CCME

2022 External Quality Review

FIRST CHOICE VIP CARE PLUS BY SELECT HEALTH OF SOUTH CAROLINA

Submitted: December 15, 2022

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

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EXECUTIVE SUMMARY

At the request of the South Carolina Department of Health and Human Services (SCDHHS), The Carolinas Center for Medical Excellence (CCME) conducted an External Quality Review (EQR) of First Choice VIP Care Plus, a South Carolina Healthy Connections Prime Medicare-Medicaid Plan operated by Select Health of South Carolina (Select Health). This review focused on network adequacy for home and community-based service (HCBS) and behavioral health providers, over- and under-utilization, and care transitions.

The goals of the review are to:

- Determine if Select Health is in compliance with service delivery as mandated in the contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2021 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of continued improvement.
- Validate that contracted health care services are being delivered and are of acceptable quality.

Methodology

The process CCME used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid Managed Care Organization EQRs. The review consisted of two segments. The first was a desk review of materials and documents received from Select Health and reviewed in the CCME offices. These items focused on administrative functions, committee minutes, member and provider demographics, over and under-utilization data, and care transition files.

The second segment was an onsite review conducted virtually on November 16, 2022, and November 17, 2022. The onsite visit focused on areas not covered in the desk review and areas requiring further clarification.

Summary and Overall Findings

An overview of the findings for each section follows and is detailed in the tabular spreadsheet (Attachment 1). CCME classifies areas of review as “Met” (meeting a standard); “Partially Met” (acceptable but needing improvement); and “Not Met” (failing a standard).

Network Adequacy:

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

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

CCME requested a complete list of all contracted HCBS providers currently in Select Health's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. Using the Waiver Members 2022 Membership Report submitted by Select Health, 42 counties were documented as having members with one member in a county labeled as "Other." Of the 294 services across 42 counties, 294 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%. Refer to *Table 1: HCBS Provider Adequacy Results* for a detailed breakdown by county and service.

TABLE 1: HCBS Provider Adequacy Results

County	Unique Providers	Minimum Required	Score
Abbeville			
Adult Day Health	2	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met
Personal Care	41	2	Met
Respite	10	2	Met
Telemonitoring	3	2	Met
Aiken			
Adult Day Health	6	2	Met
Case Management	12	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	46	2	Met
Respite	13	2	Met
Telemonitoring	3	2	Met
Allendale			
Adult Day Health	5	2	Met
Case Management	12	2	Met
Home Delivered Meals	4	2	Met
PERS	13	2	Met
Personal Care	37	2	Met
Respite	11	2	Met
Telemonitoring	4	2	Met
Anderson			
Adult Day Health	7	3	Met
Case Management	11	3	Met
Home Delivered Meals	6	3	Met
PERS	17	3	Met
Personal Care	68	3	Met
Respite	15	3	Met
Telemonitoring	5	3	Met
Bamberg			
Adult Day Health	7	2	Met
Case Management	13	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	42	2	Met
Respite	11	2	Met
Telemonitoring	4	2	Met
Barnwell			
Adult Day Health	4	2	Met
Case Management	11	2	Met
Home Delivered Meals	4	2	Met
PERS	14	2	Met
Personal Care	40	2	Met
Respite	11	2	Met
Telemonitoring	4	2	Met
Beaufort			
Adult Day Health	4	2	Met
Case Management	11	2	Met
Home Delivered Meals	4	2	Met
PERS	13	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	34	2	Met
Respite	13	2	Met
Telemonitoring	3	2	Met
Berkeley			
Adult Day Health	6	2	Met
Case Management	12	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	45	2	Met
Respite	15	2	Met
Telemonitoring	5	2	Met
Calhoun			
Adult Day Health	10	2	Met
Case Management	12	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met
Personal Care	46	2	Met
Respite	13	2	Met
Telemonitoring	4	2	Met
Charleston			
Adult Day Health	7	3	Met
Case Management	12	3	Met
Home Delivered Meals	6	3	Met
PERS	13	3	Met
Personal Care	49	3	Met
Respite	15	3	Met
Telemonitoring	5	3	Met
Cherokee			
Adult Day Health	5	2	Met
Case Management	9	2	Met
Home Delivered Meals	4	2	Met
PERS	15	2	Met
Personal Care	41	2	Met
Respite	12	2	Met
Telemonitoring	5	2	Met
Chester			
Adult Day Health	8	2	Met
Case Management	9	2	Met
Home Delivered Meals	4	2	Met
PERS	14	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	48	2	Met
Respite	16	2	Met
Telemonitoring	3	2	Met
Chesterfield			
Adult Day Health	5	2	Met
Case Management	11	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	43	2	Met
Respite	16	2	Met
Telemonitoring	3	2	Met
Clarendon			
Adult Day Health	5	2	Met
Case Management	15	2	Met
Home Delivered Meals	6	2	Met
PERS	13	2	Met
Personal Care	54	2	Met
Respite	15	2	Met
Telemonitoring	3	2	Met
Colleton			
Adult Day Health	6	2	Met
Case Management	11	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	35	2	Met
Respite	12	2	Met
Telemonitoring	4	2	Met
Dillon			
Adult Day Health	5	2	Met
Case Management	12	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	47	2	Met
Respite	14	2	Met
Telemonitoring	3	2	Met
Dorchester			
Adult Day Health	7	2	Met
Case Management	12	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	41	2	Met
Respite	14	2	Met
Telemonitoring	5	2	Met
Edgefield			
Adult Day Health	3	2	Met
Case Management	13	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met
Personal Care	40	2	Met
Respite	11	2	Met
Telemonitoring	3	2	Met
Fairfield			
Adult Day Health	8	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met
Personal Care	53	2	Met
Respite	14	2	Met
Telemonitoring	3	2	Met
Florence			
Adult Day Health	6	3	Met
Case Management	15	3	Met
Home Delivered Meals	5	3	Met
PERS	13	3	Met
Personal Care	59	3	Met
Respite	16	3	Met
Telemonitoring	3	3	Met
Georgetown			
Adult Day Health	7	2	Met
Case Management	13	2	Met
Home Delivered Meals	4	2	Met
PERS	13	2	Met
Personal Care	54	2	Met
Respite	14	2	Met
Telemonitoring	3	2	Met
Greenville			
Adult Day Health	8	3	Met
Case Management	16	3	Met
Home Delivered Meals	6	3	Met
PERS	17	3	Met

County	Unique Providers	Minimum Required	Score
Personal Care	77	3	Met
Respite	15	3	Met
Telemonitoring	5	3	Met
Greenwood			
Adult Day Health	2	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met
Personal Care	53	2	Met
Respite	13	2	Met
Telemonitoring	3	2	Met
Hampton			
Adult Day Health	4	2	Met
Case Management	11	2	Met
Home Delivered Meals	4	2	Met
PERS	13	2	Met
Personal Care	30	2	Met
Respite	11	2	Met
Telemonitoring	4	2	Met
Jasper			
Adult Day Health	4	2	Met
Case Management	11	2	Met
Home Delivered Meals	4	2	Met
PERS	13	2	Met
Personal Care	29	2	Met
Respite	11	2	Met
Telemonitoring	3	2	Met
Kershaw			
Adult Day Health	12	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	57	2	Met
Respite	16	2	Met
Telemonitoring	3	2	Met
Laurens			
Adult Day Health	2	2	Met
Case Management	14	2	Met
Home Delivered Meals	6	2	Met
PERS	14	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	67	2	Met
Respite	15	2	Met
Telemonitoring	5	2	Met
Lee			
Adult Day Health	5	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met
Personal Care	46	2	Met
Respite	14	2	Met
Telemonitoring	3	2	Met
Lexington			
Adult Day Health	9	2	Met
Case Management	17	2	Met
Home Delivered Meals	4	2	Met
PERS	14	2	Met
Personal Care	72	2	Met
Respite	15	2	Met
Telemonitoring	4	2	Met
Marion			
Adult Day Health	4	2	Met
Case Management	13	2	Met
Home Delivered Meals	4	2	Met
PERS	14	2	Met
Personal Care	52	2	Met
Respite	14	2	Met
Telemonitoring	3	2	Met
Marlboro			
Adult Day Health	4	2	Met
Case Management	8	2	Met
Home Delivered Meals	4	2	Met
PERS	13	2	Met
Personal Care	41	2	Met
Respite	13	2	Met
Telemonitoring	3	2	Met
McCormick			
Adult Day Health	2	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	14	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	37	2	Met
Respite	10	2	Met
Telemonitoring	3	2	Met
Newberry			
Adult Day Health	10	2	Met
Case Management	14	2	Met
Home Delivered Meals	6	2	Met
PERS	14	2	Met
Personal Care	54	2	Met
Respite	13	2	Met
Telemonitoring	3	2	Met
Oconee			
Adult Day Health	4	2	Met
Case Management	10	2	Met
Home Delivered Meals	5	2	Met
PERS	17	2	Met
Personal Care	49	2	Met
Respite	14	2	Met
Telemonitoring	4	2	Met
Orangeburg			
Adult Day Health	12	2	Met
Case Management	14	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	62	2	Met
Respite	14	2	Met
Telemonitoring	4	2	Met
Pickens			
Adult Day Health	4	2	Met
Case Management	15	2	Met
Home Delivered Meals	6	2	Met
PERS	17	2	Met
Personal Care	64	2	Met
Respite	14	2	Met
Telemonitoring	5	2	Met
Richland			
Adult Day Health	12	3	Met
Case Management	16	3	Met
Home Delivered Meals	4	3	Met
PERS	14	3	Met

County	Unique Providers	Minimum Required	Score
Personal Care	83	3	Met
Respite	16	3	Met
Telemonitoring	4	3	Met
Saluda			
Adult Day Health	5	2	Met
Case Management	15	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met
Personal Care	48	2	Met
Respite	11	2	Met
Telemonitoring	3	2	Met
Spartanburg			
Adult Day Health	6	3	Met
Case Management	11	3	Met
Home Delivered Meals	6	3	Met
PERS	16	3	Met
Personal Care	72	3	Met
Respite	14	3	Met
Telemonitoring	5	3	Met
Sumter			
Adult Day Health	6	2	Met
Case Management	16	2	Met
Home Delivered Meals	7	2	Met
PERS	13	2	Met
Personal Care	61	2	Met
Respite	15	2	Met
Telemonitoring	3	2	Met
Union			
Adult Day Health	8	2	Met
Case Management	9	2	Met
Home Delivered Meals	4	2	Met
PERS	15	2	Met
Personal Care	48	2	Met
Respite	14	2	Met
Telemonitoring	4	2	Met
Williamsburg			
Adult Day Health	7	2	Met
Case Management	16	2	Met
Home Delivered Meals	5	2	Met
PERS	13	2	Met

County	Unique Providers	Minimum Required	Score
Personal Care	49	2	Met
Respite	14	2	Met
Telemonitoring	3	2	Met
Total that Met Minimum (sum of all services across 42 counties with minimum required providers met)	294		
Total Required (sum all of services across 42 counties: (42 counties, 7 services for each county)	294		
Percentage MET	100%		
VALIDATION DECISION	MET		

Documentation: 2022 Select Health HCBS Provider List 9.7.22 Excel File submitted by Select Health

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

The information on BH providers was submitted to the desk materials. The requirements as set forth by the State were compared to submitted information. The GeoAccess reports showed that at least 99% of members have access to at least one BH outpatient and inpatient provider, and at least one CMHC using the 50-miles radius requirement for Metro areas, and 100% of members have access for Micro and Rural areas. The average distance is 7.6 miles and 8.8 minutes for CMHCs in Metro areas; 10.7 miles and 11.9 minutes for Micro areas; and 10.1 miles and 11 minutes for Rural access to CMHCs. Select Health met all network adequacy requirements for BH providers.

Evaluation of Over/Under Utilization:

Over-and under-utilization focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services.

Select Health submitted several reports that addressed the over and under-utilization measures. The inpatient medical/surgical length of stay (LOS) was just below 10 days as

of October 2021. The LOS for Skilled Nursing Facilities was just above 10 days as of the latest report. Other measures reported included:

- ER utilization was shown to be 2,500 unique members from October 2021 to August 2022, which is a rate of 34.3%.
- Number and percentage of enrollees receiving mental health services was reported to be 36.62% for October 2021 to August 2022.
- Readmissions were reported and monitored monthly over the year; the rate ranged from 10.92% to 18.45% (highest in January 2022). Top Diagnosis for readmission was sepsis (36.45%).

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

Care Transitions:

Transition of Care (TOC) services and activities are described in the Integrated Care Management Program Description, Policy CM 156.201, Comprehensive Care Management & Care Coordination, and Policy CM 156.209, Comprehensive Transitional Care.

CCME reviewed a sample of 30-day readmission files submitted by Select Health. Overall, the file review indicated staff consistently attempted to conduct the required follow-up within 72 hours of discharge. When unable to contact members throughout the transition period, staff attempted to obtain alternate contact information from other sources, such as home health agencies, PCPs, pharmacies etc. involved in the member's care.

There were issues noted in the files reviewed, including:

- Some files reflected no attempts to contact the facility's Case Management/Discharge Planning staff to collaborate in discharge planning. However, page 3 of Policy CM 156.209 states, "Upon receipt of an authorization request at the time of admission, the Care Coordinator is alerted and contacts the discharge planner by the end of the following business day to obtain admission information, treatment plan, Enrollee status, and to initiate discharge/transition planning."
- Some files did not provide evidence of any collaboration with the PCP when the member was admitted or discharged. Page 4 of Policy CM 156.209 states, "The Care Coordinator (or designee) will request a copy of discharge instructions, or other transition plans and ascertain whether these transition plans were sent to the PCP." It further states, "The Care Coordinator (or designee) will submit all discharge instructions and transition plans via fax to the PCP or treating provider."
- Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done. This is a repeat finding from the previous EQR.

See *Table 2: Previous Care Transitions Quality Improvement Items* for the 2021 EQR findings and Select Health's response to the Quality Improvement Plan.

Table 2: Previous Care Transitions Quality Improvement Items

Standard	EQR Comments
III. Care Transitions	
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	Transition of care (TOC) services and functions are defined and described in the Integrated Care Management Program Description and policies such as CM 156.209, Comprehensive Transitional Care, and CM 156.201, Comprehensive Care Management & Care Coordination. CCME conducted a file review for members who were readmitted within 30 days of discharge from a hospital. Files revealed that transition planning activities began when staff received notification of the member's admission or discharge. The assigned Care Coordinators, Care Connectors, and Community Health Navigators assisted with facilitating various TOC activities such as following up with family members, outreach to facility staff, making reminder phone calls, contacting pharmacies, and contacting providers when needed. CCME identified documentation of TOC functions in majority of the files reviewed, such as: •Consistently faxed communication with PCPs. •Timely communication of admission and discharge notifications among staff. •Contact and collaboration with case managers in facilities. •Documentation of clinical follow-up phone calls within 72 hours. •Medication monitoring. However, the majority of files did not include documentation of a reassessment after a trigger event, such as a hospitalization or change in the member's status. *Quality Improvement Plan: Ensure reassessments are performed according to requirements in SC CICO Three-Way Contract, Section 2.6.3.9.*
Select Health Response: On 8/2/21, the Select Health Population Health (Care Management) leader provided additional education to the CM team related to compliance with the CICO 3-Way Contract, Section 2.6.3.9. Specifically addressed were the need to document reassessments related to "trigger" events or change in member's health status (i.e., discharge from hospital to home, change in diagnosis, or change in caregiver support). The CM leader also provided an updated process for transition of care reassessments within the clinical documentation system (JIVA). Please see attached meeting minutes included as	

Standard	EQR Comments
supportive evidence. The requirements of the CICO 3-Way Contract Section 2.6.3.9 have also been included in the Select Health, Population Health internal documentation audit process moving forward.	

Select Health collects data on member transitions at various levels of care. During the previous (2021) EQR, CCME could not determine if data for transitions to higher levels of care was analyzed and discussed to evaluate for contributing factors or to identify improvement opportunities. Select Health addressed this issue with a Quality Improvement Plan. The table that follows provides an overview of the previously identified issue and Select Health's response.

Table 3: Care Transition Analysis Quality Improvement Items

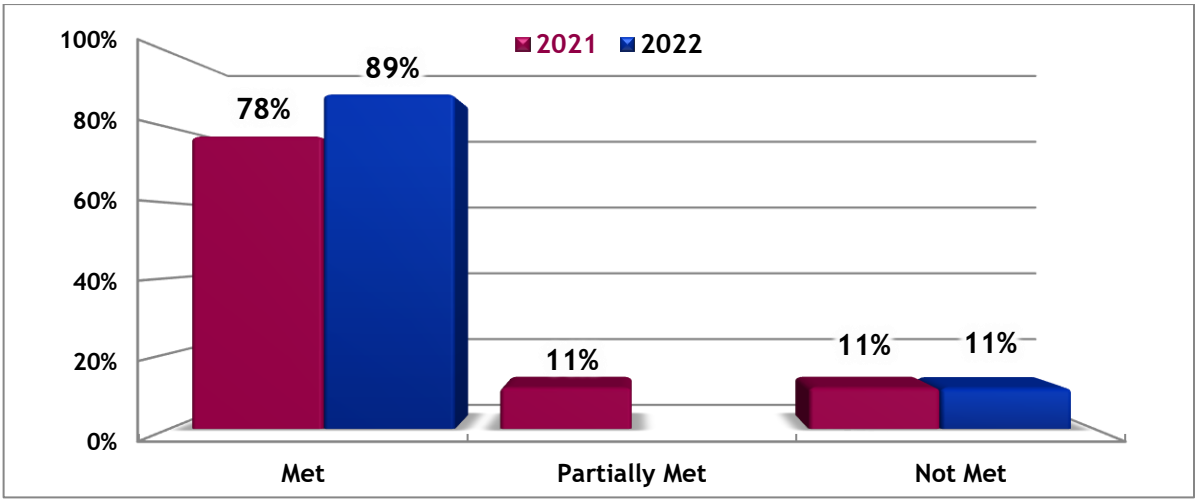
Standard	EQR Comments
III. Care Transitions	
2. Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes.	Select Health collects data on member transitions between hospitals, nursing facilities, and the community. The plan provided a spreadsheet reporting 4,269 transitions between May 1, 2020, and April 30, 2021, of which 1,610 were transitions to a higher level of care. However, after review of committee meeting minutes and the Quality Program Evaluation, CCME could not determine if this data was analyzed and discussed to evaluate for contributing factors or to identify improvement opportunities. During the onsite Select Health staff could not confirm that analysis and discussions of data for transitions resulting in a higher level of care occurred, and later responded that the Plan will review and discuss transitions data in quarterly Quality Assessment and Performance Improvement Committee Meetings going forward. *Quality Improvement Plan: Ensure that transitions resulting in a higher level of care are analyzed and discussed to evaluate for contributing factors and to identify improvement opportunities.*
Select Health Response: The Plan's Medicare data team will trend the data from the 2.6 regulatory report and share the data with the appropriate internal business owners. The report will be reviewed and discussed at the quarterly SC MMP QAPI meetings to evaluate contributing factors and, when applicable, identify improvement opportunities. The report review will be documented in the SC MMP QAPI meeting minutes.	

For this EQR, Select Health submitted the Readmission and Follow up Dashboard Report covering the period of January 2021 – December 2021, and the Hospital Admission/Discharge Transitions report. The dashboard included a summary of the top 10 categories and diagnoses for admissions and readmissions. The analysis of this data was not included. This was discussed during the onsite and Select Health explained the process for presenting this data to the Quality Assessment and Performance Improvement Committee for review and recommendations. An example of the data submitted to the committee was provided after the onsite. This additional information demonstrated the report submitted to the committee. key points were highlighted for committee discussion. Select Health also submitted a summary of 1st and 2nd quarter 2022 data with the analysis and planned interventions such as small group meetings or huddles and a plan to drill down to the member level data to determine if there are contributing factors.

Conclusions

The 2022 Annual EQR shows that 89% of the standards reviewed were scored as "Met" and 11% of the standards were scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2021 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Select Health met SCDHHS' requirements for their HCBS and BH networks and the evaluation of data collected for over and underutilization. CCME found Select Health continues to be out of compliance with meeting the requirements related to completing a reassessment following a trigger event, such as a hospitalization or change in the member's status. Similar findings were noted in the 2020 and 2021 EQRs. The following table provides an overview of the 2020, 2021, and 2022 issues identified with Care Transitions.

Table 3: Three Year Transition of Care Issues

EQR Review Year	Transition of Care Issues
2020	• Inconsistent documentation of collaboration with facility case management or discharge planning staff. • In most files, there was little evidence of collaboration with the member's PCP when transitions occurred. • Clinical and non-clinical supports needed by the member were not clearly documented in most of the files. • Documentation of transition/aftercare appointments was lacking in most of the files. • Identification of barriers to after-care and strategies to address the barriers was identified in just over half of the files. • The required 72-hour follow-up was either not conducted or was not conducted within the required timeframe. • No documentation of formal medication reconciliation and formal reassessment.
2021	• The files did not include documentation of a reassessment after a trigger event, such as a hospitalization or change in the member's status.
2022	• Some files reflected no attempts to contact the facility's Case Management/Discharge Planning staff to collaborate in discharge planning. • Some files did not provide evidence of any collaboration with the PCP when the member was admitted or discharged. • Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done.

Following the 2021 EQR, Select Health submitted a Quality Improvement Plan to address the deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on August 20, 2021.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plan for ensuring a reassessment is conducted after a trigger event was not implemented.

ATTACHMENTS

Attachment 1: Tabular Spreadsheet

A. Attachment 1: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME CICO Data Collection Tool

Plan Name:	**First Choice VIP Care Plus by Select Health of SC**
Collection Date:	**2022**

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
I. Provider Network Adequacy				
1. The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services.	X			CCME requested a complete list of all contracted HCBS providers currently in Select Health's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. Using the Waiver Members 2022 Membership Report submitted by Select Health, 42 counties were documented as having members, with one member in a county labeled as "Other." Of the 294 services across 42 counties, there were 294 that met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%.
2. The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services.	X			The information on BH providers was submitted to the desk materials. The requirements as set forth by the State were compared to submitted information. The GeoAccess reports showed that at least 99% of members have access to at least one BH outpatient and inpatient provider, and at least one CMHC using the 50-miles radius requirement for Metro areas. 100% of members have access for Micro and Rural areas. The average distance is 7.6 miles and 8.8 minutes for CMHCs in Metro areas;

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
				10.7 miles and 11.9 minutes for Micro areas; and 10.1 miles and 11 minutes for Rural access to CMHCs. Select Health met all the network adequacy requirements for BH providers.
II. Evaluation of Over/Under Utilization				
1. The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to:				Select Health submitted several reports that addressed the over and under-utilization measures.
1.1 30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers);	X			Readmissions were reported and monitored monthly over the year; the rate ranged from 10.92% to 18.45% (highest in January 2022). The top diagnosis for readmissions was sepsis (36.45%).
1.2 Length of stay for hospitalizations;	X			The inpatient medical/surgical length of stay (LOS) was just below 10 days as of October 2021.
1.3 Length of stay in nursing homes;	X			The LOS for Skilled Nursing Facilities was just above 10 days as of the latest report.
1.4 Emergency room utilization;	X			ER utilization was shown to be 2,500 unique members from October 21 to August 2022 which is a rate of 34.3%.
1.5 Number and percentage of enrollees receiving mental health services.	X			Number and percentage of enrollees receiving mental health services was reported to be 36.62% for October 2021 to August 2022.

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
III. Care Transitions				
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.			X	Transition of care (TOC) services and activities are described in the Integrated Care Management Program Description, Policy CM 156.201, Comprehensive Care Management & Care Coordination, and Policy CM 156.209, Comprehensive Transitional Care. CCME reviewed a sample of 30-day readmission files submitted by Select Health. Overall, the file review indicated staff consistently attempted to conduct the required follow-up within 72 hours of discharge. When unable to contact members throughout the transition period, staff attempted to obtain alternate contact information from other sources, such as home health agencies, PCPs, and pharmacies involved in the member's care. There were issues noted in the reviewed files, including: •Some files reflected no attempts to contact the facility's Case Management/Discharge Planning staff to collaborate in discharge planning. However, page three of Policy CM 156.209 states, "Upon receipt of an authorization request at the time of admission, the Care Coordinator is alerted and contacts the discharge planner by the end of the following business day to obtain admission information, treatment plan, enrollee status, and to initiate discharge/transition planning." •Some files did not provide evidence of any collaboration with the PCP when the member admitted or discharged. Page four of Policy CM 156.209 states, "The Care Coordinator (or designee) will request a copy of discharge instructions, or other transition plans and ascertain whether these transition plans were sent to

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
				the PCP. 1. The Care Coordinator (or designee) will submit all discharge instructions and transition plans via fax to the PCP or treating provider." •Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done. Page four of Policy CM 156.209 addresses the phone call or home visit conducted by the Care Coordinator (or designee) within 72 hours of transition and states, "A reassessment of the Enrollee's condition and needs will be completed during this contact." This is a repeat finding from the previous EQR. *Quality Improvement Plan: Ensure all contractual transition of care requirements are met and staff comply with processes documented in Policy CM 156.209, Comprehensive Transitional Care.*
2. Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes.	X			For this EQR, Select Health submitted the Readmission and Follow up Dashboard Report covering the period of January – December 2021, and the Hospital Admission/Discharge Transitions report. The dashboard included a summary of the top 10 categories and diagnoses for admissions and readmissions. The analysis of this data was not included. This was discussed during the onsite and Select Health explained the process for presenting this data to the Quality Assessment and Performance Improvement Committee for review and recommendations. An example of the data submitted to the committee was provided after the onsite. This additional information demonstrated the report submitted to the committee; key points were highlighted for committee discussion. Select Health also submitted a summary of 1st and 2nd quarter 2022 data with the analysis and with planned

STANDARD	SCORE			COMMENTS
	Met	Partially Met	Not Met	
				interventions such as small group meetings or huddles and a plan to drill down to the member level data to determine if there are contributing factors.