal Resolutions.

If the MCO or SCDHHS Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. If the MCO or SCDHHS Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with State policy and regulations.

1. Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person to ask questions, file a provider dispute and resolve problems.
2. Identify a staff person specifically designated to receive and process provider disputes.
3. For contracted In-Network Providers, the Provider Dispute System must address any adverse action including the denial or reduction of claims for services included on a clean claim.
4. For non-contracted Out-Of-Network Providers, the Provider Dispute System will address nonpayment, denial or reduction of a covered service rendered out of network, including emergency care.
5. The MCO's Provider Dispute System does not have to address MCO's decision to not contract with a Provider, MCO's decision to terminate a contract with a provider, denials due to

payment adjustments for National Correct Coding Initiative (NCCI), or services that are not covered under this Contract.

6. Establish a process to thoroughly investigate each provider dispute using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's written policies and procedures.
7. Ensure that individuals with the authority to require corrective action are involved in the Provider Dispute System.
8. Implement written policies and procedures that detail the operation of the Provider Dispute System and submit its Provider Dispute System policies and procedures to SCDHHS annually.

The policies and procedures must include at a minimum:

1. Providers must be allowed thirty calendar days from the receipt of notice of an adverse action to file a written dispute.
2. Establish a process to thoroughly investigate each provider dispute using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's written policies and procedures.
3. Ensure that individuals with the authority to require corrective action are involved in the Provider Dispute System.
4. Implement written policies and procedures that detail the operation of the Provider Dispute System and submit its Provider Dispute System policies and procedures to SCDHHS annually.

The policies and procedures must include, at a minimum:

1. Providers must be allowed thirty calendar days from the receipt of notice of an adverse action to file a written dispute.
2. A description of how a provider may file a dispute with the MCO for issues that are to be addressed by the Provider Dispute System and under what circumstances a provider may file a dispute directly to SCDHHS for those decisions that are not a unique function of the MCO.
3. A description of how the MCO's Provider Relations Staff are trained to distinguish between a provider dispute and a member grievance or appeal in which the provider is acting on the member's behalf, consistent with requirements specified in the Managed Care Policy and Procedures Guide.
4. For disputes related to denial of payment or reduction in payment, the MCO must allow providers to consolidate disputes of multiple claims that involve the same or similar payment issues, regardless of the number of individual patients or payment claims included in the bundled complaint.
5. The MCO must investigate and render a decision regarding disputes within thirty calendar days of the request of the provider dispute. The MCO's review must consist of an administrative review conducted by a supervisor and/or manager employed by the MCO with the authority to revise the determination of the initial claims if needed.
6. For Disputes involving medical necessity, or a clinical issue, the MCO must ensure that decision-makers are health care professionals with appropriate clinical expertise.
7. To the extent additional information is required to render a decision on the Dispute, the

MCO may extend the timeframe by fifteen days based on mutual agreement of the Provider and the MCO.

8. A description of the methods used to ensure that MCO's executive staff with the authority to require corrective action are involved in the Dispute System process(es), as necessary.
9. A process for giving Providers (or their representatives) the opportunity to present their dispute(s) in person.
10. Identification of specific individuals who have authority to administer the Provider Dispute Process.
11. A system to capture, track, and report the status and resolution of all provider disputes, including all associated documentation. This system must capture and track all provider disputes, whether received by telephone, in person, or in writing; and a provision requiring the MCO to report the status of all provider disputes and their resolution to Department on a quarterly basis in the format required by Department.
12. SCDHHS monitors grievance and appeals through MCO reporting requirements.

26. Sub Contractual Relationships and Delegation

The MCO is responsible for ensuring that all delegates (also known as subMCOs in the MCO contract) adhere to the same requirements, including accreditation requirements, as would be expected of the MCOs themselves. The MCOs must utilize written agreements with any delegates and must specify the delegated activities and reporting responsibilities. MCOs are prohibited from forming agreements with third parties for the performance of functions not required of the MCO, that involve members.

Each MCO must monitor its delegates' performance on an ongoing basis, to include an annual review that is consistent with industry standards and applicable laws. If deficiencies or areas for improvement are found, the MCO is required to take corrective action. Use of a delegate does not change the MCOs obligations under the contract. The MCO must also notify SCDHHS of delegation and must ensure that federal regulations for contracts are followed. Finally, the MCO must access the Office of Inspector General (OIG) electronic databases on a monthly basis to identify whether any individuals with whom the MCO has a relationship are prohibited from receiving federal funds.

Measurement and Improvement Standards

27. Practice Guidelines

The MCO Contract requires that each MCO adopt practice guidelines in accordance with 42 CFR § 438.236(b). These guidelines must be based on valid and reliable clinical evidence or a consensus of physical and behavioral health care professionals in the particular field; consider the needs of the member; be adopted in consultation with contracting physical and behavioral health care professionals and be reviewed and updated periodically as appropriate.

Each MCO is required to distribute the guidelines to all affected providers and, upon request, to members and potential members. Distribution methods may include posting on the MCOs's website and provision of written

materials upon request. The MCO must ensure that decisions for utilization management, member education, coverage of services and other areas to which guidelines apply should be consistent with the guidelines. Finally, the MCO must establish a process to encourage the adoption of the guidelines.

28. Quality Assessment and Performance Improvement Program

Each MCO is required to carry out two quality improvement projects (QIP) annually, and the MCO may select the topics for the QIPs. Both the QIPs and the quality program more generally of each MCO is evaluated as part of the External Quality Review (EQR) process. In addition, each MCO is required to report HEDIS measures to SCDHHS annually.

29. Health Information Systems

Each MCO is required to maintain a health information system that collects, analyzes, integrates, and reports data. Health information systems must provide information on such topics as utilization, claims, grievances, appeals, and disenrollments. The MCO must comply with all of the reporting requirements established by SCDHHS in such references as the Medicaid Managed Care Policy and Procedure Manual Reporting Table and Reports Companion Guide. The MCO must connect using TCP/IP protocol to a specific port using ConnectDirect software after signing a Trading Partners Agreement as required by SCDHHS's Information Technology area.

Section IV. Improvement and Interventions

30. Quality of Care Improvement

SCDHHS has planned quality improvement efforts for 2018. The following table lists ongoing efforts and planned changes:

Quality Initiative	Status	Planned Changes
1. NCQA Accreditation	MCOs are required to maintain NCQA accreditation.	No planned changes for 2019. The initiative will be maintained.

2. Quality Index Withhold Program	A portion of claims payments are withheld and earned back if thresholds are met in the Diabetes, Women's Preventive Health, and Children's Preventive Health Indices. In addition, a new Quality Index, for Behavioral Health, has been announced and is scheduled for evaluation for possible inclusion in the withhold program in future years.	
3. PCMH Incentive Program	SCDHHS through MCO contracts offers incentives to PCMH- recognized practices. SCDHHS offers additional support through its contracts with the South Carolina Office of Rural Health (SCORH) and through the South Carolina Medical Association. In addition, SCDHHS continues to participate in the SCPCPCA.	

	(SCMA), which provides intensive educational support on a voluntary basis to practices pursuing PCMH recognition.	no changes to the methodology were to be pursued as of yet. In 2018 SCDHHS is working with the SCORH and the SCMA to plan further development of their efforts to support the PCMH process, including guiding practices in the alignment of the PCMH program with other quality initiatives, such as the withhold program.
4. Payment Reform (APM Goals)	MCOs must engage in alternative payment model contracting as a percentage of their overall contracts in order to avoid being unable to earn back 25% of their withheld dollars (see quality initiative #2 above).	The APM percentage goal for the calendar year 2017 contracting is 20%; the goal rises to 30% for the calendar year 2018. For the calendar year 2017 report due in April of 2018, MCOs have been instructed to report by Learning Action Network (LAN) categories. The percentage goal for future years will be evaluated.
5. Auto-Assignment	MCOs are assigned members who do not choose to select a managed care plan on a rotating basis that is weighted according to the star rating assigned by NCQA based heavily on HEDIS and CAHPS scores.	SCDHHS plans to maintain this initiative.
6. QTIP	Pediatric practices voluntarily participate in a SCDHHS quality improvement program.	SCDHHS would like to expand the QTIP model and is approaching groups to gauge interest. Pediatric QTIP will continue and will be focused on 3-6-year-old for the calendar year 2019.
7. BOI	The birth outcomes initiative is a monthly gathering of stakeholders to discuss efforts to improve outcomes for mothers and children.	SCDHHS remains a stakeholder in BOI. BOI's focus changes annually and is most recently focused on Safe Sleep.

SCDHHS may make additions or changes to the listed quality initiatives in the event of new information or other opportunities to improve quality become known.

Intermediate Sanctions

31. Intermediate Sanctions to Address Quality of Care

Federal law requires a provision for sanctions and conditions for MCO contract terminations that should be imposed in the event that an MCO's quality improvement process ultimately fails to meet expectations of the contract. One example of sanctions directly relevant to the required NCQA

accreditation aspect of the quality strategy is the following: SCDHHS has the discretion to impose liquidated damages, cease the enrollment of additional Members to the MCO, and reassign members who are currently enrolled in the MCO during the period between the Contractor's failure to achieve the required level of accreditation and the subsequent review." Sections 17 and 18 of the MCO contract provide further requirements, including requirements for corrective action plans, with respect to terminations and sanctions more generally for failure to meet contractual obligations.

Health Information Technology

32. Information System Support for Quality Strategy

SCDHHS utilizes its own internal health data and informatics unit as well as a third party, the Institute for Families in Society (IFS) in the University of South Carolina, to supplement its own information systems in the area of quality. IFS receives claims and encounters data and accesses MMIS eligibility data and synthesizes that information to provide additional quality-related analyses. Notably, IFS uses certified HEDIS software (from Veriscend) to generate HEDIS rates that combine managed care encounter data with FFS claims data. The resulting administrative rates are reported to CMS for Core Measures reporting.

Section V. Delivery System Reforms

33. Populations and Services Incorporated into Managed Care

Populations included in managed care are listed and updated on SCDHHS's website which can be found along with other information at the following link: https://msp.scdhhs.gov/managedcare//site-page/reference-tools. Examples of some of the populations or payment categories included in managed care as of this writing include low income families; aged, blind, and disabled (ABD); working disabled; Optional Coverage for Women and Infants (OCWI); breast and cervical cancer. Examples of populations or payment categories that are eligible for voluntary enrollment in managed care include children in foster care. Examples of populations or payment categories that remain in the fee-for-service form of Medicaid include certain individuals in nursing homes or who are on community waivers.

Regarding services, in recent years, SCDHHS has made two additions to managed care services: 1) a demonstration grant supported a dual eligibles program administered by three MCOs and 2) expanded behavioral health services were carved in to the managed care contract recently. Substance abuse services are also included in managed care. Children in foster care are also served by Medicaid and are primarily assigned to one MCO.

34. Performance Measures Applicable to Delivery System Reforms

The MCO contract established withhold quality measures that MCOs must meet as measured by HEDIS: a diabetic quality index (A1c testing, A1c poor control, eye exam, medical attention for nephropathy); a women's preventive health index (timeliness of prenatal care, breast cancer screening, cervical cancer screening, and chlamydia screening); and a children's preventive health index (well-child visits for children up to 15 months old, 3-6 year olds, and adolescents, and body mass index). The newly formed behavioral health quality index will contain measures relevant to both behavioral health and substance abuse services. There index consists of six relevant HEDIS measures and will be evaluated for possible inclusion into a bonus or withhold measures in the future.

35. Performance Improvement Projects

MCOs are required by contract to carry out at least two formal performance improvement projects annually, which are validated by the External Quality Reviews (EQR). More detail is available in the annual EQRs which are published in the Quality Initiatives portion of the Managed Care section on SCDHHS's website.

36. Special Terms and Conditions to Delivery System Reforms

There are no special terms and conditions to report.

Section VI. Conclusions and Opportunities

37. Successes and Best or Promising Practices

As a broad overview, SCDHHS's Quality Strategy has been successful. The five MCOs all remain accredited by the National Committee for Quality Assurance. All MCOs undergo an annual external quality review. Therefore, there are extensive third-party checks across hundreds of aspects of health plan performance to ensure quality foundations are in place.

In addition, SCDHHS's withhold program has been successful at incentivizing increased HEDIS performance. For RY2018], 9 of the 12 HEDIS withhold measures statewide exceeded the goal set based on the 50th percentile for the CMS Atlanta region. In addition, SCDHHS's APM contracting goal has been met each year so the incentive to reach that goal in order to avoid penalties to the withhold program seems to be working.

38. Quality of Care Challenges

The South Carolina Medicaid population continues to struggle with meeting the 50th percentile regionally for individuals with diabetes with A1c result (an indicator of how well controlled blood sugar has been over a period of time) greater than 9%. A second measure not reaching the 50th percentile regionally is well-child visits for 3, 4, 5 and 6-year olds. Both of these measures will be given more emphasis in the withhold program to attempt to meet the 50th percentile goals.

39. Data Collection Challenges and Opportunities

One of the biggest data-related challenges facing South Carolina is one facing the rest of the industry as well: medical records and medical data beyond that captured by claims are not widely shared electronically or available for measurement. The lack of non-claims data limits what can be measured. This lack represents an opportunity to improve coordination of care and to improve the collection of data.

The second area of challenge in data collection is the Alternative Payment Model (APM) contracts. APM contracting is reported via a template completed by the MCOs annually and has been limited to a broad category of all types of APMs lumped together. Going forward, MCOs will be requested to provide greater detail in types of APMs that contribute towards meeting their overall APM goal.

40. Quality Improvement Recommendations

It has been noted that HEDIS measure improvement requires time to develop. Many potentially effective HEDIS measure interventions are aimed at changing behavior, either of members, providers or both, and behavior changes often take repeat messaging before they become habitual and widespread. SCDHHS

recognizes this and is addressing this by stabilizing which HEDIS measures are focused on, rather than completely changing the set of HEDIS measures to be incentivized going forward. Going forward, SCDHHS intends to leverage data analysis to reconcile selected HEDIS measures to the specific needs of the South Carolina Medicaid population.

In the future, SCDHHS may wish to develop actions to lead the way for a greater exchange of electronic medical records to improve the availability of data available both for treatment purposes and for purposes of informing quality strategy decisions through improved measurement.

41. Grants Supportive of Quality of Care

SCDHHS's QTIP program was started by a demonstration grant but is no longer supported by grant funds. Aside from the dual eligible demonstration grant, SCDHHS does not have other grants supportive of quality of care.

For questions and comments regarding this Quality Strategy, please contact the Division of Quality and Health Outcomes at quality@scdhhs.gov.